Violations of the Right to Health due to Limited Access to Protection of Health during the COVID-19 Pandemic in the Republic of Croatia and Possible Legal Implications

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VIOLATIONS OF THE RIGHT TO HEALTH DUE TO LIMITED ACCESS TO PROTECTION OF HEALTH DURING THE COVID-19 PANDEMIC IN THE REPUBLIC OF CROATIA AND POSSIBLE LEGAL IMPLICATIONS

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Abstract The battle against the COVID-19 pandemic is still the most important problem and a great challenge for the overburdened health system in the Republic of Croatia. This paper examines the research into how violations of humans' right to health occurred due to the inaccessibility to health protection for uninfected persons during the COVID-19 pandemic. The research implemented showed that a system of anti-epidemic measures which completely suspended or significantly reduced the possibility to access primary and hospital health care, stopped preventive programs of cancer detection. Much medical research has already revealed the possible harmful effects to people's health in the increase in cases of the contraction of and death from cancer and other serious illnesses, particularly in relation to certain vulnerable groups for example, women and oncology patients. The author concludes that the right to access protection of health during the COVID-19 pandemic in the Republic of Croatia was significantly limited and analyzes possible legal consequences which could occur due to the suspension or limitation to the right to access health care as a violation of the right to health.

Keywords
inaccessibility to healthcare, anti-epidemic measures, vulnerable groups, legal consequences, force majeure/absolute necessity

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1 Introduction

The COVID-19 pandemic, which is a new disease caused by the SARS-CoV-2 virus, has posed serious challenges for societies all over the world. The effects of this threat to public health will be felt for generations. The attention of both the general and professional public is focused on issues of varying forms of inaccessibility to healthcare and protection of health resulting from the pandemic. The accessibility of healthcare as an imperative component of the right to health during the pandemic has been severely disrupted and has had and will certainly continue to have serious implications for people's life and health. It is a fact that the pandemic does not affect all people equally because some have access to life saving protection of health while others do not (*Statement on European Solidarity and the Protection of Fundamental Rights in the Covid-19 Pandemic*, 2020: 88). The lack of access to healthcare has impacted not only people infected with the coronavirus and who were sick with COVID-19 but also those who needed protection of health in the form of diagnostics and/or therapy for other serious illnesses. The pandemic, extraordinary as it may be, nevertheless should not be a justification for the consequences which will lead to an even larger number of lives lost and worsening of health due to the inaccessibility of healthcare. "Everyone, without exception, has the right to life-saving interventions and this responsibility lies with the government. The scarcity of resources or the use of public or private insurance schemes should never be a justification to discriminate against certain groups of patients. Everybody has the right to health" (The Office of the High Commissioner for Human Rights UN, 2020). This particularly relates to vulnerable groups of people such as oncological patients, people with disabilities, older persons, minority communities, indigenous peoples, internally displaced people, people affected by extreme poverty, people who live in residential institutions, people in detention, homeless people, migrants, addicts, etc. (The Office of the High Commissioner for Human Rights UN, 2020). This non-discriminatory approach to health protection and human equality demands that special attention is given to certain vulnerable groups. In addition to social inequalities which worsen the risk of contracting COVID-19, among those key vulnerable groups are the elderly with chronic conditions and non-COVID infected persons with other serious illnesses (Montel et al., 2020: 230). Therefore, the right to health presumes the principle of accessibility, equality and equity: accessibility is ensured by physically, geographically and economically accessible protection of health, particularly at the

primary level, while equity is ensured by not permitting discrimination (Mujović Zornić, 2016: 58).

The fight against the pandemic is still the most pressing problem facing the healthcare system in Croatia. Given that the Law on Protection of the Population from Infectious Diseases guarantees all persons with infectious diseases both the right and the obligation to treatment and to adhere to regulations and directions, it necessarilly follows that all those infected with COVID-19 should be ensured access to treatment. However, stress on the healthcare system stemming from the pandemic has greatly reduced both material and human resources required for treating non-infected patients as well as for implementation of screening programs to detect and prevent cancer. Also, in the so-called „third wave" of the epidemic that occurred in Croatia in April 2021, all non-urgent operations were postponed and treatment for oncological patients and patients in intensive care units was significantly reduced.[1]

Since the pandemic has had such negative consequences on the overall right to health as defined by international law, it is necessary to critically question to what extent directions for combatting COVID-19 were instituted pursuant to the legal framework of the right to health (Montel et al., 2020: 228). It is indisputable that measures taken to fight the epidemic, although undertaken to protect lives and people's health, limit certain other human rights and freedoms (Omejec, 2020).

The aims of this paper are both to analyze how violations of the human right to health occurred because people were unable to access or had limited access to the protection of health during the COVID-19 pandemic in Croatia and to determine what health and legal consequences resulted as a consequence.

[1] Doctor from Varaždin: 26 persons on respirator, must cancel some operations, N1 from 22 April 2021.

2 Brief overview of legal regulations pertaining to access to protection of health in international documents

The right to health is defined in international law accepted by Member States of the United Nations (hereinafter: UN), the Council of Europe (hereinafter: CE) and the European Union (hereinafter: EU). The inalienable right to health is an inclusive right whose essential elements are: availability, accessibility, acceptability, quality, participation and accountability (OHCHR and the right to health). It includes four standards (AAAQ) which protection of health must have (Marković, 2016: 119). Core minimum obligations emerging from the right to health are contained in General Comment No. 14: The Right to the Highest Attainable Standard of Health[2] (Committee on Economic Social and Cultural Rights UN, 2000), which first places the obligation to ensure the right to access health institutions, goods and services on a non-discriminatory basis, particularly for vulnerable or marginalized groups. Even though this document is not legally binding, it is nevertheless the basis for interpreting the normative contents for the right to health and for its adjustment in the context of the COVID-19 pandemic (Montel et al., 2020: 228). The Universal Declaration on Bioethics and Human Rights (UNESCO, 2005) emphasizes that health is fundamental to life and that enjoying the highest standards of health care which can be reached represents one of the fundamental rights of every human being without discrimination. Therefore, it is a governmental obligation to enhance accessibility to quality health care and basic medicines, particularly for the health of women and children (Article 14. sec. 2. a).

The right to health is not found *expressis verbis* among legal guarantees in the European Convention for the Protection of Human Rights and Fundamental Freedoms (hereinafter: ECHR) or its Protocols. Nevertheless, countries according to decisions of the European Court of Human Rights (hereinafter: ECtHR) related to Article 2 and Article 8 of ECPHR, must pass regulations binding public and private hospitals to adopt appropriate measures for the protection of the life and corporal integrity of their patients (ECtHR, *Jurica v. Croatia*, & 84). In the EtCHR judgment of 2001 of *Cyprus v. Turkey* (appl. 25781/94) the court held that pursuant

[2] Explanation of contents of right to health from article 12 of International Covenant on Economic, Social and Cultural Rights UN which acknowledges that everyone has the right to enjoy the highest possible standards of physical and mental health.

to Article 2 of ECHR, government liability is possible if it risks the life of an individual when it denies him/her medical care available to the general public (Murgel, 2020: 26). The right to health includes the right to prevention, treatment and monitoring of illness and equal and timely access to health services such as basic medicine and medical care. Everyone has the right to access preventative protection of health and the right to health protection under the conditions established by national law and practice (Article 35 of the Charter of Fundamental Rights of the European Union). In achieving the right to health care, all forms of discrimination are prohibited on any basis such as gender, race, color of skin, ethnic or social origin, genetic features, language, religion or beliefs, political or any other opinion, membership of a national minority, property, birth, disability, age or sexual orientation (Article 21 of the Charter of Fundamental Rights of the European Union). The Council of Europe in the Oviedo Convention prescribes the obligation to ensure equitable access to health care of appropriate quality, taking into account health needs and available resources (Article 3). The European Committee of Social Rights issued a *Statement of Interpretation on the Right to Protection of Health in Times of Pandemic* emphasizing the interrelation of the right to protection of health with other rights enshrined in the European Social Charter (April 2020). This Statement is based on the powerful international legal framework on the right to health (Montel et al. 2020: 238). At the same time, Article 11 of the European Social Charter prescribes that the right to protection of health stipulates preventing, as far as possible, epidemic diseases. Every person has the right to timely access to quality, preventative, and curative health care. Timely access means that everyone can access health care when needed. Good quality healthcare means that it should be relevant, appropriate, safe and effective. (European Commission, European Semester Thematic Factsheet, Health systems, 2017: 2).

Also relevant for analyzing the present topics are documents by the World Health Organization (hereinafter: WHO) concerning COVID-19, like operational guidance for maintaining essential health services during an outbreak: interim guidance of 2020. These guidelines emphasize the need to establish which health services and care must continue to be given to patients not infected with COVID. In order to reduce the risk of the health system collapsing, the guidelines suggest that many services can either be postponed or halted. Also, governments must establish a triage system so as to effectively manage the flow of patients in cases involving both Covid-

infected and non-Covid infected patients. If offering basic services is threatened, it is necessary to identify those health services which should be given priority and these are: prevention of infectious diseases, particularly vaccination; reproductive health including care during pregnancy and giving birth; care for vulnerable groups such as newborns and the elderly; chronic illnesses and mental health conditions; continuity of inpatient therapy; emergency health conditions and basic diagnostic medical imaging, laboratory services, and blood bank services. Priority must be given to preventing infectious diseases, preventing morbidity and mortality of mothers and children, preventing acute worsening of chronic conditions by continuing treatment, and emergency cases. In conclusion, it is necessary to revise strategies for managing health services according to how the epidemic progresses. Also, during the pandemic, the Council of Europe, in their guidance to governments on respecting human rights, democracy and the rule of law as the relevant standards in the area of human rights, in particular emphasizes the right of access to health care and demands from governments to pay particular attention to vulnerable groups to enable consistency in peoples' right to equitable access to health care (Respecting democracy, rule of law and human rights in the framework of the COVID-19 sanitary crisis: 2020: 4).

3 Access to Healthcare in Croatia during the COVID-19 pandemic

3.1 Legal framework for regulating the right to access protection of health in Croatia

Although the right to protection of health as one of the subjective human rights is not recognized by all countries (Shupitskaya, 2020: 218), the Republic of Croatia has accepted it and ratified all European documents protecting that right, and all multilateral UN agreements which protect the right to health of certain groups, for example, the Convention on the Rights of Persons with Disability as well as Convention on the Rights of Children, among others. In the Croatian legal system, the right to health is encompassed within economic, social, and cultural rights and the Constitution of the Republic of Croatia (hereinafter: CRC) guarantees everyone the right to protection of health pursuant to law (Article 59 CRC). The CRC also enshrines the rights to equality and protection from discrimination based on race, color of skin, gender, language, religion, political or other beliefs, national or social

origin, property, birth, education, social position, or other characteristics (Article 14 CRC). Normative regulation of the right to health is contained in health regulations, primarily in the Health Care Act (hereinafter: HCA) and in the Patient Rights Protection Act (hereinafter: PRPA). The HCA defines healthcare coverage as a system of social, group and individual measures, services and activities for the preservation and advancement of health, prevention of disease, early detection of illness, timely treatment and healthcare, rehabilitation, and palliative care (Article 4 HCA). Every person is guaranteed the right to obtain the highest possible level of health pursuant to provisions in the law which regulate compulsory health insurance. Additionally, in emergency situations everyone is obliged to provide first aid to the injured or ill person and enable them to receive access to urgent medical assistance (Article 5 HCA). Healthcare coverage for the population of the Republic of Croatia is also implemented under the principle of accessibility, utilizing a holistic approach in the primary protection of health, and as a specialized approach in specialized-consultative and hospital protection of health (Article 13 HCA). Pursuant to Article 17 HCA, the principle of a holistic approach to primary protection of health is ensured by the implementation of united measures to improve health and prevent disease and by treatment, healthcare, rehabilitation, and palliative care.

The PRPA defines a patient as any person, sick or healthy, who seeks or who is provided with certain measures or services in the aim of preserving or improving health, preventing disease, treatment or healthcare and rehabilitation (Article 1 PRPA). The principle of accessibility to the protection of patient rights implies equal opportunity to protection of health for all patients in the Republic of Croatia (Article 5 PRPA). The Law on Medical Practice (hereinafter: LMP) prescribes the duties owed by doctors to their patients. Among the duties are the duty to implement necessary measures of prevention, diagnosis, treatment, that is, rehabilitation of all persons for whom s/he is the chosen doctor or who are referred to him/her for healthcare. In emergencies[3] s/he is obliged to provide help to every sick person without delay and is obliged to take on other sick patients according to the level of medical priority or according to the waiting list (Article 18 LMP). Achieving the highest possible level of health in Croatia is linked to compulsory health insurance, which ensures all insured patients' rights and obligations according to the principles

[3] States of emergency are those which because of failure to give medical help, could result in permanent harmful consequences to the health (disability) or life of sick person.

of mutuality, solidarity and equality (Compulsory Health Insurance Act, hereinafter: CHIA, Article 3 sec. 2).[4] The right to protection of health stemming from Croatia's compulsory health insurance system includes the right to the primary protection of health, specialist-consultative protection of health, hospital protection of health and the right to medicines (Article 18 sec. 1 CHIA). The stated medical services in the form of diagnostic and therapy procedures are ensured under equal conditions for all insured persons (Article 19 sec. 1 CHIA). This achieved accessibility, or so-called medical basket, encompasses a huge variety of health services. However, an unequal allocation of resources stemming from anti-epidemic measures instituted due to the pandemic, has formed a barrier to the availability of these services given that the largest number of resources (hospital and medical staff) are in central Croatia and its metropolis (OECD/European Observatory on Health Systems and Policies, 2019: 16). Consequently, many Croatians residing in rural areas are, unfortunately, and as a practical matter, unable to avail themselves of the full medical basket of services they are entitled to.

3.2 Anti-epidemic measures prescribed for primary protection of health and hospitalization in Croatia during the COVID-19 pandemic

The new SARS-CoV-2 corona virus was confirmed for the first time in Croatia 25 February 2020. Despite the existence of a normative framework for regulating access to protection of health, there was no appropriate legal framework in existence for preventing the spread of this kind of infectious disease. Therefore, immediately, normatively greater powers were given to the Civil Protection Headquarters of the Republic of Croatia (hereinafter: Headquarters) for reaching decisions and directions to protect the life and health of citizens, the environment and so on. The Headquarters makes decisions in cooperation with both the Ministry of Health (hereinafter: MH) and the Croatian Institute of Public Health, under direct government supervision. The Headquarters reaches decisions according to the principles of effectiveness and rationality so that it can constitutionally guarantee that the rights and freedoms if its citizens at every moment only be limited as much as is necessary and appropriate to the nature of the need for limitation thereof. (Interpellation of the Republic of Croatia's government's work, 2020: 5). At the very

[4] Overall population is given universal protection of health coverage and there is no possibility to exit the system of permanent health insurance (OECD/European Observatory on Health Systems and Policies, 2019: 9).

beginning of the declaration of the epidemic in the Republic of Croatia (11 March 2020), the Crisis Committee MH[5] instituted *Instructions for action in providing protection of health in primary protection of health and out of hospital specialist-consultative protection of health in order to prevent the spread of COVID-19 disease* (hereinafter: Instructions).[6] The Instructions stipulate the maximum possible reduction of patient presence in surgeries and the performance of only urgent and unpostponable check-ups and procedures for the duration of the pandemic. In order to reduce postponable or unnecessary surgery visits, and to create the possibility of issuing referrals and patient advice from home, the Instructions recommended that telecommunication with patients be improved and increased via telecommunication channels or other forms of communication with patients (landline, mobile phone, SMS, videoconferencing, e-mail and so on). In the area of family medicine, the Instructions recommended that for all palliative and chronic patients, treatment be given at home or in aged care facilities via increased home visits by family doctors, healthcare, and physical therapy at home via mobile palliative team visits. The Instructions also recommended that the number of in-person visits with chronic patients not suffering from any acute health symptoms be reduced via patient supervision utilizing telephone or other forms of communication. The Instructions pointed out the possibility of using the issuing A5 referrals[7] for consultation with doctors in the hospital system, without patient attendance. Additionally, the Instructions recommended that physical therapy services be postponed while gynecological procedures, including checkups for pregnant women, and for women with oncological diseases, should continue for the duration of the epidemic in line with the professional assessments of the gynecologist. Also, the same general measures to prevent the spread of infection were instructed for the activities of occupational and sports medicine, palliative care, and for the patronage activity. The organization of additional, specifically separate surgeries for examining patients suspected of coronavirus infection, were ordered to be opened 24 hours around the clock. All healthcare workers in the network of

[5] Crisis Committee of MH manages and coordinates the work of health institutions and private health workers in crisis situations (Article 196 of HCA).

[6] Immediately before that the Minister of Health passed the Decision on Measures of Mobilization, organization and allocation of work and hours of work, change of place and conditions of work of health institutions and their staff and private health workers in the public health service network and the use of medical-technological equipment and other means.

[7] Novelties in the Croatian health system are a special kind of referral with which the patient's state of health via the internet appointments are made with family doctor and specialist. In that way, if not necessary, the patient doesn't need to go to the hospital, and wait for specialist tests.

public health services were obliged to participate.[8] Taking into consideration the reduced scope of the work of hospital institutions and hospital capacity which were freed up when needed for the hospitalization of coronavirus infected patients, the Instructions conclusively recommended that only life-endangered patients, patients suffering from unpostponable health conditions and oncology patients be sent for check-ups or hospitalization.

Concerning hospital treatment of persons not infected with COVID-19, but that were nevertheless a priority either because of urgent and unpostponable medical care needs or because they were oncology patients, an adaptation of hospital capacity according to patient demands (i.e., triage system) was carried out. The availability of health workers was achieved by temporarily allocating them from their parent health institution to health institutions in need (Interpellation on government activity, 2020: 9, hereinafter: Interpellation). Also, a reorganization of hospital institutions was carried out in order to treat patients infected with COVID-19, while still maintaining optimal hospital capacity in other vital areas, particularly in treating cancer and cardiovascular diseases as the most common causes of mortal illness in the Croatian population. After the so-called *lock down* (March and April 2020), regular hospital activity slowly returned. Priority was given to reestablishing new appointments for those patients who had appointments cancelled and for setting appointment for those patients on waiting lists, activating all areas of hospital services, and carrying out urgent and unpostponable interventions (Interpellation, 2020: 12). However, in the face of the so-called second wave of the pandemic, the MH on 26 October 2020, instructed hospital health institutions on the need to reduce underused capacities and activities in specialist-consultative activities while continuing to organize care for priority groups, in particular oncology patients. Accordingly, Clinical Hospital Dubrava was the primary respiratory-intensive care center for the City of Zagreb, while the rest of the hospital resources were employed for treating patients not infected with the Coronavirus. However, the MH on 2 November 2020, ordered that Clinical Hospital Dubrava ensure (temporarily) only health care for COVID-19-infected persons and that patients who had appointments for specialist-consultative medical examinations and hospital treatment be sent to their chosen general practitioner primary healthcare provider (hereinafter: GP) for further appropriate

[8] It is the obligation of all health workers to participate in preventing and combatting infectious disease (Article 64 HCA).

treatment, and that medical examinations and treatment be arranged in other medical institutions in Zagreb (Interpellation, 2020: 14). At the same time, the MH in November 2020, enacted the *Decision on establishment and activity of the Call Center* to ensure protection of health for oncological patients in hospital health institutions during the COVID-19 pandemic.[9]

3.3 Possible harmful health consequences for non-Covid patients due to limited access to protection of health during the COVID-19 pandemic

Even though it is generally accepted that the priority is treating COVID-19 infected patients, in all countries the issue has been raised that, at the same time, it is important to ensure that other non-infected persons suffering from other serious health conditions receive appropriate treatment. Consider the situation in the United Kingdom for example. Because of the non-obligatory nature of the National Health Service[10] recommendations in the United Kingdom, patients at high risk of cancer were faced with delayed treatment. Because of the redistribution of health workers, the UK's national cancer prevention program, which annually uncovered approximately five percent of all diagnosed cancers, was halted (Jones et al. 2020: 748). The number of high-risk patients whom doctors referred for diagnosis of possible cancer fell by approximately 70 percent in Scotland and Northern Ireland (Montel et al. 2020: 230). Research is already pointing that the inaccessibility to basic diagnostic tests during the pandemic will result in a large number of additional mortalities from cancers of the breast, intestine, lung and esophagus over a period of one to five years and will, regardless of diagnostic tests diagnosing 40 percent of patients with cancer, necessitate the need for urgent measures to abate the indirect effects of the COVID-19 pandemic on patients with cancer (Maringe et al., 2020: 1033). In the Netherlands, which provides its citizens with general access to basic health services via a primary care doctor serving as the „gatekeeper" to secondary

[9] Article 197 HCA gives the Minister of Health powers to in cases of extraordinary circumstances, catastrophes and epidemics of greater scope to undertake measures and activities such as mobilization, organization and allocation of work and hours of work, change to the place and conditions of work of certain health institutions and their workers and of private health workers in the network of public health services for the duration of such circumstances.

[10] The state has delegated its responsibility to ensure everyone access to health services and institutions to local health funds, which has created inequity in accessing health coverage among regions (Montel et al. 2020: 230).

care, data reveal a significant fall in the number of diagnosed cancers[11] compared to the pre-COVID-19 pandemic period (see Dinmohamed et al., 2020: 750). Furthermore, a global problem is limited access to the protection of women's health. In response to COVID-19, in March 2020, WHO issued interim guidance for maintaining essential services during an outbreak, which included advice to prioritize services related to reproductive health and to make efforts to avert maternal and child mortality and morbidity. But COVID-19 has a "devastating" effect on women and girls (Cousins, 2020: 301).[12] One of the biggest challenges facing women under the present COVID-19 lockdown is their inability to seek medical advice from a primary healthcare practitioner (Mobasheri, 2021).

The situation is almost identical in Croatia, where disruptions to primary and secondary healthcare coverage will certainly have medium- to long-term consequences both in terms of worsening certain chronic health conditions and delaying the diagnosis of new illnesses because diagnostic-therapy procedures were either delayed or postponed. According to data from the reports of the Ombudsman in 2020 (hereinafter: Ombudsman's report), due to the priority of implementing anti-epidemic measures, patient visits to healthcare institutions have been reduced and only emergency and unpostponable medical examinations and procedures have been carried out. Although doctors have opened other channels of communication with patients (for example, e-mail, mobile phone, SMS messages), accessibility continues to be reduced and it was often impossible to talk with a doctor. Citizens had greatly reduced access to healthcare services which were not related to COVID, so considerably fewer people used healthcare coverage from family doctors during April 2020 than in April 2019.[13] Comparing the first nine months of 2019 and 2020, the number of patient visits to family doctors decreased by 21.49 percent (Ombudsman's report, 2021: 27). The epidemic and the resulting mobilization of the healthcare system in March and April 2020 have caused significant disruptions and problems because a large number of medical examinations, diagnostic procedures

[11] In the time of closing systems and reorganizing health systems in Holland 35 percent fewer tumors were diagnosed and 80 percent fewer skin tumors (Vrdoljak, 2020).

[12] United Nations Population Fund (UNFPA) predicts there could be up to 7 million unintended pregnancies worldwide because of the crisis and losing access to contraception, with potentially thousands of deaths from unsafe abortions and complicated births due to inadequate access to emergency care. Also, Cousins added that "the skyrocketing of gender-based violence", which is a "pandemic within a pandemic "(Cousins, 2020).

[13] And the number of contacts with health cover was significantly reduced during March, April and May in 2020 compared to the same period in 2019 (Korištenje primarne zdravstvene zaštite u vrijeme epidemije COVID-19 u Republici Hrvatskoj, 2020).

and operations were cancelled or postponed. As a consequence of instructing the hospital system to increase capacities for isolation and intensive care treatment of COVID patients and for urgent non-COVID patients from March to May 2020, the number of chronically ill patients whose checkups and therapy were postponed, as well as those whose already scheduled appointment dates for first specialist medical examinations and operations were cancelled, has increased.[14] Given that certain hospitals in October 2020 were transformed primarily into places for treating COVID-19 patients, all persons with appointments for specialist medical examinations or hospital treatment unrelated to COVID-19, were transferred to other hospitals or referred to their chosen GP. However, with their chosen GP, they could only get new appointment times in other hospitals, so they waited again as they did the first time they were placed on the waiting list. Also, in Croatia in 2020, the number of first specialist appointments was drastically reduced (55,007 in comparison to 129,356 in 2019, that is, by 42 percent), as well as for check-ups (280,599 compared to 515,590 in 2019 that is, by 54.4 percent). Despite this, the average daily wait remained the same for both types of medical examinations, which led to a significant increase on the waiting lists (Ombudsman's report, 2021: 30). In Croatia in April 2021, the MH and Coordinator of Croatian Family Medicine (KoHOM) polemicized on the „great dysfunctionality "in primary protection of health by „directing non-urgent cases to Emergency Hospital Departments." The MH warned of the overburdening of emergency departments because „patients most often came on their own initiative, because their doctors were not available". From the KoHOM it was shown that this was due to the fact that certain patients wait for months or a year for some diagnostic tests, revealing the fact that family doctors in 2020 directed all of 2.8 percent of patients, or two patients weekly, to emergency departments.[15]

[14] To assist clinicians in reaching difficult decisions which include risk of advancing the disease or complications of relevant clinical societies and associations in many countries have issued directions, for example, the recommendation that at the height of the pandemic only emergent operations continue, such as perforated or actively bleeding cancers while the English NHS recommended hospitals to give preference to patients in need of emergency operations in the next 24 to 72 hours (Richard et al., 2020: 2).

[15] Patients themselves go to Emergency Departments because their doctors are not available (Beroš, 2021).

The situation with oncology patients warrants special discussion. In the last report from the five-year-long global report of malignant disease survivors, published in the journal entitled The Lancet in March 2018, Croatia, according to the results of treatment of malignant diseases, was at the bottom of the list of European countries (Kelemenić-Dražin et al., 2020: 299). Oncology is a multidisciplinary profession. Consequently, the quality care of patients depends not only upon internal and radiation oncologists but also on a range of other activities, which unfortunately have been reduced and placed under great strain as a result of the pandemic. Surgery functioned for some time only at the level of absolute emergency (Pleština, 2021: 46). The number of patients treated in medical units of Croatian hospitals due to malignant diseases during March and April 2020 was 2,048 less than in the same period in 2019.[16] Also, the implementation of preventative national programs for early detection of cancer of the breast, cervical spine, and large intestine, as leading causes of death in Croatia, were temporarily halted. Programs for cancer screening stopped, even when they were in place, as there was no appropriate response from the general population (Pleština, 2021: 47). In Croatia, an analysis was conducted regarding the number of patients that were newly diagnosed as having breast cancer during *lock down*. In the first two weeks of May in 2020, the number of newly diagnosed women undergoing biopsy and carcinoma diagnosis was almost 50 percent less than in the first two weeks in 2019. The possible consequences of late tumor diagnosis, as with postponed check-ups, are worse treatment outcomes and illness in advanced stages (Vrdoljak, 2020).[17] During the pandemic, cancer survivors were again lost in transition (Koczwara, 2020). Treatment simply cannot be halted. Stopping and/or postponing screening for early detection of cancer sends both the public and primary healthcare the message that cancer can wait (Jones et al. 2020: 748). The dire consequences of this message can be found in the data from the Croatian State Department of Statistics. The data shows that in April 2021, 30.7 percent more people died than in the five-year period (2015-2019) for the same month and that the number of dead in the period from March 2020 to April 2021 increased by 11.7 percent as compared to the five-year period before the epidemic

[16] Due to clinical hospital Dubrava in Zagreb being designated as a COVID-19 center, there was a fall in operations, dependent on the type of cancer up to 70%. Retrieved from: http://hr.n1info.com/Vijesti/a575707/Udar-pandemije-na-oboljele-od-raka (15 March 2020).

[17] Referrals in the women's health service in Croatia are most frequently issued for diagnostic tests. 58.3 percent of the total number of referrals pertain to referrals to the clinical cytology, medical microbiology and parasitology, and the medical biochemistry service (Hrvatski zavod za javno zdravstvo 2020: 16).

was declared.[18] The spike in the number of mortality cases can be attributed to three causes 1) death from coronavirus itself, 2) death caused from non-diagnosed coronavirus and 3) death as a consequence of disruptions in the regular activities of the healthcare system stemming from the pandemic (Rudež, 2021).

In Croatia, for a variety of objective and subjective reasons, there has been too much discrimination in the area of healthcare. The pandemic has had the greatest adverse health impact on the lives of people who already were disadvantaged. This primarily relates to the most vulnerable – the poor, the elderly, people with disability, the ill, the homeless, migrants, persons at risk of social exclusion and others who are marginalized in society generally (Štefančić, 2020: 38). Increased flexibility in the approach to health coverage, while admittedly benefitting many, also has the opposite impact on the marginalized people in society (Jones et al., 2020: 748). Consider, for example, the anti-epidemic measure of forbidding accompaniment. This measure either prevented or hindered many patients, such as the elderly, oncological patients, patients with poor mobility, patients that live at locations distant from treatment centers, etc. from access to necessary healthcare. The elderly living in poverty have limited access to health-care services due to lack of cyber knowledge or because they live in closed spaces such as aged care homes and already face aged discrimination ('ageism'). Many cannot drive, have no one to drive them, and often lack public transport. Therefore, they need particular protection of rights (*Kornfeld-Matte, 2020).*[19] Forbidding movement out of one's place of residence additionally hindered access to healthcare services for the many living in rural areas. Doctors in private practice mainly continued their line of business under epidemic conditions, but their services were not available to poorer citizens. Under such circumstances, some citizens were left without adequate medical coverage, and the chronically ill or those whose health requires prompt, regular and timely care were particularly vulnerable. For many, if not practically all such patients, proper care can only take place in person; on line consultations, even when possible, generally are not practical. This situation can be considered as discrimination based on economic status in accessing health coverage (Ombudsman's report, 2021: 38).

[18] Government Department of Statistics of the Republic of Croatia Effects of the COVID-19 disease pandemic on social- economic- indicators.

[19] On the discrimination of the elderly during the pandemic see den Exter, 2020.

4 Legal implications of harmful health consequences due to inaccessibility to protection of health during the COVID-19 pandemic-force majeure/ultimate necessity/state of emergency?

Harmful health consequences resulting from the violation of the right to health during the COVID-19 pandemic has a bearing upon various forms of liability of health workers and/or institutions and government in criminal, compensation, disciplinary and administrative law. Under COVID-19 pandemic conditions, all laws applicable under normal conditions are still in force (D'Aloja et al., 2020). It has been estimated that patients could suffer significant harm in 50 percent of various cases because of either postponed or cancelled medical procedures (Montel et al., 2020: 230). The health care system, during certain periods, was exclusively available only for emergency cases for persons not infected with COVID-19. Therefore, the impact of the pandemic on the application of law in the sense of its legal qualification can certainly be observed with respect to the issue of liability for harmful consequences to health. The impossibility of accessing protection of health for persons not infected with COVID-19 affects the application of the civil law, both with respect to contracts and to liability for harm which could result from the pandemic (Barbić, 2021: 9). Also, limiting access to healthcare, either due to its complete postponement or its delay, which in turn has deleterious effects on the results of medical treatment, raises the possibility of criminal liability on behalf of both healthcare workers and/or healthcare institutions. This is the case because the right to health in Croatia is also protected by the Criminal Code (hereinafter: CC), within the criminal acts against people's health. A serious question then that arises is how best to legally deal with the fact that in Croatia in 2020 there were 26.2 percent or 338 fewer patients recorded to have undergone surgery for lung or bronchial cancer (Drljača, 2021). Another dilemma is how the legal system should deal with situations where patients, because of the pandemic and the ensuing limitations and restrictions on receiving timely medical care, suffered and will suffer harmful consequences because they had not been tested, received a diagnosis, or received appropriate therapy or a necessary medical operation.

The answers to these important questions must be considered in the context of certain objective facts. The COVID-19 pandemic represents a huge burden on the health system. The dangerous effects of the epidemic on healthcare were also caused by the shortage of health workers, health workers that were overloaded and at risk of infection, while the wider scale of the epidemic demanded increased engagement of the health system to care for patients infected with COVID-19. Even though health systems were not completely prepared for this dangerous disease, doctors and other health workers were on the front line battling the virus with maximum exposure to the risk of infection. Wards and intensive care units were full, with overworked and exhausted health workers under extreme stress due to overtime, difficult working conditions and constant fear of infection. Work under increased physical, psychological and emotional strains of that stress, for some doctors and other medical staff, resulted in *burnout* (British Medical Association-BMA survey COVID-19 tracker survey February 2021). In a real sense, all medical workers could be considered as victims of the COVID-19 pandemic. According to data from FNOMCeO (Federazione Nazionale degli Ordini dei Medici Chirurghi e degli Odontoiari), which kept a list of doctors who died during the COVID-19 epidemic, from the beginning of the epidemic to 31. 03. 2021, in Italy a total of 358 doctors died.[20] In Serbia, from March 2020 to 16 March 2021, from the consequences of the corona virus, 92 doctors, 12 dentists and two pharmacists or a total of 106 medical workers have died. At the same time, 33 in Albania, and two doctors in Croatia, died (Anđelković, 2021).

Which harmful consequences can occur as a result of the COVID-19 pandemic in public and private law? For example, if fulfillment of contractual obligations is rendered impossible, many will certainly point to the doctrines of force majeure, ultimate necessity, or extraordinary circumstances. What effect does the COVID-19 pandemic have on the application of the law on compensation? According to the general rules of contractual law, strict liability for damages exists if cumulatively the general presumptions of that liability are fulfilled: the subjects of liability for damages (tort-feasor and injured party), the tort, damage, causal connection, illegality objectively, and in the case of subjective liability for damage, tort-feasor fault (Baretić, 2021: 103). In the application of all these presumptions of liability of

[20] Accessible: https://portale.fnomceo.it/elenco-dei-medici-caduti-nel-corso-dellepidemia-di-covid-19/ (4 June 2021).

physical and legal entities for harm to health, and because of the inability to access the protection of health, several difficulties emerge: an increased difficulty to prove damages and the causal connection between those damages and the limited access to healthcare due to the anti-epidemic measures that were instituted; establishing the injured party's contribution to their own damage; and, damage onset as a result of force majeure.

Liability for damages in medicine is possible when there is a breach of the rules in the medical profession, that is, due to so-called medical error in diagnosis and therapy. Most errors in medicine stem from diagnostic procedures, as reaching a diagnosis is an extremely important procedure. Doctors have a duty to establish the nature of the disease based on the known symptoms. Doctor error can result both as a result of an inaccurate diagnosis and also a missed diagnosis. Even though diagnosing cancer is a priority in the health system, in the context of the COVID-19 crisis, preventive screening for early diagnosis was postponed, and the diagnosis of cancer on the basis of symptoms became necessary and very important. However, for family doctors, the COVID-19 pandemic impacted on all aspects of their „normal "work. They had reduced availability of in-office appointments for patients and often had to resort to telephone triage and video consultations. Therefore, the COVID-19 pandemic negatively impacted the ability to diagnose patients with cancer because, for example, the lack of screening and hence the detection and identification of such cases (Jones et al., 2020: 748). Telephone or online consultations are quite simply insufficient and cannot replace personal consultations and in-office procedures (Koczwara, 2020: 1).[21] To ensure additional staffing capacity, equipment and space for intensive care of COVID-19 infected persons, the capacities for cancer operations were reduced. Moreover, the patients themselves infected with COVID-19 after hospital admission for an operation reluctantly consented. (Richards et al. 2020: 2).

[21] Shows that the greatest problem for young doctors is that they too often neglect having conversations with their patients. A fundamental principle guiding good practices of doctor behavior is that in the process of diagnosis and treatment it is critically important for doctors to have direct conversations with the patient and to take his/her anamnesis. As opposed to just relying on technology, the patient's history of health with his/her fundamental physical tests (inspection, palpitations, percussion etc.) lead to correct diagnosis in 70 percent of cases (Kirch et al., 1996).

In compensation law there is a special category of liability for failing to offer emergency care. In short, persons who, without risking danger to themselves, fail to provide assistance to someone whose life was in danger, are answerable for the damage caused by that omission, if that damage under the circumstances should have been predicted.[22] Therefore, a civil claim in damages for failure to provide emergency treatment exists when a health worker fails to fulfil the legal obligation to provide medical assistance in emergency situations. At the same time, this failure can also constitute a criminal act, punishable under Article 183 of the CC.[23]

Can the COVID-19 pandemic in civil, commercial, and administrative law be considered as *vis maior*? It's a notorious fact that the inception of this infectious disease is, in fact, an extraordinary event which was difficult to foresee (at least in its scope and breadth) and/or prevent and consequently the question arises as to whether the damages related to anti-epidemic measures came about from *vis maior* which liberates various actors from liability (in situations where they otherwise would be exposed to liability for their actions/inactions) for damage occurred (Staničić, 2021: 134). The generally accepted view is that *vis maior* exonerates government from liability for that damage and also from that arising from the epidemic as a direct consequence from it - illness, permanent effects from the disease and death are really consequences of that force majeure and the State cannot be held responsible for that kind of damage (*Ibid*). However, other forms of damage directly linked to the epidemic, but which also occur because of the government's anti-epidemic measures or the implementation thereof, at least according to Staničić, cannot be considered as damage by force majeure and in such cases, at least in principle, there is State liability for such damage if government prescribed conditions are fulfilled (*Ibid.*). In the case of State liability for damage occurring from anti-epidemic measures, certainly the biggest hurdle the claimant faces would be in proving causation, namely, that the damage in fact was caused due to illegal and incorrect government activities (Staničić, 2021: 146). Also, no general principle exists on the basis of which it can be established that the COVID-19 pandemic represents a *force majeure* and justification for the non-fulfillment of contractual obligations

[22] Article 1082 sec. 1 pursuant to sec. 2 from Law on Obligations if equity requires it, the court can liberate such a person from damages.

[23] Doctor of medicine, doctor of dental medicine or other health worker who without postponement does not offer medical help to person in need of such help due to danger of harmful consequences to his/her health or life will be sentenced to prison for three years.

which could lead to liability in damages (Cesarec Nöthig & Štaba, 2020). In the Croatian legal system, *force majeure* is defined in Article 343 of the Law on Obligations as "*an external, unpredictable, and extraordinary event which cannot be prevented, removed or avoided in which case the defendant would be liberated from liability*".[24]

Criminal law recognizes a concept known as the collision of duties. Simply stated, this means fulfilling one duty is only possible by breaching another. If a doctor can only help one of several seriously injured persons, is the doctor's omission towards those not given treatment illegal? (Horvatić et al. 2017: 59). Did the omission concern a specific situation of necessity related to *conflicting duties* and *force majeure* (*vis maior*)? Force majeure is certainly a form of coercion and provides a generally recognized foundational, legal basis for excluding criminal liability.[25] In Croatia, as a fundamental concept of criminal law, absolute force (*vis absoluta*) excludes the existence of free will (Novoselec & Martinović, 2019: 149), while for compulsive force (*vis compulsiva*) or threat which could have been resisted, the principles of effect of ultimate necessity are applied (Horvatić et al., 2017: 11). From the provision on justifying necessity in German criminal law (§ 34), it can be concluded that, avoiding the greater danger legalizes accepting the lesser evil. This means priority treatment (i.e., triage) of those most in acute need allows choice and emergency medical assistance is the valid criterion for choice (Zimmermann, 2020). Hence, the doctor can provide medical assistance firstly to the more seriously injured person while in the case of the less seriously injured, there is justifiable necessity for not immediately providing medical treatment to that patient. This doctrine therefore excuses liability for what otherwise would constitute the criminal act of omission to offer medical assistance in emergency situations as set forth in Article 183 of the CC (Novoselec & Martinović, 2019: 148). However, in situations involving conflicting duties of the same level of medical seriousness, for example, if help must be offered to multiple persons suffering medical conditions with comparable degrees of seriousness, the

[24] The concept of force majeure in European law can be confirmed by the opinion of independent lawyers Jääskinen in the case before the Court of Justice of the EU C-509/11: if there is no special legal definition of force majeure in the latest regulations, the condition for recognizing the case of force majeure is that external circumstances to which the legal subjects refer have consequences which are so doubtless and unavoidable that the parties to the case cannot carry out their obligations. The concept of force majeure must be interpreted as unusual and unpredictable circumstances out of control of the mentioned subjects, the consequences of which cannot be avoided despite duty of care (Cesarec Nöthig & Štaba, 2020).

[25] So, the Dutch criminal law regulates that the person who is coerced by the force majeure is not responsible for the criminal act (Article 40 Criminal Code of Netherlands). Coercion exists when the doctor is faced with conflict of duties.

opinion to save one person to the exclusion of others prevails and the doctor is free to choose (Kurtović Mišić et al., 2021: 429).[26]

Because of this, should Croatia nevertheless declare a state of emergency because of a great natural disaster, i.e., the epidemic, and then would the various medical dilemmas as posed above constitute events caused by force majeure (Staničić, 2021: 135)? The CRC concept of „great natural disasters "is only mentioned in one place in the context of the possibility of external limitations of human rights and freedoms and does not offer a definition of the very concept, leaving this task for further formulation by the legislator (Gardašević, 2021: 37). The Law on Abating and Removing Natural Disasters of 2019 does not apply to situations involving epidemic/pandemic infectious diseases such as COVID-19 since under this Law this is not considered to be a "natural disaster". However an epidemic could be classified as a natural disaster by interpreting the general clause from Article 3 sec. 2 of that law as „*another occurrence of such scope which depending on local circumstances, causes significant disorders to the lives of people in a certain area* ". The opposite view holds that considering COVID-19 a *de facto* natural disaster would not be consistent with the valid legislative framework (Staničić, 2021: 135). In Judgment U-I-1372/2020 of 14 September 2020 (with five separate opinions), the Constitutional Court of the Republic of Croatia discussed the fact that Croatia is one of the countries that did not declare a state of emergency due to the COVID-19 pandemic.

The "hidden victims" of COVID-19 are the many persons who, because for various reasons, could not access medical care, had to postpone further treatment, had to cancel operations, were screened for cancer in a belated fashion, suffered of will suffer in the future, damage to their health. The Croatian judiciary has yet to rule on whether the COVID-19 pandemic fits within the scope of the traditional force majeure/ultimate necessity doctrines such that these hidden victims will be denied claims for damages. Foreign judicatures will soon hold the first hearings on the lawsuit commenced by a widow of a skier who is seeking payment of 100,000 Euros compensation from the Austrian government for the death of her husband allegedly caused by complications from contracting COVID-19 while skiing in Austria.[27] In

[26] For supralegal necessity see Novoselec & Martinović, 2019: 148.

[27] about the matter concerns lawsuits for damages filed by plaintiffs from Austria and Germany, asserting that the Austrian government was too slow to react to the emergence of coronavirus in Ischgl and other ski resorts. More

theory, there are stances according to which, in cases when governmental powers justifiably believe in the existence of an epidemic threat, courts tend to welcome all government measures which were not violent, or not instituted in the bad faith, or not used as a pretext for discrimination (or not discriminatory per se), even when later such measures are confirmed to have been erroneous. Certain healthcare workers, members of state and local health bodies and municipalities themselves are not responsible for mistaken assessments and the actions taken in light of such assessments, so long as they act both in good faith and within the scope of their powers (Underhill, 2020: 62). However, judicatures can shape some areas of pandemic response such as, for example an effective compensation system for medical carelessness, a system of consumer protection or reaction to intentional/negligent transmission and spread of infectious diseases (Underhill, 2020: 63).

5 Conclusion

All Member States of the Council of Europe, in order to protect people's lives and health, undertook either the same or similar anti-epidemic measures, which were only differentiated by their scope and intensity. Organizing access to protection of health in the Republic of Croatia during the COVID-19 pandemic was also harmonized with WHO directions and key actions in the strategy of managing health resources under pandemic conditions: creating a list of basic health services, those which can be postponed or re-directed, reducing and limiting the number of face-to-face meetings with those offering these health services, repurposing health institutions, reallocating health staff capacity, forming services for acute care in certain emergency units, and by redirecting the management of chronic illnesses by maintaining a medicine supply chain. Even though it is indisputable that the possibility of accessing protection of health for uninfected persons directly depends on the duration of the epidemic, that is, on the increase of those infected with COVID-19, nevertheless, even under these difficult pandemic conditions, the State remains obliged to ensure its citizens their rights to the availability and quality of health services. The limitations and restrictions that the Croatian government has

than 6.000 people from 45 countries confirmed that they became infected at winter resorts, mostly in Ischgl, where tourists continued to ski and party while the coronavirus was spreading. All lawsuits were collected by the Austrian Association of Consumer Rights VSV. Lawsuits included various consequences of infection, from death to permanent damage to health. Source: *Jutarnji list* dated 4 May 2021.

placed on access to protection of health during the COVID-19 pandemic largely mirror those imposed by governments of other countries. We may also conclude that Croatia has not entirely suspended the right to protection of health, although it has significantly limited the right in order to ensure both the sustainable and quality functioning of the health system. However, the key is to strike an appropriate balance between not overburdening the Croatian health system as a whole (to the ultimate detriment of all) while at the same time ensuring the continuity of the functioning of the health system in treating illnesses other than those stemming from COVID-19.

Unfortunately, due to breaches in this continuity resulting from the COVID-19 pandemic, negative effects are unavoidable and will impact uninfected persons who already are or will become sick with other serious illnesses (primarily cancer, diabetes, chronic respiratory and cardiovascular disease). Much medical research has already confirmed that an increase in the number of ill, as well as in the number of deaths due to cancer and other serious illnesses, which could have been detected earlier, is to be expected. Can both current and future negative health outcomes be minimized by better management of pandemic crisis policy? Can continuity, despite reductions in resources, be ensured through the establishment of a regime to treat key chronic illnesses? In addition to these admittedly difficult questions, a special problem rests with the discriminatory effect that certain anti-epidemic measures has on the already-marginalized members of the society; the elderly, the poor, the homebound, the chronically ill, those residing in rural areas, etc. The reality is that such citizens do not have equal quality and accessibility of protection of health in ordinary times. The unfortunate fact is that delivery of healthcare to citizens is not always symmetric. Anti-epidemic measures enacted by governments only serve to heighten these problems, so that adequate (even basic) healthcare becomes even more difficult to access; that is, more asymmetrical than in normal times.

A part of both the general and professional public still believe that the adopted measures were disproportional and that basic human rights were unnecessarily infringed upon. Many such persons filed constitutional lawsuits. Regardless of the fact that the Constitutional Court of the Republic of Croatia dismissed all of them, the public has issued a clarion call to the Croatian government that certain legislative amendments and other actions should be made so as to be better prepared for similar

crises that will occur in the future. The institutional model of combatting the pandemic sparked in Croatia a range of forms of resistance in opposition to the legitimacy and diversity of anti-epidemic measures, the legitimacy of the very Headquarters itself and its framework of powers, the necessity of declaring state of emergency and so on.

After more than a year since the beginning of the pandemic, initial unknowns about the virus and non-existence of medicines and vaccines for COVID-19, it is time to propose certain improvements. The duration and harmful consequences of the pandemic give justifiable cause for solutions *de lege ferenda* which could in future times help prevent limiting the right to access to medical protection. From today's perspective, it can be concluded that the overall organization of the health system could be better, because that organization was subject to numerous regulations, decisions, and recommendations of various bodies of executive power. Also, measures limiting access to medical protection, for example, epidemiological measures of self-isolation, must at every moment be proportionate to the dangers to health and adapt to the current epidemiological situation, particularly in situations in which there are tests for the disease or infection as milder measures. It is not only reasonable but logical that the standard assessments of proportionality limiting human rights and freedoms in the second, third or further 'wave' of the pandemic were stricter than at the beginning of the pandemic, especially because vaccines did not exist at the outset of the crisis and because treatments for those infected also were sparce. Therefore, attention should be given to the legislative regulation of criteria and the way the epidemiologic measure of self-isolation is enforced, because, apart from prohibiting freedom of movement, it also unjustifiably denied the right to legal protection before independent courts. In the Republic of Croatia, there are currently various and often contradictory legal and sublegal regulations which regulate the area of combatting the spread of the infectious coronavirus. Legislative determination of limiting fundamental human rights, including the right to health, is necessary. Given that freedoms and rights can only be limited by law in order to protect the freedom, rights and health of others, it would be necessary to clearly and precisely dissolve the existing clash (antinomy) of regulations of powers of various government and public bodies and the constituents and supervision of the work of the Headquarters. The government of the Republic of Croatia has a Scientific Council as its advisory body, but the work of this council could be more transparent.

In order to reduce the harmful effects of not having access to medical treatment, the government should in the future recognize the right to welfare payments for not only self-employed workers affected by the measures, but also at least for those at risk and vulnerable/marginalized groups for example, the elderly and oncological patients, as compensation for obtaining medication and medical examinations and checkups privately. Given that all persons contribute to the compulsory medical insurance scheme, in the long term those rights should be regulated by law. Furthermore, although the CC enables the legislator to legally limit certain freedoms and rights in order to protect health, even without explicitly declaring a state of emergency, one could consider constitutional changes in the form of more precisely defining the application of Articles 16 and 17, that is, clarifying the criteria for those circumstances that warrant activation of a state of emergency.

Finally, the legal implications of violating the right to health due to inaccessibility or limited access to health protection, and which resulted in harmful consequences to people's health or in their death, is yet to be the subject of discussion in legal theory and court practice.

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