



Health Reform Monitor

Origins and effects of the 2014–2016 national strategy for palliative care in Croatia[☆]



Karmen Lončarek^{a,*}, Aleksandar Džakula^b, Renata Mardetko^c, Anna Sagan^d

^a Department of Palliative Medicine, Rijeka University Hospital Center, Krešimirova 42, 51000 Rijeka, Croatia

^b Department of Social Medicine and Organization of Health Care, Andrija Štampar School of Public Health, University of Zagreb School of Medicine, Rockefellerova 3, 10000 Zagreb, Croatia

^c Centre for Coordination of Palliative Care of the City of Zagreb, Preradovičeva 17/1, 10000 Zagreb, Croatia

^d European Observatory on Health Systems and Policies, LSE Health and Social Care, Sheffield Street, London WC2A 2AE, United Kingdom

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ABSTRACT

Croatia is among the last countries in Europe to develop organized palliative care at the national level. Real changes in this area started after the parliamentary elections in 2011 and culminated in the 2013 adoption of the Strategic Plan for Palliative Care Development 2014–2016. The National Board for Palliative Care (NBPC), appointed by the Ministry of Health, was in charge of creating a scalable palliative care model and national guidelines. The Board drew on experiences from both neighbouring countries with similar societies and/or health care models (Bosnia and Herzegovina, Poland) and an international leader in palliative care (United Kingdom). It recognised that provision of palliative care in Croatia, thus far based on volunteering and isolated enthusiastic activities, needed to be improved through professionalization, regulation, and organized development. A variety of policy measures was used to implement these changes, including the introduction of professional guidelines and new payment models. The development of new palliative care structures and services significantly increased the number of patients who could access palliative care, from around 1–2% of patients needing such care in 2011 to 20–35% in 2014. It also ensured the provision of more appropriate services at each point of the palliative care pathway. The Strategy was extended for the 2017–2020 period.

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1. Background

The Croatian health care system is funded predominantly from public sources, which account for over 80% of total spending on health [1]. The remainder is covered by out-of-pocket payments. The Croatian Health Insurance Fund (CHIF) is the sole insurer in the mandatory health insurance system, and is the main purchaser of health care services [2]. Twenty-one counties manage primary and secondary health care facilities and own the latter. Private practices provide primary care, with the majority of them (over 70%) oper-

ating as ‘concessions’¹ in county owned health centres². Tertiary health care facilities are state-owned.

Although Croatia has recognized the right to palliative care as a legal right since 2003 (in the 2003 amendment of the Health Care Act), not much has been done until 2011 to develop formal palliative care and to assure access to it (Table 1). The provision of end-of-life care largely relied on the few enthusiastic individuals and groups and their volunteering activities [3]. Within the statutory health care system, palliative care was mainly provided at primary care level and was limited to four palliative care support teams (three paid teams in Rijeka and one in Pula) and four (unpaid) volunteer hospice teams in Zagreb) [4,5]. According to estimates, annually, between 26,000 and 46,000 patients nearing the end of

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* Corresponding author at: Zavod za palijativnu medicinu KBC Rijeka, Krešimirova 42, 51000 Rijeka, Croatia.

E-mail addresses: karmen.loncarek@uniri.hr (K. Lončarek), adzakula@snz.hr (A. Džakula), renata.mardetko@dzck.hr (R. Mardetko), a.sagan@lse.ac.uk (A. Sagan).

¹ A ‘concession’ in the context of the Croatian health system is a model of public–private partnership (PPP), whereby county governments organize tenders for the provision of primary health care services for the chosen types of primary care specialties, depending on county-specific needs.

² According to the legislation, there must be at least one primary health centre per county and at least three in the city of Zagreb.

Table 1
Key developments in palliative care in Croatia until 2016.

Year	Key developments
1994	The Croatian Society for Hospice/Palliative Care is founded
2000	The Croatian Association on Pain Treatment (Croatian Medical Association) is founded
2002	The Regional Hospice Centre in Zagreb is opened by the Croatian Association of Hospice Friends
	David Oliver from Wisdom Hospice in Rochester, England, is elected as visiting Professor of the Medical Faculty, University of Zagreb
2003	Kathleen Foley from the Open Society Institute, New York, is elected as guest Professor of the Medical Faculty, University of Zagreb
2008	The first mobile palliative care team established in Rijeka
2011	Amendments to the Health Care Act enable provision of palliative care at the secondary level of care
	Adoption of the National Health Care Strategy 2012–2020
2012	The first coordination centre for palliative care established in Zagreb
	Ministry of Health appoints the National Board for Palliative Care (NBPC)
2013	Adoption of the Strategic Plan for Palliative Care Development 2014–2016
	First hospice opened in Rijeka (14 beds)
2014	The Ministry of Health appoints the Board for the Implementation of the National Strategy of Palliative Care
	Palliative wards established in ten hospitals
2015	The first department of palliative medicine established at the University Hospital Rijeka
2016	The Croatian programme of integrated palliative care included into the EU-funded Horizon2020 project SELFIE 2020

Source: Authors based on Centeno et al. [4], Ministry of Health of Republic of Croatia [9], and SELFIE 2020 Work Package 2 Report for Croatia [10].

life require some form of palliative care in Croatia [6]. In 2011, less than 500 patients, or at most 2% of patients needing palliative care had access to such care [7], demonstrating the high level of unmet need in this area.

Limited public funding (the result of the poor economic situation), the inadequate regulation and training in the area of palliative care, and the lack of a strategic plan were all responsible for hampering the development of a formal palliative care program. The lack of a strategic plan could be mostly explained by the instability of the leadership, i.e. the frequent changes in personnel, particularly in the Ministry of Health [8].

Since 2010, growing number of civic initiatives and public awareness activities have drawn media attention to the inadequacy of palliative care [11–13]. Following the parliamentary elections in 2011, the new government appointed the National Board for Palliative Care (NBPC) and officially recognized the need for a national strategy for palliative care [5]. Between 2012 and late 2013, the Strategic Plan for Palliative Care 2014–2016 was developed, putting forward a new model of ‘integrated palliative care’ to be implemented on the national scale. This model incorporated palliative care into all levels of care (from primary to tertiary), and into the wider welfare system.

In this paper, we analyze the policy process that led to the implementation of the Strategic Plan for Palliative Care 2014–2016 (Section 3), as well as its content (Section 4), and offer preliminary insights into its implementation (Section 5). Finally, we offer lessons for other countries (Section 6).

2. Health policy processes

It was not until the 2011 parliamentary elections that real developments in the field of palliative care had started. The first step was the adoption of the National Health Care Strategy 2012–2020 [14]. The Strategy recognized the limitations of the existing legal framework for palliative care set out in the 2003 amendment of the Health Care Act. The Act (Art. 83) envisioned the provision of palliative care mostly as a service provided alongside primary care [15]: “A palliative care institution is a health care institution that provides home visits by interdisciplinary teams (doctor, nurse, physiotherapist, and social worker trained in working with dying patients), a pain clinic, and a day care centre.” In accordance with the Act,

county-owned primary health centers are responsible for organizing the provision of palliative care in their area, if it is not otherwise organized [15].

In 2012, the Ministry of Health asked experts in the field of health care organization from the Zagreb School of Medicine to review existing models of palliative care organization and delivery in Croatia. The purpose was the development of a national palliative health care strategy, and a care model that could be scaled nationally. The White Paper on the Standards and Norms for Hospice and Palliative Care in Europe, written by the European Association for Palliative Care (EAPC) [16,17], and the Recommendation REC(2003)24 of the Committee of Ministers of the Council of Europe to the member states on the organization of palliative care [18], served as a framework for the new model. In January 2012, experts started a series of workshops to agree on the recommended way forward. This was the beginning of a comprehensive public consultation process that lasted two years, and culminated in the adoption of the Strategic Plan for Palliative Care 2014–2016 in December of 2013.

The key findings of this exercise, summarized in the guidelines for the Strategic Plan were as follows: there is great need for the development of palliative care; some models of good practice can already be found in Croatia, but they need further improvement; there are resources in the health care and social welfare sectors that could be used for the provision of palliative care, but they are insufficient, or inappropriately utilized. The recommendations to the Ministry of Health were the following: first, palliative care should be included among the priorities for the health care system; and, second, palliative care should be developed as an integral part of the existing health care model, rather than as a parallel system based on volunteering and other informal activities.

In February 2012, the Ministry of Health appointed the NBPC. The Board consisted of twelve experts in palliative care, public health, social welfare, health insurance, and medical education. Its tasks were to analyze the existing organization and provision of palliative care; identify barriers to achieving international standards in palliative care; create guidelines for a new model of palliative care provision; and, finally, to systematize all the above in a strategic plan [12].

The Board drew on experiences from two neighbouring countries with similar societies and/or health care models (Bosnia and

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