

SYMPOSIUM ON THE EXPERIENCES IN THE IMPLEMENTATION OF HEALTHCARE REFORM IN CROATIA

The symposium with international participation entitled Experiences in the Implementation of Healthcare Reform in the Republic of Croatia took place on October 27-29, 2009 at Plitvice Lakes. The Symposium was organized by the Ministry of Health and Social Welfare of the Republic of Croatia and Andrija Štampar School of Public Health, School of Medicine, University of Zagreb, under the personal auspices of Jadranka Kosor, Prime Minister. The plan of implementation and results acquired to date in healthcare reform in the Republic of Croatia were presented at the conference, with special reference to the novel concept of healthcare financing, the role and responsibilities of local government and self-government, reform of the primary and hospital healthcare system, reform of emergency medical service, and role of education and training of healthcare workers.

In Croatia, healthcare reform that involves the overall healthcare system with all its segments has been in effect since 2008. The concept and objective set by Darko Milinović, MD, Minister of Health and Social Welfare, as the reform initiator and his team, is to bring the patient-insuree in the center of service, to improve the population health, the level of healthcare and healthcare indicators, and to upgrade the healthcare system. The financial healthcare indicators recorded in mid-2008 made healthcare reform absolutely necessary.

In his reform program, Minister of Health and Social Welfare describes the reform objectives as follows: to achieve fixed healthcare allocations from the budget for the next three years; to ensure social sensitivity, accessibility and solidarity; to find new financing sources; to enable reduction in the rate of contribution for healthcare in order to stimulate the national economy competitiveness; to abolish the monopoly of the Croatian Institute of Health Insurance (CIHI); and to contribute to the reinforcement of in-

dividual responsibility, decentralization and fighting corruption.

A considerable part of the Symposium program was dedicated to the reform of hospital healthcare, with the introductory lecture on this topic held by academician Zvonko Kusić as head of the Task Force for Monitoring Healthcare Reform in Hospital and Specialist-Consultation Healthcare (Task Force). Academician Zvonko Kusić is head of the University Department of Oncology and Nuclear Medicine, Sestre milosrdnice University Hospital in Zagreb and has great experience at leading positions in healthcare system as Director of Sestre milosrdnice University Hospital for several years, Vice-President of the National Health Council of the Republic of Croatia, and member or head of many commissions and councils. Besides academician Kusić, members of the Task Force were: Head Doctor Marcel Majsec, MD, MS; Professor Herman Haller, MD, PhD; Professor Vlado Jukić, MD, PhD; Velibor Drakulić, MD; Mirela Crnić, MBA; and Dario Nakić, MD. The Task Force held a number of sessions and was in charge of monitoring the course of reform in hospital healthcare.

At the beginning of his presentation, academician Kusić gave a survey of difficulties found in the healthcare system before the reform was launched. First of all, there were no multiple sources of healthcare system financing, along with a very high level of payroll allocation of as much as 15 percent, which was the highest rate in Europe. In addition, a great deal of insurees did not pay their contribution for health insurance, thus the debt grew at a rate of 2 billion HRK *per* year. In the public, healthcare system was perceived as a corrupted setting, while being burdened with the lack of physicians (in part due to the decreased popularity of the profession and their drain to other, better paid services), lack of hospital standardization, inappropriate or nonexistent computerization, and unsound

relations between primary healthcare and specialist-consultation healthcare. He gave an overview of the hospital financing pattern, showing that hospital limits in the 2008-2009 period were at first increased and then reduced, however, recession was met in relatively good conditions owing to the increased hospital budgets. The main changes in the model of hospital system financing referred to the new method of accounting and paying treatment costs through the introduction of the Croatian version of the internationally relevant Diagnosis Related Groups (DRG) system, in Croatia named Diagnostic Therapeutic Groups (DTG); changes in the method of payment for intensive treatment through the introduction of the SAPS II score; and introduction of the new system of accounting patient payment. DRG as a valid method of hospital service accounting was introduced at the beginning of 2009, with the aim to stimulate and reward efficient hospital work; to ensure equity for all hospitals and patients; to reach equal footing on determining hospital limits; to stimulate hospitals to reduce expenditures but not on the account of patients and efficacious treatment; easier management and cost control; transparency on making contracts on healthcare; hospital stay reduction; stimulating day hospitals; and introduction of high-quality hospital computerization. DRG system includes and enables development of clinical protocols and guidelines, control of hospital admission justifiability and proper planning of discharge from the hospital. DRG system implies a number of financial risks in case of misunderstanding, but also a more efficient internal and external control and introduction of hospital categorization. The introduction of DRG system resulted in some favorable indicators such as reduced treatment time, increased patient turnover, integration of medical procedures and financial indicators, increased mean cost of treatment and cost of treatment *per* day, however, still at a relatively low index of case complexity (probably due to inadequate coding); to say the truth, in the conditions of recession, the presented financial gain cannot result in increased hospital budgets. Academician Kusić referred to difficulties encountered in DRG implementation, such as incompleteness of the system, its relying on the physicians' responsibility, DRG coding and filling out is not administrative but medical task, some diagnoses are missing in the system, one-day hospitalization, patient transfer from one hospital to another, etc.

After long time, hospital revenues increased with the introduction of the new system of patient payments through additional insurance and cash payments.

Reduction of waiting lists for diagnostic and operative procedures through introduction of the National Waiting Lists and hospital units for central patient appointments was one of the major goals of the reform. This step was expected to upgrade the quality and accessibility of healthcare, transparency and reduction of waiting lists, while the pilot project of patient appointment for hospital procedures from primary healthcare facilities has been under way. Since the introduction of the National Waiting List, waiting lists have been reduced by 30%-50% by patient referral to other institutions and stimulation of shift work and weekend work (greatest reductions were recorded in the waiting lists for computed tomography, magnetic resonance imaging, heart ultrasonography, and hip arthroplasty); waiting lists for the most common operative procedures are shorter than those in industrialized West European countries. The project of central appointment has pointed to some difficulties, especially in terms of inadequate hospital computerization, which requires considerable financial resources, the need of uniform software for central appointments at the national level, and the need of networking all healthcare institutions in Croatia. In addition, there are problems related to the lack of professionals and premises; patient failure to present for appointed examination, thus leaving the appointment unutilized; increase in the requests for diagnostic procedures; and excessive patient pressure for examinations and treatment at large centers (university hospitals and university hospital centers), which has resulted in paradoxical increase in waiting lists.

Considering waiting lists, there is enough room for additional improvements. Computerization of the healthcare system should be completed and the project of e-appointments should be introduced, where family physician will make electronic appointments for diagnostic and therapeutic procedures for his patients. The role of family physician should be reinforced and additionally motivated, providing them with a higher level of independence, in order for ever more patients to be taken due care at family physician offices, without the need to go to hospitals for (unnecessary) specialist examinations and procedures. Numerous analyses have shown the accessibility of specialist healthcare

to be too broad and primary care physicians have the key role in solving this problem. Many examinations are unnecessary and unjustified, or are unnecessarily repeated, thus posing great financial burden upon the system. In order to rationalize diagnostic procedures, it is necessary to establish and use the guidelines and protocols set by professional medical societies for the diagnosis of the currently most common diseases.

Another step to improve the healthcare system was the foundation of the Agency for Quality and Accreditation in Healthcare (Agency). Upgrading the quality and accessibility of healthcare at the resources available is the best support to the healthcare reform. The main objectives of the Agency are development of national standards in the diagnosis and treatment, and hospital evaluation through categorization and accreditations. Accreditations will be allocated for a 4-year period and will stimulate additional contracts (revenues) with insurance companies. The whole procedure and process should lead to improved patient safety and healthcare quality. The Agency will have a department for development and assessment of healthcare technologies, which will be in charge of following the development of medical technology and its clinical use in the national conditions. It is well known that the continuous increase in the price of medical technology, i.e. novel diagnostic and therapeutic devices, cannot be covered through payroll allocations for healthcare even by high-industrialized countries.

The international tenders for very expensive drugs have significantly improved (rationalized) the system of purchase and utilization of this group of drugs. The list of these drugs includes drugs used in the treatment of some malignant, neurologic, infectious and genetic diseases.

Successful healthcare reform definitely requires updating of medical equipment, which is necessary for high-quality diagnosis and therapy. Therefore, purchase of capital equipment is under way, for the first time at the national level.

In spite of the sophisticated and modern equipment, healthcare system relies on manpower. Great steps forward have also been made in this segment, e.g., compulsory payment of trainees and approving specific residencies-sub residencies. It is known that the number of physicians *per* the population of Croatia

is too low according to the European Union criteria, while the age structure of the specialists is very unfavorable. In order to overcome these problems, many residencies have been approved. Yet, many fields suffer from the lack of specialists, such as pediatrics, gynecology, anesthesiology, surgery, internal medicine, etc. The popularity of medical profession among the young has declined due to negative social atmosphere, unfavorable attitudes of the public and mass media towards physicians, and inadequate payment for the very responsible job. It has resulted in rather low interest for the demanding medical profession among the young and generally reduced interest in the profession.

In conclusion, academician Kusić emphasized that, despite global recession and its impact on local circumstances, and organizational difficulties, there were some favorable indicators of the hospital system reform. There are challenges to manage in terms of maintaining financial stability of the system in the conditions of increased costs of treatment and gross national product decrease, medical equipment updating, retaining high-quality professionals within the national healthcare system, and implementation of complete system computerization. He also pointed to the importance of fostering initial enthusiasm in the face of difficulties that cannot be avoided in the process of settling such a large system as healthcare system.

Besides Croatian professionals involved in the planning and implementation of the healthcare reform, participation of renowned international guests, health ministers of the neighboring countries and representatives of respective international organizations, contributed greatly to the importance of the Symposium. Health ministers from the following countries were present at the Symposium: Slovenia, Austria, Hungary, Bosnia and Herzegovina, Serbia, Macedonia, Albania and Montenegro, and representatives of the World Health Organization and World Bank.

All the respectful guests took part in the panel discussion on the topic of maintaining healthcare quality in the time of crisis and experiencing crisis as a problem or challenge for healthcare system, having additionally enriched the quality of the Symposium.

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