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EUROPEAN SOCIAL CHARTER

3rd report on the implementation of
the European Social Charter

submitted by

THE GOVERNMENT OF CROATIA

(Articles 11, 13 and 14
for the period 01/01/2005 – 31/12/2007)

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Ministry of the Economy, Labour and Entrepreneurship

Report by the Government of the Republic of Croatia for the period between January 2005 and December 2007 on the measures taken to give effect to the accepted provisions of the European Social Charter

January 2009

Article 11 – The right to protection of health

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

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, as well as accidents.*

Legislation of the Republic of Croatia

In the Republic of Croatia, the right to protection of health is regulated by the Constitution of the Republic of Croatia (Official Gazette, no. 41/01 – revised text, and 55/01 – corrigendum of the revised text), laws and subordinate regulations.

Article 56 of the Constitution provides that everyone shall be guaranteed the right to health care, in conformity with law.

- Health Care Act (OG 121/03, 44/05 Decision by the Constitutional Court of the Republic of Croatia no. U-I-2747/03 of 23 March 2005, which repealed Article 1, paragraph 2 by deleting the part of the sentence: "or subordinate regulation"; 48/05 – corrigendum, and 85/06).
- Act on the Health Care of Foreigners in the Republic of Croatia (Official Gazette, no. 114/97)
- Act on Protecting the Population from Infectious Diseases (OG 79/07 and 113/08)
- Medical Profession Act (OG 121/03)
- Protection of Patients' Rights Act (OG 169/04)
- Compulsory Health Insurance Act (OG 85/06, 105/06, 118/06, 77/07, 111/07, 35/08)
- Voluntary Health Insurance Act (OG 85/06)
- Occupational Health and Safety Insurance Act (OG 85/06)
- Medicines and Medical Products Act (OG 121/03, 177/04)
- Medicines Act (OG 71/07)
- Blood and Blood Components Act (OG 79/06)
- Act on the Removal and Transplantation of Parts of the Human Body for Treatment Purposes (OG 177/04)
- Health Care Quality Act (OG 107/07)
- Health Records Act (OG 53/91)
- Official Statistics Act (OG 103/03)
- Act on the Rights of Homeland War Veterans and Their Family Members (OG 174/04)
- Registration Number Act (OG 9/92)
- Act on Amendments to the Registration Number Act (OG 66/02)
- Personal Identification Number Act (OG 60/08)

Plan and Programme of Health Care Measures in Compulsory Health Insurance (OG 126/06)
Ordinance on implementing the Health Records Act in the area of in-patient care and addiction monitoring (OG 44/00)
Ordinance on implementing the Health Records Act in the area of the primary and specialist and consultant health care (OG 4/95)
Ordinance on the child's health card from birth to the age of majority (OG 126/06)

Ordinance on post-mortem procedure and determining the time and cause of death (OG 121/99)
Ordinance on amendments to the Ordinance on post-mortem procedure and determining the time and cause of death (OG 133/99)
Ordinance on amendments to the Ordinance on post-mortem procedure and determining the time and cause of death (OG 112/00)
Ordinance on the modes of implementing immunisation, seroprophylaxis and chemoprophylaxis against infectious diseases and on the persons subject to this obligation (OG 164/04)
Ordinance on the monitoring of side-effects of medicines and medical products (OG 29/05)
Ordinance on the procedure for carrying out medical examinations of persons under medical supervision (OG 23/94, 93/00)
Plan and Programme of Health Care Measures in Compulsory Health Insurance (OG 126/06)
Vaccination Schedule for the current year (2008-2010)
Ordinance on basic health insurance rights and on the conditions and procedure for granting these rights (Official Gazette, no. 64/06 – revised text; and 98/06)
Ordinance on compulsory health insurance rights and on the conditions and procedure for granting these rights (Official Gazette, no. 120/06, 136/06, 56/07 and 96/07)
Ordinance on the procedure for registration and de-registration, and the duration of the status of an insured person of the Croatian Institute for Health Insurance in the basic health insurance scheme (Official Gazette, nos. 28/02, 43/03 and 51/05)
Ordinance on the procedure for registering, de-registering and gaining the status of an insured person in the compulsory health insurance scheme (Official Gazette, nos. 31/07, 56/07, 96/07 and 130/07)
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. 46/07 – revised text)
Ordinance on orthopaedic and other aids (Official Gazette, no. 93/03 – revised text, 158/03 and 74/04)
Ordinance on the conditions and methods of exercising the right to orthopaedic and other aids (Official Gazette, nos. 89/07 – revised text, 134/07 and 11/08)
Ordinance on the rights, conditions and methods of receiving health care services in foreign countries (Official Gazette, nos. 12/06 – revised text and 24/06)
Ordinance on the rights, conditions and methods of receiving health care services in foreign countries (Official Gazette, nos. 80/07 and 85/07 – corrigendum)
Ordinance on the conditions and means of exercising rights in the basic health insurance scheme in connection with nursing care provided at the patient's home (Official Gazette, no. 76/02)
Ordinance on the conditions and means of exercising the right to receive nursing care at home in the compulsory health insurance scheme (Official Gazette, no. 40/07)
Decision on the content and form of the document proving the status of an insured person in the basic health insurance scheme administered by the Croatian Institute for Health Insurance (Official Gazette, nos. 28/02, 11/03, 158/03, 161/04, 51/05 and 155/05)
Decision on the content and form of the document proving the status of an insured person of the Croatian Institute for Health Insurance (Official Gazette, no. 4/07)
Basic Network of Medical Services (Official Gazette, nos. 188/04 and 115/07)
Decision on special standards and criteria for their application in providing primary health care services under the compulsory health insurance scheme (Official Gazette, nos. 142/06 and 13/07)

Ordinance on minimum conditions regarding premises, staffing and medical and technical equipment needed to provide health services (Official Gazette, no. 90/04, Article 5 of the Ordinance on the classification of medical and technical equipment for health institutions OG 55/07 – Article 57 does not apply)
Ordinance on the classification of medical and technical equipment for health institutions OG 55/07

Strategy for Official Statistics Development of the Republic of Croatia 2004-2012 (OG 28/05)
National Health Development Strategy 2006-2011 (OG 72/06)

Morbidity and mortality

The greatest public health problem in the Republic of Croatia is widespread chronic diseases 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 and poisonings, and respiratory system diseases.

During 2005 the most frequent groups of diseases treated in hospitals were diseases of the circulatory system, tumours, diseases of the digestive system, diseases of the respiratory system and diseases of the genitourinary system. When it comes to hospital treatment, women outnumbered men 1.02 to 1. In 2005 women were most frequently hospitalised for tumours (14.1% - 42,235, 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% - 49,932 of which angina pectoris was the most common), then tumours (13.3% - 39,009, the most common being malignant tumours of the bronchi and lungs).

During 2006 the most frequent groups of diseases treated in hospitals were tumours, diseases of the circulatory system, diseases of the digestive system, diseases of the genitourinary system and diseases of the respiratory system. When it comes to hospital treatment, women outnumbered men 1.08 to 1. In 2006 women were most frequently hospitalised for tumours (14.6% - 47,592, 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% - 45,102 of which angina pectoris was the most common), then tumours (14% - 42,252, the most common being malignant tumours of the bronchi and lungs).

The leading causes of death are from the group of circulatory diseases, tumours, injuries and poisonings, digestive and respiratory system diseases. On average, 50,000 persons die every year in Croatia, and three quarters of them die from circulatory diseases and tumours.

According to the World Health Organisation, the statistics on causes of death is in many countries the most reliable source of health information for 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 cannot enter the correct cause of death without co-operation with the physician who treated the person concerned before death and medical documentation. Death diagnoses are coded in accordance with the International Classification of Diseases, the data are processed and categorised by some characteristics, other than death diagnoses, which are also very important: age, sex, place of death, place of residence. As well as for the assessment of the health situation of the population, some 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 in 2005, 2006 and 2007

According to figures from the Central Bureau of Statistics, in 2005 a total of 51,790 people died who had permanent or temporary residence in the territory of the Republic of Croatia. In 2006 the number of people who died was 50,378 and in 2007 52,367 (Table 1)

Table 1 The number of deaths, mortality rate per 100,000 of the population and gender distribution

	2005	2006	2007
Number of deaths	51,790	50,378	52,367
Rate/100.000	1,167.1	1,135.3	1,180.1
% men	50.3	50.3	50.2
% women	49.7	49.7	49.8

Source: Documentation of the State Institute for Public Health
Data processing: Croatian National Institute of Public Health

According to data from the Croatian National Institute of Public Health, the leading cause of death is the group of circulatory diseases from which more than 50% of people died. Thus, in 2005 a total of 26,029 people died – 562.5/100,000 of the population, in 2006 a total of 25,611 people died – 577.2/100,000 of the population, and in 2007 the number of people who died was 26,506 – 597.3/100,000 of the population. When it comes to tumours, the second leading cause of death, in 2005 there were 12,783 deaths or 288.1/100,000 of the population, in 2006 the number of deaths was 12,700 – 286.2/100,000 and in 2007 12,853 – 289.6/100,000. In 2005 the third leading cause of death were respiratory diseases (3,180 persons – 71.7/100,000), followed by injuries and poisonings (2,878 persons or 64.9/100,000), digestive diseases (2,360 or 53.2/100,000), and other, less common causes. In 2006 the third leading cause of death were injuries and poisonings (2,751 persons – 62/100,000), followed by respiratory diseases (2,494 persons or 56.2/100,000), digestive diseases (2,321/100,000), and other, less common causes (Table 2). In 2007, the rank order of groups of diseases causing death was the same as that in 2006.

In 2005 the share of unknown and insufficiently defined causes of death was 1.3%. In 2006 it fell to 1% and in 2007 it remained at the same level, which is the result of good co-operation with county commissioners for health statistics and coroners all over Croatia.

Table 2 The number of deaths, mortality rate per 100,000 of the population per groups of diseases in Croatia in 2005, 2006 and 2007

	2005		2006		2007	
Groups of diseases	Number	Rate/100,000	Number	Rate/100,000	Number	Rate/100,000
Circulatory system diseases	26,029	586.57	25,611	577.15	26,029	586.57
Tumours	12,783	288.07	12,700	286.20	12,783	288.07
Injuries, poisonings and some other consequences of external causes	2,878	64.86	2,751	61.99	2,878	64.86
Respiratory system diseases	3,180	71.66	2,494	56.20	3,180	71.66

Digestive system diseases	2,360	53.18	2,321	52.30	2,360	53.18
Unknown and insufficiently defined causes of death	657	14.81	520	11.72	657	14.81

The rank order of leading causes of death in men, by groups of diseases, was the same in 2005, 2006 and 2007. In other words, circulatory diseases ranked first, followed by tumours, injuries and poisonings were in the third position, and then there were respiratory system diseases and digestive system diseases (Table 3).

Table 3 The structure of causes of death in 2005, 2006 and 2007 – men

Groups of diseases	**2005**	**2006**	**2007**
	%	%	%
Circulatory system diseases	43.5	44.3	43.4
Tumours	28.8	29.3	28.9
Injuries, poisonings and some other consequences of external causes	7.5	7.1	7.5
Respiratory system diseases	7	5.8	5.9
Digestive system diseases	5.5	5.7	5.6
Other	7.7	7.8	8.7

Source: Documentation of the Central Bureau of Statistics
Data processing: Croatian National Institute of Public Health

The rank order of leading causes of death in women, by groups of diseases, was the same in 2005, 2006 and 2007. In other words, circulatory diseases ranked first, followed by tumours, respiratory system diseases were in the third position, and then there were injuries and poisonings and digestive system diseases (Table 4).

Table 4 The structure of causes of death in 2005, 2006 and 2007 – women

Groups of diseases	**2005**	**2006**	**2007**
	%	%	%
Circulatory system diseases	57.1	57.4	57.9
Tumours	20.6	21.5	20.2
Respiratory system diseases	5.3	4.1	4.2
Injuries, poisonings and some other consequences of external causes	3.6	3.8	3.8
Digestive system	3.6	3.6	3.4

diseases			
Other	9.8	9.6	10.5

Source: Documentation of the Central Bureau of Statistics
Data processing: Croatian National Institute of Public Health

PROVIDING UNIVERSAL ACCESS TO HEALTH CARE

The *Health Care Act* (Official Gazette, nos. 121/03, 44/05, 48/05, 85/06), regulates principles, measures and the manner of implementing and organising health care, those responsible for health care in society, the rights and obligations of persons using health care and the contents, the manner of performance and supervision of medical activities.

The organisation of health care should ensure the following principles:
– the comprehensiveness of health care, by including the entire population in the implementation of adequate health care measures;
– the continuity of health care by organising health care for citizens of all ages;
– the accessibility of health care, by the distribution of medical institutions, companies providing medical services and health workers, which should enable all citizens equal conditions of health care, especially in primary health care;
– an integral approach in primary health care and a specialised approach by ensuring and developing specialised clinical achievements in public health and developing know-how and applying it in practice.

The accessibility of health care is ensured by a network of health institutions and health workers on the territory of the Republic of Croatia, which enables more or less equal conditions of health care for the entire population, and especially at the level of primary health care.

The *Basic Network of Medical Services* (Official Gazette, no. 188/2004) determines the necessary number of health institutions, companies and private-sector health workers for the whole territory of the Republic of Croatia, and for local self-government units.

The Basic Network of Medical Services is adopted by the Government of the Republic of Croatia, on the basis of Article 38 of the Health Care Act (Official Gazette, nos. 121/2003 and 48/2005). This is done at the proposal of the Minister of Health and Social Welfare, upon previously obtaining an opinion from the Croatian Institute for Health Insurance, the Croatian National Institute of Public Health and the competent chambers and representative bodies of regional self-government.

On the basis of the 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.

Standards for defining the Basic Network are the total population of the Republic of Croatia, the total number of insured persons of 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.

The basic network determines the necessary number of health institutions, private-sector health workers, that is the largest possible number of primary health care teams, nurses, the number of specialist and consultant health care teams and specialised diagnostics by individual branches, the necessary number of physical therapists, the necessary number of beds by individual branches and types of hospitals, and the necessary 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 regional self-government units and local self-government units.

The 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 sickness benefit. In the Republic of Croatia there are compulsory and voluntary health insurance schemes. 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. Every citizen of the Republic of Croatia is obliged to register for compulsory health insurance.

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 or stay on a business visa, and refugees (after the expiration of three months of the date when their status is recognised) 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. A foreigner who has been granted the status of an asylee in the Republic of Croatia has the obligation to register for compulsory health insurance in accordance with the Asylum Act. All persons insured under the compulsory health insurance scheme have the rights and obligations provided for by this scheme on the basis of the principles of reciprocity and solidarity, in the manner and under the conditions laid down in the Compulsory Health Insurance Act. All insured persons enjoy the rights provided for by the compulsory health insurance scheme under the same conditions, and the extent of these rights is determined by the provisions of the Compulsory Health Insurance Act. Voluntary health insurance is administered in the manner and under the conditions provided for by a separate law.

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 an insured person of the CIHI, pursuant to the provisions of the Ordinance on the procedure for registering, de-registering and gaining the status of an insured person in the compulsory health insurance scheme.

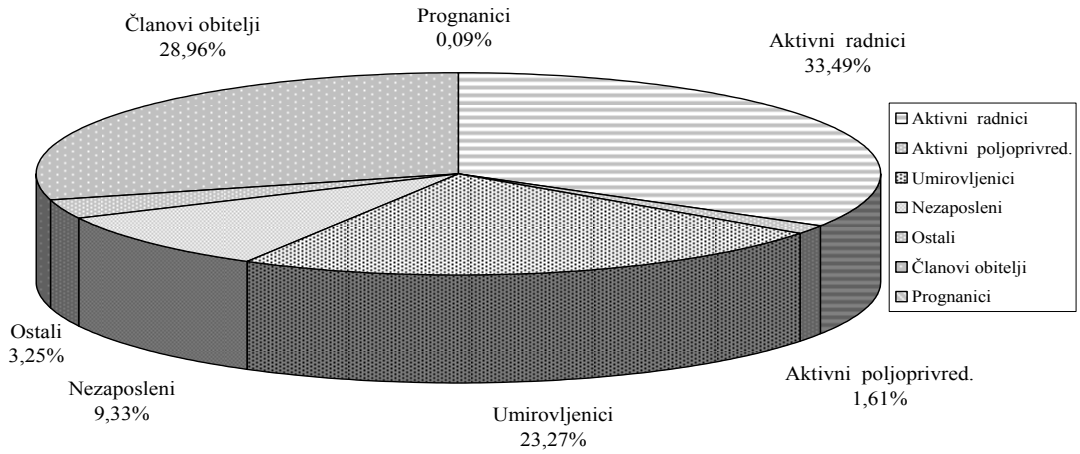
The status of an insured person is granted by CIHI regional offices, on the basis of an application for registration for compulsory health insurance. These applications are filed with regional offices by legal or natural persons, within 15 days of the day of occurrence or change of circumstances on the 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 1 January 2005 and 31 December 2007

According to figures from the CIHI, in **2005** 4,330,493 persons on average were entitled to health care. As regards the structure of insured persons in 2005, the largest group were active workers (33.49%), then family members (28.96%), pensioners (23.27%), unemployed people (9.33%), active farmers (1.61%), others (3.25%), and displaced persons (0.09%).

Chart 1



Numerical presentation:

	Average number I-XII 2005
- active workers	1,450,057
- active farmers	69,684
- pensioners	1,007,865
- unemployed people	404,236
- others	140,783
- family members	1,253,903
- displaced persons	3,965
Total	**4,330,493**

Republic of Croatia

The number of insured persons registered in the CIHI's database, who were entitled to health care in the Republic of Croatia in **2006**, rose by 0.62% in comparison with 2005.

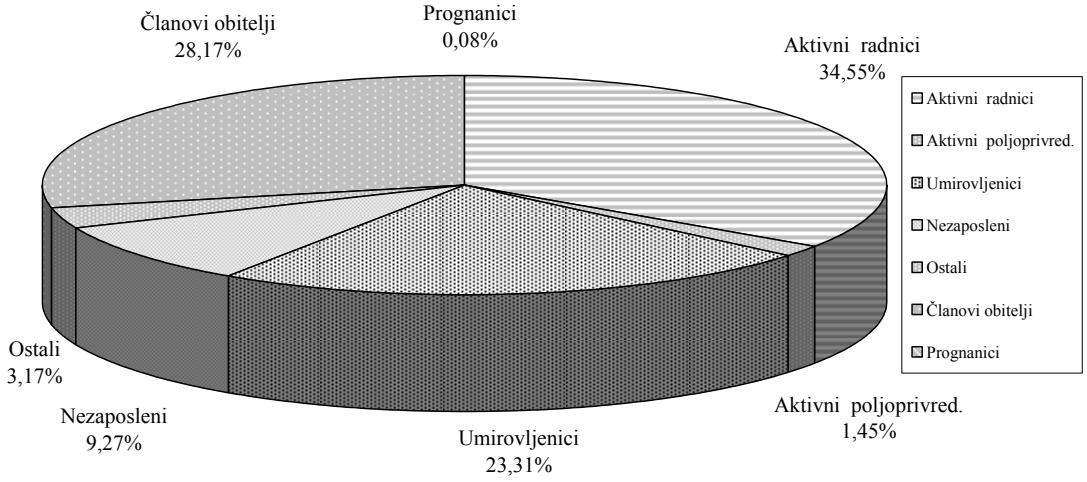
Of the total number of insured persons, 4,357,552 in 2006, the number of active employees increased in absolute terms by 55,490 persons or 3.83%. The number of pensioners increased in absolute terms by 7,958 persons or 0.79%, whereas the number of insured persons belonging to other categories dropped in both absolute and relative terms in comparison with the year 2005, which is evident from the following:

	Average number	
	I-XII 2005	**I-XII 2006**
- active workers	1,450,057	1,505,547
- active farmers	69,684	63,270
- pensioners	1,007,865	1,015,823
- unemployed people	404,236	403,988
- others	140,783	138,195
- family members	1,253,903	1,227,569
- displaced persons	3,965	3,160
Total	**4,330,493**	**4,357,552**

Republic of Croatia

The structure of insured persons is such that active insured persons-workers make up 34.55% of the total number, pensioners 23.31%, family members 28.17%, unemployed people 9.27%, and other categories (farmers, others, displaced persons) 4.70%.

Chart 2



According to figures for **2007**, a total of 4,361,008 persons were registered on average, which was a 0.08% increase from the same period of 2006 (or 3,456 persons more).

A total of 1,547,523 active insured persons were registered and the number of employees increased by 41.976 or 2.79% in comparison with the year before, which points to the

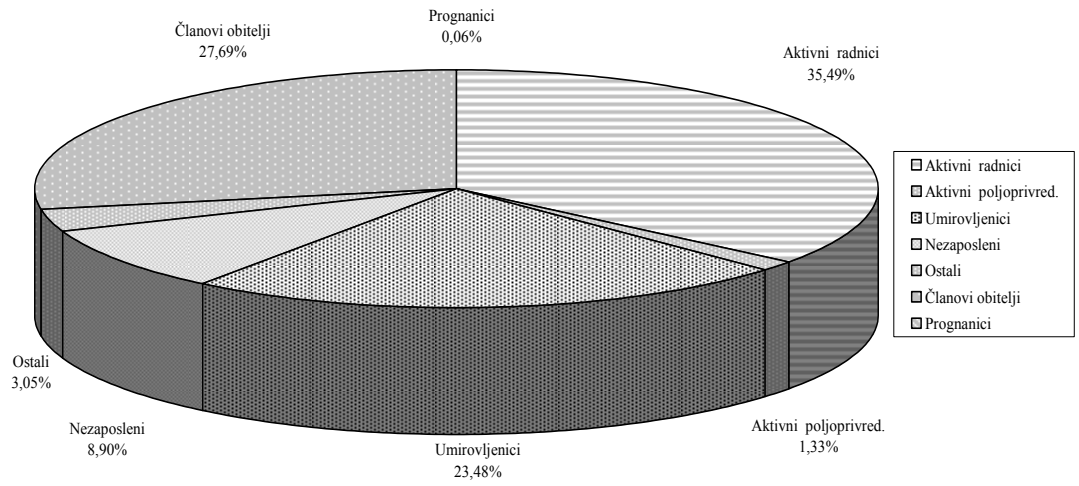
conclusion that the number of unemployed people was falling and the number of contribution payers was on the increase.

Of 1,547,523 active insures persons, there were 696,638 women or 45.02%.

The number of pensioners increased by 8,080 or 0.80%, whilst the number of members of other categories largely fell in comparison with 2006, which is seen from the following presentation:

	Average number	
	I-XII 2006	**I-XII 2007**
- active workers	1,505,547	1,547,523
- active farmers	63,270	57,906
- pensioners	1,015,823	1,023,903
- unemployed people	403,988	388,286
- others	138,195	133,186
- family members	1,227,569	1,207,595
- displaced persons	3,160	2,609
Total Republic of Croatia	**4,357,552**	**4,361,008**

Chart 3



As shown by the above presentation of the structure of insured persons, active insured persons make up 35.49%, pensioners 23.48%, unemployed people 8.90%, family members 27.69% and all others (farmers, others, displaced persons) make up 4.44%.

Measures taken to simplify the procedure for registering for compulsory health insurance and the use of health care facilities by insured persons

The Ordinance on the procedure for registering, de-registering and gaining the status of an insured person in the compulsory health insurance scheme, which entered into force on 31 March 2007, introduced a number of new elements simplifying the procedure for registering for compulsory health insurance and the use of health care facilities by persons insured with the Croatian Institute for Health Insurance.

The Ordinance establishes:

a) the obligation of any CIHI regional office, including branch offices, to receive and process applications for compulsory health insurance, applications for changes to compulsory health insurance status and applications for de-registration from compulsory health insurance (hereinafter: "applications"), regardless of the place of permanent or temporary residence of the applicant, or his or her place of temporary or permanent stay, in the case of foreigners. This contrasts the previous regulation, according to which an insured person was obliged to submit an application for compulsory health insurance to the CIHI regional office in the region in which he or she had permanent or temporary residence.

b) the introduction of "e-applications", enabling legal persons obliged to pay contributions to submit applications for compulsory health insurance by electronic means (internet), seven days a week, 24 hours a day.

c) the simplification of the procedure for applying for compulsory health insurance for persons employed under fixed-term employment contracts. Their employers no longer need to produce contracts for each separate period extending the employee's employment, eliminating the need for de-registration and re-registration on each such occasion. Instead, employers may now simply enter the starting date of employment on the appropriate form, and omit the date of cessation. The employee's registration thus remains valid until employment actually ceases, at which time de-registration takes place and the date is inserted in the de-registration form for compulsory health insurance.

d) the issuing of health insurance identity cards for the first time for persons who have been granted the status of asylees.

The *Decision on the content and form of the identification document proving the status of an insured person of the Croatian Institute for Health Insurance,* which entered into force on 18 January 2007, introduced the following:

a) the so-called health insurance "smart card". The card is being issued in stages for different categories of persons insured with the CIHI, and within a period of five years, beginning on 18 January 2007, it should completely replace the existing health insurance identity card.

Persons insured with the CIHI will find the procedure for registering for and de-registering from compulsory health insurance simplified, since the card will be issued for a period of five years and will not be changed within that period, even if the person's legal basis for applying for compulsory health insurance changes.

b) In addition, all persons in employment will be issued with health insurance identity cards for a four-year period, regardless of whether they have been employed under fixed-term or open-ended employment contracts. Until this Decision entered into force, persons who had been employed under a fixed-term employment contract were issued cards for the periods of

employment stipulated in their contracts, and if no such period was stipulated, the card was issued for a period of one year.

In addition, the delivery of health insurance identity cards to insured persons' home addresses has been introduced, with the exception of certain categories of insured persons (those who have registered with the CIHI within the prescribed 30-day period, pupils in regular education who are not registered for compulsory health insurance through their parents, and others), who will be required to collect their health insurance identity cards in the appropriate CIHI regional offices.

The manner in which the right to health care is exercised

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 CIHI's general legal acts. Health care services can be used on the territory of the Republic of Croatia in health institutions, companies providing health services, private health practitioners and providers of orthopaedic and other aids with whom the CIHI has entered into a contract on the provision of health care, or on the production, delivery or repair of orthopaedic or other aids (CIHI contractors). 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 up to the full price of the health care services received, either directly to the health care provider 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, unless the patient is entitled to full coverage of health care services by the CIHI or has been exempted from this obligation in accordance with the provisions of the Compulsory Health Insurance Act, which is proved by the appropriate document issued by the CIHI.

In relation to the **Committee's request** for additional information about the effects of privatisation of a part of the health system, we would like to stress that in July 2006 the Voluntary Health Insurance Act was passed, which regulates the types, conditions and procedures for implementing voluntary health insurance schemes. Voluntary health insurance is divided into supplementary, additional and private health insurance.

Supplementary and additional health insurance schemes are forms of long-term insurance, contracted for a period of at least one year. Supplementary and additional health insurance schemes are non-life insurance schemes, governed by the Insurance Act.

As already stated, supplementary health insurance is used to cover a portion of health care costs up to the full price of the health care services received under the compulsory health insurance scheme (supplementary payment). Namely, pursuant to the provisions of the Compulsory Health Insurance Act, insured persons are obliged to pay a portion of health care costs, as a percentage of the full price of health services received, either directly to the provider of health services or through supplementary health insurance run by the Croatian Institute for Health Insurance or insurance companies.

Additional health insurance provides for a higher standard of health care within the compulsory health insurance scheme, and for broader rights than 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, pursuant to the Insurance Act.

The Act on Amendments to the Health Insurance Act (applied since 1 October 2005) introduced the obligation to pay the administrative fee when using health care services under the compulsory health insurance scheme. This obligation was in force during the entire period to which this report relates, that is to say, up until 31 December 2007.

The administrative fee was paid for the following:

-	each examination by the attending primary health care physician	HRK 10.00
-	each prescription issued	HRK 10.00
-	each referral slip for specialist and consultant health care	HRK 10.00
-	each referral slip for hospitalisation	HRK 10.00
-	each examination performed as part of the specialist and consultant health care, without a referral slip	HRK 10.00
-	each attested certificate for an orthopaedic or other aid	HRK 10.00
-	each order for transportation in an ambulance	HRK 5.00

The sum of administrative fees paid on a monthly basis by an insured person could not exceed 0.91% of the budgetary base, or HRK 30.00. Everyone was obliged to pay the administrative fee, regardless of whether they had been exempted from supplementary payments or taken out a supplementary health insurance policy. The only exception were children under 18 years of age and disabled persons with body damage of at least 80%. No fees were payable for preventive examinations provided for by the Plan and Programme of Health Care Measures.

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:

- primary health care,
- specialist and consultant health care,
- hospital health care,
- the right to use medicines,
- the right to dental-prosthetic services and dental-prosthetic replacements,

- the right to use orthopaedic and other aids,
- 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, gynaecologist, dentist or paediatrician, selected according to the procedure laid down in the Ordinance on the procedure for exercising the right to a free choice of doctor and dentist in the primary health care system. By way of an 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 temporarily stays 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,
- 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 person in his or her home, and that he or she indicates the need for nursing care at home,
- temporary or permanent condition making the patient unable to take care of himself or herself,
- after complex surgical procedures requiring wound bandaging and care, and care for anus praeter or other types of stoma,
- for patients suffering from terminal stage diseases.

Medical care provided by health visitors

As part of the health visiting programme, insured persons are offered professional assistance and care:

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

Emergency medical assistance

An insured person is entitled to emergency medical assistance, which includes the provision of diagnostic and therapeutic services required to eliminate the imminent danger to his or her life or health, without a referral sheet, at the nearest primary medicine clinic according to his or her place of permanent or temporary residence or the place where the insured person is found at the moment of receiving emergency medical assistance, and in:

- the emergency service of a community health centre,
- an emergency medical assistance facility,
- the emergency service of a hospital.

If this proves to be necessary, the doctor who provided emergency medical assistance to the injured person is obliged to arrange for the transportation of the insured person to the nearest hospital which can provide the patient with the necessary health care.

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.

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 health practitioner, according to the place of his or her permanent or temporary residence, which has entered into a contract with the CIHI, which covers the provision of the requested medical service. This form of health care may be exercised on the basis of a referral sheet, which is valid for 30 days and is issued by the attending physician:

- family (general) medicine practitioner
- paediatrician
- gynaecologist
- dentist.

If the insured person wishes to undergo a specialist examination or a diagnostic or therapeutic procedure in another contracting health institution or in the office of another private health practitioner, other than the nearest specialist's office with contract with the CIHI on the provision of the requested medical service, to which the insured person was referred by his or her attending physician, such person is entitled to receive the requested medical care on the basis of the referral sheet issued (regardless of the name of the CIHI's contractor appearing on the referral sheet), but he or she is not entitled to any compensation for transportation costs or to ambulance transportation at the expense of the CIHI.

A CIHI's contractor is obliged to immediately receive the insured person, and no later than within 30 days of the date when the insured person first contacted them, bringing a referral sheet issued by his or her attending physician. When a CIHI's contractor fails to provide the insured person with the requested medical care within the time limit of 30 days of the date when the insured person first contacted them, bringing the referral sheet issued by his or her attending physician, the contractor is obliged to provide the insured person with medical care

within the time limit of 60 days of the date when the insured person first contacted them. The contracting health institution or private health practitioner, to whom the insured person was referred for an initial specialist examination, are obliged to enable such person to undergo this examination within no later than 30 days of the date when the insured person first contacted them and submitted a referral sheet issued by his or her attending physician.

Initial specialist examination

The Ordinance on the rights, conditions and means of exercising rights in the compulsory health insurance scheme, which entered into force on 15 November 2006, regulates a special procedure for realising the right to undergo an initial specialist examination. The important characteristics of the "initial specialist examination" are that it is the first specialist examination for a specific diagnosis and that it does not include any tests or diagnostic procedures.

As part of the procedure for arranging an initial specialist examination, the attending physician is obliged to refer the insured person to a contracting health institution or private health practitioner, closest to the insured person's permanent or temporary residence, which is capable of carrying out the requested examination. A referral sheet for an initial specialist examination is valid for 30 days, and the insured person is obliged to contact the contracting health institution or private health practitioner to whom he or she was referred within this time limit.

The contracting health institution or private health practitioner to whom the insured person was referred for an initial specialist examination is obliged to enable the insured person to undergo this examination within no later than 30 days of the date when he or she first contacted them bringing a referral sheet issued by his or her attending physician. If the CIHI's contractor is unable to immediately carry out the necessary initial specialist examination, the date of appointment for this examination should be written down on the referral sheet, and this date must be within 30 days of the date when the insured person first contacted the CIHI's contractor. If the contracting health institution or private health practitioner is unable to arrange for the insured person to undergo an initial specialist examination immediately or within 30 days, they are obliged to write on the referral sheet:

- the date when the insured person first contacted them,
- an indication stating that they did not arrange for the insured person to undergo a specialist examination and that they are unable to arrange for him or her to undergo this examination within 30 days.

This indication must be certified by a signature of the responsible person and the stamp of the health institution or doctor's clinic.

An insured person has the right to undergo an initial specialist examination in a non-contracting health institution or private health practitioner, under the following conditions:

- if he or she contacted the contracting health institution or private health practitioner to whom he or she had been referred by his or her attending physician within 30 days of the date when the referral sheet was issued
- if the contracting health institution or private health practitioner to whom the insured person had been referred did not arrange for him or her to undergo an initial specialist examination within 30 days of the day when he or she had first contacted them, which must be indicated on the referral sheet.

If all the prescribed conditions are met, the insured person may file a request for the recovery of costs of the initial specialist examination carried out in a non-contracting institution. This request should be filed with the CIHI regional office which has jurisdiction for the place of his or her permanent or temporary residence.

3. Health care provided in hospitals

An insured person receives hospital treatment at the nearest hospital according to the place of his or her permanent or temporary residence, which is capable of providing the requested medical service, on the basis of a referral sheet for hospital treatment, valid for 30 days, which was issued by the insured person's attending primary health care physician or a doctor from an emergency medical assistance facility.

If the insured person wishes to receive treatment at another hospital, other than the nearest hospital with which the Institute has contracted the requested health care services and to which he or she was referred by his or her attending physician, such insured person may do so (regardless of the name of the CIHI's contracting hospital appearing on the referral sheet), but he or she is not entitled to any compensation for transportation costs or to ambulance transportation at the expense of the CIHI.

The contracting hospital is obliged to admit the insured person for hospital treatment within the shortest possible time, and if the insured person's life is threatened, such admission must be granted without delay. If the contracting hospital fails to admit the insured person within 30 days of the day when the insured person first contacted them, it is obliged to provide the insured person with health care services at their hospital within 60 days of the date when the insured person first contacted the hospital.

Medical rehabilitation at hospital

The insured person exercises the right to medical rehabilitation at a contracting hospital either in continuation of hospital treatment (initial rehabilitation) or on the basis of a referral sheet issued by his or her attending physician (maintaining rehabilitation), for an illness, medical condition or consequences of an injury from the List of Illnesses, Medical Conditions and Consequences of Injuries for Which Medical Rehabilitation is Approved, which is established by 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, for which an approval was given by the CIHI's medical commission.

An insured person who wishes to receive medical rehabilitation services approved at some other specialist hospital, other than that approved by the medical commission of the CIHI's regional office, is entitled to receive these services pursuant to Article 43 of the Ordinance on the rights, conditions and means of exercising rights in the compulsory health insurance scheme, but cannot claim compensation for transportation costs or to ambulance transportation from the CIHI.

The right to stay with the child whilst in hospital

The right to whole-day (24 hours a day) stay with the child

Until the entry into force of the Ordinance on amendments to the Ordinance on the rights, conditions and methods for realising basic health insurance rights on 12 March 2005, mothers were entitled to stay with their hospitalised children 24 hours a day, depending on the accommodation capacities of the contracting hospital, under the condition that the child was younger than 6 months, that the child was breastfed and that the mother's permanent or temporary residence was more than 25 km away from the hospital.

During this stay, a mother with the status of an insured person granted on the basis of her employment or self-employment (economic or professional activities) was entitled to salary compensation for a sick leave. A new regulation made it possible for mothers to stay with their children whilst in hospital regardless of the distance between the mother's permanent or temporary residence and the hospital where the child receives medical treatment.

The right to day-time stay with the child (not during the night)

The Ordinance on amendments to the Ordinance on the rights, conditions and methods for realising basic health insurance rights, which entered into force on 26 May 2005, made it possible for one parent of a child under 5 years of age, who was hospitalised for an acute condition, to stay with the child during the day.

Under the Ordinance on amendments to the Ordinance on the rights, conditions and methods for realising basic health insurance rights, which entered into force on 9 August 2007, the same right may be enjoyed by an insured person – a parent of a child with developmental difficulties of whatever age, 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.

During this stay, a mother with the status of an insured person granted on the basis of her employment or self-employment (economic or professional activities) is entitled to salary compensation for a sick leave.

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

Until the entry into force of 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 provided at the patient's home, on 26 April 2007, the insured person designated to accompany the child (one of the child's parents or person taking care of the child) was entitled to stay with the child under three years of age at a specialist hospital providing medical rehabilitation services under the condition that a special "Mum-Child" training programme for persons accompanying children (parents) was applied and in situations when the child was breastfed (in that case the right to be with the child was granted to the mother).

With the entry into force of the new regulation, the same right as above was granted to a person accompanying a child with special heath needs, when the presence of the child's parent or the person taking care of the child is necessary for medical rehabilitation purposes. The

child's age is irrelevant in that case. While exercising this right, the person accompanying the child, who was granted the status of an insured person on the basis of his or her employment or self-employment (economic or professional activities), is entitled to salary compensation for a sick leave.

At the same time, in relation to the Committee's enquiry as to whether hospital patients will be expected to bear the full cost of meals and accommodation in cases excluding serious or chronic illnesses, according to Article 15, paragraph 2, points 3 and 4 of the Compulsory Health Insurance Act, persons who have not taken out supplementary health insurance are required to participate in the costs of meals and accommodation, as follows:

- 25% of the costs of hospital treatment for chronic illnesses
- 30% of the costs of hospital treatment for acute illnesses.

The above obligations will be waived in the case of hospital treatment:

- for chronic psychiatric illnesses
- involving chemotherapy and radiation therapy
- involving human organ removal or transplant for the purposes of treatment
- involving intensive care.

In response to the Committee's enquiry concerning waiting lists for the treatments listed, it should be pointed out that hospital waiting lists in certain contractual areas (health service contracts between hospital and health institutions and the CIHI) are compiled for specialist and consultant health services, specialist diagnostics and in-patient/out-patient treatment, primarily because of the large numbers of patients requiring such services and the limitations present in providing them. The length of waiting lists varies according to the type of hospital in question, its services and the specific characteristics of individual hospitals.

Bearing in mind guaranteed rights to health care and safeguarding the highest possible health standards on the one hand, and existing problems in terms of hospital waiting lists in contractual areas on the other, the Ministry of Health and Social Welfare, in co-operation with all hospitals in Croatia and the Croatian Institute for Health Insurance, is actively pursuing a series of measures aimed at reducing existing hospital waiting lists in the Republic of Croatia.

During 2004, 2005 and 2006, a survey of waiting lists was carried out (for all contractual areas in hospital treatment – specialist and consultant health care, diagnostic tests, in-patient treatment and operations). Based on indicators, a package of measures aimed at reducing waiting lists was prepared in December 2005. It includes the following:

- work reorganisation (introduction of two shifts)
- supplementary education of health workers within six months
- reorganisation of duty rotas and ready response teams
- employment of new medical staff
- acquisition of medical equipment
- refurbishment of inadequate facilities.

In accordance with this package of measures for reducing waiting lists, and depending on information received on the problems of existing waiting lists and proposals for reducing them, the above activities are implemented on a continuous basis, as are those concerning the acquisition of new medical equipment and investing in the extension or refurbishment of inadequate hospital facilities.

A certain number of younger doctors is being introduced in the health system by means of supplementary education and new specialist courses, implemented according to the Plan for Specialisation and Narrow Specialisation. The aim is to fill existing vacancies and replace the number of doctors expected to retire according to legal provisions. During 2004, the Ministry of Health and Social Welfare approved 420 specialisations and 105 narrow specialisations for doctors of medicine, dentists, pharmacists and medical biochemists.

In 2005, 470 specialisations and 151 narrow specialisations were approved, while according to the Plan for Specialisation and Narrow Specialisation, in 2006 the largest number so far was approved (530 specialisations and 171 narrow specialisations). Ongoing professional training for health workers (including attending expert meetings and congresses in the Republic of Croatia and abroad, participating in ongoing training courses and post-graduate studies in the Republic of Croatia and abroad), has enabled health workers employed in hospitals to continue their education and provide health services at the level of leading European countries. In the period between January 2005 and May 2006, a total of 6,164 health workers participated in various kinds of training.

YEAR	NUMBER OF SPECIALISATIONS APPROVED	NUMBER OF NARROW SPECIALISATIONS APPROVED
2004	420	160
2005	470	151
2006	530	171

An analysis of waiting lists in all contractual areas in health care in all hospitals shows improvement in terms of gradual reduction of waiting lists, thanks to the measures implemented as part of the package for reducing waiting lists, which was distributed to all hospitals in 2005. The results are particularly evident in terms of waiting lists for diagnostic tests and specialist examinations.

Upon processing the information received, it was evident that waiting lists for diagnostic tests have been reduced by 21.6% and waiting lists for specialist examinations by 20.7%. Waiting lists for diagnostic tests differ from hospital to hospital, but on average, waiting lists are longer than 60 days in clinical hospitals, but shorter in general hospitals or specialist hospitals.

DIAGNOSTIC TESTS (waiting lists > 60 days):

- GENERAL HOSPITALS 40%
- SPECIALIST HOSPITALS 3%
- CLINICAL HOSPITALS 57%

The longest lists are for:

Diagnostic test	*Average wait depending on hospital*
CT	2-3 months
NMR	3-4 months
Thyroid ultrasound	2-3.5 months (depending on the hospital)
Heart ultrasound	about 2.5-3 months (average)
Breast ultrasound	2-3 months (depending on the hospital)
TCD	2-6 months (depending on the hospital)

CDFI carotid and vertebral artery	6 months
Goldmann visual field	4 months
Densitometry	2-3 months (depending on the hospital)

The waiting lists for specialist examinations (SCHC – specialist and consultant health care) differ from hospital to hospital, but are on average longer than 60 days in clinical institutions and shorter in general hospitals and specialist hospitals.

SCHC waiting lists > 60 days:

- GENERAL HOSPITALS 27%
- SPECIALIST HOSPITALS 3%
- CLINICAL HOSPITALS 70%

SCHC – average waiting lists, depending on the hospital

Specialist cardiac operations	around 3 months
Visual field	4 months
Endocrine examinations	around 3 months (in Zagreb)
Physical therapy	3 months

The waiting lists for in-patient hospital treatment (elective operations, etc.) differ from hospital to hospital, but on average, are longer than 60 days in clinical hospitals and shorter in general and specialist hospitals.

HOSPITAL TREATMENT waiting lists > 60 days:

- GENERAL HOSPITALS 25%
- SPECIALIST HOSPITALS 4%
- CLINICAL HOSPITALS 71%

Operational procedure	*Average wait, depending on hospital*
Hip replacement	> minimum 12 months
Knee replacement	> minimum 12 months
Cataract removal (PHACO)	> minimum 6 months (Zagreb, Rijeka)
Cold surgical operations	> minimum 10 months

In order to continue this trend in reducing waiting lists for contractual hospital health care, the Ministry of Health and Social Welfare, in co-operation with all hospital institutions, plans to continue implementing activities aimed at reducing waiting lists, with the goal of making all forms of health care available.

These activities include continuing measures already initiated (work in two shifts, ongoing training of health workers, possible supplementary reorganisation of duty rotas and ready response teams, employment of new medical staff, replacement of medical equipment and refurbishment of inadequate hospital facilities).

Another important activity is the computerisation of the entire health system, which will make information on waiting lists available on the web sites of individual hospitals.

Computerisation would eliminate the current situation, in which the same patient may appear on the waiting lists of several hospitals, leading to a false picture of the length of waiting lists.

One measure which would lead to reductions in waiting lists is the regulation of initial specialist examinations, in accordance with the provisions of the Ordinance on the rights, conditions and means of exercising rights in the compulsory health insurance scheme (Articles 38 and 39) (Official Gazette, nos. 120/06, 136/06).

In addition, with the aim of improving quality and ensuring the principles of equality and timely provision of health care services, activities within the framework of the Plan for Developing Cardiac Surgery in the Republic of Croatia will be implemented. This is a project to extend the range of cardiac surgery at Dubrava Clinical Hospital and develop it in regional centres (Osijek and Split). Activities which have already been initiated, in terms of training appropriately highly specialised staff and acquiring sophisticated equipment required for the care of cardiac patients, will continue.

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

Until the entry into force of the new Compulsory Health Insurance Act on 3 August 2006, the CIHI had a single list of medicines. Insured persons were entitled to use the medicines included in the CIHI's List of Medicines under the conditions and in the way prescribed by the Health Insurance Act. By way of an exception, an insured person could be approved a medicine not included in the List of Medicines at the expense of the CIHI's funds, on the basis of medical findings, assessment and opinion of the Medical Commission of the CIHI's Directorate and under the condition that the use of this medicine was recommended by the Medicines Commission of the hospital where the insured person was receiving medical treatment. By way of another exception, an insured person could also be approved a medicine not included in the List of Medicines at the expense of the CIHI's funds, even if he or she did not meet the requirements prescribed by the List of Medicines of the CIHI. The new Compulsory Health Insurance Act of 3 August 2006 introduced the basic and supplementary lists of medicines. The Basic List of Medicines includes the most purposeful medicines from the medical and economic point of view, for treating all illnesses, to which insured persons are entitled at the full expense of the CIHI.

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 Supplementary List of Medicines indicates the amount of the difference to be paid by the insured person, either directly or through any of the supplementary health insurance schemes. The medicines included in the Supplementary List of Medicines may only be prescribed 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 pay a price difference between this medicine and the equivalent medicine included in the Basic List of Medicines. Pursuant to the Voluntary Health Insurance Act, the CIHI cannot provide coverage for price difference for medicines included in the Supplementary List of Medicines within the supplementary health insurance scheme.

Establishing a list of very expensive medicines

In 2005 the Decision establishing a list of very expensive medicine, paid from a special fund was rendered, which introduced a special budgetary allocation for these medicines in the State Budget of the Republic of Croatia. The "Fund for Very Expensive Medicines" enabled all citizens of the Republic of Croatia, regardless of their social or financial status, to use, free of

charge, the most expensive and modern medicines to treat various diseases such as hereditary diseases in children, malignant tumours, haemophilia, hepatitis C, multiple sclerosis, etc.

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

Orthopaedic and other aids and dental aids, available to insured persons at the expense of the compulsory health insurance scheme, if medically indicated, are 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. An aid included in the List of Aids is prescribed to the insured person by a medical doctor or dentist of the relevant specialisation, a general/family medicine practitioner or dentist with whom the CIHI has entered into a contract on the provision of health care, using the form entitled "Certificate on the entitlement to an aid". After that, the insured person is obliged to have this Certificate verified at CIHI's regional office.

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, repair of the aid by the supplier of orthopaedic and other aids with whom the CIHI has entered into a contract on the supply of aids.

If an insured person permanently uses certain aids or expendable supplies from a group of aids of the same kind (e.g. catheters, diapers, bags, condoms, needles, syringes, strips, etc.) due to his or her state of health, the competent medical commission approves these aids once a year. This approval is verified on the form "Certificate on the entitlement to an aid", which is signed by the general/family medicine doctor on the basis of the approval given for the quantity required for a period of three months.

By way of an exception and on the basis of the approved annual quantity, aids for digestive system, aids for genitourinary system and aids for diabetes may be verified in the quantity required for a period of six months. Another exception is that an insured person may, on the proposal of a contracting doctor and with the approval of the Medical Commission of the CIHI's Directorate, exercise the right to an aid not included in the List of Aids, if there is a medical indication. The Ordinance on orthopaedic and other aids (Official Gazette, nos. 93/03 – revised text, 158/03 and 74/04), which was applied in the period between 1 January 1997 and 1 May 2006, was amended on several occasions, but as the time passed it showed considerable deficiencies for the following reasons:

- medical indication was not transparently defined,
- orthopaedic aids were technologically outdated,
- the prices of orthopaedic aids had not changed since 1997.

For this reason, a new Ordinance on the conditions and means of exercising the right to orthopaedic and other aids was issued, which entered into force on 1 May 2006. Along with members of the CIHI's Workers Commission, prominent doctors of various specialisations, who represented the medical profession, participated in drawing up the new Ordinance. In addition, consultations were held with many organisations of disabled people, e.g. with representatives of associations of deaf and hard of hearing persons, blind persons, persons using aids for the digestive system, persons suffering from diabetes, etc. In distinction from the old Ordinance, the new Ordinance improved access to aids by insured persons and ensured more reasonable use of aids. It also specified that contracts with suppliers of orthopaedic aids

should clearly specify their obligations regarding repair and maintenance of aids, subject to recommended periods of use, as specified by manufacturers of aids, and provided for the possibility of reconstruction of aids and further use of reconstructed aids.

The Ordinance brought some novelties:
- it introduced generic names for all aids,
- it defined and prescribed medical indication for each aid, describing in objective, medical terms the need for each aid and guaranteeing reasonable use of aids and regulating the right to use aids,
- it established technical standards for serially manufactured aids in comparison with those made individually,
- it improved the procedure for granting the right to an aid to insured persons permanently using certain aids or expendable supplies from a group of aids of the same kind (e.g. catheters, diapers, bags, condoms, needles, syringes, strips, etc.), due to their state of health, by providing that they shall be approved by competent medical commissions once a year instead of every three months as it had been the case before.

6. The right to use health care services abroad

Health care abroad includes health care services used in foreign countries in the following cases:

- during a business trip – stay abroad shorter than 30 days,
- during work or professional training or education – stay abroad longer than 30 days,
- while staying abroad for private business,
- while undergoing medical treatment abroad on the basis of a CIHI's decision by which the person concerned is referred to a foreign health institution for treatment.

Business trip, work and 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 her 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 with the competent CIHI regional office and obtain a certificate from them 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 or professional training or education, a person may only use health care services at the expense of the CIHI which cannot be postponed until his or her return to the Republic of Croatia. If the need arises to use health care services, the insured person is obliged to immediately contact the CIHI regional office according to his or her permanent or temporary residence, so that his or her health condition can be monitored and an assessment be made as to the need for his or her return, i.e. transportation back to the Republic of Croatia. If the insured person fails to do this, he or she will not be entitled to health care services at the expense of the CIHI, except in situations when he or she proves that he or she was unable to immediately contact them for justified reasons.

Stay abroad for private reasons

Insured persons enjoy the right to use health care services abroad under the condition that they have previously paid a special contribution for using health care services abroad at the CIHI's regional office and that they have registered their stay abroad. Failing this, insured persons are not entitled to receive health care services abroad at the expense of the CIHI. 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. When an insured person needs to use health care services, he or she is obliged to immediately contact the CIHI's regional office according to his or her permanent or temporary residence, so that his or her health condition can be monitored and an assessment be made as to the need for his or her return, i.e. transportation back to the Republic of Croatia. If the insured person fails to do this, he or she will not be entitled to use health care services at the expense of the CIHI, except in situations when he or she proves that he or she was unable to immediately contact them for justified reasons.

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 cannot be provided at CIHI's contracting health institutions 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 health care to insured persons **to the following extents**:

1. Complete coverage at the expense of the CIHI:

- preventive health care for children, pupils and university students in regular education, and adults, except for preventive check-ups arranged by employers or local and regional self-government units pursuant to law and other regulations,
- curative health care and medical rehabilitation of children, pupils and university students in regular education,
- orthopaedic and other aids for children up to 18 years of age, pursuant to a general legal act of the CIHI,
- preventive and curative health care for adults on the level of primary health care, which is not regulated otherwise by items 2 to 5,
- preventive and curative health care for women in connection with family planning, pregnancy and childbirth, and other health needs of women and early detection of cancer,
- preventive and curative dental health care for children up to 18 years of age and pregnant women,
- 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,

- compulsory vaccination, immunoprophylaxis, and chemoprophylaxis,
- laboratory tests, radiological and other diagnostic procedures on the level of primary health care,
- medically indispensable health care in hospitals, except for accommodation and food costs referred to in items 3 and 4,
- accommodation and food costs for chronic psychiatric patients receiving health care in hospitals,
- chemotherapy and radiotherapy, including the costs of accommodation and food whilst in hospital,
- health care relating to human organ removal or transplant for the purposes of treatment, including the costs of accommodation and food whilst in hospital,
- emergency medical assistance, including the costs of accommodation and food whilst receiving intensive care in hospital,
- emergency dental assistance,
- emergency medical transportation,
- house calls for acute conditions,
- medical treatment at home,
- health care provided by health visitors,
- ambulance transportation for special categories of patients pursuant to a general legal act adopted by the minister responsible for health matters,
- nursing care in the patient's home,
- health care and medical rehabilitation in the event of an employment injury or occupational disease, including orthopaedic and other aids pursuant to a general legal act of the CIHI,
- until the entry into force of the new Compulsory Health Insurance Act on 3 August 2006 the CIHI had provided full coverage of medicines from its List of Medicines, when these medicines were used for hospital treatment, and for medicines prescribed in the primary health care, other than those referred to in items 3, 5 and 6.

2. 85% of the price is covered at the expense of the CIHI:

- specialist and consultant health care including daily hospital care and surgical procedures in daily hospital care, except for physical medicine and rehabilitation,
- specialist diagnostic procedures other than those carried out on the primary health care level,
- orthopaedic and other aids specified by a general legal act of the CIHI,
- medical treatment abroad pursuant to a general legal act of the CIHI,
- physical medicine and rehabilitation in the patient's home,
- specialist and consultant dental health care for adults in the field of periodontics,
- specialist and consultant dental health care for adults in the field of oral surgery,

3. 75% of the price is covered at the expense of the CIHI:

- the costs of accommodation and food whilst in hospital for treatment of chronic diseases,
- dental health care in the field of mobile and fixed prosthetics for persons over 65 years of age,
- until the entry into force of the new Compulsory Health Insurance Act on 3 August 2006 the CIHI had been covering 75% of the costs of medicines from its List of Medicines, which were prescribed in the primary health care, other than those referred to in items 1, 5 and 6.

4. 70% of the price is covered at the expense of the CIHI:

- specialist and consultant health care in physical medicine and rehabilitation,
- the costs of accommodation and food whilst in hospital for treatment of acute diseases.

5. 50% of the price is covered at the expense of the CIHI:

- dental health care in the field of mobile and fixed prosthetics for adults,
- until the entry into force of the new Compulsory Health Insurance Act on 3 August 2006 the CIHI had been covering 50% of the costs of medicines from its List of Medicines, which were prescribed in the primary health care, other than those referred to in items 1, 3 and 6 of this paragraph, and at least 25% of the cost of the medicines included in the CIHI's List of Medicines that were prescribed in primary health care, except for those referred to in items 1, 3, and 5.

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 6 November 1997 and has not subject to any amendments. Within the meaning of this Act, foreigners are persons who are not Croatian nationals, and who are staying in the Republic of Croatia on the basis of a temporary or extended stay permit, stay on a business visa, stay on the basis of approval of permanent settlement, stay on invitation from a Croatian state authority, stay on the basis of refugee status, persons involved in procedures for granting refugee status, persons with no nationality or persons under deportation orders whose extradition is not possible due to their extremely serious medical condition, and also minor foreigners found in the territory of the Republic of Croatia without parental supervision.

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 nationals.** 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 coverage on another basis. A foreigner who was approved extended stay, stay on a business visa or refugee status (in the period of three months after being granted the refugee status, unless he or she is provided with health care coverage on another basis) is obliged to personally register with the competent office of the Croatian Institute for Health Insurance, according to his or her residence. Such foreigner is considered to be under the obligation to pay health insurance contributions (contribution payer).

Health care of the following persons is financed from the State Budget:

- foreigners who are entitled to health care under 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 those 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.

A health institution or private health practitioner who has offered emergency medical services to a foreigner will charge the costs of these services to the foreigner if such foreigner cannot produce a written document proving that he or she is entitled to health care under health insurance regulations of the Republic of Croatia or other special regulations or under an international agreement.

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 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 health practitioner will have these costs recovered from the State Budget.

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

To further improve the health of the population and the quality of the health system, the CIHI introduced many novelties when it comes to organising and financing health care in the period 2005-2007, which resulted in extended life expectancy in the Republic of Croatia from 74.73 years in 2003 to 75.90 years in 2006. In late 2005, in addition to capitation fee payments, new financing arrangements were introduced in the area of family/general medicine, health protection of pre-school children and health protection of women involving supplementary

payments for individual diagnostic or therapeutic procedures. This has improved the performance at lower levels of the health care and the availability of health care for insured persons.

Pursuant to the provisions of the Compulsory Health Insurance Act, health protection of children (0-18 years of age) at all levels of health care is completely free of charge. According to data from the database of CIHI's insured person, on 31 December 2007 there were 289,215 registered insured persons aged 0-7, and 549,691 aged 7-18. In 2007 the CIHI entered into contracts with 253 specialist paediatrician teams on the primary health care level, providing health care services to 224,458 insured person aged 0-7 and 167,868 insured persons aged 7-18. The remaining insured persons aged 0-18 were cared for by general/family medicine teams. This means that the coverage of children aged 0-7 by specialist paediatrician teams was 78% and it showed a mild growth tendency. According to the provisions of the Basic Network of Medical Services (hereinafter: "the Basic Network"), there should be 315 teams for health protection of pre-school children on the territory of the Republic of Croatia, and contracts have been concluded with 253 teams. Having noticed a declining trend of the number of specialist paediatrician teams and taking into account the provisions of the Basic Network, the CIHI started financing specialisations in paediatrics back in 2004. At this moment the CIHI is financing 50 specialisations in paediatrics to meet the needs of the primary health care system.

It should, in particular, be pointed out that the CIHI provided additional funding for teams providing health protection to pre-school children in demographically declining areas, to ensure that health care standards are met as provided for under the compulsory health insurance scheme. In view of the importance of the preventive health care for children under 18 years of age, it should be stressed that, as part of its preventive and educational health protection measures for schoolchildren and university students, the CIHI contracted the services of 148 teams of school medicine specialists equally distributed across the Republic of Croatia, and in this way allowed access to this form of health protection for all children. On Croatian islands and in demographically declining areas, the CIHI provided additional funding for health teams engaged for this type of services, according to special standards. We would also like to note that the Plan and Programme of Health Care Measures in Compulsory Health Insurance outlines, in a comprehensive and systematic manner, preventive health care measures for children aged 0-7, implemented by specialist paediatric teams or general/family medicine teams, as well as those for children in the 7-18 age group, implemented by school medicine teams engaged under contracts for preventive and educational health protection measures for schoolchildren and university students. As part of these measures, regular check-ups are carried out to monitor, amongst other things, sexual development and risky sexual behaviour in schoolchildren and university students, specific reproductive health screenings are run, and counselling and health education services are provided to them. All the necessary diagnostic or therapeutic procedures for children aged 7-18 are indicated by attending primary health care physicians or by teams responsible for implementing preventive and educational health protection measures for schoolchildren and university students, in conjunction with attending primary health care physicians.

Health protection of women is provided at three levels of health care. At the primary health care level, the CIHI entered into contracts with health institutions/private health practitioners engaging the services of 256 teams for health protection of women covering a total 1,498,912 CIHI insurees – women over 15 years of age. Teams for health protection of women implement preventive and medical treatment measures pursuant to the Plan and Programme of

Health Care Measures from Compulsory Health Insurance. According to information from the Croatian National Institute of Public Health, there were 1,657,620 visits to doctor's offices and 1,177,425 examinations in 2006, whilst in 2007 there were 1,576,379 visits and 1,124,597 examinations.

The "National Programme for Early Detection of Breast Cancer" has been implemented since 2006, with the aim of promoting early detection of breast cancer, which should result in the reduction of mortality by 20-25% in a five-year period. The screening covers all women in the 50-69 age group, and it is carried out every other year. The basic screening method is mammography, which can detect changes in breast even two years before the tumour can be palpated. More than 270,000 invitations to free mammography screening were sent, and 51% of those invited responded to the invitation. A total of 261 cases of early breast cancer were detected, and these persons now have greater chances of full recovery.

Since 2004 the general/family medicine practitioners working under contracts with the CIHI have been carrying out preventive examinations of insured persons older than 50. Until October 2007, about 50,000 insured persons underwent preventive examinations. Pathological conditions were found in 44% of those who were examined, and 9,751 insured persons were referred for further specialist and consultant workup.

Persons insured with the CIHI who are older than 65 receive health care services from their attending primary health care physicians, who, on the basis of medical indication, can either treat them medically on their own or refer them for further tests and treatment at the secondary or tertiary levels of health care. We would like to note that general/family medicine teams attending to relatively large numbers of persons above 65 years of age generate higher revenues on account of annual capitation fees, because their patients have greater health needs.

The biggest step forward in terms of payment methods for health care services was the introduction of payments based on diagnosis-related groups (DRGs) in 2006. During 2007, all hospitals providing treatment to patients suffering from acute diseases were sending bills to the CIHI for hospital services rendered according to the new DRG scheme. This method of payment leads to an increased efficiency and quality of health care in hospitals, and it is used in all European Union countries.

In mid-October 2007 the "National Programme for Early Detection of Colon Cancer" was launched. The goal of this Programme is to reduce deaths from colon cancer by 15% in the first five years of its implementation. The screening for colon cancer covers men and women in the 50-75 age group, and it is carried out every other year. The basic screening method is the faecal occult blood test. A total of 600,000 persons will receive faecal occult blood test kits at their home address. Those whose tests results are positive will be invited for further workup, i.e. for a colonoscopy. This project is unique in Europe because the Republic of Croatia will be the first country where this type of programme for early detection of colon cancer is implemented on the whole national territory.

To improve health protection of insured persons, the CIHI financed a total of 1,428 specialisations in the period between 2004 and 2007. Of this number, 610 registrars specialising in family medicine completed their specialisations – which began in 2003 as part of the Project of Harmonising the Family Medicine Practice with European Standards – by the end of 2007. CIHI also covered the costs of post-graduate studies in the amount of HRK

8,000.00 for each registrar, and the remaining part in the amount of HRK 4,000.00 was paid by the lease holder in person or by the health institution. The funds spent to cover two thirds of the fees for family medicine specialisations equalled HRK 27,246,526 in 2006 (this amount also included the costs of specialisations which had begun in 2003, 2004 and 2005) and HRK 21,415,425.57 in 2007.

In the aforesaid four years, the CIHI financed traineeship for health workers with junior college and university qualifications and specifically for: medical doctors, doctors of dental medicine, medical biochemistry graduates, graduate pharmacists, registered nurses, senior physical therapists, senior occupational therapists, senior laboratory medicine practitioners and medical radiology practitioners. The financing was arranged in such a way that CIHI would first enter into a contract with the health institution where the health worker was on a traineeship programme. On the basis of these contracts, the CIHI would compensate the health institution for the gross salaries paid to the trainee. In this way, health workers were enabled to start their traineeship within the shortest possible time and health institutions were offered support in financing these traineeships.

To ensure uniform availability of health care, in 2004 the Government of the Republic of Croatia adopted the Basic Network of Medical Services. The CIHI regularly issues tenders in the towns and municipalities where the network is understaffed. At the request of a county or local self-government unit, the procedure for amending the Basic Network may be initiated, if such request is found to be justified. Thus, to introduce a number additional primary health care teams, especially on Croatian islands and in mountainous regions, on 7 November 2007 the first amendments to the Basic Network of Medical Services were adopted and published (Official Gazette, no. 115/07).

In response to the Committee's enquiry concerning information and statistical data on effective access to health care by all disadvantaged groups of the population, it should be pointed out that, pursuant to the Action Plan for the Decade of Roma Inclusion, the Ministry of Health and Social Welfare is responsible for implementing the following measures:

1. Health education and education for the Roma, particularly women

At the end of 2004, a seminar was organised to train educators from five counties in which the largest numbers of resident Roma are registered, according to the 2001 Population Census. At the end of 2005, a seminar was held in the CNIPH for representatives of another eleven counties. The participants were future co-ordinators and implementers of activities relating to improving the health status and health protection of Roma in these counties. During the seminar, presentations were made of pilot research carried out through a survey on the health status of the Roma and their use of health care services, and on guidelines for intervention. The participants then devised county health priorities for the Roma according to local needs, along with proposed sources of funding. They were also given training packs containing expert material relating to health education and promotion, as an aid in carrying out health training for health visitors and institutes of public health. The following conclusions were reached:

a) Most health priorities are determined by basic living conditions and communal infrastructure. Undeveloped Roma settlements, which have no mains water, drains or other elements of communal infrastructure, including waste disposal facilities, foster inappropriate living conditions in terms of hygiene and sanitation. Therefore the counties must first resolve basic living conditions, financed in co-operation with state

and local community funds from the state, county and municipal budgets. Local community funds must be ensured for pest and insect control and disinfection, as well as the removal of stray dogs from Roma settlements.

b) The responsibility and joint responsibility of the Roma was emphasised, in terms of acquiring the documentation they need in order to exercise certain rights, including the right to health insurance. Since the proportion of the educated among the Roma is small and the proportion of the uneducated and illiterate, who need help resolving their problems (e.g. filling in forms and applications), is large, it would be useful to have Roma advice centres at county level, which could provide advice and expert assistance in resolving such problems.
c) It is absolutely necessary to establish better communication with the Office for National Minorities, so that county work groups can be acquainted with the opportunities for submitting local projects to improve the health and other needs of the Roma for grants or other sources of financing.
d) At the county level, a detailed elaboration of health priorities will be prepared and a co-ordinating work group officially appointed to monitor implementation and provide an assessment of implemented measures, as specified by county plans. Research will need to be carried out in order to determine county health priorities, since such research will enable an insight to be gained into the basic indicators of Roma social and health conditions.
e) Two modes of implementing health education activities are proposed: the first is to train Roma assistants who would help health visitors and various Roma associations (cultural clubs, etc.) to carry out health education and to exploit the potential of co-operating with health institutions, schools, pre-schools and the local media.

2. Carrying out the health survey

Compilation and processing of data on the health status of Roma was carried out by means of a pilot project in the selected county in 2005. The research was carried out in co-operation with the Institute for Anthropology on a part of the Roma population of Osijek- Baranja County who live in the Darda area of Baranja (117 households). On the basis of the data processed, an expert analysis was made of the social-demographic and health characteristics of individuals and households in the Roma settlement in Darda. All the numerical indicators were presented in detail in the "Survey on the Health Status and Health Protection of the Roma Population – Results of Pilot Research in Darda".

3. Improving the vaccination coverage

The CNIPH is responsible for implementing this measure, in co-operation with county institutes of public health, according to the tasks defined in the Health Care Act. The CNIPH also analyses the epidemiological status in the field, proposes, organises and carries out preventive and anti-epidemiological measures, and plans, supervises and evaluates the implementation of compulsory immunisation. Vaccination is the responsibility of parents and doctors in primary health care, who take care of the part of the population assigned to them. The implementation of the compulsory vaccination programme, i.e. child vaccination rate, is monitored by means of annual vaccination reports compiled by vaccinators by age and vaccine, not by national affiliation. Taking into account the realistic fact that most Roma do not avail themselves of their guaranteed rights to health protection, institutes of public health come to Roma settlements and carry out vaccination. From time to time, the vaccination status of Roma children is monitored and if necessary, supplementary vaccination provided.

In counties in which a certain proportion of children have not been adequately immunised, and parents do not respond to invitations to bring them for vaccination, nor co-operate with the epidemiological services, it is planned to carry out health education, with the aim of building a positive attitude to vaccination among the Roma, if it is possible for children to be vaccinated by a selected paediatrician or during drives carried out by epidemiologists. As an example, we could mention the Primorje-Gorski Kotar County, which carried out a survey of the vaccination status of Roma children in the Rijeka district of Rujevica in the spring of 2005. Following several meetings with representatives of Roma associations, a drive was successfully carried to vaccinate pre-school children who had missed out on compulsory vaccination.

4. Improving the working conditions of health visitors providing care for the Roma population

Health visitor services, operating within community health centres, are concerned with caring for the entire population of a particular area, regardless of their health insurance, pursuant to contracts with the Croatian Institute for Health Insurance. Thus, health visitors should make visits to Roma settlements, including to people with no health insurance, as part of their regular work. The goal of the measure envisaged is to improve communication and team work between the health system in the field (community health centres) and the social welfare system (social welfare centres), which can be achieved by joint efforts at county levels, aimed at improving co-ordination. In some counties, such co-operation has reached praiseworthy levels and has produced results in the field; however, in others, there is room for improvement. For example, thanks to the excellent co-operation between the health visitors working in the Čakovec Community Health Centre and attending primary health care doctors to whom the Roma settlements of the Međimurje County tend to gravitate, vaccination coverage of pre-school Roma children in most of these settlements has almost reached the obligatory level of 90%. Health visitors in the Međimurje County visit the Roma settlements several times a month (visiting women, pregnant women, women in puerperium and newborn babies, infants, small children, pre-school and school age children, young people, the chronically sick, the elderly and infirm, those with mental problems, disabled people, and others) and carry out health education for the Roma population, with the aim of advancing health culture and preventing disease.

5. Creating the pre-conditions for ensuring the availability of health care for Roma who have basic health insurance rights, particularly the most vulnerable groups (infants, small children and school age children, pregnant women, disabled people)

The implementation of this measure includes research into the health of the Roma (by means of a survey), for the purpose of compiling data on the health status of the Roma and specific groups within the Roma community, through a pilot project carried out in selected counties in 2005 (and to be carried out in other counties between 2006 and 2015).

6. Informing the Roma of the opportunities they have to exercise the right to health care through compulsory health insurance, by disseminating information in Roma settlements

In 2005, measures were taken to inform the Roma population of the opportunities they have to exercise the right to health care through compulsory health insurance, with the aim of improving their health and health care, by disseminating information in Roma settlements. The Ministry of Health and Social Welfare, in co-operation with the Croatian Institute for

Health Insurance, produced a brochure entitled "My rights" in Roma languages, with information on using health care services.

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 rights, conditions and means of exercising rights in the compulsory health insurance scheme.

As a rule, an insured person applies for the right to a monetary benefit or other rights under the compulsory health insurance scheme to the competent regional or branch office of the CIHI, according to the 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 CIHI's regional office competent 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 CIHI's Directorate, within 15 days of the date when the decision was received. The appeal may be filed in person or sent by mail to the CIHI's regional office which rendered the first instance decision. A decision rendered by the CIHI's Directorate 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.

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 co-ordination. Public health services in 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 co-ordinates and supervises the work of the network of local public health services.

The Croatian Institute of Public Health is a health institution in charge of performing the following public health services: the epidemiology of quarantine and other infectious diseases, microbiology, the epidemiology of chronic widespread diseases, immunisation, sanitation, social medicine and health statistics, popular health education, advancement of health and disease prevention, health ecology, school medicine, prevention of addictions and toxicology. County institutes of public health (21) with their hygiene and epidemiology branches are part of the public health services in the regional and local self-government units, and in addition to basic hygiene and epidemiology services and the activities related to social medicine and health statistics, they also provide microbiological and health ecology services, as well as school medicine services which were included in the public health system in 1998. An important role in the implementation of public health policies is played by the sanitary inspection, as an administrative instrument.

The Croatian National Institute of Public Health is a health institution responsible for performing public health services. It, amongst other things, 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, co-ordinates 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 records in the field of addiction diseases (including tobacco, alcohol and psychoactive drugs).

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

- implement specific health protection of children and youth, in particular in primary and secondary schools, and faculties in their respective areas,
- collect, control and analyse statistical reports in the field of health, including those on addiction diseases, at the level of units of regional self-government, for the Croatian National Institute of Public Health,
- continually implement the measures of hygiene and epidemiology protection and carry out epidemiological analyses of the situation in their respective areas, and, if necessary, undertake anti-epidemic measures and supervise the implementation of the compulsory immunisation programme.

Infectious diseases are diagnosed by health institutions owned by the state: the "Dr Fran Mihaljević" Clinic for Infectious Diseases, clinical hospital centres, clinical hospitals and state health institutes, 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. In 2005 there were 72 hospitals and sanatoria in the Republic of Croatia, as well as 2 clinical (teaching) hospital centres, 12 clinical hospitals and clinics, 22 general hospitals and 26 specialist hospitals and one sanatorium. There were also 9 private hospitals which did not submit reports. In 2006 there were 71 hospitals and sanatoria, 2 clinical (teaching) hospital centres, 12 clinical hospitals and clinics, 22 general hospitals and 26 specialist hospitals and one sanatorium, as well as 8 private hospitals and sanatoria which did not submit reports. Pursuant to Article 154 of the Health Care Act, private practice may not be performed in the following services:

Institutions for treating tuberculosis

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.	Pulmonary diseases and tuberculosis hospital	Klenovnik

6. Polyclinic for respiratory system diseases	Zagreb
7. 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 2007 figures from the Service for the Epidemiology of Infectious Diseases of the Croatian National Institute of Public Health, the situation as regards the group of genital or sexually transmitted diseases is relatively favourable, as they had low and sporadic incidence: syphilis (31), gonorrhoea (15), AIDS (7).

Institutions for treating AIDS

1. The "Dr. Fran Mihaljević" Clinic for Infectious Diseases, Zagreb
   - This clinic is also the Reference Centre of the Ministry of Health and Social Welfare 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 2006, the group of mental illnesses and disorders was ranked seventh on the list of the causes of hospitalisation in Croatia, with the share of 7.0%. However, when it comes to the number of hospital days, it is at the top of the list, with the share of 21.9% of the total number of hospital days. This actually means that one in five hospital days in Croatia is used for treating mental disorders. Schizophrenia is out in front (33.7%) in the total number of hospital days used for treating mental illnesses and disorders. Age standardised rate of hospital incidence of schizophrenia has not shown any significant changes for years, and on average equals 0.26/1,000 of the population above 15 years of age.

Psychiatric treatment in the Republic of Croatia is provided by in-patient and out-patient services of 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, Osijek
9. Psychiatric wards in County General Hospitals	Counties
10. Child Protection Centre of the City of Zagreb	Zagreb

After the court with jurisdiction 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 (Official Gazette, nos. 111/97, 128/99, 79/02).

Health protection of women

In 2006 a total of 1,503,885 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, 876,892 or 58.3% actually consulted their gynaecologists, which was a decline in comparison with 2005 when gynaecologists' services were used by 61.6% of women. According to population estimates of the Central Bureau of Statistics, in 2006 2,301,100 women (2,200 fewer women than in 2005) lived in Croatia, and their share in the total population was 51.8%. Of that number, there were 1,061,800 women in child-bearing age (46.1%) and 1,961,000 women over 15 years of age, who were potential users.

In 2006, in the area of health protection of women, a total of 217 teams worked under contracts with the Croatian Institute for Health Insurance (CIHI) on a full time basis, and 32 teams on a part-time basis. In comparison with the year 2005, the number of full-time teams working under contract fell (-1), as did the number of part-time teams (-2). At the same time, the number of teams in private clinics not operating under contracts with the CIHI fell by 2 for full-time teams and by 1 for part-time teams.

A special area of attention in the health protection of women is the care of pregnant women and women after childbirth. Every pregnant woman was examined 7.5 times on average at the level of the entire Croatia. In comparison with the previous years, certain pathological findings in pregnancy were on the increase. In 2006 48.9% such cases were discovered (2005: 45.7%; 2004: 42.8%; 2003: 44.1%).

In 2006, a total of 447,640 preventive examinations were carried out (the rate was 421.58/1,000 women of child-bearing age), which reflected a decline from the previous year, 2005 (427.5/1,000) when the highest rate of preventive examinations was recorded after 1990. The majority of preventive examinations were actually regular gynaecologic check-ups (63.0%). In 2006 a total of 127,909 preventive breast examinations were carried out as part of the health protection of women (the rate of 120.5/1,000 women of child-bearing age; 2005: 119.9/1,000; 2004: 113.8/1,000). The percentage of examinations revealing pathological findings in 2006 was 5.7% (5.5% in 2005; 5.3% in 2004; 8.2% in 2003).

In 2006 the number of smear tests (PAP smears) continued to increase. A total of 449,713 smear tests were performed. The rate of smear tests was 423.5 per 1,000 women of child-bearing age and 229.3 per 1,000 women older than 15 (2005: the rates were 405.6/1,000 and 221.5/1,000, respectively). Pathological findings were also on the increase, from 8.4% in 2005 to 10.3% in 2006.

The most frequent diseases and conditions for which women came to the gynaecologist and used services of primary health protection of women in 2006 remained almost the same as in the several preceding years. These were: urinary and genital diseases with the share of 48.7%; factors affecting the health and contact with the health services (25.9%); infectious and parasitic diseases (12.1%), pregnancy, childbirth and puerperium (5.6%); tumours (5.0%); and other groups of conditions (2.7%). In 2006, menopausal and perimenopausal disorders were

ranked first (14.4%) on the list of diseases and conditions, followed by candidiasis (10.3%), inflammatory diseases of the pelvic organs (10.3%), menstrual disorders (8.9%), cervix inflammation (4.5%), cervix displasia (4.5%), bladder inflammation (3.4%), trichomoniasis (3.2%), and other diseases.

In 2007 a total of 1,501,782 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, 885,389 or 58.96% actually consulted their gynaecologists. According to population estimates of the Central Bureau of Statistics, in 2007 2,298,000 women lived in Croatia, and their share in the total population was 51.8%. Of that number, there were 1,808,800 women over 15 years of age, who were potential users and 1,053,600 women in child-bearing age (45.8%).

In 2007, in the area of health protection of women, a total of 222 teams worked under contracts with the Croatian Institute for Health Insurance (CIHI) on a full time basis, and 31 teams on a part-time basis. In comparison with the year 2006, the number of full-time teams working under contract continued to increase (+5). At the same time, the number of teams in private clinics not operating under contracts with the CIHI fell by 1,5 team (from 53 to 52 teams for full-time teams and from 5 to 4 for part-time teams).

When it comes to the health protection of pregnant women and women after childbirth, it should be noted that the number of examinations per pregnant woman ranged from 5.2 in the Virovitica-Podravina County to 10.6 in the Zadar County, with an average of 7.6 examinations on the national level. In this connection, account should be taken of the fact that a certain number of pregnant women, especially those with high-risk pregnancies, receive health care services at the specialist and consultant level and in hospitals. A pathological condition in pregnancy was found in 48.1% pregnant women, which was slightly less than in 2006 (48.9%).

According to reports received from primary health care clinics providing health protection to women in 2007 (with and without contracts with the CIHI), the number of visits for family planning purposes fell in comparison from the preceding years. In 2007 there were 98,604 visits for family planning and/or birth control purposes. Oral contraceptives were most frequently prescribed (78.1%), followed by intrauterine devices (15.1%).

In 2007, a total of 483,054 preventive examinations were carried out in the primary health care of women (the rate was 458.5/1,000 women of child-bearing age), which was the highest rate since 1990. The majority of preventive examinations were actually regular gynaecologic check-ups (62.4%). In 2007 a total of 131,147 preventive breast examinations were carried out as part of the health protection of women (the rate was 124.5/1,000). The percentage of examinations revealing pathological findings in 2007 was 5.1%, which was a reduction from the preceding year.

In 2007 a total of 448,691 cervical smears were taken (the rate was 425.9/1,000, slightly higher than in the preceding year). Of the total number of smear tests, pathological findings were revealed in 9.7% cases, which was a decrease in comparison with the preceding year (10.3%).

The most frequent reasons for which women came to the gynaecologist and used services of the primary health protection of women in 2007 did not change in relation to the several

preceding years. These were: urinary and genital diseases with the share of 47.8%; factors affecting the health and contact with the health services (27.5%); infectious and parasitic diseases (12.1%), pregnancy, childbirth and puerperium (5.5%) and tumours (4.5%). In 2007, menopausal and perimenopausal disorders were ranked first (13.5%) on the list of diseases and conditions, followed by candidiasis (10.9%), inflammatory diseases of the pelvic organs (9.7%), and menstrual disorders (9.3%)

In 2006, 728,233 persons were treated in hospitals (in 2005 this number was 689,100), including stays in hospital for childbirth, abortion and hospital rehabilitation. The number of women treated was somewhat higher than the number of men (1.24:1).

The leading groups of diseases in the hospital treatment of women in 2005 were tumours (14.1% – most frequently malignant breast tumours), circulatory system diseases (12.8% – most frequently cerebral infarction), urinary and genital diseases (10.5% – most frequently excessive, frequent or irregular menstruation), diseases of the digestive system (7.7% – most frequently cholelithiasis) and diseases of the respiratory system (7.3% – most frequent diagnosis was chronic tonsil and adenoid disease), and other diseases and conditions (47.6%).

The leading groups of diseases in the hospital treatment of women in 2006 were tumours (14.6% – most frequently malignant breast tumours), circulatory system diseases (12.7% – most frequently cerebral infarction), urinary and genital diseases (10.4% – most frequently excessive, frequent or irregular menstruation), diseases of the digestive system (7.6% – most frequently cholelithiasis) and diseases of the respiratory system (6.5% – most frequent diagnosis was chronic tonsil and adenoid disease), and other diseases and conditions (48.2%).

Regarding the Committee's enquiry requesting updated information on maternal death rates and the steps taken to improve the situation, we must point out that the maternal death rate has been at a very low level for years, and is limited to occasional cases.

For example, in 2005 three women died in Croatia due to complications during pregnancy, childbirth or puerperium (7/100,000 live births). However, of these three, only one died of causes directly related to pregnancy or childbirth (amniotic fluid embolism), and the other two died of causes not directly related to pregnancy, childbirth or puerperium; one as the result of a heart defect caused by an earlier episode of rheumatic fever (mitral valve stenosis), and the other of an acute neurological problem (myelitis transversalis). According to WHO cause of death codes prescribed in the International Classification of Diseases and Related Health Problems – 10th revision (Volumes 1 and 2), member states are required to report on all deaths of women during pregnancy, childbirth or up to 42 days after giving birth, giving the direct and indirect obstetric causes of death.

In adherence to these regulations, Croatia regularly submits information to the World Health Organisation on maternal deaths in the manner prescribed. Taking only the direct obstetric causes of maternal death, the rate was 2.48/100,000 live births in Croatia in 2005, rather than 7/100,000. The situation in 2006 was similar, when four women died of complications during pregnancy, childbirth or puerperium, i.e. 9.7/100,000 live births.

In 2007 six women died in Croatia of complications during pregnancy, childbirth or puerperium (14.31/100,000 live births). Three deaths were directly related to causes arising from pregnancy (two as a result of missed abortions – ICD code O02.1; one as a result of chorioamnionitis – ICD code O41.1) while the other three deaths were due to indirect causes

which occurred or were exacerbated during pregnancy, childbirth or puerperium (coronary artery aneurism, cardiomyopathy and addiction to psycho-active drugs). The maternal death rate due to direct obstetric causes in Croatia in 2007 was 7.15/100,000 live births, as opposed to the rate of 14.31/100,000, which included deaths due to both obstetric and non-obstetric causes. These statistics show a greater number of maternal deaths caused by non-related causes, than the number caused by causes directly related to pregnancy, childbirth or puerperium.

The Committee is correct in thinking that maternal death is a preventable risk and that countries should take all necessary steps in organising and making available health care, in order to reduce this risk to zero.

In order to reduce the maternal death rate 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 (OG 126/06, see excerpt from the Programme for Health Protection of Women in Annex 1). This programme is being financed entirely by compulsory health insurance, which covers almost all citizens in the Republic of Croatia.

Primary health care of infants and small children – 2005 indicators

Primary health care of infants and small children is mostly provided by services for health care of infants and small children and only to a smaller extent by general/family medicine practitioners. When it comes to the number of doctors and insurees in the services for health care of infants and children, one team was in charge of 1,326 insurees on average, of whom there were 884 children in the 0-6 age group, and the rest were children of school age. Health care provided by these services covered 72.7% of pre-school children (212,505 children), whereas other pre-school children (about 27.3% or 79,974 children), mostly living in rural areas and on islands, were cared for by family/general medicine services.

In 2005 a total of 515,675 preventive examinations of children younger than 7 years of age were carried out in both types of primary health care services for children. Of these, there were 253,613 preventive examinations of infants (5.5 examinations per infant), and 262,062 preventive examinations of children in the 1-6 age group (1.1 examinations per child).

Services for health care of infants and small children carried out 5.5 preventive examinations per infant, whereas family/general medicine services carried out 3.83 preventive examinations on average. In the group of infants who underwent regular check-ups, undernutrition was recorded in 1.6% cases and overnutrition in 2.4%. A total of 55.3% of infants in the 0-2 months group were exclusively breastfed (56.0% in 2004), and 22.2% (22.0% in 2004) were both breastfed and fed by breast milk substitutes, 16.4% were formula-fed (16.9% in 2004), and for 6.1% feeding history was unknown. In the group of infants older than three months of age, the share of exclusively breastfed infants fell to 35.8% in the under 6 months group and to 18.5% in the 6-11 months group, and with the introduction of supplementary food, the use of substitutes for breast milk was increased. A total of 70.2% of infants who underwent regular check-ups were given prophylaxis against rickets (72.8% in 2004) and 11.1% were given prophylaxis against anaemia (12.8% in 2004). Signs of rickets were found in 0.3% of infants (0.6% in 2004). The most frequent development disorder found in infants during regular check-ups was slowed psychomotor development, found in 2.3% of examined infants (2.4% in 2004). The shares of other disorders, such as phimosis (0.9%), congenital hip

dislocation (0.5%), congenital heart defects (0.3%), other congenital anomalies, muscular and skeletal deformations or cryptorchism (0.2%) were lower than 1%.

In the group of small children who underwent regular check-ups, undernutrition was recorded in 1.6% cases (in 2004 in 1.6% cases) and overnutrition in 2.2% (in 2004 in 2.1%). The most frequent pathological condition found during regular check-ups was carious teeth – 10.4% (10.9% in 2004), followed by dyslalia – 3.0% (3.1% in 2004), muscular and skeletal limb deformations – 2.2% (2.4% in 2004), phimosis – 2.1% (1.9% in 2004), strabismus – 1.7% (1.6% in 2004).

According to the morbidity report, the number of recorded diseases and conditions up to 7 years of age was 992,855 (1,032,787 in 2004). The most frequent diseases were respiratory system diseases (53.6% in 2005; 51.9% in 2004), then infectious and parasitic diseases (8.9% in 2005; 9.2% in 2004), ear diseases (6.1% in 2005; 6.1% in 2004), skin diseases and diseases of subcutaneous tissue (5.3% in 2005; 5.3% in 2004), and eye and adnexal diseases (3.3% in 2005; 3.2% in 2004). The same rank order of leading causes of morbidity was recorded in the school age group.

Primary health care of infants and small children – 2006 indicators

According to 2006 data on the number of doctors and insurees in the services for health care of infants and children, one team was in charge of 1,364 insurees on average, of whom there were 872 children in the 0-6 age group, and the rest were children of school age. Health care provided by these services covered 75.2% of pre-school children (217,720 children), whereas other pre-school children (about 24.8% or 71,026 children), mostly living in rural areas and on islands, were cared for by family/general medicine services.

In 2006 a total of 499,803 preventive examinations of children younger than 7 years of age were carried out in both types of primary health care services for children. Of these, there were 240,572 preventive examinations of infants (5.1 examinations per infant), and 259,231 preventive examinations of children in the 1-6 age group (1.1 examinations per child). Services for health care of infants and small children carried out 5.2 preventive examinations per infant, whereas family/general medicine services carried out 4 preventive examinations on average.

In the group of infants who underwent regular check-ups, undernutrition was recorded in 1.7% cases and overnutrition in 3%. A total of 57.4% of infants in the 0-2 months group were exclusively breastfed (55.3% in 2005), and 21.5% (22.2% in 2005) were both breastfed and fed by breast milk substitutes, 16.1% were formula-fed (16.4% in 2005), and for 5% feeding history was unknown. In the group of infants older than three months of age, the share of exclusively breastfed infants fell to 37.6% in the under 6 months group and to 17.2% in the 6-11 months group, and with the introduction of supplementary food, the use of substitutes for breast milk was increased. A total of 65.6% of infants who underwent regular check-ups were given prophylaxis against rickets (70.2% in 2005) and 11.3% were given prophylaxis against anaemia (11.1% in 2005). Signs of rickets were found in 0.5% of infants (0.3% in 2005). The most frequent development disorder found in infants during regular check-ups was slowed psychomotor development, found in 2.5% of examined infants (2.3% in 2005). The shares of other disorders, such as phimosis (0.8%), congenital hip dislocation (0.5%), congenital heart defects (0.4%), muscular and skeletal deformations, cryptorchism and other congenital anomalies (0.2%) were lower than 1%.

In the group of small children who underwent regular check-ups, undernutrition was recorded in 1.7% cases (in 2005 in 1.6% cases) and overnutrition in 2.6% (in 2005 in 2.3%). The most frequent pathological condition found during regular check-ups was carious teeth – 9.8% (10.4% in 2005), followed by dyslalia – 3.1% (3.0% in 2005), phimosis – 2.0% (2.1% in 2005), muscular and skeletal limb deformations – 1.7% (2.2% in 2005), strabismus – 1.5% (1.7% in 2005).

According to the 2006 morbidity report, the number of recorded diseases and conditions up to 7 years of age was 1,004,357 (992,855 in 2005) and 245,918 in the school age group. The most frequent diseases diagnosed in pre-school children were respiratory system diseases – 51.2% (53.6% in 2005), then infectious and parasitic diseases – 8.9% (8.9% in 2005), ear diseases – 6.3% (6.1% in 2005), skin diseases and diseases of subcutaneous tissue – 5.5% (5.3% in 2005), and symptoms, signs, and other clinical and laboratory findings – 3.6% (3.2% in 2005). The rank order of leading causes of morbidity in school-age children was the same for the first (respiratory diseases – 51.9%) and the second (infectious – 9.3%) groups of diseases. Skin diseases and diseases of subcutaneous tissue ranked third (6.2%), ear diseases ranked fourth (5.6%), and symptoms, signs, and other clinical and laboratory findings were in the fifth position (4.6%).

Primary health care of infants and small children – 2007 indicators

According to 2007 data on the number of doctors and insurees in the services for health care of infants and children, one team was in charge of 1,405 insurees on average, of whom there were 882 children in the 0-6 age group, and the rest were children of school age.

In 2007, 259 teams within the services for health care of infants and children provided health care to 79.6% of pre-school children (228,494 children), whereas other pre-school children (20.4% or 58,416 children), mostly living in rural areas and on islands, were cared for by family/general medicine services.

In 2007 a total of 510,231 preventive examinations of children younger than 7 years of age were carried out in both types of primary health care services for children. Of these, there were 236,882 preventive examinations of infants (4.9 examinations per infant), and 273,409 preventive examinations of children in the 1-6 age group (1.2 examinations per child). Services for health care of infants and small children carried out 5 preventive examinations per infant, whereas family/general medicine services carried out 4.1 preventive examinations on average.

A total of 319,116 regular check-ups of infants and small children were carried 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).

In the group of infants who underwent regular check-ups, undernutrition was recorded in 1.6% cases and overnutrition in 2.6%. A total of 51.3% of infants in the 0-2 months group were exclusively breastfed (57.4% in 2005), and 19% (21.5% in 2006) were both breastfed and fed by breast milk substitutes, 15.1% were formula-fed (16.1% in 2006), and for 14.6% feeding history was unknown. In the group of infants older than three months of age, the share of exclusively breastfed infants fell to 32.4% in the under 6 months group and to 16.5% in the 6-11 months group, and with the introduction of supplementary food, the use of substitutes for

breast milk was increased. A total of 60.8% of infants who underwent regular check-ups were given prophylaxis against rickets (65.6% in 2006 and 10.4% were given prophylaxis against anaemia (11.1% in 2006). Signs of rickets were found in 0.4% of infants (0.5% in 2006). The most frequent development disorder found in infants during regular check-ups was slowed psychomotor development, found in 2.6% of examined infants (2.5% in 2006). The shares of other disorders, such as phimosis (0.9%), congenital hip dislocation (0.5%), congenital heart defects (0.4%), cryptorchism (0.2%), other congenital anomalies and muscular and skeletal deformations were lower than 1%. In the group of small children who underwent regular check-ups, undernutrition was recorded in 1.4% cases (in 2006 in 1.7% cases) and overnutrition in 2.3% (in 2006 in 2.6%). The most frequent pathological condition found during regular check-ups was carious teeth – 9.9% (9.8% in 2006), followed by dyslalia – 3.1% (3.1% in 2006), phimosis – 2.0% (2.0% in 2006), muscular and skeletal limb deformations – 1.8% (1.7% in 2006), strabismus – 1.5% (1.5% in 2006).

According to the 2007 morbidity report, the number of recorded diseases and conditions up to 7 years of age was 1,021,742 (1,004,357 in 2006). The most frequent diseases were respiratory system diseases – 51.1% (51.2% in 2006), then infectious and parasitic diseases – 9.0% (8.9% in 2006), ear diseases – 6.4% (6.3% in 2006), skin diseases and diseases of subcutaneous tissue – 5.3% (5.5% in 2006), and symptoms, signs, and other clinical and laboratory findings – 3.5% (3.6% in 2006). The same rank order of leading causes of morbidity was recorded in the school age group.

Reasons for hospital treatment of pre-school children in 2005, 2006 and 2007

According to figures from the Croatian National Institute of Public Health, in 2005 hospital treatment was provided to 41,905 children in the 0-5 age group, most frequently for diseases belonging to the following groups: respiratory system diseases – 24.4% (the most common diagnosis was chronic disease of tonsils and adenoids), specific conditions in the perinatal period – 23% (most commonly for neonatal jaundice), infectious and parasitic diseases – 8.9% (most commonly for diarrhoea and gastroenteritis), and other – 43.7%.

In 2006 hospital treatment was provided to 52,737 children in the 0-5 age group, most frequently for diseases belonging to the following groups: respiratory system diseases – 22.3% (the most common diagnosis was chronic disease of tonsils and adenoids), specific conditions in the perinatal period – 19.3% (most commonly for neonatal jaundice), infectious and parasitic diseases – 10.3% (most commonly for diarrhoea and gastroenteritis), and other – 48.1%.

In 2007 hospital treatment was provided to 50,303 children in the 0-5 age group, most frequently for diseases belonging to the following groups: respiratory system diseases – 25.2% (the most common diagnosis was chronic disease of tonsils and adenoids), specific conditions in the perinatal period – 19.3% (most commonly for neonatal jaundice), infectious and parasitic diseases – 9.7% (most commonly for diarrhoea and gastroenteritis), and other – 45.8%.

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

Schoolchildren, young people and regular students comprise about 15.5% of the population of Croatia. According to statistics provided by the Central Bureau of Statistics, in the academic year 2006/2007 there were 382,441 children registered in primary schools, 186,588 in secondary schools and 100,455 full-time students. Due to negative demographic trends, the number of children in primary and secondary schools in Croatia is gradually decreasing, and there were around 9,000 fewer children registered in 2006/2007 than in the previous year.

In primary health care, sick children of school age and university students are cared for by general practitioners or family doctors, while preventive and specific health care is provided by school doctors 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 persons, both individual and mass approaches are used in preventive programmes. Methods include physical examinations, screening, regular and other preventive check-ups, along with compulsory vaccination programme, various types of counselling, individual interviews and counselling for parents, pupils and teachers, as well as contemporary activities to teach and promote health care, in the form of interactive methods of learning and working with parents and local communities.

Entire generations of children are given examinations before registering in Year One of primary school (44,747 such examinations were carried out before the commencement of the academic year 2006/2007, 46,942 in the year before, and 48,705 in the year before that). In line with the programme of regular check-ups, during the academic year 2006/2007, 43,004 children in Year Five were examined (88%), while in the previous year, 44,102 children were examined (91%). In Year Eight, 43,159 children were examined and given careers advice (92%). The year before, the figure was 45,938 (also 92%), while in the year before that 49,823 pupils were examined (99%). The number of pupils given a regular check-up during Year One of secondary school was 33,630 (64%), while in the year before it was 35,956 (68%), which was a little higher than in previous years. In the academic year 2006/2007, 446,432 vaccinations were carried out in primary schools and 44,235 in secondary schools. Vaccination levels reached legal requirements (90%, and 95% for measles).

In the academic year 2006/2007, 18,034 first year students attended regular check-ups (18,532 in 2005/2006). Altogether 1,884 students were referred for follow-up check-ups, a somewhat higher number than in the previous year (1,130). Selective examinations were carried out on 2,402 students (1,187 of which were in relation to adapted programmes of physical and health education), while 6,480 students were examined before taking up residence in students halls of residence (6,922 in 2005/2006). A total of 25,578 students made visits to counselling centres, compared to 19,145 in the year before and 14,065 in the year before that. The most frequent reasons for seeking counselling were problems concerning reproductive health (7,840), chronic illnesses (5,092) and mental health (3,288), followed by some forms of risky behaviour (3,183) and problems with studying (1,218). Health education sessions were attended by 12,179 students (14,888 in 2005/2006), in the form of lectures, panel discussions or group work.

According to figures from the Croatian National Institute of Public Health, in 2005 medical treatment was provided to 48,504 patients in the 6-19 age group. The most common diseases were respiratory system diseases – 22.7% (chronic disease of tonsils and adenoids), injuries and poisonings – 14.4% (superficial head injuries), symptoms and signs – 9.6% (abdomen and pelvis pain), digestive system diseases – 8.2% (acute appendicitis), followed by infectious and parasitic diseases – 6.3% (diarrhoea and gastroenteritis) and other – 38.8%.

In 2006 medical treatment was provided to 53,415 patients in the 6-19 age group. The most common diseases were respiratory system diseases – 20.4% (chronic disease of tonsils and adenoids), injuries and poisonings – 13.9% (superficial head injuries), symptoms and signs – 10.5% (abdomen and pelvis pain), digestive system diseases – 7.9% (acute appendicitis), followed by infectious and parasitic diseases – 7.5% (diarrhoea and gastroenteritis) and other – 39.8%.

The Plans and Programmes of Health Care Measures, which are adopted in Croatia every two years, encompass measures of primary, secondary and tertiary prevention.

The Health Care Plan of the Republic of Croatia

The Health Care Plan of the Republic of Croatia is adopted by the Government of the Republic of Croatia, at the proposal of the minister responsible for health, in accordance with Article 6 of the Health Care Act (OG 121/2003 and 48/2005).

With the aim of implementing health care in the unified system of health services of the Republic of Croatia, the Health Care Plan of the Republic of Croatia defines the following:
– the tasks and objectives of health care,
– the priority areas of development,
– the health needs of the population that are of special interest to the Republic of Croatia,
– specific needs and possibilities of implementing health care in specific areas,
– those responsible for different tasks and Plan implementation deadlines,
– the basis for the development of health services according to different levels, including training and further education of personnel and the basis for the development of the health care system,
– the criteria for defining the basic network of medical services in the Republic of Croatia.

The implementation of this Plan is ensured by medical institutions, companies that provide health services and health workers, who implement the measures defined in the Health Care Plan and Programme, in the manner and under the conditions prescribed by law, and with the aim of:
– protecting and improving the health of the general population;
– increasing life expectancy and reducing mortality;
– increasing the number of years without morbidity and/or disability;
– ensuring the highest possible level of physical and psychological health, and working on the improvement of the quality of life by preserving health and functional abilities.

The organisation of health care has to ensure the following principles:
– the comprehensiveness of health care, by including the entire population in the implementation of adequate health care measures;
– the continuity of health care by organising health care for citizens of all ages;

– the accessibility of health care, by the distribution of health institutions, companies that provide health services and health workers, which should enable all citizens equal conditions of health care, especially in primary health care;
– an integral approach in primary health care and a specialised approach by ensuring and developing specialised clinical achievements in public health and developing know-how and applying it in practice.

Primary prevention encompasses vaccination programmes, antenatal care with a prescribed number of antenatal controls, preventive health care for infants and children of pre-school age, regular medical check ups at school age, and examinations with the aim of preventing malignant diseases.

The Plan and Programme of Health Care Measures
The Plan and Programme of Health Care Measures is adopted by the minister responsible for health on the basis of Article 17, paragraph 1 of the Health Care Act (OG 121/2003 and 48/2005), at the proposal of the Croatian Institute for Health Insurance and the Croatian National Institute of Public Health.

The Plan and Programme of Health Care Measures defines a set of measures and procedures to be applied for individuals, groups, and the wider community with the aim of protecting health, and it defines activities in accordance with the defined resources and objectives, the entities that are obliged to implement these activities and the manner of their implementation.

Health care measures are a set of activities, i.e. preventive, therapeutic and rehabilitative medical procedures at different levels of health protection, aimed at achieving a specific goal.

The strategic goals of the Plan and Programme of Health Care Measures are the following:
- raising the level of health of the general population by implementing the health promotion programme, and reducing the prevalence of health risk factors;
- reducing morbidity, mortality and disability caused by diseases, injuries and conditions that can be influenced by preventive measures and efficient health care;
- dedicating special attention to the health of groups under increased risk and to measures of improving their health.

In accordance with the analysis of the health of general population, the main implementation goals of the Plan and Programme of Health Care Measures are the following:
- improving the health of the general population,
- increasing life expectancy and reducing mortality,
- increasing the number of years without morbidity and/or disability,
- ensuring the maximum possible level of physical and psychological health by efforts to increase the quality of life through preserving health and functional capacities.

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

Health care of infants and small children is offered through two branches of the primary health care system: services for health care of children and general/family medicine, according to the insurees' (parents') free choice of doctor.

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 126/06) is 4 examinations per infant and 4 examinations of small children, with vaccination as prescribed by the Compulsory Vaccination Programme.

In 2005 of the total preventive visits by infants in the primary health care system (253,613), 240,266 or 94.7% were preventive examinations (regular check-ups and/or examinations before vaccination), and 13,347 (5.3%) were visits for counselling. Of the total preventive visits by small children in the primary health care system (262,062), 233,398 or 89.1% were preventive examinations (regular check-ups and/or examinations before vaccination) and 28,664 (10.9%) were visits for counselling.

In 2006 of the total preventive visits by infants in the primary health care system (240,572), 225,966 or 93.9% were preventive examinations (regular check-ups and/or examinations before vaccination) and 14,606 (6.1%) were visits for counselling. Of the total preventive visits by small children in the primary health care system (259,231), 233,013 or 89.9% were preventive examinations (regular check-ups and/or examinations before vaccination) and 26,218 (10.1%) were visits for counselling.

In 2007 of the total preventive visits by infants in the primary health care system (236,822), 222,487 or 93.9% were preventive examinations (regular check-ups and/or examinations before vaccination) and 14,335 (6.1%) were visits for counselling. Of the total preventive visits by small children in the primary health care system (273,409), 244,769 or 89.5% were preventive examinations (regular check-ups and/or examinations before vaccination) and 28,640 (10.5%) were visits for counselling.

PREVENTIVE EXAMINATIONS FOR THE ADULT POPULATION

During 2006, a total of 65,531 regular, periodic and follow-up examinations were carried out within general practice/family medicine on adults in the Republic of Croatia. This represents 14% fewer than in 2005 and 82% fewer than in 1990.

The low number of preventive examinations and house calls is an indication that general practice/family medicine lacks the mechanisms to finance preventive activities, and has become a passive health service, 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.

On an initiative from the Ministry of Health and Social Welfare and the Croatian Institute for Health Insurance, and following the signing of the first contracts in 2004 concerning preventive examinations for insured persons over the age of 45, between the Croatian Institute for Health Insurance and family medicine teams, and with the continuing implementation of preventive examinations in 2005, 2006 and 2007, the following results have been achieved: **in four years, around 43,000 people have been examined** and included in preventive, curative and general health care according to their needs.

To date, the Programme has included about 16% of the target population aged between 50 and 80, who have no regular contact with their chosen general practitioner or family doctor (it varies from 3 to 70% from county to county).

Treating malignant diseases

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

The total number of newly diagnosed cases of invasive cancer (ICD codes C00-C97, not including skin cancer, C44) in 2005 was 20,714, of whom 11,301 were men and 9,413 women. The incidence rate was 466.8/100,000 (529.1/100,000 for men and 409.0/100,000 for women). The five most common sites for cancer in men, which cover 54% of new cases, are the trachea, bronchi and lungs (21%), the prostrate gland (13%), the colon (8%), the rectum, rectosigmoid and anus (6%) and the bladder (6%). The five most common sites for cancer in women, which cover 50% of new cases, are the breasts (24%), the colon (8%) the trachea, bronchi and lungs (7%), the rectum, rectosigmoid and anus (6%) and the ovaries (5%). At the end of 2006, a national programme for the early detection of breast cancer was launched, and at the end of 2007, a national programme for the early detection of colon cancer.

Rehabilitation

Hospitals for rheumatic diseases and rehabilitation

1. Thalassotherapija Crikvenica
2. Daruvarske Toplice (Daruvar Spa)
3. "Naftalan" Ivanić Grad
4. Krapinske toplice (Krapina Spa)
5. Lipik
6. "Biokovka" Makarska
7. Thalassotherapija Opatija
8. Stubičke Toplice (Stubica Spa)
9. Varažinske Toplice (Varaždin Spa)
10. "Kalos" Vela Luka
11. Topusko
12. Physical therapy and rehabilitation wards in 2 general hospitals, 2 clinical hospital centres and 3 clinical hospitals

Health care staff and associates

In relation to the Committee's request for *supplementary information, which would allow an assessment to be made of the level of health care staff and equipment* in the health system of the Republic of Croatia, the following information is provided:

Health care staff in 2005

At the end of 2005 there were 67,716 permanent staff employed in the health system of the Republic of Croatia (working under open-ended employment contracts). Of these, 49,792 were health staff and associates, 4,869 administrators and 13,055 technical staff.

The structure of the permanent staff shows that the greatest proportion have secondary qualifications (37.6%), administrative and technical staff make up 26.5%, doctors 16.4%, health staff with junior college education 9.5%, dentists 4.6%, pharmacists 3.7%, other university degree staff (psychologists, speech therapists, social workers, special needs teachers and others) 1.1%, and semi-skilled health workers 0.6%. A further 7,921 health staff

and associates were employed on a temporary basis (under fixed-term employment contracts). In other words, on 31 December 2005 a total of 57,713 health staff and associates were employed on a permanent or temporary basis (compared with 52,684 in 2000).

The number of doctors per 100,000 population has increased in comparison to 1980 by almost one-third (from 167 to 250 in 2005), which is still less that the EU average (347/100,000). The EU-15 average in 2003 was 362/100,000, while the 10 newest members had an average of 278/100,000, according to data from 2004.

Nurses represent almost half of the total number of health care staff employed (46.1%). In the group of health care staff with secondary and junior college education (31,908 employees), nurses and medical technicians make up 72% and the others are mostly health engineers and technicians. The number of nurses per 100,000 population has risen from 354 in 1980 to 518 in 2005, which is still significantly less than the EU average (731/100,000 in 2004).

Of 22,974 nurses, 15% have senior nursing qualifications. Another indicator is the number of midwives, and this figure is also submitted to the WHO European Health for All Database (HFA-DB). Croatia recorded the highest number of midwives sixteen years ago, in 1988 (1,877), since when the number has slowly dropped, to 1,510 in 2005. In 2005 there were 2.1 nurses employed for every doctor in permanent employment (2.3 in 2000).

HEALTH WORKERS EMPLOYED IN STATE INSTITUTIONS AND IN PRIVATE PRACTICE (PERMANENT JOBS AND TOTAL) AND POPULATION PER ONE HEALTH WORKER, CROATIA 2005

Health workers	*Permanent*	*Population per health worker*	*Total*	*Population per health worker*
Medical doctors	11,100	400	12,022	369
Dentists	3,164	1,402	3,320	1,337
Pharmacists	2,480	1,789	2,659	1,669
Other university degree staff	716	6,198	875	5,071
Junior college education	6,463	687	7,425	598
Secondary school education	25,445	174	30,943	143
Semi-skilled	424	10,466	469	9,462
Total	**49,792**	**89**	**57,713**	**77**

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), CROATIA 2005

Medical doctors	**3,218**
Of whom specialists	1,525
Nurses – Junior college education	**208**
Nurses – Secondary school education	**2,919**

TOTAL NUMBER OF HEALTH STAFF EMPLOYED IN SCHOOL MEDICINE SERVICES, CROATIA 2005

Medical doctors	**171**
Of whom specialists	120
Nurses – Junior college education	**44**

Nurses – Secondary school education	**113**

TOTAL NUMBER OF HEALTH STAFF EMPLOYED IN EMERGENCY ASSISTANCE SERVICES, CROATIA 2005

Medical doctors	**509**
Of whom specialists	35
Nurses – Junior college education	**34**
Nurses – Secondary school education	**856**

TOTAL NUMBER OF HEALTH STAFF EMPLOYED IN OCCUPATIONAL HEALTH AND SAFETY SERVICES, CROATIA 2005

Medical doctors	**169**
Of whom specialists	155
Nurses – Junior college education	**41**
Nurses – Secondary school education	**112**

TOTAL NUMBER OF HEALTH STAFF EMPLOYED IN HEALTH VISITING SERVICES, CROATIA 2005

Nurses – Junior college education	**665**
Nurses – Secondary school education	**134**

TOTAL NUMBER OF HEALTH STAFF EMPLOYED IN NURSING CARE AND REHABILITATION SERVICES, CROATIA 2005

Health staff – Junior college education	**350**
Health staff – Secondary school education	**1,940**

Health institutions in Croatia, 31 December 2005*

Health institutions	*No. of institutions*
Community health centre	**47**
Clinical teaching hospital	**2**
Clinical hospital	**5**
Clinic	**7**
General hospital	**22**
Special hospital	**30**
Sanatorium	**7**
Institute of public health	**21**
Other state institutes:	**3**
♦ *Transfusion Medicine Institute*	1
♦ *Occupational Health and Safety Institute*	1
♦ *Toxicology Institute*	1
Emergency assistance facility	**4**
Polyclinic	**300**
Occupational health and safety institution	**12**
Company providing health services	**22**

Total	**482**

** Regardless of the type of ownership*

Pharmacies	**1,088**
Nursing care and rehabilitation institutions	**148**
Home care private practice	**124**

Health care staff in 2006

At the end of 2006 there were 68,539 permanent staff employed in the health system of the Republic of Croatia (working under open-ended employment contracts). Of these, 50,687 were health staff and associates, 4,949 administrators and 12,903 technical staff.

The structure of the permanent staff shows that the greatest proportion have secondary vocational qualifications (37.8%), administrative and technical staff make up 26.0%, doctors 16.4%, health staff with junior college education 9.7%, dentists 4.6%, pharmacists 3.7%, other university degree staff (psychologists, speech therapists, social workers, special needs teachers and others) 1.1%, and semi-skilled health workers 0.6%. A further 7,913 health staff and associates were employed on a temporary basis (under fixed-term employment contracts). In other words, on 31 December 2006 a total of 58,600 health staff and associates were employed on a permanent or temporary basis (compared with 52,684 in 2000).

The number of doctors per 100,000 population has increased in comparison to 1980 by almost one-third (from 167 to 253 in 2006), which is still less that the EU average (315/100,000). The EU-15 average in 2003 was 362/100,000, while the 12 newest members had an average of 255/100,000, according to data from 2006.

Nurses represent almost half of the total number of health care staff employed (46.1%). In the group of health care staff with secondary and junior college education (32,555 employees), nurses and medical technicians make up 72.0% and the others are mostly health engineers and technicians. The number of nurses per 100,000 population has risen from 354 in 1980 to 526 in 2006, which is still significantly less than the EU average (741/100,000 in 2006).

Of 23,355 nurses, 15% have senior nursing qualifications. Another indicator is the number of midwives, and this figure is also submitted to the WHO European Health for All Database (HFA-DB). Croatia recorded the highest number of midwives sixteen years ago, in 1988 (1,877), since when the number has slowly dropped, to 1,517 in 2005. In 2006 there were 2.1 nurses employed for every doctor in permanent employment (2.3 in 2000).

HEALTH WORKERS EMPLOYED IN STATE INSTITUTIONS AND IN PRIVATE PRACTICE (PERMANENT JOBS AND TOTAL) AND POPULATION PER ONE HEALTH WORKER, CROATIA 2006

Health workers	*Permanent*	*Population per health worker*	*Total*	*Population per health worker*
Medical doctors	11,250	400	12,149	369
Dentists	3,185	1,402	3,364	1,337
Pharmacists	2,549	1,789	2,720	1,669
Other university degree staff	748	6,198	901	5,071
Junior college education	6,668	687	7,669	598
Secondary school education	25,887	174	31,368	143

Semi-skilled	400	10,466	429	9,462
Total	**50,687**	**89**	**58,600**	**77**

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), CROATIA 2006

Medical doctors	**3,202**
Of whom specialists	1,575
Nurses – Junior college education	**178**
Nurses – Secondary school education	**2,993**

TOTAL NUMBER OF HEALTH STAFF EMPLOYED IN SCHOOL MEDICINE SERVICES, CROATIA 2006

Medical doctors	**174**
Of whom specialists	120
Nurses – Junior college education	**40**
Nurses – Secondary school education	**110**

TOTAL NUMBER OF HEALTH STAFF EMPLOYED IN EMERGENCY ASSISTANCE SERVICES, CROATIA 2006

Medical doctors	**522**
Of whom specialists	33
Nurses – Junior college education	**35**
Nurses – Secondary school education	**866**

TOTAL NUMBER OF HEALTH STAFF EMPLOYED IN OCCUPATIONAL HEALTH AND SAFETY SERVICES, CROATIA 2006

Medical doctors	**174**
Of whom specialists	157
Nurses – Junior college education	**39**
Nurses – Secondary school education	**119**

TOTAL NUMBER OF HEALTH STAFF EMPLOYED IN HEALTH VISITING SERVICES, CROATIA 2006

Nurses – Junior college education	**684**
Nurses – Secondary school education	**126**

TOTAL NUMBER OF HEALTH STAFF EMPLOYED IN NURSING CARE AND REHABILITATION SERVICES, CROATIA 2006

Health staff – Junior college education	**328**
Health staff – Secondary school education	**1,931**

Health institutions in Croatia, 31 December 2006*

Health institutions	*No. of institutions*
Community health centre	**47**
Clinical teaching hospital	**2**
Clinical hospital	**5**
Clinic	**7**
General hospital	**22**
Special hospital	**29**
Sanatorium	**6**
Institute of public health	**21**
Other state institutes:	**3**
♦ *Transfusion Medicine Institute*	1
♦ *Occupational Health and Safety Institute*	1
♦ *Toxicology Institute*	1
Emergency assistance facility	**4**
Polyclinic	**314**
Occupational health and safety institution	**12**
Company providing health services	**46**
Total	**518**

** Regardless of the type of ownership*

Pharmacies	**1,104**
Nursing care and rehabilitation institutions	**153**
Home care private practice	**117**

Health care staff in 2007

At the end of 2007 there were 70,431 permanent staff employed in the health system of the Republic of Croatia (working under open-ended employment contracts). Of these, 52,181 were health staff and associates, 5,108 administrators and 13,142 technical staff.

The structure of the permanent staff shows that the greatest proportion have secondary vocational qualifications (37.4%), administrative and technical staff make up 26.0% (2006 – 26.0%), doctors 16.8%, health staff with junior college education 9.8%, dentists 4.6%, pharmacists 3.7%, other university degree staff (psychologists, speech therapists, social workers, special needs teachers and others) 1.1%, and semi-skilled health workers 0.6%. A further 7,682 health staff and associates were employed on a temporary basis (under fixed-term employment contracts). In other words, on 31 December 2007 a total of 59,863 health staff and associates were employed on a permanent or temporary basis (compared with 52,684 in 2000).

The number of doctors per 100,000 population has increased in comparison to 1980 by almost one-third (from 167 to 266 in 2007), which is still less that the EU average (315/100,000). The EU-15 average in 2003 was 362/100,000, while the 12 newest members had an average of 255/100,000, according to data from 2006.

Nurses represent almost half of the total number of health care staff employed (45.7%). In the group of health care staff with secondary school and junior college education (33,300 employees), nurses and medical technicians make up 72.0% and the others are mostly health

engineers and technicians. The number of nurses per 100,000 population has risen from 354 in 1980 to 537 in 2007, which is still significantly less than the EU average (741/100,000 in 2006).

Of 23,852 nurses, 16% have senior nursing qualifications. Another indicator is the number of midwives, and this figure is also submitted to the WHO European Health for All Database (HFA-DB). Croatia recorded the highest number of midwives sixteen years ago, in 1988 (1,877), since when the number has slowly dropped, to 1,545 in 2007. In 2007 there were 2.0 nurses employed for every doctor in permanent employment (2.3 in 2000).

Attempts must be made to continue to lessen the number of unemployed health workers, along with enabling those with college and university qualifications to join paid traineeship programmes. In addition, the period between passing the state examination and taking up employment, for all those seeking employment in the health system, particularly doctors, dentists, pharmacists and medical biochemists, should be as short as possible.

It is also necessary to focus more attention on training middle-level and in particular senior nurses, according to curricula and study programmes and also at the level of secondary education, aligned with European Community guidelines and the recommendations of the World Health Organisation.

Within primary health care, in the narrowest sense, as carried out by general/family practices and services for health care of infants and small children, one health care team on average cares for 1,665 insured persons, of whom 1,325 on average use their services annually. Within general/family practice, one team on average cares for 1,678 insured person, of whom 1,338 on average use their services annually, while teams for infants and small children care for an average of 1,342 insured persons, of whom 1,204 on average use their services annually. According to the Health for All Database (WHO, 2006), it appears that the Croatian average of 68 primary health care doctors per 100,000 population is significantly lower than the European Union average (98.93/100,000). Before the accession of ten new members in 2004, the EU had 102.6/100,000 doctors in primary health care, and the ten new members had an average similar to Croatia's (64.16/100,000). It can be concluded that the number of insured persons/patients per team is too great, in terms of providing comprehensive, active health care at the level expected of primary health care, and diverges by between 15 and 20% from the norm in developed European Union countries. An additional problem is presented by the unequal geographical distribution of insured persons/patients among teams, so that some family medicine teams (one doctor and one nurse) care for over 2,500 insured persons, while others have less than 1,000 in their care. There are also unresolved issues concerning financing the care offered and provided, since the only criterion for paying teams is the number of insured persons in their care.

HEALTH WORKERS EMPLOYED IN STATE INSTITUTIONS AND IN PRIVATE PRACTICE (PERMANENT JOBS AND TOTAL) AND POPULATION PER ONE HEALTH WORKER, CROATIA 2007

Health workers	*Permanent*	*Population per health worker*	*Total*	*Population per health worker*
Medical doctors	11,799	376	12,149	352
Dentists	3,265	1,359	3,364	1,284
Pharmacists	2,607	1,702	2,720	1,611
Other university degree staff	809	5,485	901	4,808
Junior college education	6,933	640	7,669	548
Secondary school education	26,367	168	31,368	140

Semi-skilled	401	11,066	429	10,248
Total	**52,181**	**85**	**58,600**	**74**

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), CROATIA 2007

Medical doctors	**3,190**
Of whom specialists	1,638
Nurses – Junior college education	**177**
Nurses – Secondary school education	**2,980**

TOTAL NUMBER OF HEALTH STAFF EMPLOYED IN SCHOOL MEDICINE SERVICES, CROATIA 2007

Medical doctors	**168**
Of whom specialists	119
Nurses – Junior college education	**42**
Nurses – Secondary school education	**110**

TOTAL NUMBER OF HEALTH STAFF EMPLOYED IN EMERGENCY ASSISTANCE SERVICES, CROATIA 2007

Medical doctors	**490**
Of whom specialists	32
Nurses – Junior college education	**35**
Nurses – Secondary school education	**891**

TOTAL NUMBER OF HEALTH STAFF EMPLOYED IN OCCUPATIONAL HEALTH AND SAFETY SERVICES, CROATIA 2007

Medical doctors	**177**
Of whom specialists	160
Nurses – Junior college education	**38**
Nurses – Secondary school education	**119**

TOTAL NUMBER OF HEALTH STAFF EMPLOYED IN HEALTH VISITING SERVICES, CROATIA 2007

Nurses – Junior college education	**681**
Nurses – Secondary school education	**130**

TOTAL NUMBER OF HEALTH STAFF EMPLOYED IN NURSING CARE AND REHABILITATION SERVICES, CROATIA 2007

Health staff – Junior college education	**336**
Health staff – Secondary school education	**1930**

Health institutions in Croatia, 31 December 2007*

Health institutions	*No. of institutions*
Community health centre	**50**
Clinical teaching hospital	**3**
Clinical hospital	**4**
Clinic	**7**
General hospital	**22**
Special hospital	**31**
Sanatorium	**7**
Institute of public health	**22**
Other state institutes:	**3**
♦ *Transfusion Medicine Institute*	1
♦ *Occupational Health and Safety Institute*	1
♦ *Toxicology Institute*	1
Emergency assistance facility	**4**
Polyclinic	**321**
Occupational health and safety institution	**13**
Company providing health services	**91**
Total	**578**

** Regardless of the type of ownership*

Pharmacies	**1,110**
Nursing care and rehabilitation institutions	**156**
Home care private practice	**112**

According to figures from the Croatian National Institute of Public Health, in 2005 there were 1,088 pharmacies, and at the end of 2006 there were 1,104 pharmacies, or 0.25 pharmacies/1,000 population. A total of 2,720 pharmacy graduates were employed in state and private health institutions and private practice (2,659 in 2005). There was an average of 1,699 population per one pharmacist.

In 2005 in the work of primary health care in the narrowest sense, consisting of the health care of infants and small children and general/family medicine, a total of 2,605 teams were at work in the Republic of Croatia, with 2,605 medical doctors. Of these, there were 1,230 specialists (715 general/family medicine, 254 paediatricians, 134 occupational medicine, 106 school doctors and 21 specialists in other branches). Of the other health workers, 85 had junior college and 2,522 secondary qualifications. In comparison to 2004 the number of teams did not change significantly in 2005, there were 2.6% fewer specialist doctors and 2.3% fewer paediatricians.

In 2006 in the work of primary health care in the narrowest sense, consisting of the health care of infants and small children and general/family medicine, a total of 2,677 teams were at work in the Republic of Croatia, with 2,577 medical doctors. Of these, there were 1,280 specialists (778 general/family medicine, 259 paediatricians, 121 occupational medicine, 99 school doctors and 23 specialists in other branches). Of the other health workers, 87 had junior college education and 2,491 secondary qualifications. In comparison to 2005 the number of teams did not change significantly in 2006, there were 4% more specialist doctors and 2% more paediatricians.

In 2007 in the work of primary health care in the narrowest sense, consisting of the health care of infants and small children and general/family medicine, a total of 2,552 teams were at work in the Republic of Croatia. Of 2,552 medical doctors, there were 1,393 specialists in various branches (897 general/family medicine, 261 paediatricians, 121 occupational medicine, 94 school doctors and 20 specialists in other branches). Of the other health workers, 73 had junior college education and 2,482 secondary qualifications. In comparison to 2006, the number of teams decreased and the number of specialist doctors increased: there were 9% more specialist doctors in the primary health care system (15% more family medicine specialists, 1% more paediatricians and 3.3% fewer specialists in other branches).

In the work of dental health care, there were a total of 1,983 contracted teams at work full time in 2005 and 20 working part time. In 2005 there was a total of 4,822,811 visits to contracted teams (1.3% more than in 2004), 652,958 regular check-ups were performed (a reduction of 13.5% in comparison to 2004), 2,217,700 fillings were given (4% fewer than in 2004), and 702,816 teeth were extracted (a reduction of 2% in comparison to 2004). Dental prosthetic work was done in 296,931 cases (an increase of 21.6%) and 613,306 cases in which soft tissue treatment was performed (an increase of 10.1% in comparison to 2004). The most common diagnoses recorded in this field are dental caries, diseases of the pulp and periapical tissue, other disorders of the teeth and the supporting structure and dental and facial irregularities.

In the work of dental health care, there were a total of 1,905 contracted teams at work full time in 2006 and 47 working part time. In 2006 there was a total of 4,814,629 visits to contracted teams (similar to 2005), 611,381 regular check-ups were performed (a reduction of 6.4% in comparison to 2005), 2,216,381 fillings were given (similar to 2005), and 680,828 teeth were extracted (a reduction of 3.1% in comparison to 2005). Dental prosthetic work was done in 259,188 cases (a reduction of 12.7%) and 655,047 cases in which soft tissue treatment was performed (an increase of 6.6% in comparison to 2005). The most common diagnoses recorded in this field are dental caries, diseases of the pulp and periapical tissue, other disorders of the teeth and the supporting structure and dental and facial irregularities.

In the work of dental health care, there were a total of 2,001 contracted teams at work full time in 2007, of which there were 1,714 dental teams, 96 preventive paediatric dentistry teams and 191 teams specialised in other branches. These teams cared for 3,786,436 insurees (2.3% fewer than in 2006), of whom 1,672,530 used health care services (a 2.3% reduction in comparison to 2006). In addition to these teams, dental services were also provided by teams without contracts with the Croatian Institute for Health Insurance: of the total of 635 dental health care teams without contracts with the CIHI, there were 569 dental teams, 12 preventive paediatric dentistry teams and 54 teams specialised in other branches. According to reports received, in 2007 there was a total of 4,552,196 visits to contracted teams (a reduction of 5.5% in comparison to 2006) and 545,581 visits to teams without contract with the CIHI (a 19.8% increase in comparison to 2006). All teams, regardless of their status in terms of contract with the CIHI, performed 627,303 regular check-ups (an increase of 2.6% in comparison to 2006). A total of 2,165,395 fillings were given (a reduction of 2.3% in comparison to 2006), and 653,869 teeth were extracted (a reduction of 4.0% in comparison to 2006). In 2007, dental prosthetic work was done in 277,567 cases (an increase of 7.1% in comparison to 2006) and there were 663,825 cases in which soft tissue treatment was performed (an increase of 1.3% in comparison to 2006).

Home care and rehabilitation of patients under the guidance of medical doctors is performed by registered and authorised institutions for home health care. According to the 2005 report by the Croatian National Institution of Public Health, 108 senior nurses and 1,012 nurses with secondary school education worked in home health care. On average, there was one nurse per 3,793 insurees in the home care services. The average number of visits per nurse was 2,160 a year (an increase of 4.4% in comparison to 2004).

According to the 2006 report by the Croatian National Institution of Public Health, 119 senior nurses and 949 nurses with secondary school education worked in home health care. On average, there was one nurse per 3,982 insurees in the home care services. The average number of visits per nurse was 2,017 a year (a reduction of 7.1% in comparison to 2005).

According to the 2007 report by the Croatian National Institution of Public Health, 117 senior nurses and 970 nurses with secondary school education worked in home health care. The figures relating to the number of insurees in the primary health care system show that one nurse providing home care services was in charge of 3,984 insurees on average. The average number of visits per nurse was 2,283 a year (an increase of 13.2% in comparison to 2006).

Health visiting services are performed by nurses trained in this field. The standard is one nurse per 5,100 of the population, pursuant to the Ordinance on the standards and norms of the rights under the basic health insurance scheme (OG 2/03). The Croatian Institute for Health Insurance ensures the obligatory minimum – the right to 2 visits by a health visitor (during pregnancy, after the birth of a child and during the first year of its life and to risk groups). The total number of health visits in 2005 was 1,315,052, which was 3.1% less than in 2004. The total number of health visits in 2006 was 1,296,498, which was 1.4% less than in 2005. The total number of health visits in 2007 was 1,398,229, which was 7.8% more than in 2006.

OPERATIONS OF HOSPITALS

Capacities and operations of hospitals in Croatia in 2005

In 2005 there were 72 hospital institutions and sanatoria in the Republic of Croatia. Of these, two were clinical hospital centres, 12 clinical hospitals and clinics, 22 general hospitals and 26 specialist hospitals reporting on patient beds and 3 not reporting on patient beds, one sanatorium reporting patient beds and 6 not reporting patient beds. In addition, 9 general in-patient units and 6 maternity units outside hospitals operated in smaller towns. During the past fifteen years, 12 in-patient units and 9 maternity units outside hospitals have been closed down.

The capacity filled in 2005 was 85.82% on an annual basis (87.67% in 1990). Clinics and clinical hospital had the fullest use of capacities (90.07%) while specialist hospitals had the lowest rate (81.40%).

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 1.18 in 2005, in clinical hospital centres, clinical hospitals and clinics 0.94 and in specialist hospitals 6.80 days.

Capacities and operations of hospitals in Croatia in 2006

In 2006 there were 71 hospital institutions and sanatoria in the Republic of Croatia. Of these, two were clinical hospital centres, 12 clinical hospitals and clinics, 22 general hospitals and 26 specialist hospitals reporting on patient beds and 3 private hospitals not reporting on patient beds, one sanatorium reporting patient beds and 5 not reporting patient beds. In addition, 9 general in-patient units and 6 maternity units outside hospitals operated in smaller towns.

The capacity filled in 2006 was 84.55% on an annual basis (87.67% in 1990). Clinics and clinical hospital had the fullest use of capacities (88.11%) while specialist hospitals had the lowest rate (80.66%).

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 1.25 in 2006, in clinical hospital centres, clinical hospitals and clinics 1.11 and in specialist hospitals 6.85 days.

Capacities and operations of hospitals in Croatia in 2007

In 2007 there were 73 hospital institutions and sanatoria in the Republic of Croatia. Of these, three were clinical hospital centres, 11 clinical hospitals and clinics, 22 general hospitals and 26 specialist hospitals reporting on patient beds and 4 hospitals not reporting on patient beds, one sanatorium reporting 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. During the past fifteen years, 12 in-patient units and 9 maternity units outside hospitals have been closed down.

The capacity filled in 2007 was 83.15% on an annual basis (87.67% in 1990). Clinics and clinical hospital had the fullest use of capacities (87.17%) while specialist hospitals had the lowest rate (78.34%).

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 1.33 in 2007, in clinical hospital centres, clinical hospitals and clinics 1.20 and in specialist hospitals 7.77 days.

Total number of hospital beds in 2005

The total number of hospital beds in Croatia in 2005 was 5.46 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 2005, when there were 329 fewer beds than in 2004.

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 5.46 in 2005.

Total number of hospital beds in 2006

The total number of hospital beds in Croatia in 2006 was 5.46 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 2005, when there were 329 fewer beds than in 2004, whilst in 2006 a slight increase in the number of beds was recorded (17 more beds).

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 5.46 in 2005. In 2006 the same rate was recorded as in 2005.

Total number of hospital beds in 2007

The total number of hospital beds in Croatia in 2007 was 5.49 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 2005, when there were 329 fewer beds than in 2004. In 2006 a slight increase of the number of beds was recorded (17 beds) and in 2007 the number of beds increased by 115 in comparison to 2006.

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 5.46 in 2005. The latter rate remained unchanged in 2006 and in 2007 it was 5.49.

Acute beds in 2005

According to the type of beds per 1,000 population available in 2005, 3.60 were for acute cases (1.68 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.

A further drop in the number of beds was recorded in 2005, when there were 135 fewer beds in general hospitals and 22 fewer beds in clinics and clinical hospitals, in comparison to 2004.

Acute beds in 2006

According to the type of beds per 1,000 population available in 2006, 3.60 were for acute cases (1.69 in general hospitals and 1.91 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.

A further drop in the number of beds was recorded in 2005, when there were 135 fewer beds in general hospitals and 22 fewer beds in clinics and clinical hospitals, in comparison to 2004.

In 2006 there were 30 more beds in general hospitals than in 2005, whilst in clinics and clinical hospitals there were 5 fewer beds.

Acute beds in 2007

According to the type of beds per 1,000 population available in 2007, 3.62 were for acute cases (1.70 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 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.

A further drop in the number of beds was recorded in 2005, when there were 135 fewer beds in general hospitals and 22 fewer beds in clinics and clinical hospitals, in comparison to 2004.

In 2006 there were 30 more beds in general hospitals than in 2005, whilst in clinics and clinical hospitals there were 5 fewer beds.

In 2007 there were 28 more beds in general hospitals than in 2006, and the same increase was recorded in clinics and clinical hospitals (28 more beds).

Chronic beds in 2005

In 2005 there were 1.86 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 fewer beds available in specialist hospitals in that year, compared to 2000.

A further reduction in the number of beds was recorded in 2005, when there were 172 fewer beds in specialist hospitals in comparison to 2004.

Chronic beds in 2006

In 2006 there were 1.86 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 fewer beds available in specialist hospitals in that year, compared to 2000.

A further reduction in the number of beds was recorded in 2005, when there were 172 fewer beds in specialist hospitals in comparison to 2004, and in 2006 there were 8 fewer beds.

Chronic beds in 2007

In 2007 there were 1.87 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 fewer beds available in specialist hospitals in that year, compared to 2000.

A further reduction in the number of beds was recorded in 2005, when there were 172 fewer beds in specialist hospitals in comparison to 2004, and in 2006 there were 8 fewer beds. In 2007 there were 59 more beds.

Table 7: Hospital operations indicators, Croatia 2005

	Total	*Total acute patients*	*GHs, IPUs, MHs*	*CHCs CHs & clinics*	*Chronic, patients*
CROATIA					
1. Number of beds	24220	15972	7474	8498	8248
2. Number of beds per 1,000 population	**5.46**	**3.60**	**1.68**	**1.92**	**1.86**
3. Number of doctors	4653	4260	1805	2455	393
4. No. of beds per doctor	5.2	3.7	4.1	3.5	21.0
5. No. of discharged patients	737174	654752	325436	329316	82422
6. No. of days of hospital treatment	7586737	5136158	2342465	27936932	450579
7. Average length of treatment	10.29	7.84	7.20	8.48	29.73

8. Annual occupancy of beds	313	322	313	329	297
9. % usage of beds	85.82	88.10	85.87	90.07	81.40
10. No. of patients per bed	30.44	40.99	43.54	38.75	9.99
11. Turnover rate	1.70	1.06	1.18	0.94	6.80

Table 8: Hospital operations indicators, Croatia 2006

	Total	*Total acute patients*	*GHs, IPUs, MHs*	*CHCs CHs & clinics*	*Chronic, patients*
CROATIA					
12. Number of beds	24237	15997	7504	8493	8240
13. Number of beds per 1,000 population	**5.46**	**3.60**	**1.69**	**1.91**	**1.86**
14. Number of doctors	4788	4389	1871	2518	399
15. No. of beds per doctor	5.1	3.6	4.0	3.4	20.7
16. No. of discharged patients	752453	667543	333967	333576	84910
17. No. of days of hospital treatment	7479340	5053305	2322030	27312752426035	
18. Average length of treatment	9.94	7.57	6.95	8.19	28.57
19. Annual occupancy of beds	309	316	309	322	294
20. % usage of beds	84.55	86.55	84.78	88.11	80.66
21. No. of patients per bed	31.05	41.73	44.51	39.28	10.30
22. Turnover rate	1.82	1.18	1.25	1.11	6.85

Table 9: Hospital operations indicators, Croatia 2007

	Total	*Total acute patients*	*GHs, IPUs, MHs*	*CHCs CHs & clinics*	*Chronic, patients*
CROATIA					
23. Number of beds	24352	16053	7532	8521	8299
24. **Number of beds per 1,000 population**	**5.49**	**3.62**	**1.70**	**1.92**	**1.87**
25. Number of doctors	5043	4638	1916	2722	405
26. No. of beds per doctor	4.8	3.5	3.9	3.1	20.5
27. No. of discharged patients	750029	665640	332071	333569	84389
28. No. of days of hospital treatment	7390492	5017531	2306527	27110042372961	
29. Average length of treatment	9.85	7.54	6.95	8.13	28.12
30. Annual occupancy of beds	303	313	306	318	286
31. % usage of beds	83.15	85.63	83.90	87.17	78.34
32. No. of patients per bed	30.80	41.47	44.09	39.15	10.17
33. Turnover rate	2.00	1.26	1.33	1.20	7.77

Tuberculosis

Institutions for treating tuberculosis:

1. Institutions for treating chronic diseases:
   - Specialist hospital for pulmonary diseases "Rockefellerova"
   - Specialist hospital for respiratory diseases "Srebrnjak"
   - Hospital for pulmonary diseases and TBC "Klenovnik"

2. General hospitals:
   - Koprivnica General Hospital
   - Požega General Hospital
   - Karlovac General Hospital (in 2005)

3. Clinical hospital centres, clinical hospitals and clinics:
   - Rijeka Clinical Hospital Centre
   - Osijek Clinical Hospital
   - Split Clinical Hospital
   - Sisters of Mercy Clinical Hospital
   - Jordanovac Clinic for Pulmonary Diseases

	2006				2005			
	Total	General hospitals	CHCs, clinical hospitals and clinics	Treatment of chronic patients	Total	General hospitals	CHCs, clinical hospitals and clinics	Treatment of chronic patients
Number of beds	913	32	425	456	945	53	430	462
Number of doctors	132	5	88	39	141	11	88	42
No. of discharged patients	23,750	1,042	14,691	8,017	24,483	1,884	14,664	7,935
No. of days of hospital treatment	304,153	9,683	153,372	141,098	314,840	17,825	150,809	146,206

The share of GDP allocated for health expenditures is 7.3%.

Infant mortality and perinatal mortality rates

Infant mortality in 2005

In 2005, 242 infants died in Croatia, which represents a ratio of 5.71/1,000 live births (in 2004 this number was 245, i.e. 6.1/1,000). The largest number of newborns (0-27 days old) died in the first days of life (about 75% of newborns who died).

A total of 60.4% infants died in the age between 0-6 days (146 infants), of which 33.9% died in the first 24 hours of their lives (82), and 26.5% between 1-6 days (64). Another 10.7% (26) died in the late neonatal period, whereas 28.9% (70) 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 46.3%) and congenital anomalies (35.5%), followed by injuries, poisonings and certain other consequences of external causes, and symptoms, signs and abnormal clinical and laboratory findings not otherwise classified (4.1%). All other causes accounted for only 10.0%.

Of 242 infants who died in 2005, 58% died of fifteen leading causes of death. Of the leading causes the following were prominent: diseases arising as a result of immaturity (respiratory distress, neonatal aspiration syndrome) and related to an infection in the mother (chorioamnionitis, genitourinary infection) and other pathological conditions in pregnancy resulting in premature birth and death. Of the other leading group of causes of infant mortality, congenital malformations, we can single out congenital heart defects (malformations of aortic and mitral valves), congenital diaphragmatic hernia and chromosomopathy (Down, Edward and Patau syndromes).

Table 10 Infant mortality cause structure by ICD-10 group in 2005

ICD-10	DISEASE GROUP	NUMBER	%	RANK
I.	Certain infectious and parasitic diseases	1	0.4	8/9
II.	Neoplasms	1	0.4	8/9
III.	Diseases of the blood and blood forming organs and certain diseases involving the immune mechanism	1	0.4	8
IV.	Endocrine, nutritional and metabolic diseases	2	0.8	6/7
VI.	Diseases of the nervous system	7	2.9	5
IX.	Diseases of the circulatory system	2	0.8	6/7
X.	Diseases of the respiratory system	10	4.1	3/4
XVI.	Certain conditions originating in the perinatal period	112	46.3	1
XVII.	Congenital malformations, deformations and chromosomal abnormalities	86	35.5	2
XVIII.	Symptoms, signs and abnormal clinical and laboratory findings, NE	10	4.1	3/4
XIX.	Injury, poisoning and certain other consequences of external causes	10	4.1	3/4
	TOTAL	**242**	**100.00**	

Source of information: Croatian Central Bureau of Statistics, 2006 (DEM-2/05 Form)

Infant mortality in 2006

In 2006, 215 infants died in Croatia, which represents a ratio of 5.21/1,000 live births (in 2005 this number was 242, i.e. 5.7/1,000). The largest number of newborns (0-27 days of age) died in the first days of life (about 81% of newborns who died).

A total of 60.9% infants died in the age between 0-6 days (131 infants), of which 33.0% died in the first 24 hours of their lives (71), and 27.9% between 1-6 days (60). Another 14% (30) died in the late neonatal period, whereas 25.1% (54) 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 53.9%) and congenital anomalies (35.8%), followed by injuries, poisonings and certain other consequences of external causes, and symptoms, signs and abnormal clinical and laboratory findings not otherwise classified (3.7%). All other causes accounted for 6.6%.

Of 215 infants who died in 2006, 112 (52.1%) died of 10 leading causes of death. Of the leading causes the following were prominent: diseases arising as a result of short gestation and immaturity and most frequently related to the mother's pregnancy complications (infections and other pathological changes of placenta). Of the second leading group of causes of infant mortality, congenital malformations, we can single out chromosomopathy (Down, Edward and Patau syndromes), congenital diaphragmatic hernia and congenital heart defects.

Table 11 Infant mortality cause structure by ICD-10 group in 2006

ICD-10	DISEASE GROUP	NUMBER	%	RANK
I.	Certain infectious and parasitic diseases	2	0.9	6/7
II.	Neoplasms	1	0.5	8
III.	Diseases of the blood and blood forming organs and certain diseases involving the immune mechanism	2	0.9	6
IV.	Endocrine, nutritional and metabolic diseases	2	0.9	6/7
X.	Diseases of the respiratory system	3	1.4	5
XVI.	Certain conditions originating in the perinatal period	116	53.9	1
XVII.	Congenital malformations, deformations and chromosomal abnormalities	77	35.8	2
XVIII.	Symptoms, signs and abnormal clinical and laboratory findings, NE	8	3.7	3
XIX.	Injury, poisoning and certain other consequences of external causes	4	1.9	4
	TOTAL	**215**	**100.00**	

Source of information: Croatian Central Bureau of Statistics, 2007 (DEM-2/06 Form)

Infant mortality in 2007

In 2007, 234 infants died in Croatia, which represents a ratio of 5.7/1,000 live births. The largest number of newborns (0-27 days old) died in the first days of life (about 81% of newborns who died).

A total of 58.1% infants died in the age between 0-6 days (136 infants), of which 31.2% died in the first 24 hours of their lives (73), and 26.9% between 1-6 days (63). Another 13.2% (31) died in the late neonatal period, whereas 28.6% (67) 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 54.3%) and congenital anomalies (30.8%), followed by symptoms, signs and abnormal clinical and laboratory findings not otherwise classified (4.7%), and injuries, poisonings and certain other consequences of external causes (2.1%). All other causes accounted for 8.1%.

Of 234 infants who died in 2007, 121 (51.7%) died of 10 leading causes of death. Of the leading causes the following were prominent: diseases arising as a result of short gestation and immaturity and most frequently related to the mother's pregnancy complications (infections and other pathological changes of placenta). Of the second leading group of causes of infant mortality, congenital malformations, we can single out chromosomopathy (Down, Edward and Patau syndromes) and congenital diaphragmatic hernia.

Table 12 Infant mortality cause structure by ICD-10 group in 2007

ICD-10	DISEASE GROUP	NUMBER	%	RANK
I.	Certain infectious and parasitic diseases	1	0.4	8/9

II.	Neoplasms	1	0.4	8/9
IV.	Endocrine, nutritional and metabolic diseases	3	1.3	7
VI.	Diseases of the nervous system	1	0.4	8/9
IX.	Diseases of the circulatory system	5	2.1	5/6
X.	Diseases of the respiratory system	8	3.4	4
XVI.	Certain conditions originating in the perinatal period	127	54.3	1
XVII.	Congenital malformations, deformations and chromosomal abnormalities	72	30.8	2
XVIII.	Symptoms, signs and abnormal clinical and laboratory findings, NE	11	4.7	3
XIX.	Injury, poisoning and certain other consequences of external causes	5	2.1	5/6
	TOTAL	**234**	**100.00**	

Source of information: First Release, Croatian Central Bureau of Statistics, 2008 (ISSN 1330-0350)

Perinatal mortality in 2005

Perinatal mortality in 2005, calculated according to the WHO methodology for international comparison, was 6.4/1,000 births > 1,000 grams birth weight. The European Union average in 2005 was 6.2/1,000 births ≥ 1,000 grams birth weight. The perinatal mortality for all births (≥ 500 grams birth weight) in 2005 was 8.8/1,000.

Perinatal mortality in the Republic of Croatia is mostly the result of deaths of children in low birth weight groups, especially those with extremely low birth weight (500-999 grams) and very low birth weight (1,000-1,499 grams).

The leading causes of perinatal death were the result of premature birth due to complications in pregnancy in the mother and congenital anomalies.

Perinatal mortality in 2006

Perinatal mortality in 2006, calculated according to the WHO methodology for international comparison, was 5.3/1,000 births > 1,000 grams birth weight. The European Union average in 2006 was 6.04/1,000 births ≥ 1,000 grams birth weight. The perinatal mortality for all births (≥ 500 grams birth weight) in 2006 was 8.3/1,000 births. The leading causes of perinatal death continued to be related to short duration of pregnancy and premature birth due to complications in pregnancy and congenital anomalies.

Perinatal mortality in 2007

Perinatal mortality in 2007, calculated according to the WHO methodology for international comparison, was 4.9/1,000 births > 1,000 grams birth weight. The European Union average in 2007 was 6.1/1,000 births ≥ 1,000 grams birth weight. The perinatal mortality for all births (≥ 500 grams birth weight) in 2007 was 7.8/1,000 births. The leading causes of perinatal death continued to be related to short duration of pregnancy and premature birth due to complications in pregnancy and congenital anomalies.

Life expectancy in 2005, 2006 and 2007

According to the "Health for All" health indicators database of the World Health Organisation, in 2005 the life expectancy in Croatia at birth for both sexes together was 75,44 years, for women alone 78.92, and for men 71.9 years (Table 13). The average life expectancy at birth for EU countries for both sexes together in the same year was 78.5 years, for men alone 75.4, and for women 81.6 years.

According to the "Health for All" health indicators database of the World Health Organisation, in 2006 the life expectancy in Croatia at birth for both sexes together was 76,01 years, for women alone 79.4, and for men 72.6 years (Table 13). The average life expectancy at birth for EU countries for both sexes together in the same year was 78.7 years, for men alone 75.6, and for women 81.8 years.

According to figures from the Central Bureau of Statistics, in 2007 the life expectancy in Croatia at birth for both sexes together was 75.8 years, for women 79.2 years and for men 72.3 years.

Table 13 Life expectancy at birth in Croatia in the period 1991-2007

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*	**75.8**	**72.3**	**79.2**

Source of information: *Health for all Database 2008, WHO 2008*
**Croatian Central Bureau of Statistics, 2008*

Special measures undertaken to protect the health of pregnant women, mothers and children

Regarding the Committee's enquiry requesting *updated information on maternal death rates and the steps taken to improve the situation* to be included in the next report, we must point out that the maternal death rate has been at a very low level for years, and is limited to occasional cases. For example, in 2005 three women died in Croatia due to complications

during pregnancy, childbirth or puerperium (7/100,000 live births). However, of these three, only one died of causes directly related to pregnancy or childbirth (amniotic fluid embolism), and the other two died of causes not directly related to pregnancy, childbirth or puerperium; one as the result of a heart defect caused by an earlier episode of rheumatic fever (mitral valve stenosis), and the other of an acute neurological problem (myelitis transversalis). According to WHO cause of death codes prescribed in the International Classification of Diseases and Related Health Problems – 10th revision (Volumes 1 and 2), member states are required to report on all deaths of women during pregnancy, childbirth or up to 42 days after giving birth, giving the direct and indirect obstetric causes of death. In adherence to these regulations, Croatia regularly submits information to the World Health Organisation on maternal deaths in the manner prescribed. Taking only the direct obstetric causes of maternal death, the rate was 2.48/100,000 live births in Croatia in 2005, rather than 7/100,000. The situation in 2006 was similar, when four women died of complications during pregnancy, childbirth or puerperium, i.e. 9.7/100,000 live births, of whom two died of direct obstetric causes and two of indirect obstetric causes. Indirect obstetric causes were as follows: one pregnant woman died of adrenal gland haemorrhage (maternal death due to indirect obstetric cause according to the International Classification – ICD-10, code O99.2 "Endocrine, nutritional and metabolic diseases complicating pregnancy, childbirth and the puerperium"); one pregnant woman died of chronic renal disease (maternal death due to indirect obstetric cause according to the International Classification – ICD-10, code O99.8, or ICD-10 "Diseases of the genitourinary system", N11.9 – Chronic interstitial nephritis). Direct obstetric causes of maternal deaths were as follows: one woman died of embolism after a caesarean section (ICD-10, code O88.2), one woman died of puerperal sepsis after a caesarean section (ICD-10, code O85).

Taking only the direct obstetric causes of maternal death, the rate was 4.8/100,000 live births in Croatia in 2006, rather than 9.7/100,000.

In 2007 six women died in Croatia of complications during pregnancy, childbirth or puerperium (14.31/100,000 live births). Three deaths were directly related to causes arising from pregnancy (two as a result of missed abortions – ICD code O02.1; one as a result of chorioamnionitis – ICD code O41.1) while the other three deaths were due to indirect causes which occurred or were exacerbated during pregnancy, childbirth or puerperium (coronary artery aneurism, cardiomyopathy and addiction to psycho-active drugs). The maternal death rate due to direct obstetric causes in Croatia in 2007 was 7.15/100,000 live births, as opposed to the rate of 14.31/100,000, which included deaths due to both obstetric and non-obstetric causes.

In order to reduce the maternal death rate 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 126/06, see excerpt from the Programme for Health Protection of Women in Annex 1). This programme is being financed entirely by compulsory health insurance, which covers almost all citizens in the Republic of Croatia.
Croatia is a signatory to the "Millennium Development Goals", which contains measures to promote safe maternity (increase the number of births attended by skilled health personnel, family planning measures aimed at spacing births and affecting the number of births). In conditions of well developed maternity protection in Croatia (with 99% of births occurring in hospitals), these measures and indicators are not any longer a priority for ensuring safe maternity, as are the measures of prevention, management and early detection of complications of pregnancy.

The basic goals of the Croatian health system in relation to safe maternity and promotion of perinatal protection, according to guidelines of the Commission for Perinatal Medicine of the MHSW and the Croatian Society for Perinatal Medicine, 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 women who gave birth and their babies to the care for women with high-risk pregnancies, according to the level of risk)
2. developing specialist services, in particular neonatal services
3. developing a perinatal information system to keep track of perinatal outcomes
4. monitoring and evaluating perinatal care at all levels
5. inter-departmental co-operation in defining regulations promoting health protection rights of women and children
6. implementing the Millennium Development Goals focussing on mothers and children.

According to 2005 data from the services of primary health care of women (PHCW), every pregnant woman was examined 7 times on average by her selected gynaecologist. Some pregnant women, especially women who had to rest during their pregnancies and those with severe pathological conditions in pregnancy, underwent follow-up examinations in specialist and consultant health care services and in hospitals.

In 2005, 99.9% of all births in Croatia occurred in maternity wards. Perinatal mortality in 2005, calculated according to the WHO methodology for international comparison, was 6.4/1,000 births > 1,000 grams birth weight. The European Union average in 2004 (the most recent available data from the WHO Health for All Database) was also 6.4/1,000 births.

In 2006, 99.9% of all births in Croatia occurred in maternity wards. Perinatal mortality in 2006, calculated according to the WHO methodology for international comparison, was 5.3/1,000 births > 1,000 grams birth weight. The European Union average in 2006 (the most recent available data from the WHO Health for All Database) was 6.05/1,000 births.

In 2007, 99.9% of all births in Croatia occurred in maternity wards. Perinatal mortality in 2007, calculated according to the WHO methodology for international comparison, was 4.9/1,000 births > 1,000 grams birth weight. The European Union average in 2006 (the most recent available data from the WHO Health for All Database) was 6.05/1,000 births.

These figures show that Croatia belongs to the group of countries with a very low perinatal mortality rate (countries with a perinatal mortality rate of <5‰)

Annex 1: PROGRAMME OF MEASURES FOR THE HEALTH PROTECTION OF WOMEN

FAMILY PLANNING

1.5.1.1. Promoting reproductive health, health education and training for the purpose of acquainting the population with family planning methods and the use of contraceptives,

maintaining sexual hygiene, preventing sexually transmitted diseases, AIDS and genital cancer
- individual counselling
- distribution of printed health education material

Implementers: selected team for women's health protection, with participants from other branches of primary health care, institutes of public health and other institutions involved in health education.

1.5.1.2. Choice of most appropriate form of contraception and monitoring of women using it

After a general and gynaecological examination and a Papanicolaou test (for women using oral contraceptives, weight and blood pressure checks should be carried out every six months, and liver, AST, ALT and other tests as needed; insertion of an inter-uterine device and check-up after the next menstruation and six months after insertion; instructions on how to use a diaphragm, two or three checks to make sure the diaphragm is being inserted correctly).
Implementers: selected team for women's health protection, specialist and consultant health services.

1.5.1.3. Check-ups for the purpose of preventing pathological problems related to contraception

Regular check-ups for women, depending on the kind of contraception used, particularly for those who have not yet had children and who are using oral contraceptives.
Implementers: selected team for women's health protection.

1.5.1.4. Preventing and treating sterility

Prevention of sterility, including health information and counselling, monitoring the correct use of appropriate methods and contraceptive devices, timely diagnostic tests and treatment of the causes of sterility according to existing algorhythms, and in particular, diagnosis and treatment of infections of the female genitals.
Implementers: selected team for women's health protection in co-operation with other branches of primary health care and specialist and consultant and hospital services.

1.5.1.5. Advance gynaecological examination when planning pregnancy

Timely diagnostic tests and treatment of any condition which may affect the outcome of pregnancy or the health of the woman during pregnancy, childbirth and the puerperium.
Implementers: selected team for women's health protection.

1.5.1.6. Check-ups following terminations of pregnancy

Check-ups to be carried out within 10 to 14 days of termination, with recommendations for the best choice of contraception.
Implementers: selected team for women's health protection

1.5.2. PERINATAL PROTECTION

1.5.2.1. Antenatal care

1.5.2.1.1. Health education and training for pregnant women

Advice on nutrition, personal and sexual hygiene, health problems during pregnancy, harmful habits, addictions, employment and working conditions, legal rights during pregnancy,

preparation for birth and breastfeeding. All the above to be offered through individual counselling, during regular check-ups.
Implementers: selected team for women's health protection, with participants from other branches of primary health care, institutes of public health and other institutions involved in health education.

1.5.2.1.2. Regular check-ups for pregnant women when pregnancy is confirmed
Measuring weight and height, establishing blood group and Rh factor, immunisation tests, HBsAg, CBC, GTT, urine tests with sediment, measuring blood pressure. Gynaecological examination to establish the level of clarity of vaginal discharge, cytological Papanicolaou test (if not done during the previous twelve months), breast examination, recommendation for dental examination, noting the possible risk factors and assessing the outcome of the pregnancy for mother and child. In cases with indications, the following may also be carried out: glucose test, immunological test, microbiological cervical test, urine culture, germ distribution and antibiogram, serological tests for viral and parasitic infections (TORCH, seroreaction to lues, HIV antibodies, and genetic counselling with biochemical selection for chromosomopathy and planning karyotyping of the foetus.
Implementers: selected team for women's health care, with participants from other branches of primary health care, specialist and consultant services and laboratory services, hospital and maternity services, according to the level of perinatal care required.

1.5.2.1.3 Pregnancy check-ups
Gynaelogical examination and monitoring of blood pressure, weight and urine (test strip), three ultrasound examinations, between the 10^{th} and 14^{th}, 18^{th} and 22^{nd}, and 32^{nd} and 36^{th} weeks of pregnancy, repeat testing for HbsAg if the first test was negative, test for the presence of anti-erythrocite antibodies through immunisation tests, measuring the height of the fundus in relation to the symphysis, at least one check-up in the institution in which the women intends to give birth, around the due date, including amnioscopy and/or cardiotocography.
Two check-ups should be carried out in the first trimester, three check-ups in the second trimester and four in the third trimester, plus three ultrasound examinations, according to the procedure and guidelines of the profession.
Implementers: selected team for women's health care, in co-operation with specialist and consultant services or hospital services, i.e. the maternity unit where the woman intends to give birth.

1.5.2.1.4. Monitoring high-risk or pathological pregnancies according to levels of perinatal care
High-risk pregnancies and pathological changes during pregnancy are monitored by carrying out check-ups, and the necessary tests and treatment offered according to indications.
Implementers: selected team for women's health care in co-operation with specialist and consultant services.

1.5.2.2. Partum care

1.5.2.2.1. Expert assistance for home births and transport to maternity units
Assistance of doctors and midwives for home births and during transport to maternity units.
Implementers: selected team for women's health care in co-operation with other primary health care services.

1.5.2.3. Post partum care

1.5.2.3.1. Check-ups after giving birth
In the mother's home, following a home birth, and six weeks after the birth.
Implementers: selected team for women's health care, following a home birth, in co-operation with health visiting services, and six weeks after birth in a women's health clinic, in co-operation with health visiting services.

1.5.2.3.2. Promotion of health and health education for new mothers
Instructions on personal hygiene following giving birth and hygiene for the newborn, breastfeeding techniques, prevention of cracked nipples and mastitis:
- through individual counselling
- through distributing printed health education materials.

Implementers: selected team for women's health care, health visiting services, participation in health education of members of other primary health care services, institutes of public health and others.

1.5.3. MALIGNANT DISEASES

Breast cancer

1.5.3.1. Health education and early detection of breast cancer
- through individual counselling
- by acquainting women with the risk factors and self-examination technique and registering test results
- physical examination (palpation)

In cases with suspicious physical test results, including checking possible changes found during self-examination, send the patient for further diagnostic tests and treatment.
Implementers: selected team for women's health care, in co-operation with selected general/family medicine practitioners, health visiting services and institutes of public health.

Cervical cancer

1.5.3.2. Health education and early detection of cervical cancer
Acquaint women with risk factors (early sexual activity, large number of partners, large number of births, smoking, sexually transmitted diseases), methods of protection from sexually transmitted diseases, early detection methods (Papanicolaou test) and success in treating cervical cancer, the need to consult a doctor should any unusual bleeding or discharge occur. All women over the age of 16 should be offered health education and motivation.
Address any condition which increases the risk of cervical cancer – treatment of colpytis, benign changes to the exocervix and other conditions which increase the likelihood of the disease occurring.
Early detection and diagnosis – gynaecological examinations and cervical smear tests (Papanicolaou).
For women with average risk factors, Papanicolaou cervical smear test at least every three years between the ages of 25 and 64, preferably from the age of 20.
More frequent screening recommended for women with high risk factors: poor economic status, smokers, those who have been sexually active since before the age of 18, who have had two or more sexual partners, or whose partner has had multiple sexual partners, a history of venereal infections (chlamidia, trachomatis cervicitis, human papilloma virus of the high-risk

subtype, herpes virus, gonorrhoea, syphilis), women who have already exhibited cervical changes.
A pro-active approach is required on the part of selected teams of women's health protection services in order to implement early detection, including planning, inviting women for check-ups, carrying out check-ups and cervical smear tests and recording results on the prescribed forms.
Implementers: selected team for women's health care in co-operation with gynaecological, specialist and consultant, and laboratory services, participation in health education of selected general/family practitioners, health visiting services and institutes of public health.

Choriocarcinoma

1.5.3.3. Early detection of choriocarcinoma in women who have had hydatid moles
Quarterly gynaecological check-ups over a period of two years, referral for beta HCG testing or quantative determination of chorionic gonadotropin in the serum and urine.
Implementers: selected team for women's health care in co-operation with other specialist and laboratory services.

Ovarian cancer

1.5.3.4. Acquainting women with the risk factors connected with the occurrence of ovarian cancer and identifying groups at risk according to indications
Groups at risk: women with breast cancer or a family history of ovarian or breast cancer, endometriosis and hereditary non-polyp colon cancer (mutation of specific genes BRCA-1 and BRCA-2) and women who have never given birth. In women with cystic tumorous changes to the ovaries, regular clinical, cytological and ultrasound examinations and laparoscopy if indicated. Transvaginal ultrasounds (combined with colour Doppler) and tumour markers (CA 125) may help in diagnosis, but are not recommended for routine screening.
Implementers: selected team for women's health care in co-operation with gynaecological, specialist, consultant and hospital services and other specialist and laboratory services.

Endometric cancer

1.5.3.5. Early detection of endometric cancer in women with high risk factors
Prevention and detection: annual gynaecological examinations.
In women with high risk factors for endometric cancer (overweight women, women who have never given birth, women with a history of infertility, irregular ovulation, irregular bleeding, oestrogen hormone therapy with progesterone absence, diabetes, gall bladder diseases, hereditary non-polyp colon cancer, biopsy and cytological analysis of the endometrium is recommended (along with transvaginal ultrasound examination), and in cases of irregular bleeding in menopause, according to indications, carry out exploratory, fractioned curettage, aspiration cytology diagnostics and cytological and patho-histological examinations.
Implementers: selected team for women's health care in co-operation with gynaecological, specialist and consultant and hospital services and other specialist and laboratory services.

Precancerous changes to the vulva and vagina

1.5.3.6. Early detection and treatment of precancerous changes to the vulva and vagina
Timely diagnosis and treatment of precancerous changes.

Implementers: selected team for women's health care in co-operation with other specialist and laboratory services.

1.5.4. OTHER MEASURES FOR GYNAECOLOGICAL HEALTH PROTECTION

1.5.4.1. Reduction of factors contributing to the occurrence of stress incontinence and other forms of uncontrolled micturition

Appropriate treatment of urinary infections during pregnancy and infections of the vagina, expert management of birth, avoidance of physical exertion after giving birth, acquainting women with the need to avoid physical exertion according to the recommendations of the International Labour Organisation.

Implementers: selected team for women's health care, birth management doctors.

1.5.4.2. Suppression of the causes of menopausal problems and side-effects

In women with particularly exaggerated menopausal and post-menopausal problems – according to medical indications, establish the need for and monitor the use of hormone therapy, including advice on preventing osteoporosis.

Implementers: selected team for women's health care in co-operation with other specialist and laboratory services.

1.5.4.3. Prevention of sexually transmitted diseases

Education directed at preventing sexually transmitted diseases, including AIDS, according to the National Programme for AIDS Health Protection (health education, particularly with groups at risk, including testing for the presence of HIV antibodies in pregnant, and other women at risk, according to medical indications, as well as other protection measures). In order to protect the general population from infectious diseases, ensure the means for preventing, suppressing and treating infectious diseases in uninsured persons.

Implementers: selected team for women's health care in co-operation with other specialist and laboratory services, participation in health education of other primary health care services, institutes of public health and other institutions.

1.5.5. OTHER MEASURES

1.5.5.1. Co-operation with other primary health care services, specialist and consultant, and hospital services

In order to carry out measures and activities for promoting women's health successfully, and in treating various diseases of the genital organs, particularly carcinomas, problems during pregnancy, childbirth and the puerperium, co-operation with other primary, secondary and tertiary level services is imperative.

Implementers: selected teams for women's health care in co-operation with other primary health care services and specialist and consultant, and hospital services.

1.5.5.2. Registration, keeping records, reporting and evaluation

1.5.5.2.1. Compulsory reporting according to current regulations

Recording information in health care documentation, keeping records and reporting on work, and on the occurrence of infectious and malignant diseases, according to current regulations and within set time limits.

Implementers: selected teams for women's health care, gynaecological specialist and consultant services, and hospital services.

HEALTH PROTECTION OF PRE-SCHOOL CHILDREN

Health protection of pre-school children is mostly provided by the services for health care of infants and small children, within the primary health care system. Health protection services are provided by specialists in paediatrics (in their own clinics or in clinics leased from community health centres), who have concluded contracts for the provision of health care services to children. A smaller number of children receive health protection services from general/family medicine practitioners (general practitioners and general/family medicine specialists), if their parents have so decided while exercising their right to a free choice of doctor.

In 2006 a total of 260 teams were providing health care services to children, covering 75.2% of all pre-school children, whereas other pre-school insurees, mostly on islands and in rural areas, were cared for by general/family medicine practitioners.

Preventive examinations and counselling for child health preservation and promotion are part of the mandatory Programme of Measures for the Health Protection of Pre-school Children, which is financed entirely by compulsory health insurance.

PROGRAMME OF MEASURES FOR THE HEALTH PROTECTION OF PRE-SCHOOL CHILDREN

1.2.1. MEASURES FOR PROMOTING HEALTH AND PREVENTING DISEASE

1.2.1.1. Regular check-ups of infants aged between one and two months

- issuing records (health and vaccination); short family history (chronic and hereditary diseases, previous births, details of this pregnancy and birth); child's nutrition and details of health to date
- anthropometric measurements: body weight, height, circumference of head, body temperature
- general systematic examination (skin and mucous membranes, head, neck, chest, lungs and heart, abdomen, genitals, extremities and hips), paying particular attention to possible anomalies, damage or deviation
- psychological and motor screening
- referral for hip ultrasound, according to indication
- referral for brain ultrasound for premature babies (under 35 weeks gestation) and other newborns with perinatal risk factors
- hearing test for infants who were positive in initial testing in maternity units and those who did not pass initial testing for whatever reason
- BCG and issuing an immunisation card, if not done in the maternity unit
- phenylketonuria inhibition test and TSH capillary blood test, i.e. screening for congenital hypothyreosis, if not done in the maternity unit
- prophylaxis against rickets
- prophylaxis against anaemia in premature babies and for other indications
- advice on care and nutrition
- data entry in health documentation.

Implementers: selected primary health protection team.

1.2.1.2. Regular check-ups of infants aged 3-4 months

Confirmation and monitoring of health requirements:

- health case history for the previous period – as for the previous regular check-up
- anthropometric measurements
- general systematic examination
- psychological and motor screening
- sight screening
- neurological screening – asymmetry, reflexes, grasping with fists, grasping with feet, automatic walking
- vaccination according to vaccination timetable (preceded by measurement of body temperature) and data entry in vaccination record and immunisation card
- advice on care and nutrition
- data entry in health documentation.

Implementers: selected primary health protection team.

1.2.1.3. Regular check-ups of infants aged 6-7 months

Confirmation and monitoring of health requirements:

- health case history for the previous period – as for the previous regular check-up
- anthropometric measurements
- general systematic examination plus blood test (CBC from capillary blood)
- psychological and motor screening
- vaccination – details of previous vaccinations; vaccination or supplementary vaccination (following examination and measurement of body temperature), according to the vaccination record and timetable; data entry in vaccination record and immunisation card
- advice on care and nutrition
- data entry in health documentation.

Implementers: selected primary health protection team.

1.2.1.4. Regular check-ups of infants aged 9-10 months

Confirmation and monitoring of health requirements:

- health case history for the previous period – as for the previous regular check-up
- anthropometric measurements
- general systematic examination plus dental check
- psychological and motor screening
- check that the infant has received the first round of vaccinations
- advice on care and nutrition
- data entry in health documentation.

Implementers: selected primary health protection team.

1.2.1.5. Regular check-ups of children aged 12-15 months

Confirmation and monitoring of health requirements:

- health case history for the previous period – as for the previous regular check-up
- anthropometric measurements
- general systematic examination, check position of testes in boys, dental check
- psychological and motor screening
- advice on care and nutrition
- prophylaxis against rickets in autumn and winter
- data entry in health documentation.

Implementers: selected primary health protection team.

1.2.1.6. Regular check-ups of children aged two

Confirmation and monitoring of health requirements:

- health case history for the previous period (physical, emotional and social development)
- anthropometric measurements
- general systematic examination, check position of testes in boys
- dental examination and condition of milk teeth
- psychological and motor screening and emotional development, according to the guidelines of the profession
- special eye examination and referral to ophthalmologist for children with family histories of sight problems or showing pathological results
- laboratory tests – CBC from capillary blood
- vaccination; details of vaccinations so far; supplementary vaccination (with preceding measurement of body temperature), according to the vaccination record and timetable, data entry in vaccination record and immunisation card
- advice on nutrition
- data entry in health documentation.

Implementers: selected primary health protection team.

1.2.1.7. Regular check-ups of children aged four

Confirmation and monitoring of health requirements:

- health case history for the previous period (physical, emotional and social development)
- anthropometric measurements
- general systematic examination plus blood pressure
- condition of milk teeth
- psychological and motor screening
- special eye examination and referral to ophthalmologist for children with family histories of sight problems or showing pathological results
- laboratory tests – CBC from capillary blood, urine
- vaccination; details of vaccinations so far; supplementary vaccination (following measurement of body temperature), according to the vaccination record and timetable, data entry in vaccination record and immunisation card
- advice on nutrition
- data entry in health documentation.

Implementers: selected primary health protection team.

1.2.1.8. Regular check-ups of children aged six

Confirmation and monitoring of health requirements

- health case history for the previous period (physical, emotional and social development)
- anthropometric measurements
- general systematic examination plus blood pressure
- psychological and motor development
- sight (as per case history)
- neurological status
- examination of the extremities
- examination of the spine
- dental examination
- hearing test (as per case history)
- advice on nutrition

- data entry in health documentation.

Implementers: selected primary health protection team.

1.2.1.9. Vaccination and supplementary vaccination of infants and children up to six years of age

Following a regular check-up, vaccination is carried out according to the vaccination timetable prescribed each year by the epidemiological service of the Croatian National Institute of Public Health.

Vaccination is carried out on a continual basis throughout the year.

Implementers: selected primary health protection team.

1.2.1.10 Vaccination and supplementary vaccination of infants and children up to the age of six for hepatitis B

Vaccination for hepatitis B is compulsory for all newborn infants with HBsAG positive mothers, children who have contact within the family with HBaAG positive persons and children accommodated in social welfare institutions.

Implementers: selected primary health protection team and doctors responsible for social welfare institutions.

1.2.1.11. Promoting health, implementing health education and awareness for parents and children

Individual health education for parents in the form of counselling parents on growth and developmental problems, on nutrition (particularly the importance and advantages of natural food in infancy and establishing healthy eating habits with the aim of preventing obesity), health awareness concerning prevention of accidents and resulting injuries and other health matters.

Implementers: selected primary health protection team.

1.2.1.12. Other preventive measures

- Chemoprophylaxis and seroprophylaxis – application of certain substances (in children exposed to certain infections) according to current regulations
- Prophylaxis against rickets is given throughout infancy and after the first birthday, in autumn or winter
- Prophylaxis against anaemia is given during the first year, in individuals and groups with higher risk factors (premature babies)
- Follow-up check-ups when an infectious disease occurs and application of minor anti-epidemic measures.

Implementers: selected primary health protection team in co-operation with other primary health services and hygiene and epidemiology services within institutes of public health.

1.2.1.13. Ongoing monitoring of children with specific health risk factors and children with chronic illnesses

Individual counselling for parents or children with high health risk factors and parents of children with chronic illnesses.

Keeping records and carrying out check-ups on children with any form of chronic health problem or other illness.

Referring children with neurological risks to specialised health institutions for neurological problems, with the aim of early detection and participation in treatment and rehabilitation, according to the guidelines of the profession.

Referring for and participating in targeted and follow-up check-ups on children with psychological and physical developmental problems.
Referral to specialised centres and participation in targeted and follow-up check-ups on children with autistic and pervasive problems.
Implementers: selected primary health protection team

1.2.1.14. Other preventive measures
Examination of newborn infants immediately following home births.
Establish Apgar values in the first and fifth minute following delivery, assess the baby's general condition and maturity, measure weight and length, circumference of the head, look out for visible congenital abnormalities, damage caused during labour and other problems.
Babies born at home – TBC vaccination, phenylketonuria and hypothyreosis screening, screening for hearing damage in the nearest audiological institution.
Babies born at home – up to one month of age – TBC vaccination, capillary blood sample taken on filter paper and sent for laboratory testing to detect congenital metabolic diseases through phenylketonuria screening (Guthrie test) and capillary blood sample taken on filter paper and sent to the appropriate laboratory to test TSH and screening for congenital hypothyrosis.
Implementers: selected primary health protection team

1.2.2. DIAGNOSTICS, TREATMENT AND REHABILITATION

1.2.2.1. Diagnostics, treatment and rehabilitation
According to medical indications – application of the appropriate diagnostic and therapeutic procedures in primary health care clinics or referral and active co-operation with specialist and consultant, and hospital services (examinations, diagnostics, therapy, hospital treatment).
Rehabilitation – a proposal for carrying out rehabilitation is based on test results and opinions of specialists in physical medicine and rehabilitation, in accordance with the legal acts of the Croatian Institute for Compulsory Health Insurance. On completing rehabilitation, counselling on care and maintaining the child's achieved locomotor functions.
Implementers: selected primary health protection team in co-operation with laboratory, specialist and consultant services and other primary health care services. For rehabilitation – selected primary health protection team in co-operation with specialists in physical medicine and rehabilitation, nursing and health visiting services.

1.2.2.2. Providing emergency medical assistance
Providing medical assistance in cases of emergency in health services for the protection of infants and small children, at the scene or in the surgery, until the child is transferred to the appropriate health service.
Implementers: selected pre-school health care team in co-operation with emergency medical services.
1.2.2.3. Home treatment
Programmed treatment – follow-up check-ups and treatment at home for the chronically bedridden, terminally ill or other insured persons, depending on need, and for acute conditions which do not require hospital treatment.
The most important indicators of the need for home treatment are deteriorating or terminal chronic illness, palliative care and home treatment of bedridden patients.
Implementers: selected primary pre-school health care team in co-operation with health visiting and nursing services.

1.2.2.4. Home treatment of acute conditions
Delivered upon request based on an assessment by the selected doctor (in acute conditions, acute illnesses, in cases of deterioration in basic chronic illnesses and acute illnesses in the chronically ill).
Implementers: selected primary pre-school health care team in co-operation with visiting and nursing services.

1.2.3. OTHER MEASURES

1.2.3.1. Co-operation and co-ordination in promoting and protecting health and measures for diagnosing, treating and rehabilitating pre-school children at the level of primary health care
In order to implement successfully measures and activities for monitoring children's health, the co-operation of several services within primary health care is needed, in order to co-ordinate and resolve individual health problems concerning children as members of families.
Implementers: selected primary health care team in co-operation with other primary health care services.

1.2.3.2. Co-operation in protecting health with other children's health care services for pre-school children
In resolving problems concerning health and psycho-social problems, and in implementing certain measures to protect health, the co-operation of other pre-school children's protection services is required.
Implementers: selected primary health care team.

1.2.3.3. Co-operation and co-ordination at the level of specialist and consultant, and hospital health care services
- co-operation with maternity units through discharge notes for newborns
- establishing contact when dealing with the health problems of a joint patient (planning workup and hospital treatment and implementing treatment).
Implementers: selected primary health care team in co-operation with specialists in specialist and consultant services and in hospitals.

1.2.3.4. Issuing certificates on the state of health or reports on an insured person for use by a third party
Written certificates on a patient's state of health may be issued at the request of the insured person, on the basis of information available in the patient's health records and examination, arising from the Programme of Measures.
Implementers: selected primary pre-school health care team in co-operation with the appropriate institutions.

1.2.3.5. Registration, keeping records, evaluation and reporting
According to current regulations, including preventive measures and procedures. Medical records should be kept for each child, including details of growth and development, illnesses and treatment, vaccinations, immunisation card, and keeping notes on work as prescribed.
Reports on work and on health indicators are written on the prescribed forms and submitted within the given deadlines, along with records and reports on infectious and malignant diseases and disability, according to current regulations.
Implementers: selected primary health care team.

PROGRAMME OF MEASURES FOR THE HEALTH PROTECTION OF SCHOOLCHILDREN

The Croatian school medicine services have existed for decades. Since 1998 they have been an integral part of county institutes of public health. The doctors who work in these services, after under-graduate studies at the Medical Faculty, specialise in school medicine, which lasts three years (the new proposal is for a four-year course, entitled "School and Adolescent Medicine"). Each doctor and nurse is responsible for the preventive care of around 5,000 children, young people and regular students.

According to the Plan and Programme of Health Care Measures, parts of the obligatory programme include health education and counselling work.

COUNSELLING WORK

Counselling work is carried out separately and at advertised times in counselling centres, for at least three hours a week, for the purpose of helping resolve basic problems faced by children, adolescents, their parents, guardians and teachers; adjusting to school, failure at school, behavioural problems, developmental and maturity problems, chronic health problems, family planning, abuse of psycho-active drugs and other forms of addiction, mental health problems, etc.

Counselling for the purpose of maintaining and advancing health and healthy life styles

Work with pupils and students in resolving the most common health, psychological and social problems and directing them towards adopting healthy habits and attitudes.

Consultations with teachers and expert associate school staff

This is carried out in conjunction with each regular and other preventive check-ups, with the aim of monitoring and supervising all pupils' health.

Work with parents

Counselling work with parents, with the aim of resolving current problems related to school, behaviour and maturity, and relationships within the family.

Counselling on maintaining and advancing reproductive health

Counselling work with young people and students on relationships between the sexes, practising responsible sexual behaviour and the use of contraception.

Counselling on maintaining and advancing mental health

Counselling work with young people and students on the most common problems concerning mental health (stress, depression, anxiety, self-confidence, self-respect, etc.).

Active care for children, young people and students with chronic health problems

Monitoring pupils and students who suffer from chronic health problems, in terms of their state of health and abilities, and the protective health measures needed in education, as well as monitoring success in completing educational programmes.

Care for children, young people and students with health risks

Identifying and registering children with health risks and behavioural problems (being overweight, tendency towards addiction – consumption of alcohol, experimentation

with psycho-active drugs, tendency towards promiscuity, absconding from home, juvenile delinquency, etc.).

Individual counselling and health education work, co-operation with experts working in schools, with the child's, adolescent's or student's family, and with social work centres.

Care for pupils with mental or physical development problems

Registration and keeping of records on pupils who have been monitored by expert commissions in the health, education or social welfare systems, due to problems concerning mental or physical development. Constant co-operation with experts working in schools is needed for all children integrated in regular education or attending special schools, with the aim of monitoring their state of health and abilities, and their success in completing envisaged educational programmes.

Counselling centres for children and young people, in which children, parents and teachers can seek help in resolving the most common problems relating to growing up and children's health, organised in the form of special work, and the number of visits made to these centres continues to grow. In primary schools, the numbers grew from 132,077 in the academic year 2004/2005 to 140,738 in the academic year 2005/2006, and to 137,607 in 2006/2007. In secondary schools, the number of visits made to counselling centres increased from 42,495 in the previous academic year to 43,450 in 2006/2007. This indicates that this form of work is needed and that it was lacking in the system. In counselling centres for children and young people attached to school medicine services, primary school children and their parents most frequently seek help for problems related to chronic illnesses (42%), learning difficulties (24%) and mental health problems (19%). Among secondary school pupils, apart from chronic illnesses (34%), the most frequent problems and requests for counselling relate to reproductive health and sexually transmitted diseases (23%), learning difficulties (16%), risky behaviour (13%) and mental health (15%).

In addition to the regular activities of the counselling centres, since 2000 an attempt has been made to establish specific counselling centres for adolescent reproductive health within school medicine services (activities also listed in strategic documents such as the National Programme of Activities for Youth). In Zagreb, the City Office for Labour, Health, Social Welfare and Veterans supports a counselling centre for reproductive health in the City of Zagreb Institute of Public Health, School Medicine Service; in Rijeka, the City of Rijeka supports the "Youth Open Centre" in the Primorje-Gorski Kotar Institute of Public Health, School Medicine Service; and in Split several specific counselling centres have been organised, at the moment on a voluntary basis, within the Institute of Public Health.

Health education topics are to be found on the curricula of primary and secondary schools, within subjects such as science, biology and physical education. According to the annual programme, school medicine personnel are involved in health education issues which complement and supplement the existing curriculum.

Pursuant to the Plan and Programme of Health Care Measures, health education is carried out as follows:

HEALTH EDUCATION AND HEALTH PROMOTION

This is carried out according to the annual programme as a separate activity and/or in conjunction with regular check-ups and vaccination.

Health education activities with pupils

Primary school, Years 1-4
Personal hygiene in keeping healthy
Importance of correct nutrition and its effect on growth and development
Socially unacceptable and violent forms of behaviour and abuse
Primary school, Years 5-6
Psychological and somatic changes in puberty, menstruation
Addictions (smoking, alcohol, psycho-active drugs)
Primary school, Years 7-8
Protection from HIV/AIDS and other sexually transmitted diseases
Healthy maturing and growing up
Secondary school, Years 1-3
Family planning, abortion, contraceptive methods, marriage, family, children
Responsible sexual behaviour, sexually transmitted diseases
Protecting and caring for one's own health
Students
Individual and group work as needed or requested
Health education methods
In principle, health education is carried out in schools, by means of lectures, discussions, workshops, interviews, small group work, forums, peer education, and participation in media programmes.

Health education for parents

Participation in parents' meetings. Compulsory attendance of doctor at parents' meetings in Years 1, 4 or 5 and 8 of primary school, in relation to problems of growing up and choice of occupation, and again during the first year of secondary school.

Health education for school staff

Professional training of educational staff for the purpose of resolving specific health issues more successfully. Compulsory annual attendance at school board meetings.

In the academic year 2004/2005 314,342 primary school pupils and 77,204 secondary school pupils were involved in some form of health education. In 2005/2006 the figures were 305,236 primary school pupils and 89,498 secondary school pupils. In 2006/2007 the figures were 319,710 primary school pupils and 68,749 secondary school pupils. In addition, 61,375 parents and teachers in primary schools and 5,721 in secondary schools participated in lectures, forums or workshops concerned with health issues.

According to the latest information available for Croatia (European School Survey Project on Alcohol and Other Drugs (ESPAD)), during the previous month 36% of boys and 37% of girls aged 15-16 smoked at least one cigarette, and 32% of boys and 29% of girls had smoked more than 40 cigarettes in their lives. In Croatia, smoking is higher than the average for other countries (4% higher during lifetimes, 1% higher in the previous month).

The trend for boys has stabilised, but for girls it is still increasing and the gap between the sexes is diminishing.
Experimenting with alcohol is measured by the frequency of drinking and intoxication. In Croatia, during the previous 30 days, 15% of boys and 10% of girls drank more than 10 units. In 2003 Croatia was below average in comparison to other ESPAD countries in terms of the frequency of drinking (1% below average for drinking during the previous twelve months and 5% below average for intoxication during the previous twelve months). The frequency of drinking is increasing, since in 1999 Croatia was well below the average of all countries. The increase in frequency is particularly marked with girls.
In Croatia 24% of boys and 20% of girls aged 15-16 have experimented with marijuana, and 5% of boys and 4% of girls have taken Ecstasy.

Special measures undertaken in the health care of addicts

The system of monitoring the problem of addiction as a specific medical and social phenomenon was set up in the Croatian National Institute of Public Health in the early 1980s. From the overall figures on morbidity and mortality on a national level, the figures on persons treated for abuse of psychoactive drugs have been kept separately, so a register has been gradually built up of persons treated due to abuse of psychoactive drugs, kept by the Service for the Prevention of Addiction within the Croatian National Institute of Public Health. The treatment system is based on the National Strategy for Suppression of the Abuse of Narcotic Drugs in a network of out-patient and hospital treatment. The prevalence of drug experimentation in the adolescent population, the characteristics and trends of risky behaviours are monitored by participation in international studies (ESPAD and HBSC), co-ordinated by the Croatian National Institute of Public Health.

In 2007, a total of 7,464 persons were treated, of whom 1,779 persons sought treatment for the first time (23.8%). In the same year, a total of 5,703 persons were treated for abuse and/or addiction to narcotics, of whom 800 were treated for the first time (14.0%). The number of new heroin addicts has been steady at around 800-1,000 for several years. The average age of patients has been on the increase (from 25.7 to 29.8 years for men and from 25.8 to 29.2 years for women in the period 2001-2007), which points to the conclusion that patients remain longer in the system of treatment, with the number of new entrants being stable. According to figures on the total number of treated persons in the 15-64 age group per 100,000 population in Croatian counties, the largest number of persons registered for treatment is in the Zadar County (the rate was 599.2). The Istra County ranked second (532.6), followed by the City of Zagreb (444.2), the Dubrovnik-Neretva County (348.8), the Šibenik-Knin County (347.0), the Primorje-Gorski Kotar County (300.2), the Split-Dalmatia County (265.8). According to mortality statistics, in 2007 there were 150 deaths related to drug abuse. During the past ten years the number of deaths has been gradually growing, and the last year's number of deaths was the highest recorded so far.

Pursuant to the Health Care Act (OG 121/2003) and the Act on Amendments to the Act on Suppression of Abuse of Narcotic Drugs (OG 163/2003) the system for prevention of addiction and out-patient treatment of addicts became part of the system of the Croatian National Institute of Public Health. In this way the Centres for Prevention of Addiction became an integral part of the county institutes of public health. These Centres in their organisation and work unite the activities of health care, social protection and education with the aim of conducting constant supervision, education, psychotherapy, family therapy, HIV

and hepatitis prevention and helping resolve other problems in the lives of addicts and their families, as well as offering help to occasional users of drugs and their families.

Treatment of addicts takes place primarily within the country's health care system, but some rehabilitation measures may also take place outside the health care system (non-governmental organisations, social institutions and within the prison system). The way treatment is given is based on the approach of treatment identical to other chronic non-infectious diseases. Prescription of drugs, daily check-ups and recording the results of treatment are performed on the level of primary health care, and the overall treatment is a result of the co-operation of polyclinic specialists and hospital services as needed. Treatment is planned and conducted according to the needs of the individual and is adapted to the condition of the disease.

In treatment the Croatian Model agreed by the profession is used, which is known and recognised as such in international professional circles. The Model implies constant co-operation of specialised out-patient centres for prevention and out-patient treatment of addicts and doctors in primary health care, i.e. family medicine teams in offering treatment to addicts. This makes possible the wide availability of treatment through the primary health care system, with at the same time the provision of expert leadership by specialists, integrated and comprehensive care of addicts, de-stigmatisation and normalisation of treatment, decentralisation and preventing isolation of addicts and low programme costs.

For these activities in the prevention of addiction and treatment of addicts, in the system of health care financing is provided in accordance with the Act on the Suppression of Abuse of Narcotics Drugs from the state budget, the budgets of regional and local governments, the Croatian Institute for Health Insurance and other sources (income from games of chance). All addicts undergoing treatment in the health care system have the right to basic health insurance and all the rights arising from it.

Information about measures undertaken to protect the reproductive health of all persons, and in particular adolescents

Health care measures that aim at ensuring universal access to health care are prescribed by the Health Protection Act, and they are the following:
- protection from environmental factors harmful for health, including measures of preserving, promoting, monitoring and improving health and hygienic conditions of living and working;
- providing health education, popular health education and promoting of health with the aim of improving mental and physical abilities of persons;
- discovering and eliminating causes of illness, preventing and treating diseases, injuries and their consequences;
- special health care measures for the population older than 65 years of age;
- ensuring holistic (preventive, curative and rehabilitative) health care of children and young persons through regular medical check-ups, vaccinations and medical treatment at primary level and at the level of institutes of public health;
- ensuring holistic (preventive, curative and rehabilitative) health care of women regarding family planning, pregnancy, childbirth and motherhood, and
- specific health care of workers that encompasses preventive examinations in order to determine working abilities, monitoring health condition of workers, co-operation in exchanging information, vocational training, training in occupational medicine, work hygiene and work organisation.

Health care of persons over 65 years of age

According to the number of doctors and insurees in the work of general/family medicine, in 2005 one team cared for a total of 1,664 insurees on average, and in 2006 one team cared for a total of 1,675 insurees on average. According to the number of doctors and insurees in the work of general/family medicine, in 2007 one team cared for a total of 1,695 insurees on average. The number of older insurees varies greatly and over the past few years the number of examinations of persons older than 65 has increased, whereas the number of visits (to other health workers) is falling in total in the work of general medicine.

According to figures from the Croatian National Institute of Public Health, in 2005 only 23,101 preventive and 6,102 regular check-up examinations of persons aged 65 and over were performed, which in relation to the almost 700,000 persons of this age, according to the census of 2001, is an insignificant share of 3% for preventive and less than 1% for regular check-ups, that is 4% for regular, periodic and follow-up examinations in total.

According to figures from the Croatian National Institute of Public Health, in 2006 only 20,325 preventive and 4,994 regular check-up examinations were performed, which was an insignificant share of 3% for preventive and less than 1% for regular check-ups, that is 4% for regular, periodic and follow-up examinations in total. In 2007 only 15,518 preventive (4,807 fewer than in 2006) and 5,766 regular check-up examinations of persons aged 65 and over were performed, which in relation to the almost 700,000 persons aged 65 and over, according to the census of 2001, is an insignificant share of 2% for preventive and less than 1% for regular check-ups, that is 3% for regular, periodic and follow-up examinations in total.

The number of home examinations in the branch of general medicine of persons over 65 years of age in 2006 remained at a low level (35% less than in 1990). A particular problem in the health care of persons older than 65 years is the reduced number of house calls by other health care workers, which is 91% fewer than in 1990.

On the basis of the initiative launched by the Ministry of Health and Social Welfare in 2004, first contracts were signed between the Croatian Institute for Health Insurance and family medicine teams on performing preventive examinations (regular check-ups for persons older than 50 years), which was a good basis for improving preventive measures for adult population.

Counselling and diagnostic services

a) for schools

Preventive and specific health care of schoolchildren is provided by general/family medicine practitioners.
In the academic year 2004/2005 a total of 314,342 primary and 77,204 secondary school students received some of the forms of health education. In the academic year 2005/2006, the figure was 305,236 for primary school and 89,498 for secondary school students, and in the academic year 2006/2007, 319,710 primary school and 68,749 secondary school students. In addition, 61,375 parents and teachers in primary schools and 5,721 parents and teachers in secondary schools participated in lectures, forums or workshops on health.

b) for other groups

Employees

In the occupational medicine in 2006, there were 154 full-time teams (-2 in comparison to 2005) and 20 part-time teams (+1). In 2006, approximately 1,505,547 persons were in employment in Croatia, meaning that each team cared for 9,180 workers on average. Occupational medicine services are organised in all counties.

In 2006, 386,974 preventive examinations were carried out. The rate of preventive examinations was the same as in 2005 (148.5/1,000 employees). Between 1990 and 2006, only 2,486 occupational diseases were reported. The most frequent occupational diseases were: hearing damage caused by the harmful effects of noise (23.7%), pneumoconiosis (18.2%), damage caused by vibration (15.6%), infectious diseases (13.8%) and skin diseases (11.1%). In terms of distribution between the sexes, 70% were men and 30% women. In 2006, 98 reports of occupational diseases were received, which was 15.5% less than in 2005 (116). The total morbidity rate for 2006 was 6.51/100,000, less than in 2005 (8.00/100,000) and the least in the past several years. The highest rate of occupational diseases in terms of industry was recorded in agriculture, hunting and forestry, and it was less than in the previous year and almost the same as in 2004 (2006: 85.95/100,000; 2005: 129.47/100,000; 2004: 85.98/100,000). It was followed by health and social welfare services with the rate 21.69/100,000 (2005: 32.66/100,000; 2004: 15.99/100,000). In terms of diagnosis, in 2006 the greatest number of reports concerned diseases caused by the harmful effects of vibration (24.5%), pneumoconiosis (18.4%), skin diseases (14.3%), infectious diseases (11.2%) and hearing damage caused by the harmful effects of noise (10.2%). Four reports of malignant diseases of various organs and organ systems were also received.

In 2006, there was a total of 28,843 reports of employment injuries, which in relation to 2005 showed an increase in the absolute number of employment injuries of 9.3%. The greatest number of injuries in 2006, as in the previous years (78.5%) occurred in the workplace, while 21.5% occurred while travelling to or from work. In the workplace, men sustained the most injuries (79.5%), while women sustained 20.5%. The manufacturing industry accounted for 33.6% and remained in first place out of the total number of employment injuries in 2006, followed by the construction industry (12.8%), wholesale and retail trade, repair of motor vehicles and motorcycles and items for personal use (9.9%), public administration and defence, compulsory social insurance (7.8%), transport, storage and communications (7.1%). The total rate of employment injuries was 1,650.10/100,000, with injuries occurring in the workplace being at the level of 1,295.41/100,000 active insurees. Both these rates were higher than in the preceding year (1,560.08/100,000 and 1,233.40/100,000, respectively).

According to data from employment injury reports and reports by the State Inspectorate, in 2006 the number of fatalities rose (76 persons died). This was a 22.6% increase, i.e. 14 more workers died than in 2005. Sixty two persons died at the workplace (81.6% or 7 workers more than in 2005). With regard to fatalities resulting from injuries sustained exclusively in the workplace and the number of workers, the average rate was 4.12 per 100,000 active insured persons, which was more than in 2005 (3.79/100,000). The greatest number of fatalities and the highest rate was recorded in the construction industry (28 fatalities; 29.86/100,000).

In the **occupational medicine** in 2007, there were 163 full-time teams and 18 part-time teams, involving 170 occupational medicine specialists, 12 specialists in other fields and 13

general practitioners. In 2007, approximately 1,547,523 persons were in employment in Croatia, meaning that each team cared for 8,997 workers on average.

In 2007, 384,756 examinations were carried out, of which 58.6% were preventive health examinations for employees. The rate of preventive examinations was somewhat lower than during the previous two years (145.7/1,000 employees). The rate of periodic examinations also fell from 69.5/1,000 in 2006 to 67.0/1,000 in 2007.

Between 1990 and 2007, only 2,589 occupational diseases were reported. In terms of distribution between the sexes, 63% were men and 37% women. In 2007, 103 reports of occupational diseases were received, which is 5.1% more than in 2006. The total rate for 2007 was 6.66/100,000. The highest rate of occupational diseases in terms of industry was recorded in agriculture, hunting and forestry (120.86/100,000), fishing (60.39/100,000) and health care and social welfare (26.26/100,000). In terms of diagnosis, in 2007 the greatest number of reports concerned diseases caused by the harmful effects of vibration (32.0%), infectious diseases and chronic periarthritic changes (17.5% each), hearing damage caused by the harmful effects of noise (10.7%) and skin diseases (9.7%).

In 2007, there was a total of 24,550 reports of **employment injuries**, which in relation to 2006 showed a reduction in the absolute number of employment injuries of 1.2%. The greatest number of injuries in 2007, as in the previous years (79.1%) occurred in the workplace, while 20.9% occurred while travelling to or from work. In the workplace, men sustained the most injuries (78.1%), while women sustained 21.9%. The manufacturing industry accounted for 33.1% and remained in first place out of the absolute number of employment injuries in 2007, followed by the construction industry (12.6%). The total rate of employment injuries was 1,586.41/100,000, with injuries occurring in the workplace being at the level of 1,254.33/100,000. The highest specific rate by industry (only injuries occurring in the workplace) was in the construction industry (2,777.89), then in the manufacturing industry (2,614.37), agriculture, hunting and forestry (2,537.84) and mining and extraction (2,514.07). Seventy-seven employees died in 2007. Fifty-nine died in the workplace (76.6%), which was fewer than in 2006 (62 persons or 81.6%). With regard to fatalities resulting from injuries sustained exclusively in the workplace, the average rate was 3.81 per 100,000 active insured persons, which was less than in 2006. The greatest number of fatalities occurred in the construction industry (21 fatalities, 21.04/100,000) and the highest rate was recorded in other community, social and personal service industries (21.40/100,000).

Measures undertaken to promote health education

The basic aim of health policies 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 life styles, 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 equips them to control their own health.

The tasks of the service are:

- To propose, promote and participate in organising and implementing programmes to promote health;
- Through health education and training and the public media to publicise the necessary recommendations and promote a healthy way of life (non-smoking, correct eating habits, regular physical exercise, responsible sexual behaviour, strengthening the ability of individuals to overcome crises, etc.);
- 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 for a healthy way of life to become more simple and 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;
- In the field of health promotion, to improve co-operation with other sectors (education, the food industry, agriculture, etc.);
- 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.

Pursuant to the Act on Protecting the Population from Infectious Diseases (OG 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 infections 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.

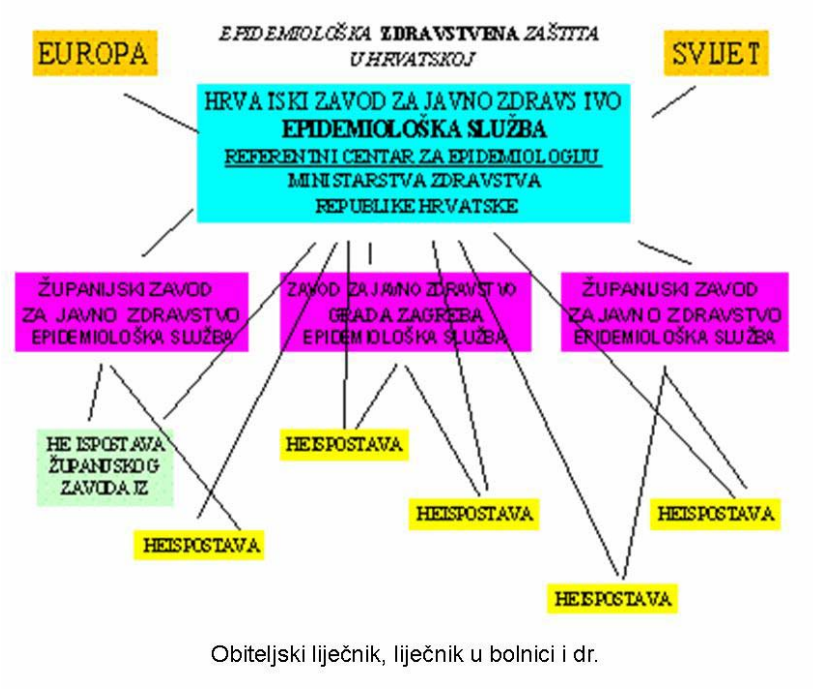
Organisation of epidemiological services in Croatia and activities relating to monitoring infectious diseases:

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.

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



Legenda:

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

Family doctor, hospital doctor or other

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 its 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 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 spread. 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 population are distributed. 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.

Vaccination coverage in Croatia

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. 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 14 Coverage of children by primary vaccination (primovaccination) in Croatia

Vaccination	2004	2005	2006	**2007**
Diphtheria – Tetanus –Pertussis (DiTePer)	95.6%	95.9%	95.9%	**96.2%**
Poliomyelitis	95.5%	96.0%	95.7%	**95.7%**
Morbilli – Parotitis – Rubella (MoPaRu)	95.7%	95.5%	95.4%	**96.1%**
Hepatitis B	98.4%	98.9%	98.6%	**94.9%**
Tuberculosis (BCG)	95.0%	95.6%	99.1%	**99.1%**
Haemophilus influenzae Type B (Hib)	95.2%	95.7%	96.0%	**96.2%**

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.

The lowest level of coverage necessary for all vaccinations is 95%. Analysis of the results by the Croatian National Institute of Public Health for 2007 shows that the level of 90% was achieved and exceeded in most of the planned vaccinations, and that the level of 95% was attained for the majority of them.

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).

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.

More than 500,000 persons are vaccinated each year, with about 900,000 individual doses of vaccine. Revaccination or supplementary vaccination is conducted according to the Programme, occasionally, throughout life. It should be particularly 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. 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.

Survey of infectious diseases in Croatia

T y p h u s a b d o m i n a l i s (abdominal typhus) In 2007 there was an exceptionally good situation and there were no registered cases of abdominal typhus. In 2006, there were only 2 cases, both imported, i.e. occurring as a result of Croats being exposed during travels abroad. In one case, the source was Peru/Bolivia, and in the other, India/Nepal.

D y s e n t e r i a b a c i l l a r i s. The situation is again very good. In 2007 only 18 cases were recorded (2006: 16).

H e p a t i t i s A (infectious hepatitis). As with the two previous diseases, this enterically transmitted disease, which is typical of poor sanitary and hygienic conditions, is clearly on the wane in Croatia. In 2007 there were only 26 cases, the same number as in 2006.

S a l m o n e l l o s i s. Salmonella infections are not necessarily linked to low sanitary and hygiene standards, but mostly to the appearance of mass, public food preparation and the rearing of animals and processing of their products for human consumption. If we add to this the fact that almost all warm- and cold-blooded animals are susceptible to salmonella bacteria, not only humans, this explains why their presence is rising in Croatia, as in most other developed countries. In 2007 slightly fewer cases were recorded than in the previous year (3,331: 4,734), but on the whole, it can be said that frequency maintains a steady level.

H e p a t i t i s B. In 2007 the number of cases was less than in the previous years (**136**: 148: 164: 215), which can be attributed to systematic vaccination. Last year the rate of occurrence in the generation vaccinated (14 to 19 year-olds) visibly decreased. From this year, 2007, the Programme includes vaccinations for Year 6 in primary schools (12 year-olds) and vaccination of newborn babies. Since hepatitis B is also transmitted between people indirectly, through blood and bodily excretions and tissues, supervision of blood for transfusion is especially important, in addition to vaccination, as are provisions for safe work procedures in health institutions, in order to avoid iatrogenic and nosocomial (hospital) infections.

P e r t u s s i s (whooping cough). There were only 123 cases in 2007, which is the result of the successful implementation of vaccination, which started in 1959 and has increased in coverage ever since. Those contracting the disease are mostly very young infants who have not yet been protected by vaccine (vaccination begins when the child is three months old).

T e t a n u s (lockjaw). The introduction of vaccines for those in their sixties in the Programme of Compulsory Vaccination for 2002, along with continuing vaccinations for children and young people, which has been carried out since 1955, has resulted in the small number of cases being reduced still further, with the prospect that this disease will soon be totally eliminated. In 2007, there were five recorded cases.

M o r b i l l i (measles). The programme of vaccination against this disease in Croatia has been highly successful. In the last few years, only a few individual cases have been recorded and in 2007, there were no cases at all (and only one in 2006). Since the start of systematic vaccination in 1968, frequency has reduced from over 20,000 cases in that year to none today (one in 2006), which means a virtual 100% reduction. It is not difficult to calculate how many people would have contracted (or died from) the disease during that period, were it not for vaccination. The high level of vaccination, which Croatian doctors – vaccinators have achieved due to strenuous efforts, must of course be maintained, in order to avoid lesser or greater epidemics among those not vaccinated. This has happened in some developed European countries, where the previously favourable situation has deteriorated.

R u b e o l a (German measles). In 2006, there were only 2 (two!) cases, as in the previous three years. In 2007, a small outbreak of rubella was registered, with 36 patients. Before the introduction of the rubella vaccine in 1976, there were more than 19,000 cases annually.

P a r o t i t i s e p i d e m i c a (mumps). After a small oscillation in occurrences (growth) in 2005, due to an outbreak among young adults who had not been vaccinated and in whom vaccination had resulted in low immunity, the number of cases registered dropped again in 2007 to 74.

T u b e r c u l o s i s a c t i v a. The positive trend in the decline in the frequency of active tuberculosis in Croatia continued in 2007, thanks to measures placing Croatia among countries with low levels of tuberculosis.
According to the Tuberculosis Register records, kept by the Service for the Epidemiology of Infectious Diseases in the Croatian National Institute of Public Health, for the first time since monitoring began, fewer than new 1,000 cases were reported in 2007, which represents an incidence rate of 22/100,000 population. In 2007 there were 988 cases, fewer than ever (2006: 1,119; 2005: 1,140; 2003: 1,470; 2002: 1,494), however, the number is still unsatisfactorily high. Resistant tuberculosis accounted for 3.1% of cases in 2007. Among those tested for multiresistance in 2007, 7 were found to have multiresistant tuberculosis (1.0%).
Newborn babies receive their first vaccination against tuberculosis in maternity units, and according to regular maternity unit reports, this is carried out successfully, covering 99.1% of newborn babies in 2007. Whatever the case, this decreasing trend indicates that measures taken are working, and is a further incentive to all those participating in the complex programme needed to fight this disease.

V a r i c e l l a (chicken pox). In Croatia, this childhood illness is not prevented by systematic mass vaccination, and occurs with a naturally high, stable level of frequency, with slight natural differentials from year to year. In 2007, there were 21,815 cases, which was more than in 2006 (19,549).

Sexually transmitted diseases

G o n o r r h o e a. The favourable situation regarding this classic venereal disease continued in 2007, with only 15 cases (17 in 2006).

S y p h i l i s. The situation with this disease is also favourable, with a low level of frequency, far below the levels of the 1960's, for example, when there were over 2,000 new cases recorded annually. In 2006 there were 48 cases, which was little more than in 2005 (38), and almost the same as in 2004 (47). In 2007 there were 31 cases recorded.

C h l a m y d i a s i s. In 2007 there were 374 cases. The frequency of chlamydia infection in the previous years was fairly high, with around 900 cases annually (966 in 2006). The availability of good microbiological diagnostics and appropriate treatment should reduce the risk of potential later side-effects of chronically untreated chlamydia infections of the pelvis minor organs, which are particularly important for healthy offspring, particularly in women.
Prevention strategy. Education, counselling and distributing information about how infections occur and how to protect oneself, early detection of infected persons, prompt treatment of patients and their contacts, prevention of serious complications, such as pelvic infection, male and female infertility, ectopic pregnancy, chronic chlamydia infection and malignant diseases

of the genital and urinary systems – all these enable the epidemiological situation concerning sexually transmitted diseases to be kept under control, protecting and advancing the sexual and reproductive health of the population. This is also important in terms of the country's demography.

The current situation in terms of sexually transmitted diseases in Croatia is monitored within the systematic surveillance of infectious diseases throughout the country. Surveillance is prescribed by legal regulations and is based on data from the epidemiological IT system, which routinely collects individual reports on cases of infectious diseases. As a source of epidemiological data on sexually transmitted diseases, reports are compiled on isolated agents of STDs and urogenital infections discovered in microbiological laboratories, as well as reports on registered diagnoses of STDs in gynaecological and dermatological-venereal clinics. Targeted epidemiological research is also carried in certain segments of the population (dermatological-venereal, gynaecological clinics, etc.). Taken by groups, although it may appear that STDs (which must be reported) represent a small proportion of the total number of infectious diseases reported, they are extremely significant in terms of public health.

The "classic" STDs, syphilis and gonorrhoea, which used to be most widespread and well-known, are now rare and occur only sporadically, but attention has turned to so-called second-generation diseases and their agents, such as non-gonococcal cervicitis and urethritis (caused by chlamydia and genital mycoplasma), hepatitis B and hepatitis C, human immunodeficiency virus infection (HIV) and acquired immune deficiency syndrome (AIDS), genital herpes and genital infections caused by the human papilloma virus (HPV). A significant drop in the number of cases of syphilis and gonorrhoea occurred in the mid 1980's, when a comprehensive approach to prevention and a wide campaign of health education issues concerning HIV/AIDS were launched, resulting in a decrease in the occurrence of other sexually transmitted diseases. In 2006, there were 17 registered cases of gonorrhoea and 48 cases of syphilis (in the mid 1970's there were about 2,000 registered cases of gonorrhoea and more than 100 cases of syphilis annually in Croatia).

Gonorrhoea and syphilis, the classic STDs, are rare and under control, and there is also a low occurrence of HIV/AIDS. According to data from Service for the Epidemiology of Infectious Diseases of the Croatian National Institute of Public Health, during 2007 there was a moderately good situation in terms of genital and sexually transmitted diseases, with a low level of occurrence – 31 cases of syphilis, 15 cases of gonorrhoea and 7 cases of AIDS:

HIV infection and AIDS

The first case of AIDS in Croatia was recorded in 1985. The monitoring and reporting of this disease, as with other infectious diseases, is regulated by the Act on Protecting the Population from Infectious Diseases (OG 79/07) and the Ordinance on the procedure for reporting infectious diseases (OG 23/94). The system is based on individual reports of persons infected with HIV, those suffering from AIDS, and the deaths of those infected with HIV. Reports are sent to the Service for the Epidemiology of Infectious Diseases of the Croatian National Institute of Public Health (CNIPH), a part of which is the HIV Section and the AIDS Register, launched in 1986. Compulsory testing of blood from volunteer donors was introduced in 1987. HIV treatment is centralised in Croatia and takes place at the "Fran Mihaljević" Clinic for Infectious Diseases, whose experts send reports directly to the CNIPH. The data is strictly confidential and is protected by the highest possible standards in data confidentiality. The proactive part of the work is carried out in the Clinic, where each infected patient is motivated

to practise protective behaviour and inform their sexual partners of the need to be tested. When needed, along with infectologists, epidemiologists from the CNIPH and county institutes of public health are called in. HIV infected persons are offered psychological and social support, and for any members of the public who are concerned, there are ten voluntary counselling and HIV testing centres (eight in Institutes of Public Health, one in the prison system and one at the Clinic) where they can be tested and receive counselling, with full anonymity and without charge. The work of the counselling centres is supervised by the Service for the Epidemiology of Infectious Diseases of the CNIPH.

The Ministry of Health's Commission for Preventing the Acquired Immune Deficiency Syndrome was established in 1990, and since 2003, its role has been taken over by the Government of Croatia's Commission for Suppressing HIV/AIDS. The first National Programme was adopted in 1993 and forms an integral part of the Programme of Measures (see C b). At present, the Programme for the period 2005-2010 is in force. According to data from the Service for the Epidemiology of Infectious Diseases of the Croatian National Institute of Public Health, by the end of 2007, 663 HIV positive persons had been registered with the Croatian National Institute of Public Health, of whom 270 were suffering from AIDS. During the last ten years, an average of 15 new cases of AIDS has been recorded each year. In 2007 there were seven new cases, while in 2006 there were twenty, which ranks Croatia among the countries with a low incidence of AIDS (4 per million population). The following modes of transmission were recorded: 11 mother-to-child (1.7%), 14 haemophiliacs (2.1%), 287 male homosexual intercourse (43.3%), 59 drug injections (8.9%), 87 heterosexual intercourse with a regular partner (13.1%), 170 casual heterosexual intercourse (25.6%), 3 recipients of blood products (0.5%) and 32 other/unknown (4.8%).

Programmes to combat HIV/AIDS infection: The Ministry of Health and Social Welfare was implementing the project **"Scaling up the HIV/AIDS Response in Croatia"** in the period 1 December 2003 to 30 December 2006. The funding for the project was provided through the Grant Agreement concluded with the Global Fund to Fight AIDS, Tuberculosis and Malaria. The total amount requested and approved for this three-year project was USD 4,945,192.00. The project was targeted at preventive activities and covered five areas of action: education of secondary school students, opening of new centres for voluntary counselling and testing, outreach programmes for high-risk groups, psycho-social support for HIV positive persons and introducing a new model for monitoring the HIV/AIDS infection. The objectives of the project include the activities aimed at significantly increasing the level of knowledge of secondary school students about the modes of transmission of HIV/AIDS and the protection against them, increasing the number of tests and counselling opportunities primarily for high-risk groups, reducing risk behaviour, increasing the quality of psycho-social support and introducing more efficient methods for data monitoring. Twelve institutions participated in the project, namely, 3 health institutions, 7 non-governmental organisations, one international organisation and one professional society, with a total of 16 programmes. After the completion of the project, all project activities continued within the framework of a special programme financed from the State Budget.

Suppressing and preventing HIV infection and AIDS is carried out according to the **Programme of Health Care Measures, the National Programme for Suppressing HIV/AIDS and other special programmes.** In Croatia there is also a **National Programme for Suppressing Addiction**. HIV patients and AIDS sufferers are treated free of charge in Croatia, using modern HAART treatment, allowing patients to enjoy a better quality of life for a longer period. In order to keep the epidemiological situation under control, measures

which have been shown to be effective continue to be implemented, along with the introduction of new programmes for preventing and treating HIV infections and AIDS. These include a programme for improving the availability of voluntary HIV counselling and testing, through the setting up of a network of centres for Voluntary Counselling and HIV Testing Services (VCTs), which are anonymous and free of charge. Second generation surveillance has also been introduced for monitoring HIV infections and AIDS, which has built up the system of epidemiological monitoring of HIV/AIDS, and which, in addition to recording deaths from and new cases of AIDS and HIV, also covers surveillance of other STDs and monitors risky behaviour in terms of HIV. Other measures include research into seroprevalence in high risk groups, harm reduction programmes, outreach in the field among the population exhibiting risky behaviour in terms of HIV and other infections transmitted via blood, including a series of preventive activities, for example distributing syringes and needles to intravenous drug users, providing substitute treatments, information, education and communication, ensuring treatment and care for HIV/AIDS patients, counselling on harm reduction, etc.

T r i c h i n e l l o s i s. Trichinellosis occurs as a result of eating infected pork, which tends to happen in Croatian households which make their own home-made meat products, but it can be said that, during the past few years, the disease has been brought under control, thanks to comprehensive veterinary measures and the prompt intervention of epidemiological services where the disease has broken out.

M a l a r i a. Since 1954, when Croatia conducted a successful anti-malarial campaign, the disease has been wiped out, so there is no indigenous malaria. Cases of imported malaria have only been recorded (people who have travelled to malarial parts of the world and returned with the disease, requiring treatment). In 2007, 8 such cases were recorded (in 2006 there were 6, and in 2005 there were 7). In all such cases, measures are taken to prevent the spread of infection. In Croatia, systematic pest control is applied to the mosquito population.

Q f e v e r. In 2006 the number of cases dropped further (28: 40) following epidemics in 2003 (206) and 2004 (104). In 2007, there were 43 cases.

M e n i n g o e n c e p h a l i t i s a c a r i n a (tick-borne meningitis, Central European viral meningitis,). In 2007 the relatively low level of incidence continued, with 11 cases in total (2006: 20, 2005: 28), possibly due in part to the vaccination of categories of people with occupational risk factors, i.e. forestry workers, hunters, natural science workers, etc.

M e n i n g o e n c e p h a l i t i s e p i d e m i c a continues to present a low level of incidence from year to year. Patients tend to be individual cases, with no secondary cases, i.e. there are no epidemiological consequences, partially thanks to the prompt application of drugs (chemoprophylaxis) for all persons at risk, which is carried out regularly by epidemiological services. In 2006 there were fewer cases than in the previous year (46, compared to 56), and the mortality rate was also lower (two deaths, or 4.3%), which throws a favourable light on treatment levels. The prevalent *Neisseria meningitides* sero-group in patients was B, as in previous years. In 2007, there were 60 cases, of whom two died.

L e g i o n e l l o s i s. In 2006 there was a visible increase in incidence, with 114 cases altogether. This increase has so far remained unexplained. It may be attributed partially to the consequences of more regular inclusion of this entity in differential diagnostic procedures in individual cases of severe or unexplained pneumonia, and the increased sensitivity of modern

diagnostic tests. To these we should add the perceptible effect of one rather large outbreak, with around fifty patients, in one accommodation institution. In 2007, there were 29 cases, of whom two died.

I n f l u e n z a (flu)**.** In the 2006/2007 flu season, 109,553 cases were recorded. The 2005/2006 season was exceptional in recording the lowest ever number of cases. There were only 1,248, almost one hundred times fewer than the previous year. A similar situation, with very few cases, prevailed in neighbouring European countries.

Epidemics registered in 2007

In addition to individual reports of infectious diseases, epidemics are also regularly reported. In 2006 there were 112 separate reports of epidemic outbreaks (2006: 102).

Table 15: Epidemics of infectious diseases registered in Croatia in 2007

Disease/Agent	Number of epidemics	Total number of cases
Salmonellosis	36	324
Toxiinfectio alimentaris, *Clostridim perfringens*	2	14
Toxiinfectio alimentaris, *Vibrio parahaemolythicus*	1	15
Toxiinfectio alimentaris	3	28
Gastroenteritis*, noro-virus*	20	999
Gastroenteritis, *adenovirus*	1	47
Gastroenteritis	13	273
Enterocolitis	1	9
Histamine food poisoning	4	24
Trichinellosis	2	20
Hepatitis A	2	11
Lambliasis	1	2
Pediculosis	6	73
Scabies	2	22
Psittacosis	3	13
Legionellosis	1	1
Pneumonia	1	150
Influenza	1	16
Angina streptococcica	2	29
Tuberculosis	2	8
Enterovirosis (mouth-hands-feet)	1	20
Varicella	3	60
Q fever	2	5
Rubella	1	47(33 confirmed)
Meningitis virosa, *ECHO 30*	1	69
Total	**112**	

Conclusion and assessment

On the basis of data from the epidemiological services of the Croatian National Institute of Public Health, the epidemiological situation concerning infectious diseases in Croatia in 2007, as in the previous years, can be assessed as *moderately good,* thanks to improved conditions in general and to the intensive work of all the important components of our health system. Diseases linked to poor hygiene standards, such as abdominal typhus, bacterial dysentery and hepatitis A, have virtually been eliminated. Diseases for which vaccinations are available have been suppressed to a minimum level (measles, German measles, mumps, whooping cough and tetanus) and some have been totally eliminated and eradicated (diphtheria and poliomyelitis). There is a high level of vaccination among the general population.

The classic venereal diseases, gonorrhoea and syphilis, are rare in occurrence and under control, and there is a low incidence of HIV/AIDS. There has been no hydric epidemic linked to the public water supply. Neither was there any epidemic incident linked to industrially manufactured food or food products. This indicates that our system supervising the public water supply and mass food production is very good and effective. However, as previously, along with these favourable factors, it should be remembered that in many places in our country certain risk factors continue to apply, for example unsatisfactory sanitary and hygiene standards, particularly in relation to the safe disposal of waste. In addition, consequences of post-war destruction and significant wartime and post-war human migration are still tangible factors. Therefore, the epidemiological situation should be regarded as potentially unsafe and directly dependent on further, uninterrupted anti-epidemic and preventive work in implementing all the measures envisaged. Evaluation of the effects of the measures can best be done by monitoring outbreaks, and our statistics on outbreaks of and mortality rates from infectious diseases, as shown here, clearly show that the measures are soundly effective, and that in this area, Croatia is virtually on a level with developed countries. In some cases (for example, the implementation of vaccination and surveillance of anthropozoonoses and others) it is among the most successful (Tables 14 and 15). Within this favourable assessment, we should still highlight tuberculosis, which although on the decrease, still requires active suppression measures. Finally, it should be said that all aspects of health can always be improved, including the area of acute infectious diseases, which continues to present a challenge.

Table 16 Infectious diseases not registered in Croatia in 2007.

DISEASE	No. of cases
Typhus abdominalis	0
Morbilli	0
Morbus Brill	0
Febris pappatasi	0
Poliomyelitis	0
Typhus murinus	0
Lyssa	0
Diphteria	0
Lepra	0
Cholera	0
Pestis	0
Typhus exantematicus	0

Ferbis recurrens	0
Hepatitis D	0
Febris flava	0
Creutzfeldt Jakob	0

Table 17 Infectious diseases in Croatia, 2007

DISEASE	Cases/deaths	DISEASE	Cases/deaths
Salmonellosis	3331	Brucellosis	2
Toxiinfectio alimentaris	4862	Tularemia	1
Enterocolitis	6528/1	Trichinellosis	24
Dysenteria bacillaris	18	Echinococcosis	18
Hepatitis A	26	Malaria	8 (import)
Hepatitis B	136	Leishmaniasis cutanea	5
Hepatitis C		Kala azar	2/1
Hepatitis vir. non identificata	11	Scabies	381
Angina streptococcica	7120	Toxoplasmosis	31
Scarlatina	2483	Meningoencephalitis ixodidea	11
Tetanus	5	Anthrax	1
Pertussis	123	Psittacosis	13
Morbilli	0	Febris hemorrhagica & sindr. Renale	26/2
Rubeola	39	Meningitis purulenta	55/1
Varicella	21815/1	Legionellosis	29/2
Parotitis epidemica	74	Enterovirosis	526
Meningitis epidemica	60/2	Pediculosis	530
Meningitis virosa	552	Taeniasis	2
Encephalitis	55/1	Pneumonia	5431/85
Leptospirosis	63/1	Herpes zoster	3369
Mononucleosis infectiosa	1330	Lyme borreliosis	266
Erysipelas	1552	Febris exanthematica mediteranea	4
Tuberculosis activa	988/32	Influenza	109553
Gonorrhoea	15	Chlamidiasis	374
Syphilis	31	Helminthiasis	292
AIDS	10/2	Rickettsiosis	9
Q febris	43		

General measures taken in the area of public health

a)
1. PREVENTION OF AIR POLLUTION

The condition of air in the Republic of Croatia has much improved in the last decade. In general, emissions of pollutant substances into the atmosphere have decreased. This is partially due to the closing of large plants, which were the sources of such emissions during the 1990's, and partially due to measures taken to fulfil the requirements of international conventions and protocols on air quality. The new Air Protection Act (OG 178/04) was passed, allowing for the further harmonisation and implementation of EU directives, and of other sectoral regulations and programmes which should have a positive effect on air quality, assuming their implementation is guaranteed. The use of low sulphur fuels in thermal energy plants contributed to the greatest improvement in air quality in 2000. Emissions of SO_2 caused by human activity were lowered by more than 25% in comparison to 1997. This level is 48% lower than the quota (117 Kt) envisaged in the *Protocol on Further Reduction of Sulphur Emissions*, and 14% lower than the quota (70 Kt) established in the *Protocol to Abate Acidification, Eutrophication and Ground-level Ozone*. Although technologically modern vehicles have reduced emissions by using higher quality fuels, the increased use of passenger vehicles has meant that this reduction has been insufficient to reduce total traffic emissions. The use of unleaded petrol has led to a 91.5% reduction in lead emissions into the atmosphere, in comparison with 1997, but at the same time, the continuing rise in the number of vehicles means that nitrous oxide emissions have slowly risen. Measuring and modelling air quality shows that air is clean in rural areas of Croatia and that in inhabited areas it satisfies existing regulations, on the whole. The percentage of towns and villages in which the air is clean or pollution imperceptible has increased, due to ongoing industrial emission control, control of fuel quality, the introduction of mains gas in villages and towns and the spread of long-distance heating in cities. Ten counties have local networks for measuring air quality, covering almost 68% of the population of Croatia.

In Rijeka, Sisak and Kutina the air is over-polluted and contains specific pollutants such as hydrogen sulphide and/or ammonia. Thanks to remediation programmes and other measures, improvement has been achieved in recent years in Rijeka and Kutina.

In general, it can be said that the condition of air quality satisfies the first category of air quality, except in inhabited areas and industrial centres. The exception is the concentration of ozone in the summer months, when AOT40 is exceeded. At this time of the year, the sun's rays generate higher levels of ozone, which is a natural phenomenon governed by geographic and climatic conditions, and the other cause is long-distance, cross-border transport of ozone precursors (photochemically reactive combinations of NMVOC and NOx) and ozone already formed.

Estimates of cross-border transports carried out according to EMEP models indicate that higher levels of ozone in Croatia are mostly the result of precursor emissions in neighbouring countries. Reductions in NOx emissions in Croatia have a barely perceptible effect on the situation, and reductions in NMVOC emissions are almost ineffective in our region. Regardless of which ozone producing factor is dominant, its effects on the environment and on people are harmful. This phenomenon is similarly present in western and central Europe and in Mediterranean countries in which AOT40 levels are exceeded.

The State Network for the Permanent Monitoring of Air Quality will significantly improve air quality monitoring and allow timely measures to be taken, as well as monitoring the protection and improvement of air quality at the national level. The Regulation on establishing the locations of stations within the State Network for the Permanent Monitoring of Air Quality and the Programme for Measuring Air Quality in these stations were adopted in 2002. Of 22 stations envisaged for the territory of the Republic of Croatia, to be set up between 2003 and 2007, eight have been established: three in Zagreb, one each in Kutina, Osijek and Sisak, and two in Rijeka. The establishment of a complete network in rural areas (7), and in national parks, nature parks and areas with vulnerable ecosystems (5) is expected to be completed by the end of 2009, within the implementation of a Phare project.

If the types of pollutants being monitored by local networks are analysed, it can be said that today, the most developed local networks in Croatia are in the Primorje-Gorski Kotar and Istra Counties, and to some extent the City of Zagreb, thanks to the dedication of the Institute for Medical Research and Labour Medicine (IMR) in maintaining continuous measuring and monitoring the development of this area. In 2006, measuring was carried out in 12 counties in 137 measuring locations altogether.

Data on air quality from local networks contains measuring information from local networks and special purpose stations, which are submitted to the Agency for Environmental Protection (AEP) by the administrative departments of towns and counties or municipal institutes of public health. Terms of reference for creating a database are currently being prepared.

Table 18 Overview of measurements by counties, 2006

County	Number of measuring locations		Parameters
	As part of the state network	As part of local networks	
Bjelovar-Bilogora	-	3	SO_2, smoke, total dustfall, Pb and Cd concentrations in TDF
City of Zagreb	3	7	SO_2, NO_2, smoke, O_3, NH_3, PM_{10}, concentrations of Pb, Cd, Mn and sulfates and BaP in PM_{10}, $PM_{2.5}$, total dustfall, and Pb, Cd and Tl concentrations in TDF
Istria	-	32	SO_2, smoke, NO_2, total dustfall, Pb and Cd concentrations in TDF, meteorological parameters
Karlovac	-	5	SO_2, smoke, total dustfall, Pb and Cd concentrations in TDF
Krapina-Zagorje	-	1	SO_2, smoke, total dustfall, Pb and Cd concentrations in TDF
Osijek-Baranja	1	20	SO_2, smoke, total dustfall, Pb, Cd and Tl concentrations in TDF

Primorje-Gorski Kotar	2	24	SO_2, smoke, NO_2, CO, O_3, H_2S, NH_3, PM_{10}, total dustfall, Pb and Cd concentrations in TDF, benzene, xylene, toluene, meteorological parameters
Sisak-Moslavina	2	12	SO_2, smoke, NO_2, H_2S, NH_3, PM_{10}, total dustfall, Pb, Cd, Hg, Ni and As concentrations in TDF, mercaptans, benzene, fluorides, meteorological parameters
Split-Dalmatia	-	15	SO_2, smoke, NO_2, total dustfall, Pb, Cd and Tl concentrations in TDF
Šibenik-Knin	-	6	SO_2, smoke, NO_2, total dustfall, Pb, Cd and Tl concentrations in TDF
Virovitica-Podravina	-	1	SO_2, smoke, NO_2
Zadar	-	3	SO_2, smoke, NO_2, total dustfall

Air quality in inhabited areas

The air quality situation in inhabited areas for 2006 is shown here in detail, on the basis of the Annual Report on Monitoring Air Quality in the State Network for the Permanent Monitoring of Air Quality, and the Annual Report on Monitoring Air Quality in Local Network Stations in the Territory of the Republic of Croatia (IMR, 2007).

Table 19 Air quality situation (Category 2 and 3) in inhabited areas, 2006

City/locality	Category 2	Category 3
Zagreb	PM_{10}, $PM_{2.5}$, BaP, NO_2, O_3	PM_{10} (one measuring location)
Rijeka	SO_2, NO_2, PM_{10}, O_3	H_2S, SO_2, O_3 (one measuring location)
Urinj	SO_2	PM_{10}
Opatija	O_3	
Bakar	SO_2, benzene	H_2S, SO_2, PM_{10}
Viškovo	PM_{10}	O_3
Zoljan	NO_2	
Bjelovar	SO_2	
Kutina	NH_3, PM_{10}	H_2S (one measuring location)
Sisak Caprag	PM_{10}	H_2S, SO_2

Šibenik centar	NO_2,	
Split Poljud	NO_2	
Solin	NO_2	

The pollutant concentration in precipitation has also decreased. The highest deposits of sulphur and nitrogen oxides, which can be attributed to anthropogenic sources, are recorded in Rijeka, Gorski Kotar and Lika. In the balance of cross-border pollutant transmissions, the Republic of Croatia continues to import more than it exports to neighbouring countries (Italy, Slovenia, Hungary, Serbia, Montenegro and Bosnia and Herzegovina). The trend of transmission of pollutant sulphurous compounds is decreasing, while nitrous compounds are increasing. There has been tangible progress in reducing or eliminating the consumption of ozone depleting substances (ODSs). Measures for the gradual reduction and elimination of ODSs have been successfully implemented, so that the total consumption of ODSs has been reduced. Through many projects, control of the import, transit and consumption of ODSs has been introduced, in particular in the consumption of ODSs and the use of alternative substances which do not damage the ozone layer.

The combustion of fuel in thermo-electric power plants and energy conversion installations contributes most (43%) to sulphur dioxide emission (SO2) and industrial combustion contributes 21%. Road traffic contributes most (40%) to nitrogen dioxide (NOx) emissions and other mobile sources and machinery contribute 25%. Agriculture contributes most (91%) to ammonia emissions, as a result of applying and using natural fertilisers. Emissions of heavy metals (Pb, Hg and Cd), particularly lead, are falling, as a result of greater proportional consumption of unleaded petrol and the lower level of lead in petrol. Mercury emissions have been reduced by the introduction of technological units for removing mercury from natural gas in CPS Molve installations, and cadmium emissions have been reduced by reducing the total volume of heating oil consumed.

The *Air Protection Act* (OG 178/04) defines the legal basis according to which, for the purposes of the Ministry for Environmental Protection, Physical Planning and Construction, the Agency for Environmental Protection develops and maintains the Air Quality Information System (AQIS), as an integral part of the Environmental Protection Information System (EPIS).

The AQIS information system has not yet been set up, but is envisaged in legal acts, according to which it should incorporate a whole range of different data, formatted in different databases, i.e. subsystems containing data from the topical area of air and climate change. The Plan for Protecting and Improving Air Quality in the Republic of Croatia 2008-2011 was prepared by the Ministry for Environmental Protection, Physical Planning and Construction and adopted by the Government on 8 May 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. The Strategy for Environmental Protection and the National Action Plan for

the Environment (OG 46/02) establish the basic goals of protecting and improving air quality, and prescribe long-term measures for achieving these goals. The basic goals are: to harmonise existing legislation with the *acquis communautaire,* to reduce emissions of harmful substances to a level which does not affect human health or the environment, and to review and upgrade the system for monitoring emissions and air quality. Since the legislative framework in the area of air protection gives an important role to units of local and regional self-government in implementing air protection policies, institutional and organisational/personnel capacities will need to be built up and strengthened. The right of access to information, which the public can understand, must be guaranteed, since this will create the preconditions for active public participation in decisions concerning air protection, and allow access to the justice system in matters concerning the environment and air quality. Within the plan for protecting and improving air quality, the first 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 concentrations 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, particularly 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 21st 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 marked. 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 alleviate the consequences of climate change by adaptation. The Ministry of Environmental Protection, Physical Planning and Construction 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.

The chemical composition of *precipitation* has been measured regularly in the meteorological stations of the Croatian State Meteorological Institute since 1981. Two of the stations in the network, Puntijarka and Zavižan, send data for inclusion in international exchange within the EMEP programme of the LRTAP Convention. The number of stations has been gradually reduced, so that today measuring is carried out in 18 stations. In all of them, daily samples of precipitation are analysed. These form the basis for an estimate of all ionic component deposits, which are mostly in the form of sulphate, nitrate and ammonia ions, which are the major culprits in acidification problems and eutrophication of the environment.

2. PREVENTION OF WATER POLLUTION

Legislation for water management is provided by the Waters Act, the Act on Financing Water Management and the Food Act, and by thirty or so subordinate regulations.

The *Waters Act* contains the institutional framework for managing water resources, regulates the legal status of water and water ownership, and the various ways in which water is managed; allocates competence to various levels of government, local administration and legal entities; and provides for the establishment of "Croatian Waters", as the legal person for water management. The Waters Act defines the concept for water management at the level of catchment/water areas. Under this Act, Croatia is divided into four catchment areas, i.e. territorial units for water management purposes. Water areas include one or more catchment areas with smaller watercourses and include surface and underground water. The City of Zagreb is defined as a separate unit. The Act regulates the elements of water management, which are: protection from water damage, use of water and water protection. The Act stipulates that the water supply for the population takes precedence over other forms of water use. The Water Act envisages the preparation of water management plans for managing water areas. The management plans should include investments needed in order to satisfy water management goals.

Article 38 of the Water Act stipulates that the quality of water for the water supply must adhere to conditions established by water classification (1^{st} grade water) and other conditions prescribed by law and subordinate regulations. This relates primarily to the control of emissions, or the prohibition on releasing waste water. An area in which a source or other bed of water used or reserved for the public water supply is found, or an area in which water is taken from rivers, lakes, storage reservoirs, etc, must be protected from accidental or deliberate contamination and from other influences which may negatively affect its sanitary safety or its abundance. To this end, water protection is carried out in accordance with the Decision on protecting sources of water, which, based on previous studies in water research, defines the size and limits of sanitary protective zones, sanitary and other maintenance conditions, and other protective measures, sources and means of financing them, as well as sanctions for violations of the provisions of this Decision. Sanitary protective zones defined by the Decision on protecting sources of water, as well as the area reserved for sanitary protective zones for which a decision has not yet been adopted, must be entered in the physical planning documents for the area in which they are found.

The average supply of water to the Croatian population from public waterworks was 76% in 2002, which means that around 3.35 million inhabitants are connected to the public water supply. It is envisaged that by the end of 2009 this level will have risen to 88%, and to 94% by 2015, which means an average increase of 1.4% annually. The supply to the population is higher in the Adriatic catchment area (86%), compared to the Black Sea catchment area (71%). The average level of the water supply is reaching European levels and has improved greatly since 1990, when it was 63%.

Monitoring and supervision of sanitary safety of drinking water is regulated by the Ordinance on sanitary safety of drinking water (OG 47/08), which has been harmonised with Council Directive 98/83/EC on the quality of water intended for human consumption. The competent state administration body for implementing the Ordinance is the Ministry of Health and Social Welfare, supervision is carried out by the Sanitary Inspectorate, and the sanitary safety of drinking water is monitored by authorised laboratories. The sanitary safety and quality of drinking water depend both on its natural composition and on adequate protection of sources of drinking water. Piezometric monitoring of wells and protected source zones, whether surface or underground waters, is not within the competence of the health system. It is based on the Regulation on water classification (OG 77/98) and the Ordinance on sanitary safety of drinking water (OG 47/08).

Different forms of monitoring the sanitary safety of drinking water:

1. The waterworks (Croatian Water Supply and Drains Grouping, EIG) is primarily responsible for sanitary safety of water supplied only to the public water supply network (more than 50 people or 10 m^3 per day), but not for the internal networks of buildings.
2. Monitoring the public water supply is the responsibility of County institutes of public health; the frequency with which samples are taken depends on the volume of water supplied, the number of inhabitants and the natural composition of the water.
3. Supervision by the Sanitary Inspectorate takes places according to a special programme, harmonised with the Framework Programme for Monitoring Environmental Factors, according to the Health Care Act.
4. The Sanitary Inspectorate of the Ministry of Health and Social Welfare, in accordance with the provisions of the Sanitary Inspection Act, supervises each public waterworks supplying more than 50,000 inhabitants.

The total number of samples inspected from all public water supply facilities (including local ones), through all levels of control (contracts with water supply companies, monitoring, supervision by the Sanitary Inspectorate) has amounted to 27,000 per year during the last decade. Most samples are inspected microbiologically and chemically, but the total degree of aberrance is not the sum of the chemical and microbiological aberrance results, since most samples are analysed using both methods.

The number of aberrant samples, chemically and microbiologically, at the level of Croatia, has been less than 10% in the last decade and the trend is continuing to fall. The causes of chemical aberration are physical characteristics, the presence of nitrogen salts, iron or manganese, higher levels of organic substances expressed as $KMnO_4$ consumption, and the microbiological aberrations include higher levels of aerobic bacteria in 1 ml, and, more rarely, the presence of indicators of faecal pollution or pathogenic bacteria.

Factors causing drinking water samples to be unsafe are usually of little significance, given their effect on human health.

Table 18 Overview of sanitary safety of drinking water from water supply facilities in Croatia, 2005/2006

Year	EXAMINED CHEMICALLY			EXAMINED MICROBIOLOGICALLY		
	No. of samples	Aberrancy	%	No. of examples	Aberrancy	%
2005	25361	1502	5.9	26345	1463	5.6
2006	26488	1975	7.46	26419	1448	5.48

The Table shows separately the chemical and microbiological safety of drinking water from water supply facilities in Croatia for 2005/2006, and provides the total number of samples examined from all public waterworks (including local ones), through all levels of monitoring (contracts with water companies, monitoring, supervision by the Sanitary Inspectorate). Drinking water supplied by the public water supply system amounted to about 79% in 2006. The lowest supply percentage is in Bjelovar- Bilogora County (around 34%), and the highest are in Istria County and Primorje-Gorski Kotar County (around 97%). The supply percentage rises by about 1% annually. There are 4,381,352 inhabitants of Croatia, and 3,368,989 are supplied from the public water supply, so that coverage is 79%.

The *Survey on the Public Water Supply* in the counties, carried out in 2005 and 2006, showed that the total number of public waterworks was 537, of which, for example, 62 are in Zagreb County + 91 in the City of Zagreb, 117 in Krapina-Zagorje County and 72 in Varaždin County. During 2007, pursuant to Article 16, paragraph 5 of the Sanitary Inspection Act (OG 27/1999), a programme for sanitary surveillance in municipal utilities companies for the production and distribution of water was prepared, with testing safety of drinking water within the range of "C" analysis, following a technological procedure in individual pumping stations, and within the range of "A" analysis, in three locations in the distribution network. Surveillance was carried out in 21 municipal utilities companies, during which 32 "C" and 91 "A" analyses were carried out.

Forty-three percent of the population of Croatia is connected to the sewage system, which is mostly present in larger towns. Although enormous material means have been invested in water protection and the level of waste water treatment has doubled in volume, the efficiency of removing pollutants is unsatisfactory. Twenty-five percent of municipal waste water is treated, but only 14% of pollution are removed. In the Republic of Croatia there are 83 plants for municipal waste water treatment, of which only 34 implement second level treatment and there are no plants at all equipped for third level treatment. The use of alternative plants for municipal waste water treatment is in the early conception stage. The main problem in protecting water is the imbalance between the level of the water supply (76%), sewage connection (43%) and waste water treatment (25%).

3. PREVENTION OF SOIL POLLUTION

According to data available, 1,056 potentially polluted locations have been reported and 69 of them have so far been confirmed. The number of potentially polluted locations is probably higher, and confirmation of the precise number is important for the Republic of Croatia. Soil

is the most neglected resource, and this has been acerbated by the lack of an integral policy to protect soil in the Republic of Croatia. At the moment, only individual, uncoordinated monitoring of the state of the soil takes place, and this is insufficient for systematic monitoring of the state of and changes to the soil. There is no systematic, national monitoring of soil pollution, only the preparation of a programme for the ongoing monitoring of Croatian soils through a pilot project. In Task ID2: Categorisation of standardised data to be monitored by ongoing observation, point 2.3 stipulates the establishment of categories and parameters for polluted localities. The project is expected to last from January 2006 to January 2009.

In November 2007, the Croatian Soil Information System (CSIS) Database was completed (part of the Environmental Protection Information System (EPIS), within the frame of the 1st stage of the project entitled "Programme for Developing the Croatian Soil Information System", which is being implemented by the Agency for Environmental Protection, with the aim of establishing the CSIS with time and space georeferential database on soils. Apart from its basic database and pedological data, the CSIS database supports and ensures that data on permanent soil monitoring are entered and processed. Thus, data from the pilot project on monitoring agricultural and forest soils are currently being entered. In the segment concerned with monitoring polluted soils, the CSIS system will need upgrading, which will be carried out by the AEP within its regular activities during spring 2008, in order to ensure that data from the pilot projects on monitoring polluted soils is entered by June 2008. Data on business activities carried out on 247 locations, provided by the Commercial Court, are being used to draw up a database of polluted soils.

B) PROTECTION FROM POLLUTION BY RADIOACTIVE SUBSTANCES

Protection from radiation in the Republic of Croatia is regulated by the following laws and subordinate regulations:

Ionising radiation:

The Act on Ionising Radiation Protection and Safety of Ionising Radiation Sources (OG 64/06), the Ordinance on the register of activities, requirements and the manner of issuing, and the validity of licences for work with sources of ionising radiation and the use of sources of ionising radiation (OG 125/06), the Ordinance on the limits of exposure to ionising radiation, and on the conditions of exposure in special circumstances and in emergency situations (OG 125/06), the Ordinance on the conditions and measures for protection against ionising radiation for carrying out activities involving x-ray units, accelerators, and other devices generating ionising radiation (OG 125/06), the Ordinance on the conditions and measures for protection against ionising radiation for carrying out activities with radioactive sources (OG 125/06), the Ordinance on the conditions for application of ionising radiation sources in medicine and dentistry (OG 125/06), the Ordinance on conditions, deadlines and methods for acquiring the required professional training and renewal of knowledge on the application of measures for protection against ionising radiation (OG 30/08), the Ordinance on medical requirements to be fulfilled by exposed workers, frequency of examinations and the content, manner and deadlines for keeping data on such examinations (OG 111/07), the Ordinance on conditions, methods, localities and time intervals for systematic testing of ionising radiation, and types and actions of radioactive substances in the environment (OG 86/00), the Ordinance on methods, scope and time limits for measuring personal irradiation of exposed workers and persons exposed to medical radiation, inspection of sources of ionising radiation and working conditions and measurement of required elements and quality

verification, testing the working order of personal protection devices and equipment, testing the working order of measuring instruments, quality assurance measures, assessment of radioactive contamination of persons, objects, the environment, premises and air inside premises in which radioactive activities are performed or radioactive sources are located, content of surveillance and measurement reports, reporting procedure and requirement to keep records, content, methods and time limits for keeping records (OG 127/07), the Ordinance on the list of professional activities involving protection from ionising radiation, requirements to be fulfilled by authorised technical services and the method of granting authorisation (OG 77/07), the Ordinance on the manner and procedure for supervision during import or export of material for which there is justified suspicion of contamination by radionuclides or of containing radioactive sources (OG 114/07), the Nuclear Safety Act (OG 173/03), the Transport of Dangerous Substances Act (OG 97/07), the Ordinance on radiological and physical safety measures for ionising radiation sources (OG 39/08), 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 (OG 44/08), the Act on Liability for Nuclear Damage (OG 143/98), the Order on border crossings and places where mandatory health monitoring is carried out of persons and their belongings, goods and means of transportation subject to such monitoring (OG 78/02).

Non-ionising radiation:

The Protection from Non-Ionising Radiation Act (OG 105/99), the Ordinance on maximum radiation from radio stations in towns and localities with characteristics of a town (OG 111/01), the Corrigendum of the Ordinance on maximum radiation from radio stations in towns and localities with characteristics of a town (OG 7/02).

International conventions and agreements:

The Act on Ratification of the Joint Convention on the Safety of Spent Fuel Management and on the Safety of Radioactive Waste Management (OG 3/99), the 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) (OG 8/07), the Convention on Nuclear Safety (OG 13/95), the Convention on Early Notification of a Nuclear Accident (OG 1/06), the Convention on Assistance in the Case of a Nuclear Accident or Radiological Emergency (OG 1/06), the Agreement between the Republic of Croatia and the Republic of Slovenia on Timely Exchange of Information in the Event of a Radiological Emergency (OG 9/98), the Corrigendum of the Agreement between the Republic of Croatia and the Republic of Slovenia on Timely Exchange of Information in the Event of a Radiological Emergency (OG 3/00), the Agreement between the Republic of Croatia and the Republic of Hungary on Timely Exchange of Information in the Event of a Radiological Emergency (OG 11/99). Dose limits for the population (1 mSv) and for occupational exposure (100 mSv in a five-year period, with maximum annual dose of 50 mSv) are regulated by the Ordinance on limits of exposure to ionising radiation and on conditions of exposure in special circumstances, and on emergency response actions (OG 125/06). This Ordinance also prescribes dose limits for extraordinary events (nuclear power plant accident). The protection in the workplace, including the protection from contamination, is regulated by the Ordinance on the conditions and measures for protection against ionising radiation for carrying out activities with radioactive sources (OG 125/06), the Ordinance on methods, scope and time limits for measuring personal irradiation of exposed workers and

persons exposed to medical radiation, inspection of sources of ionising radiation and working conditions and measurement of required elements and quality verification, testing the working order of personal protection devices and equipment, testing the working order of measuring instruments, quality assurance measures, assessment of radioactive contamination of persons, objects, the environment, premises and air inside premises in which radioactive activities are performed or radioactive sources are located, content of surveillance and measurement reports, reporting procedure and requirement to keep records, content, methods and time limits for keeping records (OG 127/07), the Ordinance on conditions, methods, localities and time intervals for systematic testing and monitoring of types and effects of radioactive substances in the air, soil, sea, rivers, lakes, underground waters, solid and liquid precipitation, drinking water, food, items in general use, and residential and business premises (OG 60/08), 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 (OG 44/08).

Protective measures in the event of an emergency are regulated by the State Plan and Programme of Measures of Protection from Ionising Radiation and Intervention in the Event of an Emergency, adopted by the Government of the Republic of Croatia at its session held on 24 April 2008 (OG 49/08). All the documents have been aligned with IAEA Recommendations.

The *State Office for Radiation Protection* is a state administrative organisation carrying out administrative and expert activities in the area of protection from ionising radiation. The activities of the Office are regulated by the Act on Ionising Radiation Protection and Safety of Ionising Radiation Sources (64/06). The State Office for Radiation Protection carries out the following activities: designs the standards and methods in monitoring the state of protection against ionising radiation; issues approvals for activities involving sources of ionising radiation; issues approvals for the procurement, import, export, transport and transit of ionising radiation sources; issues permits for use of ionising radiation sources; authorises legal persons for providing services involving protection from ionising radiation; organises and supervises, and, where necessary, carries out tests for the presence, types and intensity of ionising radiation in the environment, food and feed, medical products and items in general use, both in normal conditions and in suspected emergency; provides dosimetric assessments of exposure to ionising radiation of persons working with sources of ionising radiation, of the population from medical exposure during diagnostic and therapeutic procedures, and from exposure to ionising radiation originating from environmental radionuclides; organises and supervises, and, where necessary, inspects conditions of work with ionising radiation sources and carries out measurements of prescribed elements, and verifies the quality of equipment generating ionising radiation; supervises and maintains records on ionising radiation sources, including the production, procurement, import, transport, storage, use and disposal or export of the spent sealed radioactive sources, persons working with sources of ionising radiation, levels of irradiation of these persons, and levels of irradiation of persons subject to medical exposure through diagnostic and therapeutic examinations and other persons; organises and provides professional training for workers in protection from ionising radiation; encourages scientific, professional, statistical and other research, studies and evaluates the impact of ionising radiation; co-operates with international and domestic organisations and institutions for protection from ionising radiation; fulfils obligations taken on by the Republic of Croatia pursuant to international conventions and bilateral agreements, relating to the protection against ionising radiation, and carries out such other tasks as are within its competence on the

basis of the Protection from Ionising Radiation Act, subordinate regulations passed on the basis of this Act and other regulations.

The *State Office for Nuclear Safety* (SONS) is a state administration body with jurisdiction over nuclear safety. The activities of the Office are regulated by the Nuclear Safety Act (OG 173/03). For the purpose of implementing measures for nuclear safety and protection, the SONS issues licences to perform nuclear activities in connection with nuclear material or special equipment; conducts independent safety analyses and issues decisions or certificates regarding the sitting, planning, construction, operation and decommissioning of a facility in which a nuclear activity is to be performed; keeps records on the licences, approvals, decisions and certificates which it has issued within the scope of its authority; carries out administrative supervision of the implementation of the provisions of this Act and regulations adopted on the basis of this Act; carries out inspectional supervision with regard to the implementation of the provisions of this Act and regulations adopted on the basis of this Act; provides expert assistance in implementing the national plan and programme for procedures in the event of a nuclear accident, via the work of the Technical Support Centre; provides expert assistance in activities for preventing illicit trafficking in nuclear material to state administration bodies with jurisdiction over such activities; monitors safety conditions at nuclear power plants in the region and carries out assessments of the threat of nuclear accidents there, especially the Krško Nuclear Power Plant in Slovenia and the Paks Nuclear Power Plan in Hungary; fulfils the obligations taken on by the Republic of Croatia pursuant to international conventions and bilateral agreements concerning nuclear safety and the application of protective measures aimed at the non-proliferation of nuclear weapons; co-operates with international and domestic organisations and associations in the area of nuclear safety, and appoints its own expert representatives to take part in the work of such organisations and associations or to keep abreast of their work; co-ordinates technical co-operation with the International Atomic Energy Agency for all stakeholders from the Republic of Croatia; stimulates and supports research and development activities in accordance with the demands and requirements of developing nuclear safety in the Republic of Croatia; issues instructions for implementing international recommendations and standards in the area of nuclear safety and protection; carries out such other tasks as are within its competence on the basis of this Act, regulations adopted on the basis of this Act, and other regulations.

An important activity is informing the public, which consists of educating the public and keeping them informed during an actual nuclear accident. The population living in high-risk areas must be instructed regularly on the response system in the event of a nuclear accident. In this context, among other things, for the fifth consecutive time, a project for producing a calendar (for 2007) has been continued, using pupils' artwork on the theme of applying nuclear technology, which contains information on alertness in cases of nuclear accidents in the territory of Croatia. The calendar is aimed primarily at families living within a 25 km radius of the Krško Nuclear Power Plant and has been distributed to all primary school pupils in the area. Information on alertness in the case of a nuclear accident, with a special emphasis on protective measures to be taken in the preventive and emergency protective measures zone (25 km from the nuclear power plant) is displayed for each month of the calendar. This year, for the first time, the calendar has also been printed in English. In co-operation with the State Administration for Protection and Rescue (SAPR), the State Office for Nuclear Safety is organising specific training for the public, in the form of organised public seminars held in secondary schools and local self-government premises in high-risk areas. In addition, information on plans for emergency situations and alertness is available to the public on the

website www.dzns.hr/tpc, as are the results of daily measurements taken at automated radiological measuring stations. An important role is played by workshops, which are organised periodically for various groups within the population (SONS staff at the Technical Support Centre (TSC), civil protection staff and specific target groups such as experts, the media, the general public, etc.). Exercise drills are also carried out from time to time, with the aim of training the staff of the "112" emergency services, the TPC and the Crisis Headquarters of the SAPR, and improving their mutual communications and co-ordination. The SONS is actively involved in international exercises organised by the International Atomic Energy Agency (CONVEX) and the European Commission (ECURIE).

C) PROTECTION FROM NOISE POLLUTION

Protection from noise pollution in the Republic of Croatia is regulated by the following laws and subordinate regulations: the Noise Protection Act (OG 20/03), the Ordinance on the maximum allowed levels of noise in areas in which people live and work (OG 145/04), the Ordinance on the procedure for creation and contents of noise maps and action plans (OG 5/07), the Ordinance on activities for which noise protection measures must be established (OG 91/07), the Ordinance on protecting workers from exposure to noise at work (OG 46/08), and the Ordinance on conditions concerning the premises, equipment and employees of legal persons engaged in expert noise protection activities (OG 91/07). Systematic monitoring of noise in the environment and evaluations of the effects of noise on health do not exist in Croatia. Article 9 of the Noise Protection Act (OG 30/03), defines noise maps as "an integral part of the Republic of Croatia's Environmental Protection Information System, representing an expert basis for the preparation of physical plans." The Agency for Environmental Protection (AEP) is responsible for setting up and maintaining the EPIS, and from July to September 2007 it conducted a survey on the phase of preparation and availability of noise maps in the Republic of Croatia. A survey questionnaire was sent to addresses in all counties, the City of Zagreb, cities and municipalities which, according to Article 9 of the Noise Protection Act are required to prepare noise maps, in order to gain an idea of the actual state of the phase of preparing noise maps. Thirty-six percent of those polled, who have this obligation in law, responded. According to data received, only 4% have completed noise maps, 12% have begun preparations, while 84% have not taken any steps at all towards preparing noise maps. There are several reasons for this situation: the lack of budget finances (municipalities and cities), insufficient knowledge of the effects of noise on people, and tardiness in adopting and implementing legislation. An overview of completed noise maps, with direct links to existing noise maps, is in preparation, (http://www.azo.hr/Default.aspx?art=987). Noise measurements are carried out as part of studies of the influence of certain facilities on the environment, and as part of monitoring prescribed therein, during testing when issuing licences for work on such facilities, during risk assessments in certain workplaces, and during measuring carried out at the request of members of the public, or rather as a result of complaints about noise made to the Sanitary Inspectorate. In Croatia several institutions and companies are engaged in producing noise maps (the Croatian Civil Engineering Institute, the Shipbuilding Institute, the Civil Engineering and Architecture Faculty of the University of Split, DARH 2 d.o.o. and Gis prom).

Current legislation does not provide for obligatory central data collection and evaluation on levels of noise measured, therefore systematised date on this is not available at the moment. If complaints made by members of the public can be taken to be an indicator of the situation,

most noise pollution is caused by traffic and the entertainment and catering establishments (disco clubs, bars, etc).

D) FOOD HYGIENE INSPECTION AND FOOD SAFETY

During 2007 the Croatian National Parliament adopted legislation in the area of food safety, which is fully harmonised with EC Directive 178/02, "General Food Law" and EC "hygiene package" directives.

The Food Hygiene Regulation 852/2004 sets the general rules of hygiene in the production of all food products, the obligations of food producers (all persons engaged in the food business – from primary producers to distributors), and provides guidelines on good manufacturing practice. There is a special emphasis on internal control system (HACCP) and the responsibility of all links in the food production chain to ensure the sanitary safety of food. Since animal food products are linked to specific risks (microbiological, chemical and physical), separate hygiene rules apply to them under EC Regulation 853/2004, such as general principles for transporting animals to slaughterhouses, standards for slaughterhouses and cutting plants in terms of construction, layout, equipment, hygienic measures in producing food products of animal origin, hygiene requirements for slaughter, meat cutting and boning, emergency slaughter and conditions for storing and transporting meat.

Linked to the specific risks in producing meat and meat products, EC Regulation 854/2004 sets the rules for official veterinary controls which include checking details of the food chain (Food Chain Information – FCI), inspecting animals before slaughter, checking that regulations concerning animal welfare have been observed, inspection following slaughter, supervision of high-risk material and the side-products of slaughter, and laboratory analyses.

Along with EC Regulation 854/2004, concerning the official control of animal food products, Regulation 882/2004 covers official controls carried out to verify the implementation of the Food and Animal Feed Act and regulations on animal health and welfare. The Regulation deals with the way in which official controls are organised, the competent bodies, the organisation of laboratories, sample-taking and measures to be undertaken in emergency situations. The pre-accession process of the Republic of Croatia to the EU has led to harmonisation of legislation, within Chapter 12: Food Safety. The process consisted of reviewing legislation, bilateral negotiations and finally, harmonisation of legislation in the area of food safety.

The next step in the process should be the opening of negotiations in Chapter 12 and, eventually, the closing of this negotiating chapter.

In April 2007, the Food Act (OG 46/07) was passed, which defines the competent body in food safety as the Ministry of Agriculture, Forestry and Water Management. The competent body performs risk management, and the Croatian Food Agency provides an estimate of and in part communicates risks. The Food Act establishes the basis for ensuring high levels of protection for human health and the interests of consumers in relation to food, taking into account, in particular, the differences in supplying food, including traditional methods of production, and at the same time ensuring effective market functioning. The Act lays down basic principles and responsibilities, scientific bases, an efficient organisational structure and procedures to support the adoption of decisions in relation to sanitary safety of food and animal feed. The Food Act regulates the following areas: scope and definitions, the general

provisions of food regulations, the Croatian Food Agency, the rapid response system, emergency measures and crisis management, food hygiene, animal feed hygiene, official controls, new foodstuffs, genetically modified food and genetically modified animal feed, food and animal feed quality, traditional speciality designations, designations of origin and geographical indication, and the powers and responsibilities of the competent body. The Act is applicable to all phases of food and animal feed production, processing and distribution, except for primary production intended for personal consumption in households, or the preparation, handling and storage of food intended for personal consumption in households. The competent bodies for carrying out inspections are the Ministry of Agriculture, Fisheries and Rural Development, the Ministry of Health and Social Welfare and the State Inspectorate.

At the local level, supervision of how regulations are implemented is carried out by 21 County Offices (20 in the counties and one in the City of Zagreb), with over 800 veterinary inspectors and over 200 sanitary inspectors. The Border Veterinary and Border Sanitary Inspectorates also participate in the system by monitoring consignments of food for import.

The network of laboratories carrying out food analysis is organised around two organisations – the Croatian Veterinary Institute and the Croatian National Institute of Public Health, and altogether 30 laboratories have been authorised by the Ministry of Health. In these laboratories, around 50,000 food samples are tested each year, and the results of laboratory analysis are regularly published in the Croatian Health Service Yearbook, other publications and on the web pages of the Croatian National Institute of Public Health and the Croatian Food Agency.

Surveillance of foodborne infectious diseases is carried out by the Epidemiological Service of the Croatian National Institute of Public Health and by county institutes of public health, with their epidemiological stations in the field, pursuant to the Act on Protecting the Population from Infectious Diseases. Data on these diseases form part of the central epidemiological IT system and are published regularly.

The "hygiene package" Regulations were implemented in the legislation of the Republic of Croatia in October 2007, through of a group of ordinances published in Official Gazette 99/07: the Ordinance on food hygiene, the Ordinance on hygiene of food of animal origin, the Ordinance on official controls of food of animal origin, and the Ordinance on official controls performed to verify compliance with the provisions of regulations on food and animal feed, as well as regulations on the health and protection of animals. All those involved in the food business, who submit applications to open new premises following the entry into force of these Ordinances, must meet the requirements laid down in these regulations and the Food Act, except those areas for which special deadlines are prescribed by the provisions of Article 134 of the Food Act. Those involved in the food business and the animal feed business are obliged to align themselves with the provisions of the Food Act and the Ordinances of the "hygiene package" by 1 January 2009 at the latest, unless otherwise prescribed by other regulations (Article 134). The Food Safety and Quality Directorate has been organised within the Ministry of Agriculture, Forestry and Water Management, in order to assure an integral approach in ensuring food safety (of animal and non-animal origin) in the Republic of Croatia and co-ordination between competent bodies and other institutions involved in the food safety system.

The Directorate has been given the task of co-ordinating the activities of institutions involved in the food safety system, i.e. the Ministry of Agriculture, Fisheries and Rural Development,

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 body must ensure the co-operation of all bodies which perform official controls, and must establish co-operation with the competent bodies for food safety in EU countries and the EFSA.

In addition, the competent body will be responsible for co-ordinating the production of annual action plans relating to the performance of official controls based on risk analysis, will co-ordinate the production of guides, procedures, control lists, and reporting rules for inspectors performing official food controls, co-ordinate crisis managements situations and set up and implement a rapid response system for food and animal feed, authorise laboratories and keep an integral register of facilities. The competent body will also implement EU projects in the area of food safety, organise training sessions for inspectors performing food controls and represent the national focal point for co-operation with the European Commission in the area of food safety. It should be mentioned that, in spite of the fact that regulations in the area of the sanitary safety of food have been adopted, the competent body and all those involved in the process still need to carry out adjustments to the food safety guidelines adopted, strengthen administrative and technical capacities, and, in particular, carry out systematic training and education for officials and all others working in the food production sector, all with the purpose of protecting the health of the population. Inspections of sanitary safety of food and sample-taking during inspectional monitoring have produced the following results:

Table 19: Sanitary safety of tested food samples in 2005 and 2006 in the Republic of Croatia

Year	Type of test	Domestic origin			Imported origin			Total		
		Total	Unsafe	%	Total	Unsafe	%	Total	Unsafe	%
2005	Chemical	18,067	820	4.54	11,152	2,383	3.52	29,219	1,212	4.15
	Micro-biological	34,353	2,610	7.60	7,515	59	0.79	41,868	2,669	6.37
2006	Chemical	19,802	754	3.81	1,150	345	3.00	31,308	1,099	3.51
	Micro-biological	33,041	2,216	6.71	7,950	167	2.10	2.10	2,383	5.81

In the period 2005-2006, the most frequent causes of chemical unfitness of food were incorrectly declared ingredients, non-matching sensory characteristics due to chemical changes, the prohibited use of additives in certain food groups and, rarely, the presence of additives, pesticides, heavy metals, aphlatoxins, etc, and the presence of iodine in kitchen salt lower than the quantity prescribed by regulations. In the same period, the most frequent causes of microbiological unfitness of food were excessive count of aerobic mesophilic bacteria, yeasts, moulds or enterobacterial counts higher than permitted levels, and results showing coagulase-positive staphylococci or salmonella.

E) MINIMUM HOUSING STANDARDS

Obligation of proprietors of residential and public buildings concerning asbestos concentration testing

With regard to the obligation of proprietors of residential and public buildings concerning asbestos concentration testing, the provisions of Article 28 of the Ordinance on lift safety (OG 135/05) apply, which has been in force since 31 March 2006, and which prescribes the

obligations of proprietors and co-proprietors whose property incorporates lifts, in relation to improving the safety of existing lifts built into structures, according to which lifts must meet the requirement that brake linings must not contain asbestos.

Minimum housing standards are regulated by the Ordinance establishing the minimum technical conditions which must be applied in designing and building apartments in the Programme for the Social Stimulation of Apartment Building (OG 25/06). These conditions must be applied in terms of standard and size in building and reconstructing (extending) buildings and houses. In accordance with the Ordinance, an apartment is considered to be a separate unit and must contain at least an entrance area, one room, a food preparation room and a room for personal hygiene and toilet requirements. The Regulation on the provision of accommodation for family members of a Croatian defender who was killed, imprisoned or went missing during the Homeland War and for disabled Homeland War veterans (OG 86/2005) stipulates that an appropriate apartment be assigned on the basis of the number of family members: for a single person – 35 m², two-member family – 45 m², three-member family – 60 m², four-member family – 70 m², five-member family – 80 m², and for each additional family members a further 10 m². This Regulation allows for an adjustment of +/- 10 m² for an apartment to be considered adequate accommodation. For disabled Homeland War veterans with 100% body damage, classified as belonging to the 1st group of disabled veterans and not included in the Government of the Republic of Croatia's special programme, an adequate apartment may be one which departs from the prescribed size by +20%. In special cases, an apartment or house outside the place of the applicant's residence, in areas declared by law to be areas of special state concern, is considered as adequate accommodation if it is 20 m² larger that the size established in paragraph 1 of this Article, and if the applicant agrees to accept it.

F) MEASURES UNDERTAKEN TO SUPPRESS SMOKING, ALCOHOL AND DRUG ABUSE, INCLUDING MULTIPLE ADDICTIONS, AND FOR SUPPRESSING SEXUALLY TRANSMITTED DISEASES

The area of ***drug abuse*** is regulated by national regulations and international agreements. The basic legislative framework for suppressing abuse and smuggling of narcotic drugs in the Republic of Croatia is formed by the following laws:

- The Act on Suppressing Abuse of Narcotic Drugs (OG 107/01, 163/03, 141/04), which regulates all the basic issues of abuse of narcotic drugs; the conditions for cultivating plants from which narcotic drugs may be derived; the conditions for the preparation, possession and trade in narcotic drugs and substances which may be used to prepare narcotic drugs (so-called precursors); surveillance of plant cultivation from which narcotic drugs may be derived and of the preparation, possession and trade in narcotic drugs and substances which may be used to prepare narcotic drugs; measures for suppressing the abuse of narcotic drugs; the system for preventing addiction and helping addicts and those who occasionally use narcotic drugs; and international co-operation.
- The Criminal Code, Article 173 (abuse of narcotic drugs); Chapter XIII: criminal offences against the values protected by international law include unlawful use (possession), production, trafficking, mediating in sales and purchases and any other means by which narcotic drugs are unlawfully placed on the market.

The Republic of Croatia is a party to the most important international conventions regulating the drug problem: the UN Single Convention on Narcotic Drugs of 30 March 1961 (OG-IA 4/94), the Protocol Amending the Single Convention on Narcotic Drugs of 25 March 1972 (OG-IA 4/94), the UN Convention on Psychotropic Substances of 21 February 1971 (OG-IA 4/94), and the UN Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 20 December 1988 (OG-IA 4/94).

The following strategic documents also regulate this area: the National Strategy for the Suppression of the Abuse of Narcotic Drugs in the Republic of Croatia 2006-2012 (OG 147/05), the Action Plan for the Suppression of the Abuse of Narcotic Drugs 2006-2009 (and the implementing programmes for the Action Plan for individual years) and the Plan and Programme of Health Care Measures in Compulsory Health Insurance (OG 126/06).

The *Office for Combating Narcotic Drug Abuse of the Government of the Republic of Croatia* was set up in 2002 as the co-ordinating body in the area of suppressing drug abuse. The system of prevention and treatment functions through centres for addiction prevention in county institutes of public health, co-ordinated by the Croatian National Institute of Public Health. Its strategic documents and legal regulations have been fully aligned with EU documents in the areas of disseminating information on the possibilities of treating drug addicts, counselling, education in schools, accessible and available treatment methods, including free methadone and buprenorphin programmes, and the control of infectious diseases. In accordance with EU recommendations, data collection on persons treated within the health system for abuse of psycho-active drugs has been standardised, via the Register kept by the Croatian National Institute of Public Health in conjunction with network of county institutes of public health. Usage surveillance and protection measures prevent illegal trade in substitute drugs. Full recourse to substitute treatments is available to prisoners in prisons without substitution programmes, under medical supervision. Free vaccination against hepatitis B, and testing for HIV, hepatitis B and C is available in co-operation with the Croatian National Institute of Public Health, the Red Cross and non-governmental organisations.

Prevention and suppression of alcohol-related consequences

The area of preventing and suppressing the harmful consequences of excessive ***alcohol*** consumption is regulated by interdisciplinary regulations and documents, such as the Health Care Act (OG 121/03, 48/05, 85/06), the Road Traffic Safety Act (OG 105/04, 142/06), the Food Act (OG 117/03, 130/03, 48/04, 85/06), the Occupational Health and Safety Act (OG 59/96, 94/96 and 114/03), the Catering Act (OG 138/06), the Act on Preventing Violence at Sports Events (OG 117/03, 71/06), the Act on the Special Alcohol Tax, (OG 136/02), the Family Act (OG 116/03, 17/04, 136/04), the Ordinance on the conditions and means of informing consumers of the properties of alcoholic drink products, tobacco and tobacco products not considered to be advertising (OG 62/96, 40/98), the Ordinance on advertising wines of controlled geographical origin and fruit wines (OG 105/04), and the National Action Programme for Youth 2002 and the National Plan of Activities for the Rights and Interests of Children 2006-2012.

The legislation and practice in Croatia have been aligned with the *acquis communautaire* (Conclusion 2001/C 175/01) and Recommendation (2001/458/EC), regarding compiling information on the harmful effects of alcohol, international co-operation and local community activities. The treatment and rehabilitation of alcoholics in Croatia are carried out according

to the concept of the Zagreb Alcohology School, which involves alcoholics and their families in a system of treatment and rehabilitation following hospital discharge. Croatia promotes research into all aspects of problems concerning alcohol consumption by young people, particularly children and adolescents.

The issues involving the protection of young people, particularly adolescents, from the possible influences of alcohol abuse are regulated by laws and subordinate regulations in accordance with EU recommendations. The following areas have all been aligned: research into the extent and reasons for drinking; educational and preventive programmes; early secondary prevention; devoting particular attention to young drivers; and prohibiting sales and serving alcohol to minors in shops and catering establishments and during sporting events.

Further alignment is necessary in the areas of advertising, prohibiting the exploitation of young people in advertising, controlling advertisements which are particularly attractive to young people, involving young people in the adoption of strategic and implementing regulations and activities, and educating catering establishment proprietors and serving staff.

Limiting the use of tobacco and tobacco products

Croatia has signed and ratified the World Health Organisation Framework Convention on Tobacco Control.
The basic regulation regulating health aspects of the use of tobacco and tobacco products is the Act on Limiting the Use of Tobacco Products (OG 128/99, 137/04). Inspectional supervision of the implementation of the Act is carried out by the State Inspectorate, sanitary inspectors, health inspectors, labour inspectors and school inspectors, each within their own scope prescribed by special laws. The sanitary safety of tobacco products is monitored by authorised laboratories of the Croatian National Institute of Public Health and county institutes of public health, on the basis of the Items in General Use Act (OG 85/06). As needed, other authorised laboratories carry out laboratory analyses 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 the European Parliament and of 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 of the Council of 26 May 2003 on the approximation of the laws, regulations and administrative provisions of the Member States relating to the advertising and sponsorship of tobacco products. The HRN ASO 3308:1991 standard is used for the routine analytical cigarette smoking machine.

Existing laws and subordinate regulations have been partially aligned with the *acquis communautaire*. By the time of its accession to the EU, Croatia will have aligned the provisions of the *acquis* relating to:

- the production, presentation and sale of tobacco products, including the obligation to display general and additional health warnings, prohibition of the use of description of cigarettes which may lead to the assumption that they are less harmful (*mild*, *light*, etc.), the obligation of producers and importers to submit annuals list of the ingredients of tobacco products and their quantities, product labelling, etc;
- the promotion of tobacco products, including prohibiting sponsorship and internet advertising and sales;
- the prohibition of TV advertising, tele-shopping for tobacco products and sponsorship of TV programmes whose main topic is the production or sale of tobacco products;

- the prevention of smoking and improved supervision of tobacco, including prohibiting electronic advertising (displays) with cigarettes in self-service supermarkets, toys or sweets resembling tobacco products, sponsorship and promotional practice;
- the use of a price mechanism to reduce consumption of tobacco products.

Further alignment is envisaged with regard to measures for suppressing illegal trade, support for alternative cultures, environmental protection concerning growing and producing tobacco, legal frameworks relating to responsibility, monitoring, evaluation and reporting, and international co-operation in terms of supervising tobacco, in accordance with the Framework Convention on Tobacco Control.

With regard to the Committee's request that statistical data be included in the next report on trends in tobacco consumption, we would first like to state that, in accordance with the Ordinance on conditions concerning the sanitary safety of items for general use which can be placed on the market (OG 42/2004), the levels permitted per cigarette are 1 mg of nicotine, 10 mg of tar and 10 mg of carbon monoxide. The Ordinance entered into force in March 2004.

The Act on Limiting the Use of Tobacco Products (OG 128/1999) prescribes that each packet of tobacco products must carry a health warning, but the contents and size of the warning, and the prohibition on using names which might give the impression that the product is less harmful, need to be aligned with European legislation.

The same Act prohibits all forms of promoting smoking through the public media, in public places, buildings and means of transport, etc. In other words, it prohibits direct and indirect tobacco advertising. Tobacco products must not be sold to persons under the age of 18. Smoking is prohibited in all health and educational institutions. It is also forbidden to smoke in other public buildings, except in special areas designated for smokers and so labelled, which may not occupy more than 30% of the total building. 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. Supervision of the Act's implementation is also defined, as are fines for failing to respect the Act, which are very high, both for legal persons and private individuals.

In terms of consumption of tobacco products, according to household surveys, the proportion of average annual household expenses spent on tobacco products is stagnating (Table 1). The proportion of tobacco products in the retail trade is falling (5.12% in 2001, 4.14% in 2003). The level of cigarette sales was lower in 2004 (14,149 million) than in the three previous years. Cigarette imports showed a gradual fall in 2004 compared to 2003, while exports are rising slightly.

Annex – Table 1. Production, distribution and consumption of tobacco

	Year			
Indicator	2001	2002	2003	2004
Proportion of average annual household expenses spent on tobacco, per household member (%)		2.39	2.40	2.35

Proportion of tobacco in the retail trade (%)	5.12	4.09	4.14	/
Sale of produced cigarettes (mils. pcs)	14 716	15 047	19 554	14 149
Import (mils. pcs)	/	/	65	53
Export (mils. pcs)	/	/	7 478	7 483

Source: Central Bureau of Statistics of the Republic of Croatia, Statistical Yearbooks, 2004, 2005.

International agreements

The Republic of Croatia has ratified:
International Labour Organisation Social Security (Minimum Standards) Convention No. 102, 1952), (OG – International Agreements 2/94, 1/02)
The Republic of Croatia is also a party to the International Covenant on Economic, Social and Cultural Rights.
Eurostat document: Statistical Requirements Compendium 2002

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.*

Legislation of the Republic of Croatia

1. Constitution of the Republic of Croatia

In the Chapter entitled Economic, Social and Cultural Rights of the Constitution, it is stipulated that the right of employees and members of their families to social security and social insurance shall be regulated by law and collective agreements (Article 56). It is also stipulated that the State shall ensure the right to assistance for weak, helpless and other persons unable to meet their basic needs owing to unemployment or incapacity to work and that the State shall devote special care to the protection of disabled persons and their integration into social life (Article 57).

The social welfare system is defined by the **Social Welfare Act (Official Gazette 73/97, 27/01, 59/01, 82/01, 103/03, 44/06 and 79/07)**, as the basic act that regulates the manner of performing and financing social welfare activities, as well as its beneficiaries, rights, the procedure for exercising these rights and other important issues of social welfare.

Social welfare is the activity through which assistance is provided to socially deprived, infirm and other persons who are unable to fulfil their basic needs of life neither on their own nor with the assistance of their family members, due to adverse personal, economic, social or other circumstances.

The Social Welfare Act entered into force in July 1997 and has been applied since 1 January 1998. This Act defines the social assistance and the social welfare systems, based on the principle of subsidiarity, affirming the responsibility of every individual and family for their own social security. This regulation has gone through quite a large number of amendments, in an attempt to meet ever more complex and numerous needs of beneficiaries with available resources, and to align the social welfare system with reforms and changes in the area of social policy.

Social welfare beneficiaries are single persons and families with insufficient means to meet their basic needs of life, disabled children or mentally ill children, children who have received or should receive protection under the family and criminal legislation, persons in distress due to disturbed family relations or other forms of socially unacceptable behaviour, and adults in need of help due to disability, old age, mental illness, permanent health changes, addiction or other reasons.

The amount of a benefit is determined as a percentage of the basic rate, established by the Government of the Republic of Croatia pursuant to the provisions of the Social Welfare Act.

As part of the Second Programmatic Adjustment Loan – PAL 2, the *Strategy for a Social Benefits Reform 2007-2008* was adopted in April 2007. In accordance with the measures indicated in the Strategy, new social welfare regulations were adopted in July 2007 and, in particular, the **Act on Amendments to the Social Welfare Act (Official Gazette 79/07)** and the **Foster Care Act (Official Gazette 79/07)**. In line with the goals of the Strategy, the Act on Amendments to the Social Welfare Act simplified the procedure for granting benefits, reduced the total number of benefits and amended certain rights in terms of categories of beneficiaries and goals aimed to be achieved by these rights, and the prevention of institutionalisation. A total of HRK 148 million were provided in 2008 for the implementation of new rights introduced by these Acts and also for payments of temporary maintenance of children under the Act on Amendments to the Family Act (Official Gazette 107/07). In particular, funding was provided for the following:

- exclusion of the child's allowance from total family income for income testing purposes, which improved the financial status of families with more members (six or more members) – *better targeting*
- introduction of a new right – the right to the status of a parent-carer – *better targeting and preventing institutionalisation*
- introduction of a new benefit – personal benefit for a foster parent – *better targeting and promoting deinstitutionalisation*
- the right to temporary maintenance, pursuant to the new family legislation – *better targeting*

- the costs of recruiting 41 new staff in 18 social welfare centres, in charge of foster care activities – *improving the quality of expert work and preventing institutionalisation*.

In accordance with the goals of ensuring more equal distribution of available resources and increasing the share of social assistance expenditure in the GDP, as specified in the Strategy, on 6 March 2008 the Government of the Republic of Croatia rendered the Decision on the base rate for determining social welfare benefits. Under this Decision, the base rate was increased from HRK 400 to HRK 500. The commencement of the application of the Decision was **1 November 2008**, for which funds were ensured in the 2008 State Budget. The increase in the base rate will result in all social benefits being increased.

As part of the Pre-accession Partnership of the European Union for the Republic of Croatia, one of the two important co-operation activities in the field of employment and social inclusion is the preparation of a Joint Inclusion Memorandum (JIM). The purpose of drawing up this document is to prepare Croatia for full participation in the open co-ordination model in the field of suppression of poverty and social exclusion in the process of its accession to the European Union. This implies that Croatia will implement European Union social policy goals into its national policy.

In September 2005 the Republic of Croatia began drafting the Joint Inclusion Memorandum of the Republic of Croatia (JIM-RC), which was signed by the Government of the Republic of Croatia and the European Commission on 5 March 2007.

In line with the priorities defined in the Joint Memorandum, in April 2008 the Government of the Republic of Croatia adopted the National Implementation Plan for Social Inclusion (2007-2008), with the aim of expanding the network of social services, developing non-institutional services system, and improving access to social services by children, elderly people and persons with disabilities. The Government of the Republic of Croatia assumed an obligation to provide the European Commission and its partners with a report on the implementation of the JIM by the summer of 2008.

Those participating in the implementation of JIM measures include competent ministries, state institutes and agencies, and other bodies responsible for specific activities defined by the Implementation Plan, as well as representatives of local authorities, social partners, non-governmental organisations and providers of social services. The Implementation Plan defines the indicators to be used to measure the level of accomplishment of the activities and identifies the institutions responsible for implementing these activities. It also contains the measures for developing services for old and infirm persons, expanding the network of social services and strengthening non-institutional forms of care.

The project for developing the system of social welfare includes: further decentralisation and the transfer of authority to regional units of self-government, in order to make services more efficient and accessible to citizens; more systematic motivation and financial support for the work of non-governmental organisations and humanitarian associations; improved targeting of monetary benefits, taking into account the peculiarities of specific areas in terms of customs and lifestyle, and the needs and interests of beneficiaries, improving the quality of social services provided institutionally and non-institutionally; improving the level of public awareness of social benefits available; and computerising the system.

The project is being implemented by the Ministry of Health and Social Welfare, in co-operation with all the relevant institutions, and consists of three components:

1. Improving the provision of social services – by developing a series of social programmes, beginning with prevention, through improving the quality of service delivery, to the reintegration of beneficiaries in the community. Social services will improve in efficiency, become much more orientated towards the family and based on the principle of inclusion.

2. Strengthening the social welfare IT and management system – by introducing an IT and management system, the new organisation model for the social services will be supported, based on the principle of a "one-stop office" and this will result in better services to beneficiaries and better organisation of work in social welfare centres. The software is being produced and the necessary equipment acquired, and a training plan for the social services system in three pilot counties is in preparation. The completion of these activities is envisaged for the end of 2008, while the computerisation and equipping of social service institutions with the necessary computer equipment is expected to take place during 2009, along with the training of staff throughout the system.

3. Improving the infrastructure in social welfare institutions, thus contributing to raising the living standards of beneficiaries, along with the general quality of services offered. The aims of the third component of the Social Welfare Development Project include improving infrastructure conditions in social welfare centres, by building 13 new facilities and adapting 13 existing ones, improving safety conditions in homes housing beneficiaries by investing in sanitary and hygiene improvements in 57 social welfare homes. Funds from a World Bank Investment Loan have been provided for these improvements.

Pursuant to the *Asylum Act* (Official Gazette 79/07), the *Ordinance on the level of financial aid for asylum seekers, asylees, foreigners receiving temporary protection and foreigners receiving subsidiary protection* (Official Gazette 39/08) has been adopted. This Ordinance prescribes that the level of financial aid be determined as a percentage of the base rate for claiming social welfare benefits. In accordance with this regulation, asylees and foreigners receiving subsidiary protection who have no income, no possessions, private means or whom no one supports, may claim social welfare benefits according to the Social Welfare Act, in other words, in the same manner as Croatian nationals.

Article 13, paragraph 1

Two categories of beneficiaries are involved in claiming social welfare benefits. The first group are those who consider themselves to be poor, since they have no personal income whatsoever, or such income is below the prescribed threshold, i.e. insufficient to meet the basic needs of life.

The second category are those recipients of social welfare with specific needs, which may have arisen because of disability, age, mental illness, addiction, etc. This group includes children and young people with no appropriate parental care, children and young people with behavioural problems, victims of domestic violence and victims of trafficking in human beings. This means that not all recipients of social welfare can be regarded as "poor", since some categories of social welfare are not linked to low income, but high expenditure.

Since the social welfare system previously involved a large number of benefits, for each of which separate conditions and criteria were prescribed, the procedure for claiming benefits was complex and demanding. Thus, in the Act on Amendments to the Social Welfare Act (Official Gazette 79/07), benefits and forms of assistance have been amalgamated, meaning they are fewer in number, and common conditions were prescribed, which has lessened administration, made procedures simpler and access to benefits simpler for beneficiaries.

For example, permanent allowance now brings together the previous support allowance and the benefit for covering the costs of accommodation in a pupils' hostel. With the aim of simplifying procedures and reducing administration for beneficiaries who have so far received support allowance, permanent allowance will be increased by the amount of costs of accommodation in pupils' hostels, if a family member uses such residence services.

Since child's allowance is not considered income, the above law has annulled provisions linking child's allowance benefit to the previous support allowance, by limiting the total level of funds which can be claimed on these two grounds. Thus equal, fairer conditions for claiming permanent allowance have been created for larger families, in line with the National Population Policy.

Furthermore, this law prescribes that previous benefits for counselling, help in overcoming specific problems and one-time allowance are forms of assistance for which no administrative procedure is conducted.

There follows an overview of benefits according to the Act on Amendments to the Social Welfare Act:

1. Permanent allowance

The right to permanent allowance may be granted to persons whose income is below the income necessary for support, prescribed by the Social Welfare Act, and who are unable to earn such income by selling, leasing or renting their property that does not serve them or their family members to satisfy their basic needs. There is a provision stating that an unemployed person who is able to work should register with the competent employment service and that he or she should not reject the job offered.
The amount of the allowance depends on the particular characteristics of each family, such as: the number of family members, their ages, inability to work, pregnancy, single parenting, and it is determined as a percentage of the base rate for social welfare benefits. The purpose of this benefit is to enable beneficiaries to satisfy their basic needs (usually considered to include food and other basic, personal needs). It is assumed that everyone should work towards meeting their basic needs and the needs of persons they are obliged to support under the law or on other legal grounds, and that everyone should make efforts to prevent their own social deprivation as well as that of their family, especially children and other family members unable to support themselves, either by finding a job or by using their income or property.

A **single person** able to work, who has been granted the right to permanent allowance, is entitled to 100% of the base rate, i.e. **HRK 400.00**, whereas a **person able to work who lives within a family is entitled** to 80% of the base rate, i.e. **HRK 320.00**. Furthermore, the amount of the benefit per family member differs depending on his or her age: for a **child under 7 years of age** the amount is 80% of the base rate – **HRK 320.00**, for **a child aged 7-**

15 the amount is 90% of the base rate – **HRK 360.00**, for **a child aged 15-18, or until the end of the regular education** the amount is 100% of the base rate – HRK **400.00**.

The benefit is increased by a specific percentage in the following situations: if the beneficiary is completely unable to work living alone – by 50% of the base rate or HRK 200.00, if the beneficiary is completely unable to work but lives with his or her family – by 30% of the base rate or HRK 120.00, if the beneficiary is a pregnant woman after 12 weeks of pregnancy or a woman who has recently given birth (for a period of 2 months following the childbirth) – by 50% of the base rate or HRK 200.00, and a child of a single parent is entitled to a 25% increase or HRK 100.00.

The amount of the permanent allowance is increased by actually incurred costs of accommodation in a students' hostel, if a family member is a secondary school student accommodated in a students' hostel.

In the Republic of Croatia the permanent allowance, as the most important welfare benefit in the fight against poverty, is received by 98,747 persons, 44,146 of whom are unemployed persons able to work (data from the Ministry of Health and Social Welfare for May 2008). In 2007, this type of benefit was received by 102,953 persons and in 2006 112,508 persons. In 2008 a total of 5.8% of the population was covered by social welfare benefits, and 2.2% were receiving permanent allowance (support allowance). In 2007, social welfare allowances and benefits accounted for 0.57% of the GDP.

2. Assistance for covering housing costs is intended for covering the rent, utility fees, electricity, gas, heating, water, waste water disposal etc, *and it is approved in the amount up to one half of the permanent allowance granted to a family or single person, as the case may be;* a beneficiary who uses timber for heating, may be given $3m^3$ of timber every year or money enough to buy this quantity of timber (the funds for this benefit are provided by local and regional self-government units).

3. Assistance and care supplement – depending on the changes to their state of health, beneficiaries may claim this benefit in a reduced amount – 70% of the base rate, i.e. **HRK 280.00**, or in full – 100% of the base rate, i.e. **HRK 400.00**.

It has been prescribed that assistance and care supplement may be awarded to persons who of necessity require the permanent assistance and care of another person, due to physical or mental damage or permanent changes to their state of health, since they are unable to meet their basic needs of life themselves.

Assistance and care supplement is granted in full or in a reduced amount, depending on whether the assistance and care provided by another person is required in full or in part. The assistance and care provided by another person is considered to be required **in full** if the beneficiary cannot meet his or her own needs due to permanent changes to his or her state of health and cannot, even with orthopaedic aids, move independently around his or her own home, feed himself or herself, dress and undress, maintain personal hygiene or carry out other basic physical needs. Such assistance and care is considered to be required **in part** if the beneficiary cannot fully meet his or her basic needs due to permanent changes in his or her state of health, since he or she cannot move around independently outside the home, in order to go shopping for basic requirements or use health care services. The degree of damage is established by an expert body in accordance with the criteria prescribed in the Ordinance on

the composition and method of work of expert bodies in the procedure for granting social welfare and other benefits, according to special regulations (Official Gazette, nos. 64/02 and 105/07). The criterion for assessing the degree of damage or permanent change in a person's state of health is not the diagnosis itself, but the problems which have arisen as a result of a certain condition or disease.

4. The right to receive assistance and care in home can be awarded to persons who, due to physical or mental damage or permanent changes to their state of health, or old age, of necessity require the help and care of another person (including organising food, carrying out household chores, maintaining personal hygiene and meeting other everyday needs). These services can be claimed according to income and the possibility of organising them in the area in which the beneficiary lives.

The Act on Amendments to the Social Welfare Act (Official Gazette, no. 79/07) has introduced a new element to these benefits – expert help for families (community visiting services), as one form of non-institutional care, provided by expert staff from social welfare homes. This benefit, which can be claimed by physically or mentally impaired persons and mentally ill adults, includes provision of psycho-social rehabilitation services, in order to assist families in developing beneficiaries' abilities, with the aim of acquiring needed knowledge, skills and habits. The intention of introducing this form of care is to provide beneficiaries with expert assistance within their own families and thus avoid institutionalisation.

5. Personal disability benefit is a monetary benefit intended for persons with severe disabilities living with their families, in order to help them overcome difficulties relating to their increased specific needs. The right to a personal disability benefit is granted to persons with a severe physical or mental impairment or those suffering from grave and permanent changes of their health, if this impairment or disease occurred before they turned 18, unless they exercise the right to personal disability benefit on other grounds.

The basic requirement for exercising this right is severe health impairment according to the criteria laid down in the Ordinance on the composition and method of work of expert bodies in the procedure for granting social welfare and other benefits, according to special regulations (Official Gazette, nos. 64/02 and 105/07). The personal disability benefit for all persons suffering from severe health impairments is determined in the amount of **250%** of the base rate, i.e. **HRK 1,000.00**, unless these persons have their own income. Personal disability benefit is determined in the amount of 125% of the base rate to persons suffering from severe health impairment placed in the day care of a social welfare, educational or health institution, whose parent is at the same time on a maternity leave up to the child's 7th birthday or who is entitled to work one half of the full-time working schedule in order to be able to take care of his or her disabled child.

6. Pre-employment benefit is a financial payment made to disabled persons for as long as they remain unemployed. The level of the payment is **70%** of the base rate, i.e. **HRK 280.00**. This benefit may be awarded after the person finishes primary, secondary or higher education, and has reached his or her 15th birthday. Pre-employment benefit, which is paid in monthly instalments by social welfare centres pursuant to their administrative decisions, is charged to State Budget funds allocated to the Fund for Occupational Rehabilitation and Employment of Disabled Persons.

7. The status of parent-carer was introduced as a new benefit by the Act on Amendments to the Social Welfare Act (Official Gazette, no. 79/07). The right to the status of parent-carer, on the basis of which a payment equal to **five times the base rate** is payable, i.e. **HRK 2,000.00**, can be claimed by one parent, in cases in which he or she, following the recommendation of a doctor, is trained to carry out medical or technical procedures according to the special treatment required by his or her child, or, in special circumstances, the child is so disabled as to be completely unable to move, even with orthopaedic aids, or if the child has several serious disabilities making him or her fully dependent on parental care. One the child's parents, who claims this benefit, may not also claim the right to compulsory insurance on another basis, since a person with the status of parent-carer is considered employed according to a special regulation. The decision to award this benefit is made by social welfare centres subject to consent by the ministry competent for social welfare matters.

According to the Labour Act (Official Gazette, nos. 38/95, 137/04 – revised text), the parent of a child with severe developmental problems may claim the right to take a **leave up to the child's seventh birthday, or to work one half of the full-time working schedule**, and the necessary funds are secured from the ministry competent for social welfare matters. The parent may claim one of these rights in order to care for his or her child and receive a benefit as compensation for the time not spent working.

A certain number of parents care for the most severely disabled children, who require continual care after their seventh birthdays. According to current regulations on employment relations, such parents may claim the right to **work one half of the full-time working schedule** after the child reaches the age of seven, but this provision is insufficient to meet the round-the-clock needs of severely disabled children. Thus the introduction of the status of parent-carer has been introduced, giving these parents the opportunity to continue caring for their children and receive compensation for doing so.

8. Care outside the home is provided through institutional and non-institutional forms of care. This refers to a network of homes and activities for different categories of beneficiaries, centres for assistance and care, family homes, foster homes and organised housing. Social welfare services are provided by state homes, decentralised homes for the elderly and infirm at the county level, religious communities and associations, and other Croatian and foreign legal and natural persons offering accommodation or housing to beneficiaries. Care outside the home is only available is cases in which the beneficiary and his or her family cannot be helped by other benefits, or if this form of care is considered the most useful, in terms of upbringing, education, training, psycho-social rehabilitation, nursing, health care or other needs of the beneficiary. During the last few years, various forms of non-institutional care have played a more important role (family homes, organised housing, day-care, respite care, help in including children with physical or mental disabilities in regular pre-school or school education, etc.). The Act on Amendments to the Social Welfare Act (Official Gazette, no. 79/07) also includes in this form of benefit financial assistance for student beneficiaries of care outside the home who are no longer entitled to permanent accommodation. The level of this benefit is currently **400% of the base rate**, i.e. **HRK 1,600.00**, which provides those who have previously been accommodated in social welfare homes or foster homes with social security during full-time studies. Due to their lack of material or other support from parents and relations, such beneficiaries had previously been in a particularly difficult situation, since they would have had to resolve their basic living problems on their own when it became impossible for them to remain any longer in social welfare homes.

It is precisely with this goal in mind, i.e. improving further non-institutional forms of care and avoiding institutionalisation, that a special regulation on fostering, as a traditional form of care in the Republic of Croatia, has been adopted. The Foster Care Act (Official Gazette 79/07) prescribes in a uniform manner the rights, obligations and tasks not only of foster-parents, but also of social welfare centres, in accordance with the basic goals of social welfare reform.

9. One-time allowance is granted to a single person or a family who, due to current material difficulties, are not able to satisfy some specific needs relating, for example, to the birth of a child, education of a child, illness or death of a family member, natural disaster, purchase of basic household items, purchase of necessary clothing and footwear, etc. This type of benefit may be granted up to the amount necessary to satisfy the need for which it was approved. If the amount necessary to satisfy the need exceeds five times the base rate, i.e. HRK 2,000.00, the social welfare centre must seek approval from the ministry competent for social welfare matters. This benefit may be granted as a monetary or an in-kind benefit.

Pursuant to the Act on Amendments to the Social Welfare Act, the one-time allowance is a benefit which may be granted without conducting the administrative proceedings. This has shortened the proceedings and expert staff have greater discretion in assessing the purpose and justifiability of the request for the benefit. These amendments also increased the amount of the maximum one-time allowance that can be autonomously granted by social welfare centres, without seeking approval from the ministry competent for social welfare matters.

10. Counselling and help in overcoming current problems
This benefit includes systematic and programmed services provided to beneficiaries to help them overcome adversities and difficulties, such as illness, old-age, death of a family member, problems encountered in upbringing children, disability or long medical treatment, or other unfavourable circumstances or crisis situations. Counselling and assistance services are provided by social welfare centres' expert staff.

Article 13, paragraph 3

Social welfare institutions are social welfare centres, social welfare homes and centres for assistance and care. On 31 December 2007, there were 11,668.5 persons employed in social welfare institutions of the Republic of Croatia. Of this number 2,019.5 persons were employed in social welfare centres and 9,649 in social welfare homes.

The quality of services provided in social welfare institutions is monitored by means of internal supervision within institutions themselves, and also by means of administrative, inspectional and expert supervision carried out by the Ministry of Health and Social Welfare. Foster families are supervised by social welfare centres.

At this moment, the expert staff in the social welfare system achieve professional recognition only through their professional organisations. For this reason, the Act on Amendments to the Social Welfare Act envisaged the possibility of establishment of chambers of expert workers as independent professional organisations with the status of a legal person and vested with public authority.

Chambers are to be established with the goal of promoting, representing and co-ordinating interests of expert workers, both those employed in social welfare services and those working in other systems, such as the health system, judicial system, the economy and the civil sector.

One of the goals of establishing chambers is supervision of conscientious, responsible and professional work of expert workers in the relevant professions.

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. In the Republic of Croatia, there are 80 social welfare centres with 25 branches, performing more than 146 different functions.

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.

Professional work at social welfare centres is performed by social workers, psychologists, lawyers and special education experts, who have all passed the state exam. Professional work at social welfare centres is also performed by other professionals with the relevant educational background and qualifications, depending on the centre's jurisdiction. The requirements and the number of expert and other staff of social welfare centres and their branch offices are regulated by the Ordinance on the requirements regarding the premises, equipment and expert and other staff of social welfare centres and their branch offices (Official Gazette, nos. 120/02, 74/04 and 125/07).

A person against whom a final judgement has been delivered convicting him or her of a criminal offence against life and limb, freedoms and rights of man and citizen, personal dignity and morals, marriage, family and youth, property, or against the Republic of Croatia may not be hired as an expert staff member in social services (Article 159, paragraph 5 of the Social Welfare Act). Expert staff are obliged to carry out their work in line with the rules of the profession and respect the personalities of their beneficiaries, their dignity and the inviolability of their personal and family life. (Article 159, paragraph 1 of the Social Welfare Act). They must keep everything they learn about the beneficiary's personal or family life as a professional secret (Article 159, paragraph 2).

The procedure for granting social welfare rights is governed by the provisions of the General Administrative Procedure Act and by expert social work rules, and pursuant to Article 5, paragraph 1 of the General Administrative Procedure Act, expert staff from social welfare centres are obliged to help parties protect and exercise their rights as efficiently as possible.

Social welfare centres provide their services free of charge. The costs of proceedings incurred in connection with the exercise of social welfare rights financed from the State Budget are covered by the Ministry of Health and Social Welfare (Article 151 of the Social Welfare Act).

The activities of social welfare centres are financed from the State Budget (gross salaries, contributions payable by the employer, compensation of costs incurred by the staff, purchase of capital goods, training and professional development of the staff), and from local and regional government budgets (expenditures for material resources, audit, fees, intellectual services, etc.).

Since the procedure for granting social welfare rights is governed by the General Administrative Procedure Act and by expert social work rules (Article 136 of the Social Welfare Act), every citizen is entitled to approach an official working in the social welfare centre with territorial jurisdiction and receive information about social welfare rights and requirements that should be met to exercise these rights. Also, when the official, on the basis of the facts of the case, learns or assesses that a citizen has grounds to realise a right, he or she must point this out to them (Article 5, paragraph 2 of the General Administrative Procedure Act).

Furthermore, the official conducting the proceedings must take care that the ignorance or inexperience of the party or other persons taking part in the proceedings is not to the detriment of the rights they have by law (Article 14 of the General Administrative Procedure Act).

In this sense, every individual is entitled to approach the social welfare centre in connection with certain benefit or service, and the centre will either inform the party about the requirements and possibilities of realising this right within the social welfare system or refer him or her to other institutions responsible for dealing with this particular problem.

Free legal aid is regulated by special regulations relating to the activities of attorneys and the Croatian Bar Association in court proceedings following appeals lodged against decisions on claims for social welfare rights. The right to free legal aid is also available to parties at social welfare centres where they will be given instructions and allowed to lodge their appeals orally, for the record, on the premises of the social welfare centre and with the assistance of expert workers who will help them formulate their appeals.

The Act on Amendments to the Social Welfare Act (Official Gazette, no. 79/07) provides that, in addition to social welfare rights, beneficiaries are also entitled to other forms of assistance free of charge, including counselling and help to overcome special difficulties.

In May 2008 the Free Legal Aid Act was passed (Official Gazette, no. 62/08). This Act defines free legal aid and regulates its types and scope, defines legal aid beneficiaries, jurisdiction, procedure and requirements to obtain free legal aid, free legal aid providers, legal aid for reasons of equity, cross-border provision of free legal aid, the financing of free legal aid and the supervision of the implementation of the Act. Pursuant to this Act, free legal aid providers are: attorneys, authorised associations and institutions of higher education.

Appeals lodged against individual administrative acts issued by social welfare centres are decided by the Ministry of Health and Social Welfare. The Ministry's first- and second-instance decisions may be challenged by an administrative lawsuit filed with the

Administrative Court of the Republic of Croatia. Beneficiaries participating in proceedings for obtaining social welfare rights are not obliged to pay administrative fees. Pursuant to the provisions of Article 7, paragraph 12 of the Administrative Fees Act (Official Gazette, nos. 8/96, 77/96, 131/97, 68/98, 66/99, 116/00, 163/03 and 17/04), all files and actions undertaken to obtain social welfare rights are exempted from fees.

Court judgements rendered upon administrative lawsuits are binding. Namely, Article 62, paragraph 2 of the Administrative Disputes Act (Official Gazette, nos. 53/91, 9/92 and 77/92) prescribes that **the competent bodies are bound by the legal opinion of the court in relation to the proceedings**. Pursuant to this Act (the provisions of Article 63), if the competent body, after annulling the administrative act, passes an administrative act contrary to the legal opinion of the court, or contrary to the comments made by the court in relation to the proceedings, and the plaintiff files another lawsuit, the court shall annul the challenged act and as a rule resolve the matter itself by a judgement. This judgement shall replace the act by the competent body in its entirety. In that case, the court shall inform the body responsible for supervision. When it comes to the ministries, as central state administration bodies, their work is supervised by the Central State Office for Public Administration.

According to the Social Welfare Act, the administrative supervision of the work of social welfare centres is carried out by the ministry competent for social welfare matters.

Pursuant to the *Ordinance on the internal organisation of the Ministry of Health and Social Welfare*, which was issued by the minister of health and social welfare on 19 July 2007, the Section for Internal Supervision was established within the Department for Legal Affairs, Administrative Supervision and Second Instance Procedure of the Ministry's Directorate for Social Welfare. Four staff members are envisaged to be recruited in this Section.

Until all vacancies in the Section are filled (an announcement of vacancies has been issued), the administrative supervision of the work of social welfare centres will continue to be carried out within the Directorate for Social Welfare by a commission for administrative supervision composed of a number of experts in various fields appointed from among the staff of the relevant organisational units. Members of the commission appointed for a particular supervision assignment are appointed by the minister of health and social welfare. These members are, as a rule, lawyers, social workers, psychologists and special education experts, and they supervise the work of expert staff of the social welfare centre, each within his or her area of competence and on the basis of his or her qualifications, knowledge and working experience.

Administrative supervision is in particular focussed on: the legality of proceeding, adjudication of administrative matters, efficiency, economy and purposefulness in the performance of state administration functions insofar as they relate to the transfer of public authority. The legality and organisation of work of social welfare centres is also controlled.

The facts of the case are established by inspection of legal acts and business premises of the organisation, by interviews with expert staff from the relevant departments, by interviews with heads of departments and the director, by individual interviews with expert staff, by examination of the case file, records and documents.

A report on the administrative supervision must be submitted to the social welfare centre within 20 days of the date when such supervision was carried out.

Pursuant to the Social Welfare Act (the provisions of Article 82, paragraph 1, indent 7), social welfare centres carry out supervision of foster families. In accordance with the provisions of the Foster Care Act (Article 19, paragraph 3), the centre that issued the decision to place a person in the care of a foster family must check whether the foster family fulfils the obligations taken on in the foster care contract and, to this end, it must visit the foster family and talk with the beneficiary on a regular basis and at least three times a year.

Along with social welfare centres, there are other institutions providing social welfare services within the social welfare system, as described under Article 14.

In relation to the Committee's enquiry about medical assistance in the Republic of Croatia, it should be stated that medical assistance is received at the expense of the compulsory insurance scheme only by persons who have acquired the status of an insured person in the procedure and under the conditions prescribed by the law and general legal acts. Article 15, paragraph 2, item 1 contains a list of health services provided to insured persons at the expense of the compulsory health insurance scheme. These are:

- preventive health care for children, pupils and university students in regular education, and adults, except for preventive check-ups arranged by employers or local and regional self-government units pursuant to law and other regulations,
- curative health care and medical rehabilitation of children, pupils and university students in regular education,
- orthopaedic and other aids for children up to 18 years of age, pursuant to a general legal act of the CIHI,
- preventive and curative health care for adults on the level of primary health care, which is not regulated otherwise by items 2 to 5,
- preventive and curative health care for women in connection with family planning, pregnancy and childbirth, and other health needs of women and early detection of cancer,
- preventive and curative dental health care for children up to 18 years of age and pregnant women,
- 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,
- compulsory vaccination, immunoprophylaxis, and chemoprophylaxis,
- laboratory tests, radiological and other diagnostic procedures on the level of primary health care,
- medically indispensable health care in hospitals, except for accommodation and food costs referred to in items 3 and 4,
- accommodation and food costs for chronic psychiatric patients receiving health care in hospitals,
- chemotherapy and radiotherapy, including the costs of accommodation and food whilst in hospital,
- health care relating to human organ removal or transplant for the purposes of treatment, including the costs of accommodation and food whilst in hospital,
- emergency medical assistance, including the costs of accommodation and food whilst receiving intensive care in hospital,
- emergency dental assistance,
- emergency medical transportation,

- house calls for acute conditions,
- medical treatment at home,
- health care provided by health visitors,
- ambulance transportation for special categories of patients pursuant to a general legal act adopted by the minister responsible for health matters,
- nursing care in the patient's home,

Furthermore, in relation to the Committee's enquiry as to whether nationals of EU member states are guaranteed the same treatment with regard to medical assistance, it should be stated that foreigners with permanent stay in the Republic of Croatia exercise the right to health care pursuant to the Compulsory Health Insurance Act (OG 85/08, 105/06 and 118/06) under the same conditions as Croatian nationals with permanent residence in the Republic of Croatia, whereas foreigners who have not been approved permanent stay in the Republic of Croatia are entitled to health care pursuant to the Act on the Health Care of Foreigners in the Republic of Croatia (OG 114/97).

According to the provisions of Article 15, paragraph 2, item 1, sub-item 14 of the Compulsory Health Insurance Act, insured persons are entitled to full coverage of emergency medical assistance, including the costs of accommodation and food whilst receiving intensive care in hospital.

The provisions of Article 6, paragraph 1 of the Act on the Health Care of Foreigners in the Republic of Croatia prescribe that foreigners are entitled to emergency medical assistance, whereas paragraph 2 of the same Article stipulates that a health institution or private health practitioner who has offered emergency medical services to a foreigner will charge the costs of these services to the foreigner if such foreigner cannot produce a written document proving that he or she is entitled to health care under health insurance regulations of the Republic of Croatia or other special regulations or under an international agreement.

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.*

Article 14, paragraph 1

Pursuant to the Social Welfare Act, social welfare activities are carried out by social welfare institutions, religious communities, associations and other legal persons, foster families, family homes and natural persons as a professional activity.

Social welfare institutions are: social welfare centres, social welfare homes, centres for assistance and care and family centres.

Social welfare centre

The activities of social welfare centres are described in relation to Article 13.

Social welfare home

In the Republic of Croatia, there are 69 state homes for various categories of beneficiaries (with a total of 8,764 beneficiaries), 46 county (decentralised) homes for the elderly and infirm persons and 102 homes established by other founders, with a total of 16,779 beneficiaries (data for 2007 obtained from the Ministry of Health and Social Welfare).

The profile of employees in social welfare homes is prescribed by a special subordinate regulation – the Ordinance on the types of children's homes and homes for adults and their activities, and on the requirements regarding the premises, equipment and the necessary expert and other staff of social welfare homes (Official Gazette, nos. 101/99, 120/02 and 74/04).

Social welfare homes are established in accordance with the Public Institutions Act and the Social Welfare Act. A social welfare home is managed by the administrative management council, which is appointed by the home's founder.

Home manager is the director, who is appointed by the administrative council on the basis of a public tender. The director of a home organises and manages its work and financial operations, represents the home and acts on its behalf, undertakes all legal actions in the name and for the account of the home, represents the home in all proceedings before courts, administrative and other state bodies and legal persons vested with public authority and is responsible for the legality of the home's operations.

A social welfare home also has an expert council, composed of all expert staff. The expert council participates in developing the plan and programme of the home's activities, monitors their implementation, discusses and decides on expert issues, encourages and promotes expert work, and carries out other expert activities defined by the Social Welfare Act, the act of establishment of the home and its statute.

Each social welfare home has an expert team, whose composition differs depending on the type of the home. The following experts may be included in the work of an expert team: a social worker, a special education expert, a psychologist, a medical nurse and other expert staff. The expert team participates in developing annual programmes of work, draws up individual programmes of work for particular beneficiaries, monitors the success of rehabilitation, and resolves other expert issues. Special attention is paid to adaptation problems of individual beneficiaries and to addressing difficulties they encounter during their stay in the institution.

Care of the elderly, infirm and mentally ill adults

Care of the elderly, infirm and mentally ill adults within the social welfare system of the Republic of Croatia can be divided into institutional and non-institutional forms.

Information on existing services and how they can be used is being promoted with the aim of exercising the rights of the elderly, infirm and mentally ill adults more efficiently, and emphasising freedom of choice concerning lifestyle and services which will satisfy their needs. The programmes aimed at this group of beneficiaries are being implemented through financial forms of assistance and services rendered as institutional and non-institutional forms of assistance.

Non-institutional forms of social services are provided for socially needy persons through the existing network of social welfare centres, centres for assistance and care, and a wide network of non-governmental organisations, whose programmes are financed to a significant degree by the state.

Institutional care is organised through a network of homes for the elderly and infirm, and homes for mentally ill adults. A significant number of institutions for the elderly and infirm are privately owned, while the figure is lower in the case of institutions for mentally ill adults. A certain number of privately owned homes have contracts on mutual relations with the Ministry of Health and Social Welfare, on the basis of which certain services for these categories of persons are financed.

Organised care for the elderly, infirm and mentally ill adults in the Republic of Croatia is still mostly institutionalised, but a projection for developing a future system gives non-institutional forms a significant position. Different forms of services for beneficiaries outside institutions are still lacking in the Republic of Croatia, the system for identifying needs is insufficiently developed, and activities in the field of family support are lacking, as well as co-ordination between all local level offices working on improving these persons' quality of life.

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. These services are also available in homes for mentally ill adults.

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.

Pursuant to the Act on Amendments to the Social Welfare Act (Official Gazette 79/07), homes for mentally ill adults can provide psycho-social rehabilitation services in the form of professional family assistance (community care), and organised housing services.

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.

When discussing the elderly and infirm, it is especially necessary to emphasise their rights to social security, social and medical welfare, and their right to use the services of social service offices. The effort made to ensure the efficient realisation of these rights, with the well-being of these persons in mind, is also important. It is crucially important to promote or organise new forms of services for the elderly and infirm, which will contribute to the well-being and development of individuals and groups in the community and their adjustment to their social environments, with the aim of achieving greater independence in everyday life and exercising their rights.

There are currently 123 homes for the elderly and infirm operating in the Republic of Croatia (2 homes founded by the Republic of Croatia, 46 homes with foundation rights transferred to units of local and regional self-government, and 75 homes founded by others – units of local and regional self-government, religious communities, companies, associations and other domestic and foreign legal or natural persons).
Permanent accommodation services for mentally ill adults are provided in 18 homes founded by the Republic of Croatia, and in 7 homes founded by others (so-called private homes).

Institutional forms of care are provided for mentally ill adults who do not require hospitalisation, and whose families cannot provide appropriate care. Apart from homes for mentally ill adults, care outside their own family for this category of persons is also provided through family units and the institution of foster care.

One specific form of care in the Republic of Croatia is the newly-established family unit scheme (providing care services as a professional activity). Since these units involve a significantly smaller number of beneficiaries (between 5 and 20), compared to social welfare homes, these institutions should provide conditions closest to the family environment. So far, 106 family units for the elderly and infirm, and 18 homes for mentally ill adults have been established.

The number of professionals and other employees in homes for the elderly and infirm and in homes for mentally ill adults is determined in relation to the services the home provides, and the number and profile of the beneficiaries. These homes provide care for 17,071 beneficiaries, while the total number of employees is 5,964.5. Services provided directly for beneficiaries (accommodation and clothing, meals, nursing, health care, physiotherapy, social work, psychological support, education, psycho-social rehabilitation, occupational therapy, occupational activities), are distinguished from indirect services (e.g. accountancy, technical and auxiliary matters and cleaning).

Healthcare, nursing and personal hygiene services are provided by senior nurses (tertiary level), nurses (secondary level) and care-providers (elementary level, plus completion of a course in providing care).

Psycho-social rehabilitation services are provided by social workers (two or four year diploma or degree) and occupational therapists (secondary level or two or four year diploma or degree). Homes for mentally ill adults can employ psychologists (university graduates) and special needs professionals (university graduates).

Services are provided by homes according to methods of individual, group or teamwork, and it is especially important to adhere to the ethical principles of each profession. Experts must apply appropriate expert methods, and individual experts enjoy a certain degree of autonomy in creating particular, specific programmes.

Pursuant to Article 16 paragraph 2 of the Act on Amendments to the Act on the Organisation and Scope of Central State Administration Bodies (OG 30/04), which entered into force on 17 March 2004, the Ministry of the Family, Veterans' Affairs and Intergenerational Solidarity is responsible for submitting reports on the implementation of the programmes of intergenerational solidarity aimed at improving the life of **the elderly** as follows:

Period 17 March 2004 to 31 December 2004

The Ministry of the Family, Veterans' Affairs and Intergenerational Solidarity co-operated in implementing intergenerational solidarity programmes with bodies of units of local or regional self-government, health, social and other services, public institutions, non-governmental and civil society organisations and religious and humanitarian organisations.
Programmes of intergenerational solidarity were aimed at:

- Developing non-institutional forms of care for the elderly;
- Developing services for the needs of the elderly, providing them with services in their homes, according to their actual requirements;
- Providing support for families caring for the elderly so that family and career responsibilities can be met, and organising day-care for the elderly;
- Raising public awareness regarding the issues of aging and the elderly, and the need for mutual help and neighbourly assistance.

Programmes of intergenerational solidarity contributed to developing non-governmental and civil society organisations, encouraged volunteering, and contributed towards employment.

Programme beneficiaries were persons over the age of 65 placed in the programme by service providers, who signed contracts on co-operation in implementing the programme with the Ministry.

The basic programmes were *"Day-care for the Elderly"* and *"Household Assistance for the Elderly"*.

Within organised day-care services, programme beneficiaries were provided with the following: meals, help in maintaining personal hygiene, medical services outside the range of home nursing (monitoring blood pressure and blood sugar levels), and help in dealing with competent institutions and bodies. Occupational, sporting, recreational, cultural and artistic activities were also organised, as well as exchanges of knowledge and skills between the elderly and the young, courses and other team or individual activities that beneficiaries chose according to their own inclinations.

Household assistance involved providing services which beneficiaries received in their homes: visits to prevent isolation, help in maintaining personal hygiene, instructions on

hygiene and nutrition, performing household chores, gardening and outdoor maintenance, shopping for everyday items, groceries, medicines, hot meal deliveries, escort when needed, help with resolving issues concerning status and other matters, medical services outside the range of home nursing (monitoring blood pressure, and blood sugar levels), and help in emergencies caused by sudden illness, injuries etc.

These services were provided by members of intergenerational solidarity teams employed by programme service providers and trained in advance to work with the elderly. Unemployed women over 40 were given priority. Beneficiaries received the services free of charge and chose services according to their own requirements.

Service providers involved local association activists, volunteers and persons doing civilian service.

Co-operation in implementing the programme of intergenerational solidarity began in 2004, in areas with a high percentage of elderly people, and in areas where their living conditions were specific, for example hilly areas, island communities or areas damaged by war.

In the period 17 March 2004 to 31 December 2004, 2,886 elderly persons in 12 counties were included, while teams engaged 262 persons, including 50 volunteers.

In order to improve the quality of life of the elderly, the Ministry also started implementing projects to encourage volunteering in 2004. Young volunteers visited elderly persons to help them overcome feelings of loneliness, and bring them meals, medicines and other items. These projects were carried out as a result of co-operation between the Ministry and the Croatian Association of Pensioners and the Croatian Union of Pensioners in all counties, and with the Association of Pensioners of Zaprešić, the Town of Zaprešić and the Antun Augustinčić Primary School in the Zaprešić area within the Zagreb County. A total of 785 young volunteers provided services for 2,033 elderly persons.

The Ministry provided financial support for a project aimed at improving the quality of life of elderly and disabled persons living on their own, using a system of telephone reporting. The implementation of this project included 100 elderly and disabled persons in two counties, and employed 3 persons.

With the aim of encouraging active ageing, on the occasion of the International Day of the Elderly, a project entitled "*Sports Meetings for the Retired*" was implemented on 1 October 2004 by the Ministry, in co-operation with the Croatian Association of Pensioners and the Town of Virovitica. This involved 750 elderly persons – pensioners from all counties.

In 2004, a total of 5,769 elderly persons and 835 volunteers were involved, while 265 persons were employed.

Period 1 January 2005 to 31 December 2005

The programmes *"Day-care for the Elderly"* and *"Household Assistance for the Elderly"* involved 5,247 elderly persons and 377 people were employed to implement them.

A programme to encourage volunteering in helping the elderly, which was a continuation of co-operation between the Croatian Association of Pensioners, the Union of Pensioners and the Town of Zaprešić, and co-operation initiated with the Town of Beli Manastir, involved 2,200 elderly persons and 870 young volunteers.

The Second Sports Meeting for Pensioners was organised in Zadar by the Ministry, in cooperation with the Croatian Association of Pensioners, with 1,000 elderly persons participating from all counties.

Financial support for implementing projects organised by thirteen (13) civil society organisations (NGOs) was offered through public tenders. Through organised activities aimed at preventing social exclusion, promoting active ageing, encouraging intergenerational solidarity and volunteering the elderly were provided with various activities and services, such as help and nursing at home, cultural and educational programmes, information, foreign language courses, creative workshops during which young and old exchanged experiences, knowledge and skills, psychological and social assistance, and individual and group therapy and counselling, recreational excursions, and the social reporting system for the elderly, infirm, and the disabled, which enabled them to phone when in need. The implementation of these projects involved 1,800 beneficiaries and included elderly persons who were blind or sight-impaired, deaf or hard of hearing. One of the projects encompassed the wider area of continental Croatia, while the others covered individual counties. Thus, elderly persons in 6 counties were included overall.

In 2005, a total of 10,247 elderly persons and 870 volunteers were included, and 377 persons were employed.

Period 1 January 2006 to 31 December 2006
The programme *"Day-care and Household Assistance for the Elderly"* was implemented in 11 counties, and included a total of 2,572 elderly persons, employing 183 persons.

The programme *"Household Assistance for the Elderly"* was implemented in 9 towns and 18 municipalities in 10 counties, and included 5,232 elderly persons, employing 32 persons.

Volunteer help for the elderly in Zaprešić continued through the programme *"Youth for the Elderly"* in co-operation with the Association of Pensioners of Zaprešić, Zaprešić Social Welfare Centre and Antun Augustinčić Primary School and included 30 primary school pupils of both sexes. With their parents' consent, young volunteers were trained and included in activities helping the elderly. An activist from the Association of Pensioners accompanied two pupils on initial visits to pensioners and after they got to know each other and develop mutual trust, the young people made visits on their own. The elderly were given the opportunity to spend time with young people, while the volunteers developed a positive attitude towards the elderly.

With the aim of including volunteers of all ages in providing assistance for the elderly, a Ministry programme entitled "*Volunteer Assistance for the Elderly in Local Communities*" was implemented in co-operation with the Croatian Union of Pensioners, involving 290 persons providing volunteer assistance for 900 elderly beneficiaries. Volunteers were also successfully included in *"Day-care and Household Assistance for the Elderly"* programmes in Beli Manastir and Virovitica.

Financial means for the implementation of 15 projects aimed at providing assistance for the elderly, organised by civil society organisations, were approved by public tender. These projects included 2,500 elderly persons.

Sports meetings of Croatian pensioners were held in Karlovac, in co-operation with Karlovac County and the Town of Karlovac. One thousand elderly persons from all counties competed in sports disciplines suitable for the elderly – chess, darts, bowling and archery. In addition, an exhibition was organised of artwork by members of pensioners' associations.
With the aim of improving palliative care, co-operation between the Ministry and the Croatian Hospices Association continued via the implementation of the *Programme for the Improvement of Care for the Terminally Ill, Dying Persons and Family Members*. Comprehensive assistance and support for patients included medical assistance, psychological, social and spiritual support, and support for families in caring for ill persons and coping with grief. A total of 176 beneficiaries were included.

During 2007, advances in issues concerning the protection and promotion of the human rights of the elderly were achieved through the ongoing participation of a representative of the Ministry of the Family, Veterans' Affairs and Intergenerational Solidarity in an inter-departmental working group for proposing and drafting the National Programme for the Protection and Promotion of Human Rights 2008-2011. The Programme was adopted by the Government of the Republic of Croatia in a conclusion from a session held on 2 November 2007, and published in the Official Gazette 119/07. The National Programme for the Protection and Promotion of Human Rights 2008-2011 included the elderly, as a particularly vulnerable group, and one of its goals (NP HR, Objective 75) was to improve the quality of their lives through the implementation of programmes of intergenerational solidarity.

In issues concerning the human rights of the elderly, the ongoing participation of a representative of the Ministry in an inter-departmental working group for drafting the Proposal for the National Anti-discrimination Plan was assured for 2007. The Ministry of Justice was in charge of preparing the draft, and co-operation continued through issuing proposals and opinions on international sources, the constitutional basis and issues concerning the elderly within the scope of the Ministry of the Family, Veterans' Affairs and Intergenerational Solidarity.

In order to combat poverty and social exclusion, modernise the social welfare system, and prepare for full participation in the open method of co-ordination between social welfare and social inclusion after Croatia's accession to the EU, in 2007 a representative of the Ministry was a member of the Republic of Croatia's Commission and participated in adopting and implementing the Joint Inclusion Memorandum of the Republic of Croatia, in co-operation with the Ministry of Health and Social Welfare. This document was signed on 5 March 2007 by the European Commission and the Republic of Croatia and the First Conference was held on 2 July 2007, in Zagreb, at which progress was analysed and in-depth discussions on social welfare initiated.

As for issues concerning the elderly, in a conclusion from a session held on 23 August 2007, the Government of the Republic of Croatia adopted the Programme for the Development of Services for the Elderly within the Intergenerational Solidarity System 2008-2011 (OG 90/07), which ensured the implementation of the Ministry's programmes for intergenerational solidarity in two phases. The first phase included continuing implementation of intergenerational programmes in all areas included in pilot programmes between 1 January 2004 and 31 December 2007, and initiating at least 5 new programmes. The implementation period is 1 January to 31 December 2008. The second phase includes continuing the implementation of all first phase programmes and initiating at least 5 new programmes

annually, as well as drafting legislative proposals to regulate the system of services for the elderly throughout the Republic of Croatia. The implementation period is 1 January 2009 to 31 December 2011.

During 2007, the programme "*Day-care and Household Assistance for the Elderly"* was implemented in 15 counties, including 3,322 elderly persons as beneficiaries, and employing 232 persons. Finances from the State Budget allocated to the Ministry for the programme implementation amounted to HRK 10,323,970.00. The programme "*Household Assistance for the Elderly*" was implemented in 20 counties, 18 towns and 20 municipalities (some of which were involved in the implementation of the programme "*Day-care and Household Assistance for the Elderly"*). The number of beneficiaries was 5,219, and there were 323 employed persons. Finances from the State Budget allocated to the Ministry for the implementation of such programmes amounted to HRK 13,315,794.00.

In 2007, the implementation of programmes of intergenerational solidarity covered a total of 8,541 elderly beneficiaries and employed 555 persons.

During 2007, progress was also achieved pursuant to Article 14 paragraph 2, of the European Social Charter: the Volunteer Act was passed at the session of the Croatian Parliament held on 18 May 2007, determining the basic concepts, principles and conditions of volunteering, the rights and obligations of volunteers and volunteer organisers, volunteer contracts, the adoption of the Volunteer Code of Ethics, certificates awarded for volunteering, the state award for volunteering, and supervision of the implementation of the Act.

The Volunteer Act was published in the Official Gazette (58/07, 6 June 2007).

The central state administration body competent for the implementation of the Act is the Ministry of the Family, Veterans' Affairs and Intergenerational Solidarity (Article 18 of the Act), whose scope of work includes intergenerational solidarity.

Volunteering, within the meaning of the Act, is understood to be the voluntary investment of time, effort, knowledge and skills, through which services or activities for the welfare of others or the common good are performed in the manner envisaged in the Act, without claiming remuneration or other forms of material gain, unless otherwise stipulated in the Act (Article 3).

A volunteer may be a person of either sex with the capacity to act, who volunteers in Croatia, or abroad, pursuant to current national and international regulations, unless stipulated otherwise in the Act (Article 6).

A volunteer organiser may be any legal person registered pursuant to the Associations Act and the Open-Ended and Short-Term Foundations Act, a religious community, public institution, tourist association or other non-profit legal person organising volunteer work pursuant to the provisions of the Act. State bodies and bodies of units of local and regional self-government may also organise volunteering (Article 7).

The basic principles of volunteering defined in the Act are: prohibition of discrimination against volunteers or beneficiaries, protection for the beneficiaries of volunteering, prohibition of exploitation of volunteers, protection of volunteers who are minors, protection of volunteers deprived of capacity to act, provision of volunteering services without charge,

the willingness of volunteers to serve, solidarity in volunteering and trans-national volunteering (Articles 9-11).

Apart from the issue of volunteering by minors and persons deprived of capacity to act, who should be allowed to participate in socially useful activities which have a positive effect on their characters, and also protected from abuse or detrimental activities, the Volunteer Act pays special attention to the issue of foreign volunteers in Croatia and Croatian nationals volunteering abroad. According to the *principle of trans-national volunteering*, citizens of the Republic of Croatia volunteering abroad have all the rights and obligations envisaged in this Act and those according to obligations under international law. Volunteer organisers must include in contracts the rights from the Act for all nationals of the Republic of Croatia about to volunteer abroad. Foreigners and persons with recognised asylee status may volunteer in the Republic of Croatia, pursuant to the provisions of this Act, the Aliens Act, the Asylum Act and other regulations of the Republic of Croatia and obligations under international law. Foreign nationals may volunteer in the Republic of Croatia by regulating their temporary residence, pursuant to the provisions of the Aliens Act. Volunteer contracts, concluded in writing by foreign volunteers of either sex and pursuant to this Act, are considered grounds for issuing temporary residence permits (Article 17).

On 25 October 2007, members of the National Committee for the Development of Volunteering were appointed at a session of the Government of the Republic of Croatia. This is an advisory body of the Government of the Republic of Croatia, and its work is public. The Committee implements measures and activities with the aim of further promoting and developing volunteering (Article 19). The National Committee consists of 19 members from the public sector and civil society organisations, including independent professionals. During 2007, three sessions were held (9 and 26 November and 5 December), and a working group was formed to draft the Volunteer Code of Ethics, which will determine the rules of conduct for volunteers, volunteer organisers and volunteer beneficiaries, pursuant to the Volunteer Act.

In addition, Article 24 of the Act establishes the highest State Award conferred by the Republic of Croatia for volunteering, contributions to promoting volunteering and other volunteer activities, which is awarded annually to volunteers and volunteer organisers. A public invitation to propose candidates was published in 2007, and the State Award was conferred on 5 December 2007, International Volunteer Day.

Volunteer organisers must inform the Ministry of services or activities performed. On 31 August 2007, the Ordinance on the contents of reports by volunteer organiser on services and activities performed was issued. It was published in Official Gazette 106/07, dated 17 October 2007 (corrigendum dated 26 November 2007).

Regarding the National Strategy for Creating a Stimulating Environment for the Development of Civil Society 2006-2011 (adopted by the Government of the Republic of Croatia, along with the Operative Plan, at the session of 12 July 2006), one of the basic goals of the National Strategy was achieved by passing the Volunteer Act, and the conditions were created for developing a community in which citizens and civil society organisations, in synergy with other sectors, can participate actively, equally and responsibly, in terms of sustainable development, in building the welfare state and equal opportunities for all.

As for civil society issues, co-operation is also continuing within the Council for the Development of Civil Society of the Government of the Republic of Croatia, through the participation and active contributions as a Council member of a representative of the Ministry at Council sessions.

Furthermore, as a result of co-operation between the Ministry and the Town of Zaprešić, the Croatian Association of Pensioners and the Croatian Union of Pensioners, the 4th Sports Meeting of Croatian Pensioners was held on 5 and 6 October 2007 in Zaprešić, in which 1,000 elderly persons from throughout Croatia participated. The Ministry ensured funding for the implementation of this programme from the State Budget for 2007, in the amount of HRK 734,896.00.

During 2007, the Ministry ensured funding from the State Budget for 2007 in the amount of HRK 1,000,00.00, for the purposes of issuing a public tender for financing projects organised by civil society organisations, with the aim of improving the quality of life of the elderly. The public tender was published in the press on 4 January 2007. Applications were received for a total of 87 projects, and 17 were subsidised according to proposals made by the Commission for Appraising and Proposing Civil Society Organisations Projects. The Commission was established and appointed by a Decision of the Vice-President of the Government of the Republic of Croatia and the Minister of the Family, Veterans' Affairs and Intergenerational Solidarity, dated 22 December 2006.

We are continuing to keep abreast of the work of international organisations such as UN, UN ECE and EU.

For the purposes of informing the public, a brochure with all the relevant data and indicators on tasks and activities achieved during 2007 was published in December 2007.

At the close of 2007, the number of employees within the Directorate for Intergenerational Solidarity included the assistant minister, 12 full-time employees and one temporary replacement for an employee on maternity leave hired under a contract for services. Their job is to conduct Ministry affairs in Article 16 paragraph 3 of the Act on the Organisation and Scope of Central State Administration Bodies (Official Gazette 199/03, 30/04, 136/04, 22/05, 44/06, 5/08 and 27/08).

Care of persons with disabilities

There are 26 state homes for the disabled, in 13 of which primary and secondary education programmes are carried out. Within the range of social service activities, there are another 14 homes founded by other bodies (units of local and regional self-government, religious communities, associations and other legal and natural persons). A total of 5,038 persons are cared for in these homes, with a staff of 2,583. They include homes for the mentally retarded, those with hearing impairments and speaking and communication problems, the sight-impaired and the physically disabled.

There are various reasons why such persons require accommodation in homes, but one of the most significant is the lack of opportunity for the child or adult in question to receive adequate rehabilitation and/or education in the area in which he or she lives. The length of stay varies according to the type of care or services offered by the individual home. So, for

example, school-age children who are accommodated in order to provide them with education, on the whole remain in the home for as long as they remain in primary or secondary education. In the case of children without parents or those with inadequate parental care, and adults, the period of residence may be longer. When beneficiaries are involved in various rehabilitation programmes, the length of stay depends on the type and length of the programme.

With the aim of assuring quality of life for disabled persons accommodated in social welfare homes, rehabilitation programmes and procedures are carried out, in accordance with the needs, interests and abilities of the beneficiaries, in order to meet all their needs and respect their rights. The application of such programmes is reflected in the quality of the work and particularly in the results of rehabilitation. Intensive individual work with beneficiaries is accompanied by well-organised leisure time; beneficiaries and parents are encouraged to participate actively in rehabilitation; regular training is provided for staff, with the aim of teaching them new methods of expert work; counselling work with parents and family members is being developed, and stronger ties developed with the local community, in terms of exchanges of life experience between institutions and local communities, and intensifying activities with the aim of enabling beneficiaries to return to their own environment.

The particular goal of rehabilitation is to help disabled persons achieve or re-acquire the highest possible level of development or skills, and to help them acquire or improve their skills in order to participate fully in the local community.

In accordance with the identified need to implement the process of deinstitutionalisation, with the final goal of raising the quality of services, the development is being encouraged of a network of expert support services in the area of social welfare, at the level of local communities. This means encouraging and developing non-institutional forms of care and other forms of care in smaller institutions. The transformation of social welfare homes will continue to move in this direction.

In the area of care for disabled persons, social welfare homes provide the following non-institutional programmes:

- fostering – these programmes are realised through social welfare centres, and foster-parents are entitled to an allowance for the person in care and a personal allowance;
- expert assistance in including disabled children and young people in regular pre-school and school educational establishments – this refers to mobile services providing expert support for nursery and school teachers in regular educational establishments;:
- expert support services for psycho-social rehabilitation within the family (community visiting services);
- rehabilitation within day-care programmes – some social welfare homes provide day-care facilities, thus encouraging the model for developing day centres with a choice of services, enabling children and adults to live in their own homes (half-day and full-day programmes, and occasional visits, related to individual work and the implementation of psycho-social rehabilitation).
- Organised housing in the community – this means one or more persons (usually five) being housed together 24 hours a day, with full-time or part-time help from experts or other staff in meeting basic needs, with organised social, occupational, cultural, recreational and other activities. To be more precise, this kind of housing is aimed at organising and encouraging independent living on the part of mentally retarded

persons, i.e. providing them with housing in a flat or house intended for a small number of adults, with daily, professional supervision and help in everyday life.

Care for children without adequate parental care, children and young people with behavioural problems, victims of trafficking in human beings, victims of domestic violence, and those addicted to alcohol, drugs or other intoxicating substances.

Within the social welfare system there are 14 homes for children and young adults without adequate parental care, founded by the Republic of Croatia, and five homes run by other founders, with whom the Ministry of Health and Social Welfare has signed contracts on mutual relations. These homes accommodate a total of 1,145 beneficiaries up to the age of 21. They provide permanent or temporary accommodation, full-day and half-day care, and accommodation in housing units. The total number of staff employed is 608.

There are also 11 homes in the system for children and young people with behavioural problems, all founded by the Republic of Croatia. In these homes, court-imposed correctional measures are carried out, pursuant to the Juvenile Courts Act, and full-time accommodation, full-day and half-day care services are provided, along with expert evaluation services, short-term accommodation in reception units and accommodation in housing units. Altogether 995 beneficiaries aged between 10 and 21 are cared for in these homes. The total number of staff employed is 458.5.

During 2007, the Ministry of Health and Social Welfare facilitated and financed the work of shelters for the victims of trafficking in human beings, insofar as it related to the competence of the social welfare system.

Seven non-governmental organisations and religious communities have signed contracts on running shelters for the victims of domestic violence. These shelters can take 119 adult and child victims of domestic violence.

The Ministry of Health and Social Welfare has signed contracts on mutual relations with two institutions providing care services outside the family for those addicted to alcohol, drugs or other intoxicating substances, and with one association caring for about 160 such persons.

Centres for assistance and care

There are 16 centres for assistance and care, providing services including organising meals, carrying out household chores, maintaining personal hygiene and meeting other needs.

Centres for assistance and care may be founded by units of local and regional self-government, religious communities, companies, associations and other Croatian and foreign legal and natural persons. The county office competent for social welfare matters delivers a decision on founding such a centre when the prescribed conditions have been fulfilled, while the ministry competent for social welfare matters carries out inspectional and expert supervision of the work of the institution.

Staff who fulfil the conditions prescribed in subordinate regulations may carry out the tasks of centres for assistance and care.

Family centres

The Act on Amendments to the Social Welfare Act (Official Gazette, no. 44/06) prescribes the possibility of founding family centres. Family centres are founded by the ministry responsible for the family (the Ministry of the Family, Veterans' Affairs and Intergenerational Solidarity). Within their scope of activities, family centres provide 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. They also encourage and develop 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 encourage and implement programme activities aimed at educating and promoting family values.

Conditions, in terms of facilities, equipment and the number of professional and other staff required by family centres and their branch offices, are prescribed by the minister responsible for the family, as are requirements for claiming services through family centres.

During the last few years, forms of non-institutionalised care, provided by homes for various categories of beneficiary, centres for assistance and care in the home, foster families, family homes, organised housing, religious communities and associations and other legal and natural persons, have played an increasingly significant role in the provision of services through institutional and non-institutional forms of care. The circle of those providing such services has grown and beneficiaries have a greater choice of services, which are adapted as far as possible to their needs (individualisation).

It is precisely with this goal in mind, i.e. improving further non-institutional forms of care and avoiding institutionalisation, that a special regulation on fostering, as a traditional form of care in the Republic of Croatia, has been adopted. The Foster Care Act (Official Gazette, no. 79/07) prescribes in a uniform manner the rights, obligations and tasks not only of foster-parents, but also of social welfare centres, in accordance with the basic goals of social welfare reform.

Fostering, as a form of care outside a person's own family, had previously been regulated by seven articles in the Social Welfare Act and the Ordinance on the conditions for fostering and procedure for approving, renewing and terminating licences to foster. In order to improve fostering in the Republic of Croatia, it was decided to develop new legal solutions in this area.

One of the main results of the Foster Care Act is an improved approach to fostering. This special act has ensured the more detailed elaboration of fostering as a type of care offered outside the beneficiary's own family. The basic outcomes of the adoption of this act are:

- specialised fostering teams have been formed in social welfare centres;
- foster-parents are entitled to a personal allowance for their efforts to care on a daily basis for persons in their care;
- the number of persons cared for in a single foster home has been reduced;
- the general and specific obligations of foster-parents in relation to the type of person in their care have been regulated;
- the obligations of social welfare centres towards foster families have been regulated;
- a unified method has been prescribed for keeping records and registers on foster families and those placed with them.

Article 14, paragraph 2

In preparing for European integration, and in accordance with the strategic guidelines of economic development, the state is attempting to restructure expenditure linked to the implementation of social policies, with the aim of increasing the involvement of all three sectors – the state, the private sector and the civil sector.

In Croatia today, a significant number of associations are engaged in the area of social and humanitarian activities, non-institutional education and training for children and young people, organising leisure time for young people, cultural and technical activities, civil society development, promoting human rights, etc. Associations contribute to the process of creating and focussing social policies, particularly through the provision of social services and partner consultations.

The activities of associations in the area of social welfare focus on protecting vulnerable groups (children, young people, women, people with disabilities, those with mental problems, the elderly and infirm, the unemployed, victims of violence, victims of trafficking in human beings, the homeless, those addicted to drugs and other intoxicating substances, etc.). Alongside the associations, various foundations (open-ended and short term), religious communities and others are also involved. Their work focuses on providing psycho-social assistance (psychological assistance and assistance in social adaptation), and other social services aimed at integrating beneficiaries, enabling them to acquire knowledge and skills, which will help them overcome social exclusion and poverty. Many of these associations have been formed by people who are themselves members of vulnerable groups whose interests the associations represent.

Funds for the work of associations are provided in the State Budget and in part from the profits yielded by games of chance.

As far as associations are concerned, an important part is played by initiatives which support partnership between various service providers at the local level, in relation to social benefits, by means of programmes and projects financed by the Ministry of Health and Social Welfare.

Constitution of the Republic of Croatia

Article 49, paragraph 3 of the Constitution of the Republic of Croatia (III. Protection of Human Rights and Fundamental Freedoms, 3. Economic, Social and Cultural Rights) provides that the State shall stimulate the economic progress and social welfare, and shall care for the economic development of all its regions.

International agreements and documents

The Republic of Croatia is a party to the International Covenant on Economic, Social and Cultural Rights (Official Gazette – International Agreements 12/93) and it has ratified the International Labour Organisation Social Security (Minimum Standards) Convention No. 102, 1952), (OG – International Agreements, nos. 2/94, 1/02). When it comes to aging and the elderly, Croatia has accepted the Regional Implementation Strategy for the Madrid International Action Plan on Ageing (UN/ECE, Berlin 2002).

Primary legislation

The Act on the Organisation and Scope of Central State Administration Bodies (Official Gazette, no. 199/03), which entered into force on 22 December 2003, provided for the establishment of the Ministry of the Family, Veterans' Affairs and Intergenerational Solidarity (Article 2).

The Act on Amendments to the Act on the Organisation and Scope of Central State Administration Bodies (Official Gazette, no. 30/04), which entered into force on 17 March 2004, stipulates that the Ministry of the Family, Veterans' Affairs and Intergenerational Solidarity shall launch legislative projects aimed at improving the quality of life of the elderly; propose measures to encourage families to keep their elderly and infirm family members in their care; develop services to meet the needs of the elderly; promote non-institutional forms of care for the elderly; and carry out other tasks involving the care for the elderly which are not within the competence of other bodies (Article 16, paragraph 2).

On the basis of these provisions, on 17 March 2004, an intergenerational solidarity programme was launched in the Republic of Croatia, with the aim of improving the quality of life of the elderly.