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The pandemic and access to healthcare: Economic inequality and marginalisation in Bosnia and Herzegovina and Croatia

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Abstract: *Access to healthcare for Roma people and older adults (65+) in Bosnia and Herzegovina (BiH) and Croatia has been hampered by the COVID-19 pandemic. In responding to the pandemic, neither BiH nor Croatia have sufficiently addressed the complex and nuanced vulnerabilities of these social groups. By employing a comparative approach between the two countries, the article presents in-group and between-group differences based on gender, ethnicity, age, place of residence and legal status. The marginalisation of the Roma and older people is traced back to the structural inequalities associated with transitional state apparatus, corruption and neoliberal policies in both countries. While similar discriminatory trends are observed in both countries, the data indicate that the Croatian state apparatus is more organised in securing access to healthcare than that of Bosnia and Herzegovina.*

Key words: *Roma; older adults; Bosnia and Herzegovina; Croatia; neoliberal policies; COVID-19 pandemic*

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1. Introduction

The paper discusses the influence of the COVID-19 pandemic on access to healthcare services in Bosnia and Herzegovina (BiH) and Croatia. The comparative approach offers an account of marginalisation and discrimination of Roma people and older adults (65 years or older) in the two countries as embedded within the structural violence operating across economic and political systems and state institutions. The risks, vulnerabilities and violations of human rights endemic to the social groups is rarely nested within a singular axis of power such as class, gender, ethnicity or age. Rather, the paper reports that marginalisation and discrimination are products of the inequality regimes and relations of power which operate at flux and at different levels and domains of society (Walby 2007).

The pandemic has revealed that the main deficiency of the healthcare systems across the two countries is their dual economy, where underfunded and ill-equipped public health sectors and burgeoning private health sectors reduce the states' capacities to adequately respond to the influx of COVID-19 cases (BiEPAG 2020). Social and economic rights in the South East European region (SEE) have been in steep decline since the early 1990s. The rise of nationalisms in the region, the Yugoslav wars, and the difficulties associated with the transition from socialism to free-markets and liberal democracies as part of accession to the European Union have led to the formation of hybrid or illiberal regimes and state capture in the successor Yugoslav states (Bieber 2017, 2020). Over the last three decades, the weakened welfare systems have been subject to structural reforms proposed by the International Monetary Fund and World Bank (Kurian and Charkiewicz 2017). These include increased privatisation of welfare services, public-private partnerships and cuts in public expenditure, deepening the region's entrenched problems such as clientelism, corruption, environmental and urban degradation, and brain drain to OECD countries (measured at 19% in 2016, at the regional level) (OECD 2020).

The progressive realisation of the right to health, including the access, acceptability and quality of health — in line with CESCR General Comment No. 14 (CESCR 2000) — is contingent on the development and implementation of rights-based, gender-responsive, equity-focused policies, as well as on the well-balanced coordination of state and non-state stakeholders. Yet the partial privatisation of social and healthcare services has resulted in the placement of the burden of responsibility for social protection on the shoulders of the citizens and enabled further degradation of the right to health of the most vulnerable. Neoliberal policies tend to provide only basic health services to beneficiaries of the public health system, or create highly unfavourable conditions for access to more expensive and medically demanding health services. Thus, in responding

to the COVID-19 health crisis, the governments in BiH and Croatia have mainly been concerned with mitigation of economic ramifications brought about by lockdown measures. With the outbreak of COVID-19 in March 2020, both countries were prompt to provide testing and health treatments to patients positive to coronavirus, while providing far fewer services to the non-COVID patients.

The newly introduced measures have been based on short-term solutions and they have reflected the need for the state to ensure subsidies for out-of-work services and business during the lockdown, despite the fact that neoliberal policies for decades have been based on the rationale that the free market will be self-regulated according to its own inner logic. Although neoliberal adjustment programs are normally associated with deregulation of the state apparatus, neoliberal policies often require great intervention on the part of state institutions in providing the necessary legislative and infrastructural conditions under which it can efficiently operate (Williams and Maruthappu 2013). Numerous cases across the world show that there is little or no evidence that the growth of private companies in the provision of public health has given positive results for people (Sen and Koivusalo 1998). In fact, neoliberal policies perpetuate and deepen the existing inequalities, pushing different social groups further into the margins of society.

The research aims to investigate the health and economic crises as mutually constitutive phenomena both in BiH and Croatia. The two countries have been selected on the basis of their EU membership status, since this will largely influence their access to economic-crisis funding from the EU, the scope of that funding, the development of their human rights mechanisms, and their access to and distribution of COVID-19 vaccines. BiH signed the Stabilisation and Association Agreement (SAA) in 2016, while Croatia became a full EU member in 2013. The research is informed by the following questions: (1) What are the main institutional/structural obstacles in the welfare regimes to providing access to health for older people and Roma in BiH and Croatia respectively?; (2) In what ways have class, age, ethnicity and gender inequalities informed and shaped access to healthcare for older people and Roma in BiH and Croatia respectively, prior to and during the COVID-19 pandemic?; (3) What are the formal and informal good practices aiming to mitigate the structural barriers and ameliorate the access to healthcare of older people and Roma in BiH and Croatia?; and (4) What implications for the protection and realisation of social and economic rights in the SEE can be drawn from the marginalisation of older people and Roma in the two countries?

The methodology relies on secondary resources and analysis of the relevant legal and policy frameworks regulating the healthcare systems in the two countries. The main topics and issues identified from this data set are used for interview questions with state and non-state stakeholders

in the two countries. The purpose of the interviews is to provide deeper and more up-to-date contextualisation of the previous research through intersectional lenses. The total number of stakeholders contacted was 48, of which 26 were in BiH and 22 in Croatia. After several attempts at contacting potential research participants, eight stakeholders from the BiH cluster replied (five public administration institutions, one public hospital, one private hospital and one NGO). Only three state stakeholders from Croatia took part in the research. These are the Ministry of Health, Ministry of Human Rights and Minorities, and the Ombudswoman. It was important for this research to take into account the personal experiences and perspectives of Roma and older adults, but due to difficulties in gaining contact access the paper is limited only to the aforementioned sources. Another limitation is the lack of comprehensive and consistent data — it is dispersed among different stakeholders which typically do not take an intersectional approach.

The two sections of the paper discuss the cases of Bosnia and Herzegovina and Croatia respectively. Each section provides an overview of the organisation of the healthcare system in that country, as established by the previous research, which is followed by a discussion on the main shortcomings in the provision of access to healthcare for Roma people and older adults.

2.The healthcare system in Bosnia and Herzegovina

The effects of war in Bosnia and Herzegovina (1992–1995) made the country structurally and administratively complex and fragmented. The structural divisions existing in the state are reflected in the organisation of the public healthcare system. There is no healthcare system at the level of the state. It is organised at the entity level instead, with separate legislatures managing health protection, insurance, and institutions such as ministries, hospitals, clinics, health centres, ambulances, etc, in each of the two major entities — the Federation of BiH (FBiH), and Republika Srpska (RS) — and another in Brčko District. There are twelve ministries of health in BiH — two at the entity level, and ten at the cantonal level in FBiH — and a Department for Health and Other Services in the Brčko District Government. At the state level, there is only a Department for Health within the BiH Ministry of Civil Affairs, and the Law on Medicines and Medical Equipment. In addition, the transition towards the neoliberal market economy — a process that other former Yugoslav republics, including Croatia, had undergone too — significantly affected the healthcare system in the country. Although the public healthcare system existed in the post-war BiH, its inadequate functioning and the emergence of the private healthcare system meant that access to healthcare services became largely conditioned by the economic status of the citizens. Furthermore, the public healthcare system is bureaucratic, often corrupted and influenced by politics, while at the same time it provides services with

inadequate quality, lacks resources (including equipment and specialists), and has long waiting lists (Mujkić 2011). Insurance does not cover all treatment costs, around 20% of the population does not have insurance at all, and the costs for the treatment of the heavily sick population are relatively high (United Nations 2020b, 37).

The general problem of the relation of citizens' economic status to access to healthcare was further complicated and deepened by the COVID-19 pandemic. The pandemic has led to economic crisis, increased rates of unemployment, and functional changes in healthcare systems which became primarily focused on COVID-19-related health issues. The health system in BiH, as in Croatia, has met with many difficulties in the pandemic, not only in providing COVID-19-related services, but also in the continuity and capacity of services for other diseases and conditions, including mental health issues (Esch and Palm 2020, 77). Marginalised and vulnerable groups such as Roma and older people, who are often economically disadvantaged and regularly meet various obstacles to their access to healthcare in BiH, have been particularly negatively affected.

In March 2020, government institutions in BiH reorganised and partially closed healthcare institutions as a part of the general coronavirus strategy (United Nations 2020b, 8–9). The closure of the healthcare institutions and the focus on COVID-19 cases resulted in secondary pandemic mortality, i.e., mortality which is not directly caused by coronavirus, but is affected by the reduced capacity of the healthcare system to provide adequate and timely healthcare services during the pandemic — a phenomenon which is still not sufficiently researched (United Nations 2020b, 33–34). According to a survey about the impact of the COVID-19 pandemic on households in BIH:

> Access to healthcare and medical treatment for reasons other than COVID-19 was difficult and, in some cases, denied. Overall, 12.7 percent of respondents reported having unmet health needs during the pandemic. The hardest hit were persons with disabilities and chronic illness (18 percent of whom could not access therapy) and families with children and youth under the age of 18. 15 percent of the surveyed households reported unmet health needs. Of the people who self-identified as vulnerable, 14 percent of them reported to be unable to reach medical treatment or therapy. (UNICEF and UNDP 2020, 17)

Despite the fact that new budget plans were adopted in 2020 in both entities in BiH, which included considerable amounts for COVID-related purposes and medical equipment (United Nations 2020b, 9), the response of the healthcare system to the pandemic was inadequate. According to the World Health Organisation, the health system in BiH during the pandemic was characterised by a lack of coordination among public and between

public and private health institutions, inadequate management of the crisis, a lack of staff in the field of epidemiology and microbiology, and the lack of common databases or clear guidelines for providing basic services such as the primary healthcare services (United Nations 2020b, 9). In addition, the widespread corruption in the country continued during the pandemic and it significantly affected public healthcare (Transparency International 2020). This is well illustrated by the example of the large public procurement of unusable ventilators in April 2020 known as the "respirators affair", in which Fadil Novalić, the Prime Minister of FBiH, was one of the main actors (Esch and Palm 2020, 26). Although the ventilators do not work properly and are not suited to patients suffering from coronavirus, they are still being used in hospitals for treating COVID-19 cases. On the other hand, COVID-19 patients have been granted healthcare services free of charge in both entities during the pandemic, regardless of their citizenship and insurance status — which unfortunately has not been the case for patients who suffer from other types of health problem (European Observatory on Health Systems and Policies 2021).

2.1 Access to healthcare of the Roma population in Bosnia and Herzegovina

The Roma are the largest minority in BiH. The data from 2013 shows that around 50,000–70,000 Roma live in the country (Diskriminacija 2016), while more recent estimates from 2021 claim that the number is around 70,000–100,000 (Voice of America 2018). According to a study from 2020 into the effects of the COVID-19 pandemic on the Roma population in BiH, the health rights of Roma people were especially jeopardised during the pandemic for several reasons. The Roma group, which had been identified as a risk group, was particularly negatively impacted by the pandemic outbreak. They became more vulnerable to poverty, material deprivation and social exclusion, which resulted in them being driven to make choices between health and prevention measures on one hand and basic needs such as accommodation and food on the other (European Public Health Alliance 2020, 4). The data shows that the Roma have experienced a shortage of masks and lack of means for disinfection and hygiene during the pandemic, which represents a great health risk — especially considering the fact that Roma families in BiH are usually large, and several generations live together in small places often without access to clean water (Mehdić 2020, 7). The access to healthcare services was, as usual, not without problems for Roma since many do not have health insurance and/or are often discriminated against in this sense (ibid., 7). The results have also shown that many did not have access to the medicines they needed (ibid., 19), and that there was a lack of testing of Roma people for Coronavirus (ibid., 21). However, the unfavourable situation of the Roma population during the COVID-19 pandemic was not specific only to Bosnia and Herzegovina, but it has been present in other countries as well, as we will see in the case of Croatia.

2.1.1. The main challenges

According to the Ministry for Human Rights and Refugees in BiH, the main problem the Roma population faces in relation to access to healthcare services is that a large number of Roma persons in FBiH are uninsured, whereas this issue appears to be resolved in Republika Srpska and Brčko District.[1] However, the Ministry also reported that they did not receive any complaints from the Roma population in the country regarding their access to healthcare services. The Ministry of Health and Social Protection in Republika Srpska stated that their healthcare system does not make distinctions regarding nationality, race and age, and that it "does not create a segregation of any sort related to the people living in RS".[2] They have also stated that the main criterion for accessing healthcare services is insurance status, but that in all urgent situations access is open to everyone regardless of such status. During the state of emergency caused by COVID-19, the Health Insurance Fund of Republika Srpska financed all healthcare services regardless of their insurance status, and coronavirus patients were exempt from payment for participation in all services which are covered by compulsory health insurance".[3] The Health Centre Brčko claimed that the Roma population did not meet any specific obstacles regarding access to public healthcare services, and that the main problem with the Roma population was that they have not regularly been contacting their family doctors or general practitioners, either during or before the pandemic.[4] They stated that their public healthcare services are available and provided to everyone, and that differences are related only to the monetary compensation for people belonging to different categories of health insurance.

According to the Roma Education Fund (REF) the main difficulties Roma people in BiH face in respect to access to health protection are "the lack of adequate and complete information, economic difficulties, unemployment, and in some cases the lack of citizenship and personal documents".[5] REF has also shared that during the first few months of the pandemic the whole population, including the Roma population, had access to healthcare services regardless of their insurance status, and that covert discrimination in some public healthcare institutions does exist, but that it can be explained as being dependent on the individuals who work there. REF also emphasised that the difficulties the Roma population had in accessing services which are not related to COVID-19 were the same for all populations living in the BiH. The Institution of the Ombudsperson for Human Rights in Bosnia and Herzegovina reported that among the main

1 Interview with the Ministry for Human Rights and Refugees in Bosnia and Herzegovina.
2 Interview with the Ministry of Health and Social Protection in Republika Srpska.
3 Ibid.
4 Interview with the Health Centre Brčko.
5 Interview with the Roma Education Fund.

issues regarding access to healthcare services for Roma population in BiH are the facts that a large number of Roma still do not have health insurance, and that some Roma neighbourhoods are distant from the city centres and public transportation.[6] The Institution also informed us that they did not receive any complaints from Roma people that they had experienced discrimination related to access to public healthcare services during the pandemic, and that they have no data about the pre-existing difficulties related to access to healthcare services becoming even worse during the pandemic, but that it is "without doubt that all citizens' access to healthcare services had been made harder, which is true for Roma population to an even greater extent".[7] The "Better Future" Association of Roma Women reported in an interview that among the main issues the Roma population faces regarding access to health protection are the following: segregation of Roma neighbourhoods, the lack of health insurance, and Roma people neglecting health prevention and postponing the moment of contacting a doctor.[8] They also stated that although the whole population had issues regarding their access to healthcare services, the Roma population as one of the most vulnerable groups in the country was systematically and institutionally almost completely neglected.

2.1.2. Poverty and the consequences of prevention measures during the pandemic

The poor living conditions in Roma settlements have aggravated the spread of the COVID-19 virus within this group. For example, as the Organisation for Security and Cooperation in Europe has reported (OSCE 2020), accessing clean water and sanitation services and living in overcrowded neighbourhoods and houses are common problems for the Roma population. Roma women in particular reported not having enough running water to maintain the recommended hygiene practices, and living in small dwellings with several family members (OSCE 2020, 31). This meant it was impossible to maintain social distance, or to prevent the spread of the virus without adequate hygiene and sanitation practices. In addition, many Roma women reported bearing on their own the burden of purchasing protective masks and medical equipment, with insufficient income to afford those provisions (OSCE 2020, 31). None of the Roma men and women in the samples selected by the "Better Future" association were ever tested for COVID-19, so there is no data about the spread of the disease in Roma settlements.[9] Undoubtedly, the lack of COVID-19 testing on the Roma population constituted a systematic deprivation of their right to health.

6 Interview with the Institution of the Ombudsperson for Human Rights in Bosnia and Herzegovina.
7 Ibid.
8 Interview with the "Better Future" Association of Roma Women
9 Ibid.

Furthermore, the measures put in place by the Bosnian government (such as social distancing, self-isolation, limited movement, hygiene practices, etc.) became a strong challenge to Roma people, faced in particular by the Roma women (UN Women 2020). For example, social isolation measures have led to an increase in domestic and gender-based violence (Mehdić 2020, 7). In fact, impoverishment has a negative impact on the non-economic components of life. For example, it negatively affects mental and physical health, harmony within families and the quality of personal relationships. In times of lockdown, the combination of these phenomena resulted in an aggravated level of anxiety and stress, with not infrequent consequences in terms of aggression and violence, which escalated into a larger number of instances of domestic violence against Roma women.[10] In addition, the burden of unpaid labour from the presence of children in the household and the responsibility of caring for and disinfecting the house usually fell on women, aggravating their stress and general condition of health (OSCE 2020, 33–34). It is important to note that even before the pandemic Roma women had difficulty accessing public health services in both entities: the basic healthcare coverage for women in general trailed coverage for men by 13% and 16% in FBiH and RS respectively, while the percentage rises to 60% for Roma women (Jarke, Džindo and Jakob 2019, 7). According to the Ombudsperson, many Roma women experienced limited access to healthcare services during the COVID-19 crisis, particularly for preventive and reproductive healthcare, even if the organisation was not able to report accurate statistics for this deprivation.[11]

An example of the challenges that the pandemic faced Roma with is related to the economic measures — many Roma are employed in the service sector which was one of the most affected by lockdowns (Mehdić 2020, 7). Dervo Sejdić, the Roma representative and Head of the Council of Ministers of BiH, claims that Roma were the first who got fired when the pandemic started and that more than 30% of Roma who worked in the public sector lost their jobs (Radio Slobodna Evropa 2020b). Furthermore, education moved into the online sphere and many Roma children did not have any or adequate equipment (computers, access to internet, cell phones and electricity) for following their lessons (Mehdić 2020, 7). These problems are also often interrelated: for instance, the economic consequences which Roma suffered made it yet harder for Roma to access healthcare. Because of their frequent unemployment and poor living conditions, access to private healthcare services for most of the Roma population in BiH during the pandemic was practically impossible.

10 Ibid.
11 Interview with the Institution of the Ombudsperson for Human Rights in Bosnia and Herzegovina.

2.2. Access to healthcare of older adults (65+) in Bosnia and Herzegovina

The population in Bosnia and Herzegovina is an increasingly ageing society with an average annual rate of increase in the number of older adults of 2.48% between 1971 and 2020 (Knoema 2020). The share of the population older than 65 years of age is expected to grow to 25.2 percent while the share of the young population (below the age of 15) falls from 17.1 percent to 11.7 percent during the period 2010–2035 (FBiH Government 2013, 9). This will lead the country to have a high proportion (30% in 2060) of older adults in the overall population, as forecast by the UN Department of Economic and Social Affairs (DESA) (UNECE 2017, 3). In addition, older adults constitute a highly vulnerable category in BiH and such a situation is not likely to change in the near future.

2.2.1. Inadequate pensions and the unmet health needs of older adults (65+) in BiH

Being 65+ in Bosnia dramatically increases the probability of being poor, particularly for women (UNECE 2017), due to low monthly income and inadequate pensions, increasing living costs in the country, and strong persisting differences between rural and urban areas. In addition, older adults face a higher inclination to diseases (chronic morbidities such cardiovascular disease and neurological disorders such as dementia are particularly common) (UNECE 2017, 4). The added risk of being more susceptible to severe COVID-19 illness further aggravated the health status of older adults in BiH, with a trend similar to that in Croatia and almost every other European country. All these issues have an impact on older adults' access to health providers and services, thus negatively affecting their health.

Due to the fact that the pension system in Bosnia is of the classic Bismarckian model based on labour, the level of pensions in the country varies according to the status, quality and quantity of employment of the individual (Bartlett and Xhumari 2007, 299). Inevitably, being exposed to unemployment in working age (as happens more frequently to women) decreases the level of pension received in retirement age. According to the Bismarckian model, the amount of pension is calculated based on the payment of contributions and is influenced by the level of salary during the active period (Pranjić and Račić 2020, 166). Due to the structural problems of the labour market in the country, the average size of pensions in both entities is very low. To be specific, "average pensions in the Federation of Bosnia and Herzegovina and Republika Srpska in December 2016 amounted to approximately 189 and 175 euro per month, respectively" (Pranjić and Račić 2020, 168). On one hand, the number of beneficiaries of the pension system has progressively increased since 2010; on the other hand, the level of pensions stagnated in the same period, despite the levels of inflation affecting the minimum consumption basket in the country (Pranjić and Račić 2020, 169).

One of the main sources of vulnerability for older adults in BiH is the fact that the income they receive through pensions (retirement, disability or veteran) is insufficient to meet the real needs of this group. In fact, the combination of the high rate of unemployment during the active age, lack of competitiveness in the labour market and high rates of informal labour results in low pensions and thus a lower quality of life (UNECE 2017, 5-6). The trend of feminisation of poverty in BiH is particularly evident in the case of older women (OSCE 2020, 34): given that two out of three inactive persons in the country are women, the level of pensions is strongly characterised by gender-based inequality (Pranjić and Račić 2020, 166). The percentage of women over 65 years old who are on the lowest level of pension is higher than the corresponding percentage in the male population (almost 16 per cent, as opposed to 10 per cent of the men) (Mudrovcić 2008, 25).

By and large, older adults tend to be poor simply because they have less total monthly income than is needed to afford the minimum expenditure basket (Mudrovcić 2008, 32). As expected, trends have not reversed with the COVID-19 outbreak, which actually further exacerbated the dynamics of exclusion and impoverishment that affect older adults. For example, older adults experienced a reduction in the financial support they usually receive from family members or through remittances from migrant relatives (Mudrovcić 2008, 32). According to the World Bank, more than 9% of the total GDP in Bosnia and Herzegovina still comes from remittances from abroad (World Bank 2022): part of this amount meets the needs of older adults in the country and was reduced due to the COVID-19 outbreak (Mudrovcić 2008, 32). This has resulted in a higher rate of poverty among older people, particularly in rural areas and one-person households, and highest among women (UNECE 2017, 5). Specifically, one out of three women over 65 live alone, compared to only 15% of the men in their age group, making women more susceptible to poverty risks and health vulnerabilities (UNECE 2017, 4). The gravity of the poverty and low quality of health of a vast number of older adults in BiH is reflected in the fact that many of them have no savings with which to confront unexpected medical expenses (Mudrovcić 2008, 31).

2.2.2. The impact of the lack of health insurance on the health of older adults (65+) in BiH

One net result of the economic marginalisation of older adults in Bosnia and Herzegovina is their restricted access to healthcare, especially to those services not regularly covered by public insurance, and particularly for adults in retirement age who do not receive pensions. The entitlement to health insurance in the Federation of Bosnia and Herzegovina is reserved only to older adults who receive pensions (Pranjić and Račić 2020, 169). However, in 2012 more than half of the population over 65 years old was

reported to be receiving no pension at all, due to the fact that they had never paid contributions on account of having worked predominantly in the informal sector or in the black economy (Pranjić and Račić 2020, 168). The fact of being excluded from health insurance in Bosnia is affecting both quality of life and life expectancy, specifically because older adults tend to be more prone to chronic diseases and related problems (Pranjić and Račić 2020, 169). The people in the Federation of BiH who lack health insurance met severe difficulties in accessing public healthcare during the COVID-19 pandemic.[12] In Republika Srpska, on the other hand, even though a larger share of older adults has a form of health insurance, they reported a lack of information about how to access health services and provisions, with a similar resulting deprivation of health rights.[13] Nevertheless, the interviews implemented for the scope of this investigation did not report complaints about the level of coordination and harmonisation between different administrative levels in the country, in contrast to the experience in Croatia. Even though a hotline was activated at the national level during the COVID-19 pandemic, in order to guarantee adequate information on how to access healthcare during restrictions, this policy measure did not solve the situation.

The Ministry of Health of Republika Srpska established the Fund for Health Insurance, which provides insurance for people over 65 years old under the guiding principles of equality and solidarity.[14] In this manner, Republika Srpska partially addressed this issue but the lack of coordination and information still represent a challenge for the effective right to health of older adults in the territorial entity. The lack of adequate and coordinated policies to protect the rights (including the right of access to healthcare provisions and services) of over-65s in Bosnia is further exacerbating this situation. Half of those over 65 years old excluded from the pension system live in poverty, relying on social assistance and soup kitchens or on the financial support of relatives, with lower life expectancy (Pranjić and Račić 2020, 168–170). Due to the progressive feminisation of poverty in the country, older women tend to be poorer and to be excluded from the healthcare system more frequently than older male adults. There is a shortcoming in anti-discrimination policies against age and gender marginalisation, both in FBiH and in RS (Schwab et al. 2017).

2.2.3. Peculiarities of segregation in access to healthcare for older adults (65+) in BiH: rural and urban inequality

Another axis of marginalisation that is relevant for older adults exists in the distinction between rural and urban areas. Distances to the nearest primary health centres are problematic for older adults, and in particular for those suffering from chronic diseases or with mobility difficulties who

12 Interview with the Ministry of Human Rights and Refugees of Bosnia and Herzegovina.
13 Interview with the Ministry of Human Rights and Refugees of Bosnia and Herzegovina.
14 Interview with the Ministry of Health of Republika Srpska of Bosnia and Herzegovina.

need regular check-ups or timely medical assistance (Jarke, Džindo and Jakob 2019, 8). If it is true that everyday life is more complex anyway for people over 65 who are living in the countryside, the urban-rural differences are even more dramatic when it comes to accessing health facilities, which tend to be remote and provided with insufficient road infrastructure and inadequate (or expensive) public transportation (UNECE 2017, 7). For example, in the territorial entity of the Federation of Bosnia and Herzegovina, older adults can refer to dispensaries (in rural areas) or health centres (in urban areas) for primary healthcare services, while secondary and tertiary healthcare provisions are available only in larger urban areas (UNECE 2017, 14). This situation worsened due to the closures and lockdowns imposed on older people during the first months of the COVID-19 pandemic: prohibition of movement for people over 65 may have further restricted the access of poor and rural older adults to healthcare. However, the interviews implemented for the scope of this investigation did not clarify the eventual worsening of such living conditions.

Access to healthcare is specifically concerning for older adults due to the facts that they need public services, they lack savings, and they have to rely on limited pensions, and they are thus more likely to be affected by poverty. In addition, health insurance in the country is provided only to those older adults who receive pensions, so those who do not are de facto excluded from healthcare (World Health Organisation 2016). One study from 2008 has found that "exclusion on the health rights basis is multiple and described in detail as declining health, having ill health/disease (59.8% and 64.4%,), pain and discomfort all the time (69.2%) and not having means to meet the health needs (22.1%)" (Mudrovcić 2008, 32). The COVID-19 pandemic may have exacerbated such dynamics, but the literature and research are still scarce. The pandemic disproportionately affected older adults: the mortality rate among older patients was 15.2% (higher than the general mortality rate of 5%), the average age of hospitalised patients was 66.5 years, and the average age of patients who died from COVID-19 was 75 years (Arapović and Skočibušić 2020). Despite this, their access to public healthcare (in terms of quality and quantity) seems strongly biased by the condition of economic disadvantage in which they find themselves.

3. The healthcare system in Croatia

Croatia has a universal healthcare system providing both mandatory public insurance to all people, and voluntary insurance, which is further divided into complementary, additional and private health insurance (Mikić 2015, 4–7). Mandatory insurance is implemented by the Croatian Health Insurance Fund (CHIF) and covers the following: primary healthcare, specialist-consultative healthcare, hospital healthcare, medications determined by the basic and supplementary medicine list of the CHIF,

dental prostheses determined by the basic and supplementary prostheses list of the CHIF, orthopaedic and other medical prostheses determined by the basic and supplementary orthopaedic and other medical prostheses list of the CHIF, and the right to cross-border healthcare. Mandatory public insurance covers 80% of the costs related to the health service, and the other 20% is either covered directly by the patient or by complementary, additional or private health insurance. The minimum participation per invoice is 10 Croatian kuna and the maximum is 2,000 Croatian kuna (CHIF 2021). However, all citizens are required to pay a contribution to the mandatory health insurance, with exemptions for pensioners, people on low income, and other vulnerable groups (CHIF 2021).

After the dissolution of Yugoslavia, the transition to a market economy was characterised by reducing the scope of the free health services which were previously available through compulsory health insurance, and by the introduction of private insurance (Mikić 2015, 4–7). In 2009 a concessionary system was established, which allowed Croatia's administrative divisions, the counties, to be actively involved in the management of secondary healthcare by implementing public-private partnerships and organising tenders for the provision of specific healthcare services (Džakula et al. 2014, 19). The state is the owner of tertiary healthcare facilities, whereas most of the primary healthcare facilities have been privatised over the years. Out-of-pocket payments are related to services that are not covered by compulsory health insurance (Džakula et al. 2014, 68). The largest amount of out-of-pocket expenditure covers the following: medicines (both prescription and over-the-counter), medical devices, eye-glasses, other optical aids, hearing aids, orthopaedic aids and other prosthetic devices (CHIF 2021). The ratio of GDP spent on public health by the Croatian Government remains relatively low if compared to the majority of EU member states, rendering weak the financial position of public hospitals. The right to free healthcare has been systematically curtailed during the years since the privatisation of healthcare generated a two tiered system (Džakula et al. 2014, 20). This hierarchy means that people with higher incomes can afford high quality private services, while low-income populations have to wait in the public sector for primary services and are often unable to afford medicines (Mastilica and Kubeć 2005, 225).

In 2020, hospitals in the Republic of Croatia had to reorganise their work due to the COVID-19 outbreak. During March of 2020, the Ministry of Health made the decision that only emergency patients could be admitted for check-ups and surgeries during the pandemic, and consultations for non-life-threatening conditions should be conducted online with the doctor or via telephone counselling. Two online applications and one website containing all up-to-date information regarding the outbreak of COVID-19 were created. The first application, called "Andrija", is a digital assistant based on artificial intelligence designed to combat spreading of

the virus and to educate the public on the symptoms, whereas the second application is a tool to help patients to triage themselves before leaving their homes. Hospital policy all around the country is to admit only those patients whose life is in danger. In comparison to 2019, a significantly lower number of people used health protection or visited hospitals in Croatia in 2020. All COVID-19-related health services are covered, including diagnostics, treatment and sick leave, which means that no one is paying out-of-pocket expenses for COVID-19-related health services (European Observatory on Health Systems and Policies 2021).

3.1 Roma access to healthcare in Croatia

The access of the Roma population to the healthcare system in Croatia can be described essentially as a systemic and structural problem. The problem can be easily deduced from the mixed insurance structure of the healthcare system in the country, as individuals need to possess either public or private insurance in order to access healthcare. Indeed, what has been detected from the primary data available is that Roma burdens in access to healthcare are principally related to the lack of insurance, followed by inadequate housing, discriminatory conduct within the healthcare system, lack of financial resources, and inaccessibility to specialist examinations (Kunac, Klasnić and Klasnić 2018, 17)

Indeed, around 54.6% of Roma households in the Republic of Croatia — as reported by a national survey of 2018 on the inclusion of Roma in Croatian society — found themselves in a situation where they could not pay for a medicine or medical service that was needed by a member of the household, therefore indicating insufficient access to healthcare (Kunac, Klasnić and Klasnić 2018, 19). Around 27% of the respondents also said that, in the preceding twelve months, they had not contacted a doctor despite needing medical attention[15]. The principal reason that health services are insufficiently available to parts of the Roma population is financial, with a number of respondents reporting that going to the doctor is too expensive. Other reasons are connected to problems of transportation to health facilities (often due to the urban and physical marginalisation of the Roma community), long waiting lists and the lack of health insurance.[16]

3.1.1 The impact of the lack of health insurance on the Roma population's health

The Croatian Government's National Strategy for Inclusion of Roma recognises that the main health problem facing the Roma population

15 Interview with the Office for Human Rights and National Minorities
16 Ibid

is its insufficient health insurance coverage, often as a consequence of "unresolved status" (Government of the Republic of Croatia 2012, 19). One of the main difficulties that the Roma population faces in accessing healthcare is the lack of documentation and registration of Croatian citizenship:

> 10% of the Roma living in Croatia do not have citizenship, 6–7% are foreign citizens, while 3% do not possess any citizenship papers or other documents which certify their status, which directly affects their lack of access to health insurance, and also their access to other rights which would enable them to exercise the right to health insurance, such as the right to employment and social welfare. (Government of the Republic of Croatia 2012, 19)

However, the Strategy follows a culturist narrative in identifying the main reason for the Roma's problems in accessing the healthcare system as the "value system of Roma families and communities developed within a traditional lifestyle, resulting in insufficient appreciation of regular employment, health insurance and the right to pensions within the Roma community, and thus also poor motivation for completing their education" (Government of the Republic of Croatia 2012, 51). Apart from stigmatising the Roma population and pursuing the narrative that their lack of health insurance and consequently lower health conditions are due to their alleged system of values, the Strategy applies reductive and simplistic criteria which do not allow a deeper analysis, one which should be grounded in more structural issues (Kuhlbrandt, Footman, Rechel and McKee 2014).

The Roma population is one of the most vulnerable social categories in Croatia due to a combination of poverty, informal unemployment and social marginalisation. Consequently, they often face difficulties in receiving social assistance, with a negative impact on their health insurance status. The exclusion of Roma could be affected by their employment in the informal economy, with the consequence of not being registered in the official records of unemployment, or by not having Croatian citizenship. Thus, this also turns them into being "administratively invisible" (Kuhlbrandt, Footman, Rechel and McKee 2014, 709). A related problem is the lack of records and statistical data. It has not been possible to determine exact data on the health situation and healthcare of Roma, as neither the Croatian Institute of Public Health nor the Croatian Institute of Health Insurance collect and compile health statistics for national or ethnic origin.[17]

The Office of Human Rights and National Minorities recommended that the Croatian Institute of Public Health establish a system of analysis and

17 Interview with the Office for Human Rights and National Minorities

reporting in the field of Roma health by morbidity and socio-demographic characteristics, and even the scarce statistical data, by the end of 2020.[18] The collected data show that 89% of Roma have valid health insurance. Compared to an earlier study which found that 83% of Roma people aged 16 and over had health insurance (Dotcho 2012, 36), we notice an increase of health insurance coverage. The Institute found that health insurance coverage seems to be higher among those with better financial status, the lowest insurance coverage appears to be in northern Croatia; and considering the gender dimension, the coverage of health insurance is higher among women and older adults.[19]

3.1.2 Access to healthcare during the pandemic

Limited access to public healthcare during the pandemic has meanwhile worsened the pre-existing social and economic exclusion of the Roma population in Croatia. Indeed, even though there are no official statistical data related to the COVID-19 emergency, the 2020 report of the Ombudswoman states that in 2020 there were complaints about the fact that most Roma settlements have poor living conditions and live without access to drinking water, which results in higher risks and limited compliance with recommended hygiene measures (Ombudswoman of the Republic of Croatia 2021). The Office for Human Rights and the Rights of National Minorities declared that the main pandemic-related problem for the Roma community is job loss, either formally, with the industrial sector basically closed and service sector extremely limited, or informally, with limited mobility for temporary jobs, daily work in agriculture, or collection of secondary raw materials.[20] It can easily be deduced that unemployment and the impossibility of obtaining registration through informal jobs provoked diminished access to employment's benefits, to health insurance and therefore to healthcare facilities.

Regarding possible discriminatory acts toward the Roma population which might prevent them from getting access to public health services, the Office for Human Rights and National Minorities declared it had not received any information or complaints in this respect.[21] However, the report from the Ombudswoman states that complaints were received during 2020 about the fact that the majority of Roma settlements had poor quality of life conditions, without access to drinking water, resulting in higher risks due to limitations on applying the recommended hygiene measures. Indeed, the Office of the Ombudswoman stressed the importance of raising the level of health and sanitary protection for Roma families and settlements.[22]

18 Interview with the Office for Human Rights and National Minorities
19 Interview with the Office for Human Rights and National Minorities
20 Interview with the Office for Human Rights and National Minorities
21 Interview with the Office for Human Rights and National Minorities
22 Interview with the Office for Human Rights and National Minorities

Indeed, other problems related to access to healthcare were detected, such as limited access to public services due to limited mobility, consequent reduction in availability of social and health services, occasional lack of protective equipment (masks, gloves, disinfectants), and risks related to poor housing conditions, such as the impossibility or difficulty of maintaining social distance or complying with the rules of self-isolation, and in some cases lack of access to running water or bathroom facilities.[23]

3.2. Access to healthcare of older adults (65+) in Croatia

Competence for and regulation of services for older adults are shared between the Ministry of Demography, Family, Youth and Social Policy, the Ministry of Health, and local governments (World Bank 2020, 8). Croatia started reforms in healthcare and social services in 2019, introducing minimum benefits, improving pension provisions and introducing higher statutory retirement ages. However, due to the pandemic, the reform is currently on hold (World Bank 2020, 8). Croatia's administrative division into counties is translated into its fragmented healthcare and elderly care system, and it is reported that a low level of coordination and harmonisation exists between different administrative levels (World Bank 2020, 6). Different hospital units offer different sets of services. Lower-level centres provide only general medical examinations, whereas higher levels provide specialist examinations. Better-equipped hospitals that offer all services are usually based in the capital cities of the counties (CHIF 2021). The pandemic has particularly brought attention to existing inequalities in access to elderly care.

The healthcare system has faced serious challenges in responding to the outbreak of the COVID-19 pandemic. The already aggravated access to healthcare has worsened and the most vulnerable groups, with their pre-existing financial disadvantages, have been affected the most. Due to the nature of the virus, older people were more susceptible to the disease and were more likely to be in need of healthcare services and admission to healthcare facilities. The ageing of the population is one of the most significant demographic trends, not only in Croatia but right across the European Union, and it is reflected in the labour market and various social and health policies (Vidlička and Šikoronja 2017, 1102–1106). It is clearly stated by the World Health Organisation that it is important to distinguish the age and functional capacity of each individual (World Health Organisation 2015). However, it is undeniable that certain diseases and mental disorders occur more often among older adults, amounting to a double vulnerability for them, due to their age and their health condition (World Health Organisation 2015). With the outbreak of the COVID-19 pandemic, the position of older people has additionally worsened as age

23 Interview with the Office for Human Rights and National Minorities

increases the risks of severe illness. Older age groups are likely to suffer from severe symptoms that would require hospitalisation, intensive care and the use of ventilators. Over 95% of fatalities due to COVID-19 in Europe have been of people 60 years or older (Vidlička and Šikoronja 2017, 3). Even before the pandemic, access to healthcare, specialised treatments, palliative and community care was fragile and fraught with inequalities. Moreover, access to these health rights and services are at high risk of becoming more limited during the pandemic, resulting in these inequalities being exacerbated (United Nations 2020a, 5). Regardless of the shortage in medical staff and overburdened facilities, it must be ensured that medical protocols and triages are based on medical criteria and not on age, disability, or other chronic diseases (Age Platform Europe 2020).

Older adults, especially older women, are more likely to live on the edge of poverty and to experience social exclusion (Council of the European Union 2021). According to the statistics from 2020, every fifth person in Croatia (or 20.37% of the total population) is 65 years old or older (Croatian Bureau of Statistics 2020). The Ombudswoman report for 2020 noted that the average pension for December 2020 was lower than the poverty line of 147 Croatian kuna (approximately 19 euros) (Ombudswoman of the Republic of Croatia 2020, 55). The president of the Union of Pensioners of Croatia stated in a press release that 61% of pensioners are beneficiaries of pensions lower than the poverty line (Government of the Republic of Croatia 2020). The National Pensioners' Convention of Croatia (NPCC) and the Union of Pensioners of Croatia seek to index the minimum pension to the minimum salary; currently, the minimum pension is equivalent to 38% of the average salary in Croatia (NPCC 2020).

As Croatia has a healthcare system requiring out-of-pocket expenditure, the pandemic has shed light on existing economic inequalities that affect older people, in particular older women. The poorest among the older people face obstacles in receiving medical treatment for their existing conditions, which can increase their vulnerability to COVID-19. Older women are overrepresented among older adults (United Nations 2020a, 5), and they are more likely to have lower pensions due to having lower education and fewer paid jobs (often in domestic work), and inheriting their pension from their spouse.

In general, older adults are one of the groups that are particularly disadvantaged by neoliberal policies in healthcare, because they are more susceptible to diseases, more reliant on healthcare services, living on the edge of poverty, and not attractive to the labour market. The rates that beneficiaries of mandatory health insurance must pay, ranging from 0.75% to 15.03% depending on the service (CHIF 2021), disproportionately

affect older adults in Croatia due to their low socioeconomic status. Despite Croatia claiming that no one is paying out-of-pocket for health services related to COVID-19, one must take into account that neoliberal policies led to a general deterioration of health prior to the pandemic outbreak, thus making this group particularly vulnerable to COVID-19.

Older adults, particularly older women, for whom secondary healthcare was already inaccessible due to the distance and remoteness of some areas, found their lack of access aggravated by the outbreak of the pandemic. Older adults residing in rural areas had less access to the main hospitals, as they had to organise travel to main cities and cover the expenses. In addition to this, all patients entering these hospitals had to present a valid negative PCR test for COVID (Koronavirus.hr 2021). In practical terms, that meant that patients from rural areas needed to go to the local hospital unit to obtain the PCR test, pick up the results and arrange logistics to get to the main hospital to visit a specialist, in order to undergo surgery or any other medical intervention, including emergencies (Koronavirus.hr 2021). Even though the cost of the PCR test was covered, this process still represented a significant burden to older adults already suffering from various illnesses, including chronic diseases. Having to travel several kilometres to receive secondary healthcare services often required travelling by public transport, which was reduced across the whole country at one point. These situations put older adults in an overly dependent position, where they had to rely on relatives and acquaintances to drive them to the hospital. This could have been overcome by allowing patients to get tested at the premises of the hospital, but as an exemption so as not to overburden the facility.

At the outbreak of the pandemic, Red Cross Croatia widely distributed two booklets containing information on how to visit older adults and how to receive help as an older adult (Croatian Red Cross 2020). Bearing in mind the fact that older people do not have access to the internet, and do not comprehend how to use various electronic devices, they might therefore have had difficulties accessing the rapid flow of information. The first booklet was designed to help adults and the wider population to assist and help older adults, whereas the second booklet has been printed out and distributed to older adults physically. Red Cross Croatia has also introduced a hotline for people in isolation and quarantine to reduce the psycho-social effects of the pandemic. This information was also shared with older adults during official visits by Red Cross Croatia. This has immensely helped older adults in accessing information and comprehending which actions they ought to take to protect themselves.

3.2.1. Care homes for older adults in Croatia

In late March and early April 2020, Croatia's COVID-19 authorities adopted measures that had a severe impact on older people placed in care homes. Visits to the homes were banned entirely and beneficiaries were allowed

to leave the facilities only for exceptional reasons such as urgent medical visits (Croatian Institute of Public Health 2020). These measures were in force for several months, leaving many beneficiaries living in de facto isolation and unable to partake in their family life, with a considerably negative impact on their mental and physical health. The Ombudswoman called several times for this measure to be lifted, invoking their right to family life (Ombudswoman of the Republic of Croatia 2020). Several cases of large COVID-19 outbreaks in care homes have been reported, but the case in Split has occupied the most attention in the country. More than 10 beneficiaries had symptoms of COVID-19 but this was not reported to the hospital. Only after 49 beneficiaries registered high fever was the local hospital informed, and all of them were hospitalised urgently. The average age of the beneficiaries was 86, and 22 of them were older than 90 (Radio Slobodna Evropa 2020b). The Croatian Ombudswoman has initiated proceedings to examine the liability for such incidents, and the process is still ongoing (Buljan, Dabić, Đaković and Horvat 2020, 51). The Ministry of Demography, Family, Youth and Social Policy has discovered that one in five care homes in Croatia is illegal (Jutarnji List 2020), offering very low prices to target older people with low income, but failing to meet technical requirements or to supply necessary equipment, while providing poor services, thus increasing the vulnerability of this group and exposing them to health-related risks during the pandemic.

4. Conclusion

Our research indicates that the COVID-19 pandemic has negatively impacted the realisation of the right to health of Roma and older people in both Bosnia-Herzegovina and Croatia. The initial premise of the paper was that their marginalisation and the discrimination they face accessing healthcare are directly linked to the partial privatisation of the healthcare systems in Bosnia-Herzegovina and Croatia. The structural adjustment reforms emerging in the 1980s continue to be a dominant model of regulating expenditure in the public sector, at the expense of those who are most vulnerable on multiple and intersecting criteria such as gender, ethnicity and age. Although the neoliberal state is usually conceptualised as the deregulation of the welfare state, we instead see it as being highly invested in the regulation of administrative, legislative and institutional capacities and procedures in line with free market principles.

Both Bosnia-Herzegovina and Croatia were affected by the Yugoslav war, but its effects on administrative and political organisation have been much graver and more complex in BiH. The coordination of services and measures aimed at preventing the dissemination of COVID-19 and containing the economic crisis in BiH was hampered by the cumbersome administration and decision-making processes divided between the three constitutive peoples of the post-war country. By contrast, Croatia has

shown a greater degree of organisation in enforcing economic measures coordinating public and private health institutions and investments in digital platforms for the health services. This, however, does not mean that access to healthcare for Roma people and older adults is more reliably ensured in Croatia. At the moment, there is no data on the efficacy of these platforms for these social groups. More significantly, our analysis shows that Croatia's status as an EU member state has resulted in de facto improvements in access to health for Roma and older adults. Nonetheless, the structural barriers pertaining to employability and low income, coupled with differences in living costs and expenses for medical services in both public and private sectors, still remain pressing issues in both countries.

The imbalance in access to necessary health services for COVID and non-COVID patients had different impacts on Roma and older people, depending on their social standing. For Roma, the COVID-19 pandemic has deepened already entrenched inequalities as they face limitations to health services due to the fact that many of them do not possess necessary citizenship or health insurance. The situation for Roma is slightly more favourable in Croatia than in BiH, since Croatia has made better progress in registering Roma patients in the health system. Compared to the Roma situation in BiH where health insurance coverage seems to be gender-biased, in Croatia the coverage of health insurance is higher among women and the elderly. Although testing for COVID-19 is made available to anyone free of charge, there have been no measures implemented by state or local authorities in either country to provide Roma with adequate protection from the virus in the form of masks and hygienic gloves, or to address issues such as access to clean water and disinfectants, or keeping physical distance in overcrowded households. Another commonality in both countries is that Roma women remain particularly vulnerable and that adequate policies addressing this issue should be secured.

Older adults still remain one of the most vulnerable groups while the deficiency in available comprehensive data calls for greater attention to further research. The pandemic exacerbated problems of access to healthcare for older adults in both countries, as manifested in the inadequate provision of healthcare services to chronically ill persons and in the fact that older adults often live in poverty. The restrictions on specialist treatment during the pandemic have prolonged the waiting lists, making referrals and necessary medicines more difficult to obtain. The restrictions on the use of public transport and physical access to healthcare facilities has partly been offset by e-health services, but these have mainly been limited to routine medical consultations or to issuing and extending prescriptions. Although BiH has privatised its healthcare sector to a lesser extent than Croatia, older adults in BiH are often compelled to spend money on medical treatments either due to widespread corruption in public healthcare or the long waiting lists for specialist treatments.

Although older adults receive low incomes in both countries, our research shows that the situation is far direr in BiH because of the fact that only retired persons are entitled to health insurance. Both countries are ageing societies, partly due to the emigration of young people and the brain drain of those with qualifications. However, the COVID-19 pandemic has also slowed down the flow of remittances, on which older adults relied to provide access to healthcare. Another commonality in both countries is that rural areas continue to be depopulated, leaving households consisting only of older adults with limited access to healthcare services. Finally, the underlying idea of the paper is that the COVID-19 pandemic has not only created conditions in which the social and economic marginalisation of Roma and older people in BiH and Croatia has been intensified, but it has also pinpointed the limitations of conventional approaches to the management of economic and health crises and the need for further development of policies and solutions that will secure the right to health to a greater extent.

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