Health Care Reform in Croatia: The Consumers’ Perspective
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Aim. Assessment of the Croatian health care system (under the reform) from the perspective of the users of health care services. We analyzed the consumers’ satisfaction with health care system, health care expenses and access, and described the consumers’ attitudes toward health reform, examining the differences among sociodemographic groups.

Methods. The study is based on a data set collected in 1994 through the interviews with randomly selected adults in two major cities of Croatia: Zagreb and Split.

Results. A great proportion of respondents were dissatisfied with the current health care services, quality of health care facilities and equipment, and encountered difficulties in access. The elderly, women, and those with lower socioeconomic status were more likely to be dissatisfied and to consider out-of-pocket payments for health services as a problem. A great number of the respondents believed that the reform would either fail or would not achieve significant results. Compared to the younger and higher socio-economic group, the older and lower socioeconomic groups were more likely to evaluate the health care reform negatively.

Conclusion. Croatian government decided to rationalize the health care system without taking much account of the impact of health reform on the consumers. Revealed dissatisfaction with the health care services might be linked with the expressed doubts in health care reform and concern that changes could worsen the consumers’ position as patients.

Key words: access to health care; attitude to health; consumer satisfaction; Croatia; health care reform; health surveys; patient acceptance of health care; public opinion

When in the summer of 1990 the first multiparty parliament was established in Croatia, changes of the health care and health insurance legislation were among its first decisions. The reason was not only a gross financial loss in the health insurance but also a political decision that the government should take over the control of the previous disintegrated and uncontrolled health system (1). Health system in Croatia has undergone a number of modifications since then. Apart from the general changes in the political system and economy, a principal motive for the health care reform was a prevalent dissatisfaction with functioning of the previous health system. All main “actors” of the system were dissatisfied: government was dissatisfied with the economic inefficiency of the system, physicians were dissatisfied with their income, and citizens were mainly dissatisfied with access (waiting time, in the first place), behavior of personnel, and shortages of drugs (2,3).

Health Care Reform
Changes in the health care system in Croatia, which started in 1990, affected all the components of the system – delivery, financing, control, and reimbursement structure. The official transformation that started with alterations and amendments to the health legislation finally resulted in two new acts: Health Care Act and Health Insurance Act, approved by the Croatian Parliament in August 1993 (4). However, reorganization of the system continues and a large number of additional regulations have been introduced yearly by the Ministry of Health and the Croatian Institute for Health Insurance. The ultimate goal of the reform is to radically rationalize (reduce) the health care expenses without jeopardizing the health status of the population. The government decided to spend 7.3% of the gross national product (GNP) for health services in 1994, which, in the situation of declined economy (halved GNP in the post-war period) meant some 40% of the 1990 investment (1). Under such circumstances, most of the provisions were aimed at the reduction and control of the service costs. Several changes have so far been made in the health care system. The first among them were the centralization of financing and definition of ownership of health care facilities. The central health insurance fund at the country level and under the direct control of the government was established in 1990. The fund (“Croatian Institute for Health Insurance”) is
responsible for the realization of the health policy defined by the government and for the financing and control of health care services. The ownership of health care institutions is defined as public – institutions are either governmental or owned by a county.

New standards and normatives of the insured rights have also been established (5). The compulsory health insurance under the reformed system covers a restricted standard of health care services as determined by the Croatian Institute for Health Insurance. Subsequently, the volume of services covered (paid to providers) by insurance is limited – for example, up to three visits in primary health care, five prescriptions, two referrals to a specialist, two dentist visits, etc. – per insured per year. List of prescribed drugs is reduced and a uniform sick-leave rate determined.

Financial management of health care services has been introduced in order to control the expenditure. Providers, physicians contracted by the state insurance fund, are paid only for the provision of determined standard of services. Utilization control is thus established as a control mechanism, primarily in primary health care, and physicians become responsible for over-utilization of services.

Cost sharing (co-payments) has been introduced for almost all health care services and medicaments. Exemption has been made for children and students, persons with a minimum income, unemployed, the elderly aged 65 and over, veterans, military service personnel, and those with chronic mental illness or with communicable diseases that must be reported, for maternity care, and preventive services (immunization). In 1995, this regulation was changed and the exemption included children up to 15 years, persons with less than one and a half of minimum salary, retired with the income of less than two minimal salaries, disabled with less than three minimal salaries, veterans, refugees, and others as before (6).

Apart from compulsory health insurance, the voluntary health insurance has been established. It can be supplemental health insurance (supplemental to compulsory, for higher standard or quality of care – that is, for additional services, drugs excluded from compulsory insurance plan, and amenities), or private health insurance which is a complete insurance program, excluded from compulsory insurance, and limited for very high annual income group (US$35,000 and over) (7,8).

Privatization, as one of the main goals of a health care reform, may take two basic forms. The first is a re-established form of private practice in privately owned facilities and provided by self-employed physicians. Private practitioners may enlist patients under the contract with Health Insurance Institute or/and have private patients. In 1996, there were 6.8% private physicians and 38.7% private dentists out of the total number of physicians (9). The second possibility is a provision of services by private practitioners in public health care institutions. Starting from 1997, the government has been carrying out privatization of primary health care services. Public health care facilities are rented to physicians who become private practitioners under contract with the Croatian Institute of Health Insurance and work inside public health institution (10).

Consumers’ Satisfaction and Perspective of Reform

Although the effectiveness of a health care system has been increasingly measured by economic, as well as clinical criteria, there is a large and growing body of literature suggesting that the patients’ perceptions of the health care and particularly patients’ satisfaction become an important factor in understanding and assessing the functioning of health care services (11-17). The most important purpose of studying the patients’ satisfaction, as agreed by many authors, is the evaluation of health care (12,16,18). Patients’ satisfaction with their health care is today considered as an inevitable indicator of the quality of care and a key factor in health care organization development (15,17,19,20). With a new emphasis on quality assurance and outcome measures, patients’ satisfaction is very often seen as an expected outcome of care (21-23).

Patients’ sociodemographic characteristics, such as age, ethnicity, gender, social status, education, income, marital status, and family size, are commonly studied as determinants of satisfaction with health care (24-27). A meta-analysis performed by Hall and Dornan (27), however, showed that sociodemographic characteristics were a minor predictor of satisfaction. The overall trends indicate that satisfaction was significantly or nearly significantly associated with being older, having higher socioeconomic status, being married, and having less education. The patient’s age was found to be the most consistent determinant characteristic, whereas the patient’s gender generally did not affect satisfaction.

In Central and Eastern European countries, as in developed countries, health care systems are rarely evaluated from the consumers’ perspective. The reason might be that the objectives for the governments in reforming health policy are primarily reorganization of financing and cost containment, which is often reduced solely to expenditure cuts (1,2,28), whereas citizens’ interests are not highly ranked on their political agendas. However, the WHO European Regional Office has recently set up
the health care reform principles which put a strong emphasis on the consumer rights and citizens’ views (29,30). Thus, the Ljubljana Charter on Reforming Health Care from 1996 stresses as a fundamental principle that health care reform must address citizens’ needs, taking into account their expectations from health and health care. The citizen’s voice and choice should be as significant contribution to shaping health care services as are the decisions taken at other levels of decision-making (31).

To describe the impact of health care reform in Croatia from the perspective of users of health care services (consumers), we used the results of the study carried out in 1994 in two large cities in Croatia: Zagreb and Split. The aim of the study was to analyze the consumers’ satisfaction with the health care system, to analyze the consumers’ out-of-pocket health care expenses and access to services and medication under the reformed system, and to describe the consumers’ attitudes toward health care reform. We also examined the differences among demographic and socio-economic groups regarding satisfaction, expenses, access, and attitudes.

The current health care system may have inherited some access and quality problems from the old system. However, we assumed that changes in the health care system, although aimed at reduction in financing and directed primarily to the providers, had significantly affected the consumers’ position and could have increased the consumers’ dissatisfaction.

Subjects and Methods
This study was based on a data set collected in 1994, a year after the main changes in Croatian health care system were introduced. The data set contains information on the consumers’ opinion on the quality of health care services, perceived health care expenses, access to services and medication, and attitudes toward health care reform. It also contains data on health services utilization, self-perceived health status, and sociodemographic characteristics.

The sample was composed of adults aged 18 years or over, randomly selected from the sample of households in the cities of Zagreb and Split. All districts of those two cities were included in the study. Croatia is a small, urbanized country, with only 7% of the population living in the rural area (32). More than half of the Croatia’s urban population lives in Zagreb and Split, two cities represented by our sample. The selected adults were face-to-face interviewed by trained interviewers – students of the Zagreb and Split Medical Schools. The interview took 20 minutes on an average to be completed. The questionnaire was constructed partly on the basis of the R. Andersen’s model of health services utilization (33) and by using the Slovenian public opinion survey of attitudes on health and health care (34). However, most of the questions on the health care reform and health care expenses in our questionnaire were applied for the first time.

The sample consisted of 562 adults, 280 from Zagreb and 282 from Split. The response rate for the survey was about 70%. Overall, 400 questionnaires were distributed in each city. There were 43% male and 57% female respondents in the sample, with no significant differences between the two cities. 27.3% of the respondents were under 30 years of age, 65.5% were between 30 and 60, and 7.2% were over 60 years. The respondents from Zagreb were younger than those from Split but this was not significant. The education distribution of the sample showed that 8.4% of the respondents had primary school education, 48.8% had secondary school education, and 42.7% of the interviewed sample had higher (university) education. No significant differences were found between the two cities in the survey, although the respondents from Zagreb had to some extent higher education than those from Split.

The results on the consumers’ satisfaction, perceived problems in access, and attitudes toward health care reform were analyzed by age, gender, education, and income. In order to analyze the socio-economic group differences, we divided the sample into three income groups (low, medium, and high), each representing about one-third of the whole sample. The monthly income of the low income group was 740 Croatian Kunas (HRK, or US$140) or less; that of the medium income group HRK740-1,480 (US$140-280); and that of the high income group HRK1,480 (US$280) or more. Average monthly net income in 1994 in Croatia was HRK1,247 (US$238) (35). The education variable was highly correlated with income, with a Pearson’s correlation of 0.42 at a p<0.0001 level. Similarly, the occupation variable was also highly correlated with income, also with a significant c2 at a p<0.0001 level. In the result section, although we only presented the analysis of the income group differences, we also examined the education and occupation group differences and found similar patterns. Therefore, the income group differences actually represent broader socio-economic differences. To examine the statistical significance of the differences in those groups, c2 tests were used.

In order to analyze the latent dimensions in the consumers’ opinions, the principal component model of factor analysis with a VARIMAX rotation was used. Differences between the two cities, the age, gender, education, and income groups in the sample were analyzed by comparing the means of the
factor scores, using the t-tests and analysis of variance (ANOVA). Data analysis was performed using
the SPSS PC+ (36).

Results
Consumers’ Satisfaction, and Perceived Health Care Costs and Access
To evaluate the quality of health care services from the consumers’ perspective, the respondents
were asked the questions concerning their satisfaction, perceived access to services and
medications, and perceived health care costs (Table 1). A great proportion of respondents was
dissatisfied with the health care services in general (44.4%) and with the quality of health facilities and
equipment (48.0%) in particular. Among the reported reasons for dissatisfaction with health care
services (data not shown), the most pronounced were “unkind behavior of health care personnel”
(20.4%) and “waiting time” (18.5%). However, among the expressed reasons for satisfaction, the most
pronounced was kind behavior of health care personnel with the patients (21.5%) and quality and
professional level of care (15.8%).

Table 1: Consumers’ satisfaction and perceived health care costs and access in Croatia, 1994
(N=562). [view this table]

When asked about problems in obtaining medications, a high
percentage reported difficult or very
difficult problems in access to the needed drugs (46.6%), and a great majority (74.1%) reported costs
of drugs when buying over-the-counter as high and very high. Regarding out-of-pocket health care
expenses, such as co-payments for services and prescriptions, payments for medications, gratuities,
and gifts, a half of all respondents reported that out-of-pocket expenses were a big or very big
problem for them.

Two questions were asked to assess the perception of social
inequalities in health care services
utilization. Approximately the same percentage of respondents believed or strongly believed (32.6%),
and disbelieved or strongly disbelieved (39.1%), that in their case they would receive adequate
treatment and medication. However, when asked if they believed that some persons had easier
access to physicians and receive better care and medications than others, a large majority (75.2%)
reported that, according to their experience, it happened often or very often.

The consumers’ dissatisfaction and perceived difficulties in access were analyzed by age, gender,
education, and income group. Distribution by age showed that, although not at a significant level, the
older respondents (60 years and more) were more likely than the younger ones to be dissatisfied with
health services in general and to perceive difficulties in obtaining the needed drugs. A significantly
higher percentage of them believed that some patients very often had easier access and received
better care than others (c2=6.8, p<0.05). Younger respondents (up to 30 years), however, were found
to be significantly more dissatisfied with quality of health care facilities and equipment (c2=4.9,
p<0.10).

The gender differences were statistically significant in the females’ compared to the males’ perception
of difficulties in obtaining the drugs (c2=7.54, p<0.01). The female respondents were also more likely
to be dissatisfied with health services in general, but not at a significant level.

Analysis of influence of education revealed that respondents with lower (primary school) level of
education tended to be more dissatisfied with health care services, perceiving social inequalities in
access. They reported problems in obtaining drugs significantly more than the higher educational
groups (c2=6.5, p<0.05), while those with higher (university) education were in a higher percentage
dissatisfied with the quality of facilities and equipment (data not shown).

Analysis of the consumers’ dissatisfaction and perceived difficulties in access by the income group
(Table 2) shows that, in general, low income groups were more likely to be dissatisfied with health
care services and to experience problems in access. This income difference was highly significant for
the perceived problems in the access to medications but insignificant for the perceived quality of
health care.

As previously described, the health care reform in Croatia has introduced co-payment for various
health care services. A high proportion (31% or higher) of the respondents considered the co-
payments for various health services to be high or very high. Distribution by age, gender, education,
and income group showed that the elderly, women, those with primary school education, and from
lower income groups were much more likely to consider the amount of co-payments for the use of
various services as high or very high. The age differences were significant for co-payments for visits
to general practitioner (GP) (c2=9.9, p<0.01), for visits to specialist (c2=6.2, p<0.05), for prescribed
drugs (c2=6.7, p<0.05), and for drugs when buying over-the-counter (c2=12.8, p<0.005). The gender
differences were significant for hospital care (c2=4.0, p<0.05) and for over-the-counter payments for
drugs (c2=12.7, p<0.001). The income group differences were highly significant for most health care services (Table 3). Overall, 50% of the respondents thought that out-of-pocket payment for health care services and drugs was a big or very big problem — significantly more women than men (c2=15.5, p<0.001) and those with primary school than those with higher education (c2=10.1, p<0.01).

Table 2: Consumers’ dissatisfaction, perceived access, and income group differences (N=562).

Table 3: Respondents who consider the amount of co-payment for the use of health services high or very high, and income group differences (N=562).

Attitudes Toward Health Care Reform
Respondents were asked about their knowledge on and attitudes toward health care reform (Table 4). More than a half (55.5%) of the interviewed population in Zagreb and Split reported that they did not understand the objectives of the reform at all (35.9%) or only partly (19.6%). Only 21.5% claimed to have fully understood the reform (9.3%) or to a great extent (12.2%). When asked about their opinion on whether the reform would succeed, 46.3% believed that either the reform would not achieve significant results (34.4%) or that it would totally fail (11.9%). Only 20.7% of the respondents in Zagreb and Split believed that the health care reform would succeed, rather in the long term (17.1%) than in the near future (3.6%). As mentioned previously, the reform has introduced utilization-control procedures such as the limitations on the number of prescriptions and referrals to specialists made by primary health care physicians. The respondents were asked what that utilization control meant for them. A great proportion (43.0%) thought that the introduction of utilization control implied the limitation of their rights to health care. Only 7.2% held a positive opinion – they believed that the utilization control would reduce the financial deficit of the health care system.

The respondents were further asked how the health care reform had affected their position as patients (Table 4). A large proportion (40.0%) believed that the reform worsened their position as patients. Only 8.9% reported that the reform improved their position. A greater percentage of the respondents (40.6%) reported that the introduction of private medical practices was very important or important to them, compared to 33.5% of those who reported that it was unimportant or not at all important. However, when only strong (either positive or negative) attitudes were analyzed, it was the only question where the consumers' opinions were evenly distributed – the percentage who considered it was not important at all (24.5%) was about the same as the one considering it very important (23.5%). To further understand whether the above attitudes toward health care reform differed between various demographic and socio-economic groups, we analyzed the distribution of respondents with negative attitudes toward the reform by age, gender, education, and income. In general, the older respondents were significantly more likely than the younger ones to express negative attitudes toward health care reform; in particular, they were significantly more likely to say that the reform was totally wrong or would not succeed (c2=5.7, p<0.05), that the reform worsened their position as patients (c2=11.7, p<0.01), that the introduction of private practice was not important at all (c2=18.3, p<0.001), and that the current system was bad or very bad (c2=6.6, p<0.05). Women significantly more than men agreed that utilization control meant limitation of health care rights (c2=4.7, p<0.05) and that the reform worsened the position of patients (c2=18.6, p<0.001). The male respondents significantly more reported that they did not understand the health care reform at all (c2=4.03, p<0.05). The respondents with the lower level of education were more likely to express negative attitudes toward the reform than those with higher education. The educational differences were significant for "not understanding the reform at all" (c2=5.5, p<0.10), "considering the introduction of private practice not at all important" (c2=9.5, p<0.01), and for judging "the current health care system as bad or very bad" (c2=7.1, p<0.05). The low income groups were significantly more likely to evaluate the health care reform negatively than the high and medium income groups (Table 5).

Finally, the respondents were asked to express their opinion concerning the measures for the improvement of health care financing and quality of care (Table 6). A large majority (71.3%) agreed that the government should spend more on health care from the state budget, and should not
increase health insurance rates (90%), neither introduce higher co-payments (94.7%) nor direct payments of full price (94.3%) for the selected services. Also, 43.7% of the respondents thought that the improvement of financing was possible through the control of utilization and 40.1% that this was possible through the increase of preventive health care services and programs. When those measures were analyzed by age, gender, education, and income, we found that there were significant differences regarding the opinion that the health insurance rate should be increased – i.e., the elderly (c2=5.8, p<0.05), men (c2=3.6, p<0.05), and those with high income (c2=5.8, p<0.05) were significantly more likely to agree that health insurance rate should be increased. Significantly higher percentage of the respondents with high education (c2=23.6, p<0.001) and high income (c2=6.8, p<0.05) thought that it was necessary to increase preventive health care services and programs in order to solve the financial problems of health care system.

**Factor Analysis**

In order to recognize the latent (underlying) dimensions in the consumers' opinions on health care reform, the factor analysis was used. Altogether 16 variables measuring attitudes and satisfaction were included in the factor analysis: P1 – general assessment of health care; P2 – satisfaction with quality of facilities and equipment; P3 – assessment of co-payment for visits to GP; P4 – assessment of co-payment for visits to specialist; P5 – assessment of co-payment for hospital care; P6 – assessment of co-payment for drugs; P7 – assessment of problems in getting access to needed medication; P8 – assessment of costs for drugs, when buying over-the-counter; P9 – assessment of out-of-pocket payments for health care; P10 – assessment of respondent’s own accessibility of health care services; P11 – assessment of social inequalities in access to health care services; P12 – satisfaction with health care services in general; P23 – understanding of the health care reform; P25 – assessment of the effect of the reform on respondent as patient; P26 – assessment of the success of health care reform; and P28 – assessment of the introduction of private practice.

Three derived latent dimensions with an eigenvalue above 1.0 were obtained by factor analysis (Table 7). They accounted for 53.8% of the total variance. Communals of all three latent dimensions were >0.4. The first factor (eigenvalue 5.27456) can be interpreted as the “payments for health care and drugs problem”, with the highest loadings of 0.41-0.86 for the assessment of co-payments for health services and drugs (P3-P6), problems in getting the needed medication (P7), costs of drugs over-the-counter (P8), and out-of-pocket payments for health care problem (P9). The second factor (eigenvalue 2.17965) can be interpreted as the “satisfaction and positive assessment of health care services and access”, with the highest loadings of 0.41-0.80 for the satisfaction with health care services in general (P12), satisfaction with quality of facilities and equipment (P2), and positive assessment of overall health care system (P1), followed by the positive assessment of respondent’s accessibility to services and medication (P10), and negative assessment of the existence of social inequalities in health services utilization (P11). It is also defined by a negative assessment of “payments for health care and drugs problem” (P7-P9), that is, by the opinion that out-of-pocket payments for health services is not a problem, that there are no problems in getting the needed medication, and that costs of drugs when buying without prescription are low. The third factor (eigenvalue 1.15387) can be interpreted as the “positive attitude toward health care reform”, with the highest loadings of 0.71-0.52 for understanding of the health reform’s objectives (P23), importance of the introduction of private practice (P28), belief that reform will improve patient's position (P25), and that reform will achieve success in the near future (P26).

The differences in latent dimensions between the two cities, gender, age, education, and income groups were analyzed by t-tests (Table 8) and ANOVA. The analysis revealed that there were no significant differences in the three factors between the groups of respondents from Split and Zagreb. The male and female respondents differed significantly in the factors “payments for health care and drugs problem” (t=-1.99, p<0.05) and “satisfaction and positive assessment of health care services and access” (t=2.68, p<0.01).

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Three age groups in the sample differed significantly in the factors “payments for health care and drugs problem” (F = 5.24, p<0.01) and “positive attitude toward health care reform” (F=6.38, p<0.01). Scheffe’s multiple comparison test (at p<0.05 level) showed that group 3 (the group of the oldest
respondents) was responsible for the difference in the first factor – and groups 1 and 2 (the younger and middle age groups) were responsible for the difference in the second factor. The education groups were significantly different only in the factor “positive attitude toward health care reform” (F=5.41, p<0.005) with multiple comparison test showing that groups 2 and 3 (the secondary and high education groups) accounted for the difference.

The income groups differed significantly in all three factors: “payments for health care and drugs problem” (F=10.56, p<0.001), “satisfaction and positive assessment of health care services and access” (F=3.38, p<0.05), “positive attitude toward health care reform” (F=15.86, p<0.001). Multiple comparison tests revealed that groups 1 and 2 (the low and medium income groups) were responsible for the differences in the first factor, the group 3 (the high income group) was responsible for the difference in the second factor, and the groups 2 and 3 (the medium and high income groups) were responsible for the difference in the third factor.

We also analyzed the impact of health status and utilization of health care services on the latent dimensions. The analysis of differences between the group of respondents with self-reported poor health and the group with good health showed that there were significant differences in “payments for health care and drugs problem” (t-value=2.61, p<0.05), “satisfaction and positive assessment of health care services and access” (t-value=2.45, p<0.05), “positive attitude toward health care reform” (t-value=-6.36, p<0.001). No significant differences in factors were found regarding utilization of health care services.

Discussion

Health care reform in Croatia might be seen as a transformation of a system based on the national health insurance model, with a high degree of solidarity and virtually “free” health services but with insufficient financial resources, into a system in which health services are becoming more like commodities for which the consumers have to know the prices. The changes are primarily directed towards solving macroeconomic problems in the health care system, toward the rationalization of services and introduction of private incentives. For all that, there are tendencies to introduce the elements of a managed care model on the country level, which is a characteristic of other health care reforms in the industrialized countries. In its intention to implement the policy of greater efficiency in health care, the government, however, leaves the responsibility for its success mostly to the health care providers.

In health care as elsewhere, all important issues can be viewed from many different perspectives. The physicians may have one view, other providers, such as as hospitals, a second view, insurance companies a third view, government a fourth view, and patients a fifth view. Whereas the issues discussed can be the same, the arguments and solutions, as it was noticed in the case of the US health reform (37), may be widely disparate. Using survey data, our study examined the Croatian health care system under the reform from one perspective – that of the users of health care services. The survey on which the study was based had been carried out in 1994, a year after the implementation of the main changes in health system (two new acts on health care and on health insurance and a number of important bylaws). Although new modifications have been made into the system since then, we expect that the similar impact of the health care reform process on the consumers’ perceptions of the quality of care and satisfaction may be found today. A recent study carried out by the Croatian Ministry of Health supports these findings (38,39).

The studied sample represents urban population that accounts for 54% of the whole population of Croatia. As previous studies showed that positive perceptions and satisfactions with health care were significantly associated with a higher social status (27), we can assume that non-urban population, with lower socio-economic status in general would express even more negative opinion. More empirical research on this issue is needed.

The main results of our study show that the interviewed Croatian citizens were significantly more dissatisfied with the health care services, facilities, and equipment than they were satisfied. A great proportion of the respondents reported difficulties in obtaining medications and perceived social inequalities in access and utilization. Although the current health care system has inherited many access and quality problems from the old system, we show that changes in the health care system, primarily aimed at the rationalization in financing and management of provision, have affected the consumers’ position and could have increased the consumers’ dissatisfaction. In general, the elderly respondents, women, those with lower level of education and lower income were much more likely to be dissatisfied with health care services and to perceive problems in access.

Recent analysis of a Eurobarometer survey on the citizens’ views on health care systems allows us to compare the Croatian data on the consumers’ satisfaction with those in the 15 European Union Member States (Table 9) (40). The results for Croatia are compatible with the South European
countries where citizens were found to be less satisfied with their health care systems. In Italy (59.4%), Portugal (59.3%), and Greece (53.9%) citizens were at a higher percentage dissatisfied with their health care than in Croatia (44.4%) – although health spending in Croatia is much lower than that in the EU countries. A low level of satisfaction in Croatia can be compared to that in the United Kingdom where 40.9% of the citizens were found to be dissatisfied with their health care system.

Table 9: Satisfaction with the health care systems in the 15 EU Member States in 1996 and in Croatia in 1994, and per capita expenditure on health in US$ Purchasing Power Parities (PPP) in 1993 (for Croatia in 1994) (40). [view this table]

Introduction of co-payments for almost all health care services, reduction of the list of prescribed drugs, and private medical practice have increased the individual out-of-pocket expenses for health care and citizens’ views on health care costs as a burden. Indeed, a half of the interviewed citizens perceived big or a very big problem with out-of-pocket payments for health care. In particular, costs of drugs when buying over-the-counter were considered as high or very high by a large majority of the interviewed consumers (74.1%). Co-payments for various services, though small in amount, were considered a burden by one-third to half of all respondents. Not surprisingly, this problem is even more serious for the lower socio-economic groups (as well as elderly, women, and those with primary education).

Our results also revealed that in Croatia, while the government had been continuously reforming the health care system, many citizens “quietly protested” that they did not understand the reform’s objectives; they considered the reform would not achieve significant results or would fail; the utilization control meant for them limitation of rights to health care; and the reform had worsened their position as patients. Only one fifth understood the reform and believed in its success. Less than ten percent shared positive views – that utilization control could solve financial problems of the health care system and that the reform improved their position as patients. Prevailed dissatisfaction with the public health services is a possible explanation why a large proportion of citizens found the introduction of private practice important for them. The low socio-economic groups (and the elderly) have been put in a particularly disadvantaged position with regard to the financial burden of health care and access problems. It is not surprising then that low socio-economic groups are much more likely to have negative views on the reforms than higher socio-economic groups.

Most of the respondents favored increased spending from the state budget, strongly opposing the raising of health insurance rates or out-of-pocket payments. Significant proportion also believed that the control of the health care spending and orientation to preventive services and programs could improve the financing and quality of care.

Factor analysis revealed three underlying dimensions in the consumers’ opinions: “payments for health care and drugs problem”, “satisfaction and positive assessment of health care services and access”, and “positive attitude towards health care reform”. The payment for health care and drugs was a significant problem for the oldest group of respondents, mostly women, those with the low or medium income, and with poor health. Satisfaction and positive assessment of health care services and access was significant for high income people, mostly men, and those in good health. Shortly, those young or middle aged, with higher or secondary education, with high or medium income, and in good health, shared a positive attitude toward the health care reform.

The users of health care services in Croatia are presently becoming more and more aware that the health care services are no more “free of charge”, that health has its price and that they have to share the costs for the care of it. They are also more and more aware of the reduction in health care expenditure and decline in health care standards. This all is a surprising experience for consumers.

Their unhappiness with the changes in health care system was reflected in the responses of the majority of our sample, who expressed dissatisfaction with running of the health care system and distrust in the health care reform. They are worried that the changes could worsen their position as patients in terms of access and costs. The low socio-economic groups are in a particularly disadvantaged position with regard to the financial burden on health care and access, compared to the higher socio-economic groups. Therefore, it seems important for the decision-makers to consider the citizens’ opinion during the reform process if they want to create the system which should be not only cost-efficient but also in a higher degree responsive to the consumers’ needs and expectations.

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Received: March 5, 1998
Accepted: June 8, 1998

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