ANALYSIS OF PRIMARY HEALTHCARE REFORM IN CROATIA: THE RELEVANCE OF POLICY DESIGN

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Abstract

The thesis analyzes health care reforms in Croatia, with a special focus on primary health care reforms. Thesis aims to answer a question: Why are the overall expenditures in health increasing, and quality of the services decreasing, even though the planned reforms envisioned cost reduction and higher quality of provided health services?

Question is examined through the policy design lens and to answer the research question, theory of historical institutionalism and incremental institutional change is applied. Thesis uses qualitative methods, namely the analysis of the secondary data and semi-structured interviews with relevant stakeholders of Croatian health policy conducted by the author.

The findings show that policy design influences policy outcomes. Reforms were designed in a path dependent way, thus achieving impact that was different from what was expected. Two main challenges in policy making can be observed. Firstly, continuous decline in PHC funding means that expenses of secondary and tertiary levels of care continue to increase. Secondly, reforms often create new policies without eliminating previous policies. As a result, incoherent health policy making can be observed.

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Key words: primary health care, reform, policy design, layering, institutionalism, Croatia

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List of Abbreviations

CHIF	Croatian Health Insurance Fund
DTPs	Diagnostic and Therapeutic Procedures
GDP	Gross Domestic Product
EU	European Union
HC	Health Care
PHC	Primary Health Care
WHO	World Health Organization

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Introduction

According to World Bank data in the period between 1990 and 2010, Croatia prolonged life expectancy at birth by four years, exceeding that of other countries in the region (World Bank, 2014). This health outcome and life expectancy improvement is attributed to the effective primary health care (Keglević et al, 2014). Primary health care (PHC) is defined by the World Health Organization as:

> "essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination" (WHO, 1978: 2).

Overall, health care (HC) is usually divided among three levels of care: primary, secondary referring to hospital specialist care, and tertiary referring to therapeutic care in clinics. However, PHC is the most commonly used part of health care services and is usually the first contact with the health system of a country. Not only does the PHC focus on prevention and early diagnosis, but also leads to lower expenditures in the overall health system if implemented effectively. That is due to the crucial "gatekeeper" role that PHC plays in access to specialist services in the health system (Greenfield et al, 2016).

The importance of PHC has also been recognized by the international organizations. It began with the Alma Ata declaration from 1978 adopted at the International Conference on Primary Health Care organized by the WHO. The declaration's goal "Health for All" stated the need for immediate attention when it comes to implementation of PHC throughout the world (WHO, 1978). The need emerged from the growing inequality of health conditions among and within countries. The declaration clearly states that PHC is a crucial link to achieving the visionary goal of justly accessible and effective health care. The declaration lays out basic principles that should be transferred into the national health policies. These include the

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principles of accessibility, public participation, along with the use of appropriate technology and multisectoral collaboration to address positive health outcomes issue (WHO, 1978).

The importance of PHC plays a crucial role in the society through its goal of maintaining a healthy population. PHC strives to act through preventive care and coordinated activities among different sectors of care in order to achieve best results. As the PHC is locally present, it manages to encompass more people, thus improving the citizen's access to (HC). In addition, wide range of services is available at the PHC level. Moreover, PHC enables continuous support and health supervision of the population.

The topic of PHC is worth investigating as without PHC, it would be harder for countries to promote health, resulting in a lower access to HC. PHC serves a "gatekeeping" role to the remaining of the HC system and reduces cost on the other levels of care. Some experts say that each dollar invested in the PHC saves 10 dollars on the other levels of care.[1] Thus, it is surprising to observe constant budget reduction when it comes to the PHC in the Croatian context. Croatian HC consists of three levels: primary, secondary referring to care provided in hospitals, and tertiary level referring to specialized consultative health care. More importantly, the cost reduction is happening simultaneously with the increase in expenditure for secondary and tertiary levels of HC. The question of care provision has been on the agenda for two decades. Series of reforms were implemented in order to improve the HC in Croatia. Main objective of the reforms undertaken was to reduce the cost of the overall HC, combined with the HC quality improvement.

However, from 2013 to 2017, the The Euro Health Consumer Index shows a constant decline in the patients' perceived quality of medical services. Moreover, according to the data from the Eurostat, in the past 25 years, the overall expenditure on HC as a percentage of gross

[1] Dagmar Radin – interview by the author (Zagreb, Croatia, April 25, 2018)

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domestic product (GDP) increased from 6% to above 8%. The numbers show an increase of the budget allocated to secondary and tertiary HC, whereas the PHC budget has been in constant decline.

Since the reforms were meant to raise the quality and decrease the expenses of HC, the puzzling question that remains is: Why are the overall expenditures in health increasing, and quality of the services decreasing, even though the planned reforms envisioned cost reduction and higher quality of provided health services? The thesis particularly focuses on PHC for two reasons. Firstly, PHC is the only level of care in the Croatian context, which experiences decline in total HC expenditures share. Secondly, according to the experts and literature, PHC is crucial for cost reduction on other levels of care. The thesis aims to answer this question through the policy design lens, and the use of qualitative methods, namely the analysis of the secondary data and semi-structured interviews conducted with relevant stakeholders of Croatian health policy. Methodology and research design is discussed in the third Chapter in further detail.

The thesis is divided in four chapters. First Chapter provides relevant literature review. Scholarly articles written on the HC topic are looked upon. Literature review focuses on the articles that provide deeper understanding of the Croatian context. The second Chapter provides a theoretical framework for the analysis elaborates on the historical institutionalism and introduces four different modes of incremental policy change. This Chapter ends with some theoretical implications for the Croatian context. The third Chapter demonstrates and justifies the method used to answer the research question. The fourth Chapter of this thesis is an empirical chapter. After the overview of HC provision legal framework and the overview of PHC reforms undertaken since 1993 in Croatia, the fourth Chapter analyzes the data on expenses and quality. The Chapter finishes with the PHC analysis while simultaneously

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connecting to the theory of institutional change. Finally, the thesis concludes with the summary of the findings and implications.

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Chapter 1: Literature Review

Most of the literature on primary health care (PHC) arises from the aforementioned principles of comprehensiveness, continuity, and availability given in the Alma Ata declaration. Some scholars evaluate the implementation of the declaration principles using case studies of various countries, regardless of their economic performance, geographical position or political power (De Maeseneer, 2007; Labonte et al, 2008; Aday et al., 1980; Tarimo and Webster, 1994). For instance, Labonte et al. (2008) use case studies to evaluate how each country implements the comprehensive approach to PHC from Alma Ata trying to see how the political context influences PHC (Labonte et al, 2008). Other scholars take a step further, as they not only evaluate the application of the declaration principles, but also analyze the tools for PHC assessment. In this sense, Fracolli et al. (2014) rightfully point to distinct meanings that PHC takes in different contexts. They carried out extensive research to understand what tools are used in different context to assess the PHC success. They conclude that there is a need for creation of more trustworthy academic sources in order to achieve desired evidence-based policy making (Fracolli et al., 2014).

Furthermore, a repeatedly addressed topic is the patient satisfaction with the provision of PHC. Even though some scholars contest the validity of the patient satisfaction as a concept (Williams, 1994), this is a popular topic among academics in the field of health policy. This is not surprising as the patient satisfaction can be seen as one of the PHC quality indicators. Moreover, it is of considerable interest to highlight what is measured when assessing patient satisfaction, since this concept is connected to the quality of service that is in the focus of this thesis. Cleary and McNeill (1988) reviewed an extensive theoretical and empirical work on patient satisfaction and found that the:

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> "most frequently measured are the personal aspects of care, the technical quality of care, accessibility and availability of care, continuity of care, patient convenience, physical setting, financial considerations, and efficacy" (Cleary and McNeill, 1988:3).

In addition, research from Campbell et al. (2001) explores in further detail concept of patient satisfaction showing how some characteristics of respondents can influence the results. Their research shows that age and ethnicity of the respondent can influence the respondent's assessments of the PHC, while there were no dissimilarities in assessment between gender groups (Campbell et al., 2001). This is crucial to keep in mind while using patient satisfaction surveys, discussed in more detail in the fourth Chapter.

Lastly, the literature rarely places a sole emphasis on policy aspect of the PHC reforms. Majority of academic work that is strictly policy oriented examines overall health reforms in different country contexts. However, only a few countries are analyzed through a policy lens. For instance, literature that focuses on Canada examines implementation of the PHC reform through analysis of both policy design and stakeholder mapping (Fooks, 2003). The Canadian case has been used as a best practice example connected with the policy transfer studies (Strumpf et al., 2012). Other countries, such as Slovenia, Spain, or Estonia, are analyzed more descriptively, by merely describing the policy changes (Svab and Alberth, 1999, Atun et al., 2006). It is important to note that in the health policy studies that focus on countries, the policy tools and focus change as the country context changes. For instance, articles related to Slovenia focus on organizational changes (Svab and Alberth, 1999), while those related to Estonia focus on innovative coordinated approach to health reform (Atun et al, 2006).

In terms of Croatian academia, health policy is a widely researched and represented topic. This representation corresponds to the high political significance Croatian citizens hold for accessible and high quality HC. Extensive work on health policy in the academic realm can be divided in three streams: medical, economic and political stream. The first stream is

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represented by the academics from the medical field. Their work mostly focuses on certain aspects of changes that happened with the reform and its impact on the performance of medical personnel, encompassing PHC as well. Mastilica (2005, 2010, and 2012) emerges as the most prominent author in this stream. His focus is mostly on democratic transition and how it influenced the health system and provision of PHC. In addition, many articles where he contributed examine the level of social protection and social inclusion, showing that solidarity is truly one of the main pillars of Croatian health system overall (Vončina et al, 2007; Jurlina-Alibegović et al., 2007; Mastilica, 2010).

Vončina, Džakula and Mastilica (2007) tried to tackle HC from a policy point of view, even providing policy recommendations. Their study scrutinized reforms from the 1990 to 2002, arguing that "implemented reforms over relied on acquiring additional financial resources into the funding system and on shifting health expenditure from public to private sources" (Vončina, Džakula and Mastilica, 2007: 3). They put a strong emphasis on how these changes influenced solidarity elements of the HC system. To the author's knowledge, analysis similar to the above explained, that focuses primarily on the PHC, has not yet been conducted in the Croatian context.

Moreover, multiple articles measure patient satisfaction with the provided care (Chen and Mastilica, 1998; Mastilica, 2012, Mastilica and Kušec, 2005). In sum, these articles highlight that in all given points of time, the majority of surveyed citizens were unsatisfied with the provided service. In detail, they were unsatisfied with the expenses, unequal access to care and the quality at all levels of HC.

From this analysis, one can see that PHC in Croatia has a lot of room for improvement. This premise was supported through a study by Keglević et al. (2014) which provided evidence showing that reforms which aimed to improve organization and reduce cost did not result in

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overall advancement and higher quality of the service. Research applied a sophisticated set of scores that, among other components, examined access, financing, regulation, communication and comprehensiveness of the PHC. It was concluded that Croatian PHC can be categorized as an "intermediate primary care country", meaning it scored just a little bit above average among 18 European countries (Keglević et al., 2014a: 3).

Finally, another valuable study by Keglević in this medical stream of the literature looks into the implications of the PHC privatization process that resulted in long waiting lists and shortages of PHC doctors (Keglević et al., 2014b). This research uses the routinely collected statistical data by the Croatian institutions, but opens up a question of data accuracy and calls attention to the accessibility problems. Additionally, the research emphasizes absence of quality indicators, which will be discussed further in the fourth, empirical chapter of this thesis.

The second stream of the literature is represented by the scholars focusing on the economic aspect of health polices, and particularly its financial sustainability (Bejaković, 2007; Kovač, 2013; Mihaljek, 2006, Vehovec, 2014). PHC is in this aspect mostly covered as a part of a greater health system. Mihaljek (2006) connects health reform to the pension system reform with the reasoning that HC reform outcomes are visible right after they are implemented. In contrast, pension system reform takes time to yield positive outcomes. In addition, he argues that pension system reform makes little sense without a comprehensive HC reform that ensures high quality service. His research covers macroeconomic and microeconomic aspects of health system. Whereas the macroeconomic aspects look into financial sustainability, impact of decentralization on financing and sources of financing, the microeconomic aspects refer to management of health facilities and regulation of private HC providers (Mihaljek, 2006).

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Furthermore, Kovač (2013) identifies the need for upcoming governments to pay off considerable health care debt while simultaneously not affecting fundamental components of solidarity and accessibility that are widely integrated in the social consciousness. These two aims are hard to reconcile. When it comes to PHC, Kovač underlines that PHC has a lower share in the overall health expenses, which was achieved through years of reforms that aimed at cost reduction. However, at the same time, it affected the PHC role in preventive services that are now decreasing (Kovač, 2013).

Similarly, Bejaković (2007) accentuates the importance of PHC when it comes to decreasing total expenses in health care. He proposed institutional framework enhancement in order for PHC to solve 80% of all cases. In that case, PHC would accomplish its role as a "gatekeeper" of the whole system. Moreover, while explaining the financial setting in Croatia, he also looks at ever lower accessibility of the health care and growing patient dissatisfaction with the quality and speed of service provision (Bejaković, 2007).

Third stream of research relates health policy to politics. This stream addresses the whole health system in relation to the political factors, such as corruption, differences among political systems, or ideological aspects of privatization. For example, Radin's (2003, 2013) main objective is to understand how phenomena such as corruption or EU membership influence health policy. She analyzes the extent to which corruption influences the trust in overall health system, the influence of the World Bank on the reforms in transitional economies, as well as the influence of the EU membership on the health care system (Radin, 2003, 2013). Furthermore, this stream of literature explores the debate of public *versus* private HC in the Western Balkans and how possible changes in the provision of health policy lead to cleavages in the society (Wallace et al., 2015).

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In the newest article, Radin (forthcoming) examines how health policies that were implemented over the past 25 years influenced the financing and the organizational structures of the HC in Croatia. The article analyzes the consequences of haphazard policy making when it comes to the HC. One of the most urgent issues that the article brings is the overwhelming emigration of medical workers since Croatia joined the EU. What is most important is that this article shows how HC reforms in Croatia were created randomly, all with the sole aim of cost reduction (Radin, forthcoming). Building on this, in the following chapters, this thesis will show how the same applies not only to HC, but also to the PHC more specifically.

In sum, as shown above, whereas the medical literature focuses on the performance of medical personnel and patient satisfaction, the economic stream focuses on HC financial sustainability, and the political stream relates political factors with the health provision. It is noticeable that there is no academic work that focuses on encompassing reform theories, rather than certain aspects of reforms. In detail, there is no analysis that connects policy design to understanding the impact of HC reforms in Croatia. Thus, my thesis will contribute to the literature and theory by exploring the health reform issues from a new point of view – by linking the health care reform, and its specific segment PHC, to prominent theoretical frameworks in public policy. In other words, this thesis focuses on explaining the reasons why HC reforms did not increase the quality of health services, with a special focus on PHC. To do that, the thesis provides a theoretical framework that existing research is devoid of. In more detail, with the aim to explain how policy change occurs over time, the theoretical framework that will be used focuses on historical institutionalism and policy layering which refers to multiple policies joined together, without abandoning either of them. As the literature review showed, the decrease in quality can be explained by the lack of implementation, medical staff emigration, or long waiting lists. However, in Croatia the problem is not in the implementation. Aforementioned organizational and financial issues are simply symptoms of

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a greater problem – poor policy design. Therefore, the thesis will focus on the design related reasons that are considered to be root causes of the HC problems. The thesis will argue that policy design affects policy outcomes. In particular, failure to achieve reform goals can be found in inadequate design, specifically in the lack of integration of various policy elements introduced through the reforms.

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Chapter 2: Theoretical Approach

To explain the ways in which policy design influences reforms, historical institutionalism will be used. This theory answers a question in what way do institutions change over time, and by doing so it further supplements question presented in this thesis: Why are the overall expenditures in health increasing, and quality of the services decreasing, even though the planned reforms envisioned cost reduction and higher quality of provided health services? Furthermore, to broaden the understanding of the institutional change, notion of policy layering will be examined in further detail. In order to explain this, following paragraphs will look at some of the main concepts established by the historical institutionalism, including the role of path dependency, critical junctures and ideas in the policy making which are all relevant to understand policy design.

2.1. Historical Institutionalism

Historical institutionalism is a prominent theoretical direction of the broader study of new institutionalism. To explain its importance and characteristics, it is needed to shortly give a brief overview of the development of the study of institutions. Firstly, in the end of nineteenth century study started with old institutionalism, characterized by legalism, structuralism, holism, historicism and emphasis on normative aspect of government (Peters, 1998). Furthermore, old institutionalism is defined as "configurative studies of different administrative, legal, and political structures" (Thelen and Steinmo, 1992). Old institutionalism indicated that formal institutions are the greatest contributor to the policy change. However, that approach was unable to fully explain complicated policy processes and policy outcomes. In the 1950s and the beginning of 1960s, a new approach was introduced: behavioralism. This theoretical paradigm turned to political behavior and informal relations between actors in order to explain complex reality (Pierson, 2015).

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As the behavioralism focused extensively on informal variables which could not explain the totality of institutional change – institutionalism revival occurred. During the 1980s James March and Johan Olsen laid the foundations for the new institutionalism in their article "*The New Institutionalism: Organizational Factors in Political Life".* They oppose behaviorist views that political processes are influenced exclusively by individual actions. On the contrary, they argue that policy outcomes are significantly influenced by institutions (March and Olsen, 1984). For them:

> "the new institutionalism emphasizes the relative autonomy of political institutions, possibilities for inefficiency in history, and the importance of symbolic action to an understanding of politics" (March and Olsen, 1984, 734).

Subsequently, new institutionalism theories divided their focus among four most commonly known streams: historical institutionalism, sociological institutionalism, rational choice and discursive institutionalism (Hall and Taylor, 1996, Schmidt, 2010). Although new institutionalism developed in various directions, this thesis will focus on historical institutionalism.

For the further clarification, it is needed to define what an institution is. It should be pointed out that institutions are a contested term in political science and there is no consensus in the academia about the definition of institution. The most commonly used definition of institution is the one given by Peter Hall, who says that an institution encompasses:

> "the formal rules, compliance procedures, and standard operating practices that structure the relationship between individuals in various units of the polity and economy" (Hall, 1986: 9).

The definition of an institution varies in its scope. For instance, Ikenberry, Mastanduno and Lake (1988) differentiate among three institutional levels: "specific characteristics of government institutions, (…) overarching structures of the state, (…) nations' normative

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social order" (Ikenberry, Mastanduno and Lake, 1988: 226). The first two levels have been widely accepted to describe institutions, but the latter has received a substantial amount of criticism. Critics argued that as a variable it does restrain the behavior, but those restrictions are not institutionalized (Thelen and Steinmo, 1992).

The above example depicts debate among the definition of the term institution. In sum, in historical institutionalism it is unquestionable that institutions shape that political actors behave and construct power relations in the society. According to Thelen and Steinmo (1992), institutions are an intermediary between the actor's behavior and the policy outcomes. However, there is a discrepancy in the scope of that term institution encompasses. The term can be defined in a narrower manner where it includes strictly imposed rules, such as rules regarding party systems, trade unions, elections or relations between legislative, executive and judicial branches of government. If defined in a broader sense, institutions can also include norms or informal practices in a society (Thelen and Steinmo, 1992). For both definitions, the reoccurring notion is that institutions are always considered to be a long-lasting part of society (Mahoney and Thelen, 2010).

As mentioned, institutions have a long-lasting context. In particular, time is an essential part of the historical institutionalism as a theory. The concept is based on the notion that:

> "the policy choices made when an institution is being formed, or when a policy is initiated, will have a continuing and largely determinate influence over the policy far into the future" (Peters, 1998: 63).

This is often illustrated by the term "path dependency" (Krasner, 1984). For Thelen (1999), path dependency means that "institutions continue to evolve in response to changing environmental conditions and ongoing political maneuvering but in ways that are constrained by past trajectories" (Thelen, 1999: 387). To simplify, once a policy has been formulated,

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institutions produce a model that will persist over time. In addition, not only those policies are difficult to reshape, but also the institutions themselves. A number of scholars who study political institutions have demonstrated how institutions tend not to change over time, even though the favorable circumstances have been met (Thelen, 1999; Lieberman, 2002).

Alongside path dependence, critical junctures are an equally significant feature of historical institutionalism. The term was first introduced while connecting patterns of labor incorporation with radical changes of the Latin American governments (Collier and Collier, 1991). Critical junctures refer to points in time that are "crucial founding moments of institutional formation that send countries along broadly different developmental paths" (Thelen, 1999: 387). For instance, great economic crisis can be considered a critical juncture. Path dependence and critical juncture are related concepts, both related to the equilibrium model of institutional change (Peters 1998: 84). This model assumes that institutional inertia lasts for a long time, while the critical junctures rarely occur. Critical junctures are the points in which exogenous shocks prompt an institutional change (Béland, 2009). Notably, the policy will evolve in a predetermined way, until a powerful force overcomes the inertia (Peters, 1998). That powerful source offers "relatively rare moment of political openness in the history of a given institution" (Capoccia, 2015: 173).

Lastly, the role of ideas will be examined when it comes to policy making. Evidently, policies are shaped by various interests, and people gather in diverse advocacy collations in order to influence the policy outcomes. The most successful ideas become institutionalized and embedded into public policies (Steinmo, 2007). For the overall understanding of institutional change it is important to grasp "which ideas win (…) why, and with what consequences for whom" (Lieberman, 2002: 700). Additionally, it is crucial to understand how certain ideas managed to stand out from numerous ideas in the public sphere and how they managed to influence the political behavior and the environment (Lieberman, 2002).

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After briefly summarizing the development of the study of institutions and outlining the main characteristics of historical institutionalism, following sections will examine in more detail incremental types of institutional change. Incrementalism is used to explain institutional change in a more stable setting. Thelen (2004) initiated the debate on this issue, without abandoning ideas of institutional change prompted by sudden and radical changes. She examined incremental change that occurs in a stable political environment over time. The following sections will examine four types of gradual institutional change: policy layering, policy conversion, policy drift and policy displacement, replacement or revision. This chapter will be concluded with theoretical implications relevant to the case of Croatian primary health care (PHC).

2.2. Incremental Institutional Change

More recent work on institutional change is focusing on incremental change (Hacker, 2004; Thelen, 2004, Béland, 2007, van der Heijden, 2010). This objective is contrasted to the great and sudden changes explored in the previous extensive work done on historical institutionalism. As discussed in the section above, that research was oriented towards the notion that policies are "sticky" and that institutions more or less lack the ability to change unless there is a great, monumental happening. Through the analysis of the literature that explores incremental institutional change, a lack of systematization is observable. Often some terms overlap in their meaning and vary from author to author. For instance, conversion and drift are used interchangeably. Hacker differentiates between four types of policy change: drift, conversion, layering and revision. The difference among them is in the difficulty to achieve goals and cost when it comes to replacement of the existing policy (Hacker, 2004). Four modes are depicted in the Table 1., followed by examples relevant for the Croatian case which is important for the analysis in Chapter 4. Policy modes are elaborated in the following sections.

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Barriers to Authoritative Policy Change	Barriers to Internal Policy Conversion: High	Barriers to Internal Policy Conversion: Low
High	**Drift** (Transformation of stable policy due to changing circumstances) *Example:* reducing the scope of accessibility to the health care system due to changes in financing schemes	**Conversion** (Internal adaptation of existing policy) *Example:* not observed in the Croatian case
Low	**Layering** (Creation of the new policy without elimination of old policy) *Example:* health care reform from the 1996; while transitioning to the privatized practices, some doctors held the public office simultaneously	**Revision/Displacement** (Replacement, or elimination of existing policy) *Example*: policy of territorial affiliation to the primary health care doctor; inherited from Yugoslavia; replaced with the 1993 reform

Table 1. Modes of policy change

Source: modified using the data retrieved from Hacker, 2004: 248.

Thelen (2004) identifies layering as a method of institutional change. According to her, layering marks:

"the grafting of new elements onto an otherwise stable institutional framework. Such amendments (...) can alter the overall trajectory of an institution's development" (Thelen, 2004: 35).

Policy layering occurs when policy alterations are joined consecutively to existing policy, without policy displacement. In other words, changes are combined, without integration or abolishment. It results in gradual modifications in both status and structure of a policy (Béland, 2007; van der Heijden, 2010).

Policy conversion refers to situation in which new stakeholders or new objectives change the institution fundamentally (Thelen, 2003). It can often be observed that some institutions or policies modify their original purpose, through actions of interested political stakeholders. Policy conversion cannot easily be noticed, thus Hacker, Pierson and Thelen (2015) refer to both drift and conversion as a "hidden faces of institutional change" (Hacker, Pierson and Thelen, 2015: 180).

Policy drift was introduced by Hacker (2004), as an additional concept to conversion and layering by Thelen (2004). It occurs while institutions are adapting to changes in socioeconomic context (Béland, 2009). In detail, policy drift is not characterized with the change of formal rules. On the contrary, "drift is defined as a failure of relevant decision makers to update formal rules when shifting circumstances change social effects of those rules" (Hacker, Pierson and Thelen, 2015: 181). Policy drift is common in advanced societies, as the "absence of updating existing institutions to changing circumstances" (van der Heijden, 2010: 5) and can be observed in many cases such as deteriorating purchase power of pensioners or decline in welfare benefits.

A situation in which one policy is completely replaced by the new policy is called policy displacement, replacement or revision. This type of change is troublesome to be found in real world (Petek, 2013). Other types of institutional change that were examined are prevailing.

2.3. Theory Implications

Historical institutionalism and incremental institutional change are connected, as they both explain how institutions change over time. The four policy modes on incremental institutional change build upon the theory of historical institutionalism. For the analysis of the Croatian context, two most relevant concepts from these theories are path dependency and policy layering.

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Theory of historical institutionalism connects the scale of current difficulties of the Croatian PHC with the incoherent decisions and reforms made in the past. In this manner, theory provides a meaningful insight to policy making in the Croatian context. Policies that try to tackle the provision of health care services are designed accordingly to the past experience – policies are path dependent. The reforms are poorly designed as they are embedded in inaccurate foundations of constant emphasis on cost reduction. Those policies are simply joint together, without eliminating the old policies.

Sticky policies can be observed in the Croatian case where institutions lack the ability to change considerably. In the Croatian example stakeholders are averse to implementing a structural reform of the unsustainable health system. One partial reason for this is in the lack of political will to change the PHC principles of solidarity and inclusivity on which the PHC is founded. Fourth, empirical Chapter of this thesis further analyzes modes of incremental institutional change and the concept of path dependency in the Croatian context.

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Chapter 3: Methodology and Research Design

The focus of this thesis is the series of the health care (HC) reforms implemented from 1993 onwards. In more detail, thesis examines success of HC reform by focusing on primary health care (PHC). The undertaken reforms had a task to ensure better organizational setting and reduce expenditures in health care. Additionally, goal was to ensure higher quality health service. However, according to the Legatum Prosperity Index (2017), Croatia is among the lower scoring countries of the European Union when it comes to health care. Moreover, Croatia has lower life expectancy than the average of the EU. The case of Croatia is chosen as a relevant example of a most recent EU member state that struggles with the extensive financial burden of health services to the public budget, migration of health care workers and decline in satisfaction with the quality of the service. All of the above mentioned problems seek an answer through a structural reform. Thus, it is interesting to observe in what way policy design of the reform influenced the policy outcomes in the Croatian context. In particular, it is observed how the design affected the costs and quality of HC. Additionally, learning from the Croatian case can help the countries in the region which are in the process of EU negotiations. Those countries can use the best practices adopted to avoid some common pitfalls.

This thesis is based on the qualitative research through the analysis of the secondary data, including academic articles, government documents, reform strategies and national health plans. Figure 1. depicts which key laws and strategies were examined. Data on health expenditure in Croatia is analyzed in order to depict trends in the expenses. Data is gathered from annually published statistic reports and Eurostat publications. Moreover, surveys on perceived quality of the health system conducted by scholars are taken into account.

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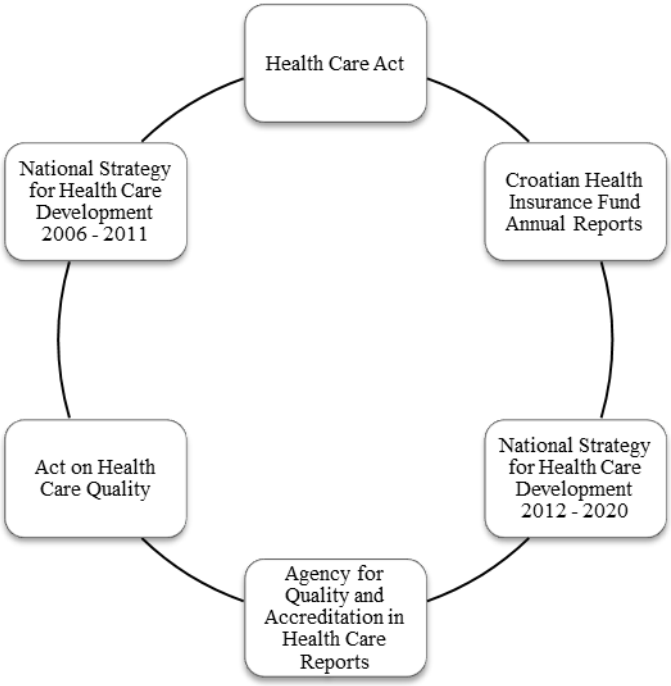
Figure 1. Key documents for the analysis



Furthermore, to gain understanding of ongoing problems, three semi-structured interviews were conducted. The semi-structured interviews were chosen as a method since they provide a deeper insight into health service provision process, consequences of the reforms on the daily tasks, and opinions of the relevant stakeholders. Semi-structured interviews allowed for flexibility as there was a sufficient amount of time for the respondents to ask follow up questions. Moreover, through the interview an outline was followed in order to cover all the topics of interest. In particular, outline for all three interviews covered two questions from each of the following four areas of interest: PHC challenges, impact of the reforms to the HC service provision, policy making process and respondents' input on possible improvements to the HC system. Emphasis was given to different areas of interest, depending on respondents' profession. While preparing for the interviews, the author followed the instructions given by Kvale (1996) on how to avoid biases, phrase questions in an understandable manner and steer the respondent, while allowing flexibility.

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Interviews were conducted in April 2018. Two interviews were conducted in person, while one was conducted through e-mail correspondence. Interviews were conducted with the following stakeholders: Dagmar Radin, the expert in the field of health policy, who further clarified institutional challenges of the primary health care in Croatia. Furthermore, primary health care practitioner Ksenija Miljević, provided a valuable insight in everyday issues that arise from a poorly designed policy and reforms that are not implemented coherently. Lastly, Hrvoje Beclin, the representative of the City of Zagreb Health Office, whose answers were used to resolve some uncertainties regarding the organizational aspects of the health policy in Croatia. The interviews will be used in the fourth Chapter in order to emphasize the challenges that Croatian PHC is facing.

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Chapter 4: Primary Health Care in Croatia

In the 20th century, with the remarkable work and efforts of a notable scholar Andrija Štampar, Croatia, then a part of Socialist Federal Republic of Yugoslavia was one of the leading countries when it comes to the orientation towards the Primary Health Care (PHC) and public health. His work focused on equal access to health services and emphasis on the preventive medicine. Exactly from this emphasis arises the achievement of Croatian universities becoming the first in the world to offer a specialization in PHC, back in 1960. In the following years of Yugoslavia, even though PHC was accumulating debt and lacked efficiency, it was not a subject to a serious reform. Since the 1990s and the changes to the political regime, PHC, as well as the Croatian health care (HC) in general, has been undergoing series of constant reforms. Those changes significantly affected the overall structure and organization of health care, hence influencing the quality of service provided (Keglević, Kovačić, and Pavleković, 2014).

This chapter analyzes the series of the primary health care reforms undertaken since Croatia gained its independence in 1991. This period is marked by frequent changes in the Health Care Act (HCA) and repeated proclamations of reformative measures. In order to grasp complexity of the HC system and its changes, Chapter provides overview of definitions and the legal context. Timeline of the undertaken reforms is connected to theoretical aspects of institutional change. Additionally, impact of the reforms is further stressed through analysis of the expenses and quality.

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4.1. Definitions

For the purpose of clarity, it is needed to define the provision of HC services in Croatia and the legal framework in which it is situated. Starting point for the definition is the Croatian Constitution, in which Article 59 determines the right of every individual to be granted health

protection (Croatian Constitution, 2013). Health care is further defined in HCA (Official Gazette, 154/2014) and Act on the Protection of the Rights of Patients (Official Gazette, 37/2008). HCA regulates principles and organizational aspects of the health care provision, which is in the interest of this thesis. On the contrary, the Act on Protection of the Rights of Patients regulates patients' rights, how to fulfill them and promote them. Although an important topic, this law will not be analyzed. Law is out of the thesis research scope as this thesis focuses on HC costs, quality improvement and provision of service in PHC.

HCA defines HC as a holistic set of services and activities that aim to preserve and improve health of the society. It encompasses prevention activities, early disease detection, timely treatment and rehabilitation (HCA, Article 2). According to this law, HC is divided into three levels: primary, secondary and tertiary. According to this division, as discussed earlier, PHC is oriented towards prevention, health improvement and house treatment. Secondary health care refers to specialist services in hospitals. Lastly, tertiary health care refers to health care activities that are based on detailed examination and therapy, usually carried out in clinics.

In order to fully achieve the aforementioned PHC aims of comprehensiveness, continuity, and availability, the financing aspect of the HC system is important and needs to be illustrated. Health care in Croatia can be financed from both private and public sources. In Croatia, there is a mixture among public sources, sources from voluntary insurance and individual, private sources. Approximately 80% of the public sources are gathered by the Croatian Health Insurance Fund (CHIF) from the compulsory contributions from employees and employers. The rest of the sources are gathered from the voluntary, supplementary health insurance, direct payments from the state budget, local governments and donations. In addition, there are contributions that come directly from the patients for the received service (Kovač, 2013).

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Overall, the HC is embedded in three key principles: comprehensiveness, continuity, and availability (HCA, Article 11). Continuity is closely related to PHC, as it is the only level of care that provides uninterrupted HC to the population throughout their life. In addition, to achieve continuity, HC strives to provide functionally linked and aligned service. In this respect, the principle of subsidiarity, solving the health problem at the lowest level of health care, is respected. Thus, the PHC as an important provider of health services on a local level is of great importance (HCA, 154/2014). HCA envisages universal access to health services for all people regardless of their socioeconomic background assuring the PHC availability (HCA, 154/2014). Through these principles and the rest of the law, it can be observed that HCA puts a special emphasis on the equality when it comes to the HC access, combined with the standardized quality across the country. For instance, HCA in article 71 prescribes the work of Agency for Quality and Accreditation in Health Care (HCA, Articles 154/2014).

In order to achieve the best results, PHC is organized as a team work, where at least one health worker must have completed medical studies. In respect to the scope of the work, PHC encompasses HC for women, protection of persons over the age of sixty five, HC for persons with disabilities, occupational medicine, palliative care, home care, and lastly child and youth protection (HCA, Article 26). Health centers are essential when it comes to the organizational aspect of PHC. They are managed and financed at the local level (by the counties - local government units). This organizational aspect greatly influences the financial sustainability and quality. Some counties are wealthier than others, resulting in difference in quality across Croatia.

The types of financing and employment of doctors present a special challenge for effective functioning of PHC. First model of employment is the classical model where a PHC doctor is a public official who is financed through public sources. These doctors are given all the essential equipment needed for the service provision. Being a public official, this type of PHC

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doctors lack autonomy over funds or investment into new equipment. Another type of employment is the private one. Doctors are contracted by the counties and CHIF. Private doctors are financed on the basis of capitation, but they have to fund their staff and equip their own practices. After defining the setting of HC provision, the following section provides insight into the timeline of reforms and their impact. Where possible to be observed, the section connects reforms to the four modes of policy change: drift, conversion, layering and revision.

4.2. Overview of Primary Health Care Reforms in Croatia

First PHC related reform took place in 1993 and was a result of democratic transition. Those circumstances were a critical juncture in many policies. With this reform, patients had a right to freely choose their PHC doctor, opposed to territorial affiliation in the prior, Yugoslav era. This is a rare example of policy revision in the context of the Croatian PHC. Additionally, these changes laid the foundations for the upcoming reform driven by the idea of privatization. One of the crucial changes happened in the 1996, with the privatization of PHC. Proliferation of number of PHC providers is noticeable at the time (Official Gazette, 72/2006). In addition, alteration to the new system was not implemented quickly enough, thus, creating confusion in the system. More often than not, it showed that certain number of doctors held both statuses: simultaneously they received paycheck from the health centers and had private practices with all the accompanying rights and obligations (Keglević, Kovačić, Pavleković, 2014). This is one example of connection to institutional change models, especially to policy layering. This reform brought obligatory contracts with the CHIF, for the PHC doctors to become private business entities. They were obliged to hire and pay for a nurse and all additional staff.

In the period between 2001 and 2003, extensive rise of expenditure on HC occurred, as it can be observed in the Figure 2. The reform was implemented with a goal to rationalize

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expenditure in the health system. Through the informatization of the whole system, it was attempted to decrease the expenses of the health system. PHC was also encompassed in this reform. Mainly, there were changes in the way patients' data was documented and categorized. In detail, it was easier to access records, which was supposed to accelerate the service. The waiting time should decrease as each doctor can access the whole health history in a systematic way (Stanić et al., 2007). The overall objective of informatization was praiseworthy; however it made only slight improvements. This reform failed to improve vertical communication among types of HC. Issues of lack of communication will be further accentuated in the forthcoming section that analyzes main challenges of Croatian PHC.

Simultaneously with the informatization reform, there was a health insurance reform when it comes to financing of health care. The beginning of the 2000's was marked by governmental relief due to high amount of unpaid debt in health system. Supplementary insurance was introduced in 2002 with the aim to lighten the pressure on the budget (Official Gazette, 54/2002). However, this reform did not achieve the goal to reduce the expenses due to policy layering. In detail, supplementary insurance was introduced, in the same time as a generous social policy was implemented. In this particular case, many citizens' were awarded a privileged access to supplementary insurance (Radin, forthcoming) which resulted in failure to achieve the goal of budget relief. This period is important as it marks a shift of reforms' focus in HC in general. From the organizational aspect, which could have been observed in previous years, to the cost reduction that will be the main objective in the following years.

The next year of interest when assessing HC reforms is 2004. Following logic of previous years, in 2004 great efforts were made to decrease the rapid growth of expenses connected to HC. Growth of expenses is experienced due to aging population that requires more treatment and partly, due to global technological trends in medicine (Kovač, 2013). The new policy was designed in accordance to the past experience, meaning the change was path dependent.

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Reform from 2004 imposed restrictions on PHC doctors regarding the prescribing volume and sick leaves. For instance, there was a restriction on the total quantity of prescribed drugs per patient on doctors' lists. If there were deviations from the set norms, they had to be explained to the CHIF office (Official Gazette, 72/2006). It comes as no surprise that these changes invoked dissatisfaction among PHC doctors, who felt the burden of growing administrative work and regulation. In this period, co-payments were introduced. In the beginning the fees were paid for preventive services only, on the "fee for service" principle. Later on, a fee was charged for some Diagnostic and Therapeutic Procedures (DTPs), which inevitably had an influence to the accessibility of care. Unfortunately, there is no significant body of research that explores the consequences of co-payments on citizens of lower socioeconomic background (Keglević et al., 2014a).

As the previous reforms yield no sufficient revenue, the 2008 reform was somewhat more rigorous. One of the main objectives was lowering exemptions scope regarding supplementary health insurance. Furthermore, there was a desire to improve communication among different levels of care through e-medicine, which is along the lines of aforementioned informatization reform. Overall, focus of the 2008 reform remained on cost containment. As a result, PHC was severely impacted by these changes. In particular, there was an even stricter reinforcement on rules regarding the amount of sick days and prescribed medicine per patient on a doctor's list (Radin, forthcoming). New regulation policies were created without revising the previous restrictions, thus increasing the burden on the doctors. Policy layering further increased the level of PHC doctors' dissatisfaction.[2]

The implementation of strict rules was constantly planned regarding the number of patients per PHC doctor. Although the reforms envisaged range in between 1500-1700 patients, the data shows failure in this aspect. The increase of the average number of patients can be

[2] Ksenija Miljević – interview by the author (Zagreb, Croatia, April 26, 2018)

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observed throughout the years, coming to the 1 978 patients per doctor in 2013. More strikingly, two thirds of doctors who have privately contracted practices tend to have more than 2000 patients. The reasons for this statistics are twofold. Firstly, there is a lack of doctors who specialize PHC, especially in rural areas of Croatia. Secondly, until the 2004 reform and the amendments to financing, doctors benefited from having more patients as the capitation was the main source of finance. In this respect, some of PHC doctors had taken large numbers of patients, which resulted in long queues as they have a limited amount of time. On the contrary, if there was not a substantial amount of patients on a doctor's list, some were not able to afford adequate equipment. This culminated in a lower level of PHC competence to resolve issues. Accordingly, insured persons were referred to specialist care, resulting in a greater pressure on the secondary level of care (Mihaljek, 2006).

Pressure on secondary level of care further intensified expenses and government spending in the health care. As the secondary level of care is the most costly one, attempts were made to release the pressure from it. This was to be done through improvements of PHC and its "gatekeeper" role. This respectable idea that leans on the importance of PHC was not appropriately achieved due to policy making. One of the determinants of PHC reform in Croatia is reoccurring inconsistency as the new Ministers of Health come to power.

For instance, 2010 changes in HCA brought easier legal environment for doctors under concession. In detail, ten year long concessions contracts were introduced. Moreover, in 2016 there are great promises on reputation restoration. Government proposes that majority of examinations should be done in the health centers, in order to fully accomplish the full potential of PHC (Pejičić Dejanović, 2016). Nevertheless, just a year later, law amendments outplace provision of physical therapy for acute pain. The reason for that was that PHC doctors were not educated enough. Needless to say, it resulted in a backlash from many PHC

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associations, as majority of doctors already invested funds in new machines and education, following the 2016 changes and promises (Pejičić Dejanović, 2017).

The end of 2017 saw a proposal from the current minister to privatize the complete system of PHC (Rimac Lesički, 2017). The proposition was disapproved of to a high degree from the general public. As discussed earlier, strong socialist heritage that is based on equal access to high quality care is not to be overlooked when debating privatization.

This paragraph provided an insight to PHC reforms in Croatia by linking them to theory of historical institutionalism and four modes of incremental policy change. Out of four modes, two can be observed clearly. Firstly, discontinuing PHC territorial affiliation policy inherited from Yugoslavia is the example of policy displacement. Secondly, policy layering can be observed in PHC reforms, namely those after 2000s. Observing conversion was not accomplished, as it is an internal change. Lastly, policy drift can be observed when all the reforms are assessed as a whole. Overall, the HC system drifted from the goals of accessibility and high quality, which will be further explored in the following section. Not only did this paragraph show a timeline of reforms, but also a somewhat dangerous tendency of measuring efficiency only through expenses. Health policy is more than that, as the focus should be put on quality of service and achievement of positive outcomes.

4.3. Analysis of the Data on Expenses and Quality

This section will analyze data available on the HC expenses and the quality perceived among citizens. It is crucial to mention the level of difficultly faced when obtaining the data. In particular, Croatian government does not publish HC expenses in a document where they can easily be accessed and longitudinally traced. In addition, longitudinal aspect is omitted by the administrative changes. For example, until 2012 the Health Ministry was joined with the Ministry for Social Welfare, making it harder to extract expenditure data. Data on expenses is

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collected from various sources: the national statistical yearbook, international reports and scholarly articles. In addition, the expert[3] confirmed that a Croatian government lacks formal feedback mechanism when it comes to HC. Official data on patients' satisfaction is not collected and systematic quality indicators on all three levels of care do not exist.

4.3.1. Expenses

The health sector in Croatia has been accumulating debt continuously for the past two decades. The debt reached eight billion Kuna (HRK) in 2017 (Radin, forthcoming). The amount of debt poses a question of financial sustainability throughout the whole system. Therefore, it comes as no surprise that previously illustrated reforms had cost reduction as the main objective. The reforms yield little success and the health system is still confronting financial difficulties (Broz and Švaljek, 2014). The main issue is not the absolute level of spending on HC. As it can be observed in Figure 2., when compared to other EU countries, Croatia is among those who spend relatively smaller amounts.

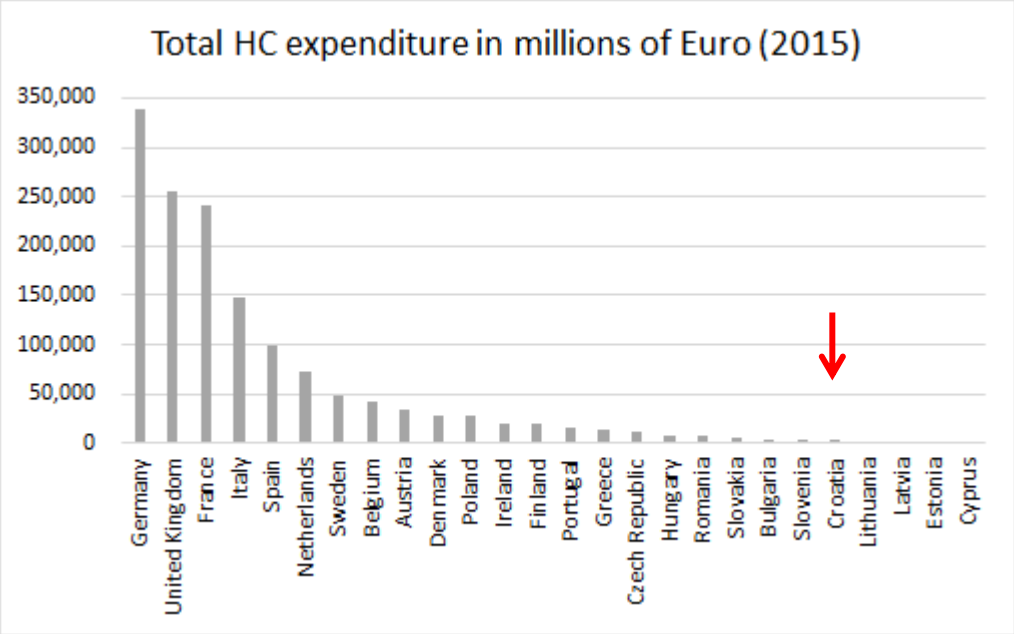

Figure 2. Total HC expenditure in millions of Euro (2015)

Source: Eurostat, 2015.

[3] Dagmar Radin – interview by the author (Zagreb, Croatia, April 25, 2018)

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Difference in total expenditure on HC among EU countries, can be explained with the economic power of a country. Developed and economically advanced countries have more funding to invest into health care. The main issue is that the spending is constantly growing and is financed by public debt. In 2015, 77% of health expenditure was coming from the public sources (Eurostat, 2015). The following Figure 3. depicts growth of HC expenditure in regards to gross domestic product (GDP). The upward sloping trend line can be observed, showing increase in the HC expenses throughout the years. The beginning of 2000s shows a decrease, as the more rigorous reforms were implemented. However, the upward trend continued in the following years.

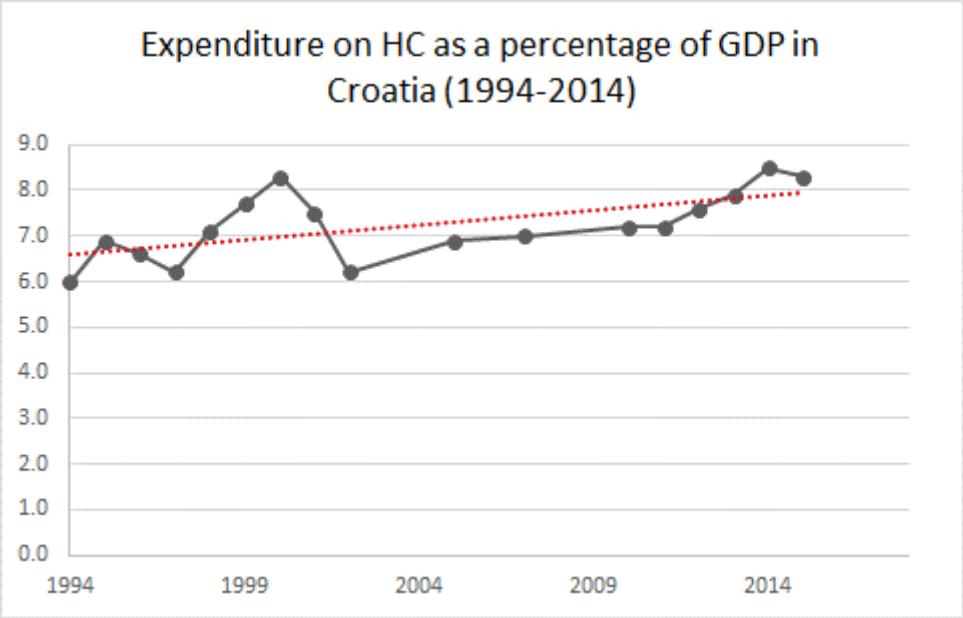

Figure 3. Expenditure on healthcare as percentage of GDP from 1994 to 2014

Source: Eurostat, 2015.

Brodarić and Keglević (2014) in their analysis illustrate the rapid growth of expenses when it comes to secondary level of care. In particular, the specialist services in hospitals show the rapid growth. In 2000 they accounted for 7% of total HC expenditures, which rose to 26.7%

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in 2013. On the contrary, the expenses for the PHC are declining and are depicted in the following Figure 4.

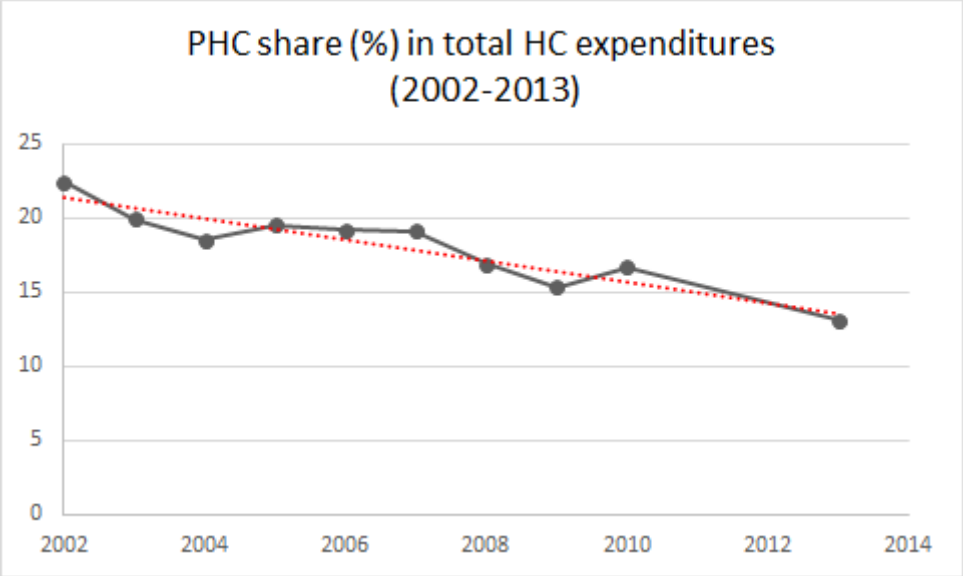

Figure 4. Primary health care share in total health care expenditures

Source: Eurostat, 2015.

Difference in the expenses among two levels of care is interesting to further analyze. As it can be observed, both the total expenditure in HC and the expenditure on secondary level of care are increasing, while the expenses for PHC are declining. As previously mentioned, importance of PHC is in the emphasis on prevention. Experts[4] claim that each dollar invested in prevention saves 10 dollars on the other levels of care. In addition, the "gatekeeping" role to the rest of the system is helpful in cost reduction on other levels of care. Following that, investment in the PHC pays off through savings on other levels of care. This being said, it is unclear why HC reforms put an emphasis on cost reduction in PHC. One partial answer is in path dependency.

[4] Dagmar Radin – interview by the author (Zagreb, Croatia, April 25, 2018)

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The expenditures are closely related to the quality of HC system and the patient satisfaction. Reforms that aim on cost reduction inevitably influence the care provision. For instance, overburdening doctors with strict regulations results in long waiting list. Thus, accumulating dissatisfaction among users. The following section shows decline in patient satisfaction and how overall, little attention is given to gathering and publicizing quality related data.

4.3.2. Quality

Similarly to the data on expenses, data regarding quality of service is difficult to obtain. Agency for Quality and Accreditation in Health Care was established in 2007 with the Act on HC quality (Official Gazette, 107/7). The law envisages for the agency to set out health quality standards and benchmarks, provide a database related to improving the quality of health care and carry out education and promoting activities. However, it is only partially fulfilled. The Agency indeed sets out health quality standards and benchmarks. Standards are vaguely defined in nine points, ranging from security to patients' experiences. There are 30 benchmarks and they mainly focus on waiting time, number of operations successfully performed or percentage of vaccinated children. This can be defined as a focus on outputs, rather than outcomes of a HC system. The lack of capacity to gather and analyze data combined with the lack of transparency can be observed in the following example. The Agency proclaims that there is the system for data collection on quality and that it publishes the patients' satisfaction survey sheet. However, there is no publication with the results of the survey. Without access to the results, the use of knowing the methodology and questions in the survey is questionable.

Whereas the Agency fails to tackle the issue of outcomes of the health system, national strategies on HC take a step towards measuring them, but not to the full extent. Here the benchmarks that can be considered are the measurements of the life expectancy and mortality rates. However, they lack providing information on efficiency of provided care and if the care

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is provided at the best possible level. The issue of outcome measurement was stressed in all three conducted interviews. In addition, all the interviewees assessed that the HC system is overall deteriorating in quality over years.

This is supported by the data on The Euro Health Consumer Index, which shows a declining trend in perceived quality among patients. In 2013, Croatia took the 19th place from the total of 34 European countries. Data from 2017 shows a drop to 26th place. In more detail, Croatia scored significantly less in accessibility and outcomes. Thus, it is interesting to look closely into available data collected to coherently conclude what aspects of HC are most troublesome when it comes to quality perceived. The data collected can be helpful when designing future HC reforms, as the literature also emphasizes that patients' input can be helpful for policy makers (Babić-Banaszak et al., 2001, Stanić et al., 2007, Popović, 2017). The following paragraph will look into patient satisfaction with some aspect of care, such as accessibility or private expenses.

In a study by A. Babić-Banaszak et al. (2001) some optimism can still be observed. Of the total of 2 252 patients asked, 72,1% was satisfied with the PHC. However, that question encompassed overall impression. But when asked how they evaluate the PHC organization, the satisfaction percentage dropped to 62.3%. What is more, this study briefly evokes the issue of reforms aimed at macroeconomic aspects and cost reduction. The study states that compared to similar studies in 1990s, patients' satisfaction is lower.

Furthermore, Stanić et al. (2007) looked into variables that influence satisfaction of the PHC provision. In the sample of 7 217, the discrepancy in the satisfaction related to the geographical area was found. In particular, people who live in rural areas tend to give lower grades to the HC system. This study emphasized the importance of nurses when it comes to patients' perception of quality.

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Recent studies show a need for improvement of the HC system. More than a quarter of citizens from Popović's (2017) study that encompassed a representative sample of 1 120, rated the whole HC system completely inefficient. In addition, 62.1% of citizens believe that total change of the system is crucial. This study also found that the majority of respondents were reluctant to privately fund higher quality HC, especially those of lower economic background. This verifies aforementioned importance of publicly provided HC in the Croatian society.

4.4. Challenges of the Primary Health Care in Croatia

This section continues the analysis of the HC reforms, drawing upon data on expenses and quality presented. Additionally, the data gathered through semi-structured interviews is used. In more detail, section explores three main challenges that PHC is facing in Croatia: lack of PHC gatekeeping role fulfillment, insufficient focus on prevention, and lastly, lack of vertical communication among levels of care. These challenges are greatly a product of reforms that focus on cost reduction. Furthermore, challenges influence the patients' satisfaction and the overall quality of the HC system.

As discussed, the main objective of HC reforms undertaken from 1990s onwards was to reduce cost. This had a significant impact on the PHC service provision, as lots of limitations were implemented. This restriction influenced the end goals of quality and satisfaction. Concessions weakened the PHC continuity and comprehensiveness. It can be observed through difficulties in the PHC organization and lack of staff during holidays or sick leaves (Official Gazette, 116/2012). One of the experts[5] refers to the reform as "explosive" reforms, as they were often passed by an emergency vote in the Croatian parliament, with the sole aim to unburden the budget. Continuously, the HC system was not looked at in its entirety.

[5] Dagmar Radin – interview by the author (Zagreb, Croatia, April 25, 2018)

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Analyzed data on expenses depicts the upward trend line when it comes to total expenditure in health care, while simultaneously showing a sharp decline in PHC share in total expenditures on HC. As a result of cost reduction, a PHC doctor was deprived the ability to provide attentive care at the primary level, thus resulting in higher pressure on secondary and tertiary levels of care. Consequently, overloading secondary and tertiary levels of care led to more expenses. As previously mentioned, HC should be provided at the lowest level possible and the PHC has the "gatekeeper" role to the rest of the system. However, the HC reforms had a different outcome. Cost reduction in PHC resulted in inadequate equipment and PHC doctors have no other choice than to refer their patients on other levels of care. In addition, interviewee Ksenija Miljević[6] emphasized lack of time to devote a patient, caused by ongoing, obligatory administrative tasks. Following that, role of PHC doctors should be increased, in order to truly achieve the gatekeeping role and reduce cost on other levels of care.

Not only is there a lack of time to be devoted to the patient, there is rarely time to spend on preventive care. Investment to preventive care and its provision brings great benefits to the society. It substantially contributes to the long-term goals of healthy population and reduces cost on other levels of care. When asked to assess to what extent she devotes time to preventive care, interviewee Ksenija Miljević answered that it ranges from very little to virtually none. In her opinion, each reform restrained her additionally, leaving no time for core assignments such as preventive care.

Organizational challenges arise from the lack of vertical communication among levels of care. In particular, there is no communication between hospitals and PHC. In reality it means that the PHC doctor has no access into documentation once the patient was referred to secondary level of care[7]. It is solely on the patient to provide the doctor with the feedback, which is

[6] Ksenija Miljević – interview by the author (Zagreb, Croatia, April 26, 2018)
[7] Hrvoje Beclin – interview by the author (e-mail correspondence)

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inefficient way of tracking health improvements. At the moment, there are talks of introducing so called e-file, which would allow easier share of information. However, the implementation is stalling due to patient rights concerns.

Challenges mentioned above ranging from dysfunctional organizational aspect, lack of system integration, absence of communication among levels of care, and overburdened doctors, took a toll on patients' satisfaction and overall perceived quality of the system. It was further proven through The Euro Health Consumer Index, showing decline in perceived HC quality. The next section brings a conclusion of the thesis with the summary of the findings and implications.

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Conclusion

The thesis analyzed health care (HC) reforms performance in Croatia, answering the question: Why are the expenditures in health increasing, and quality of the service lowering, even though the planned reforms envisioned cost reduction and higher quality of the service provided? Special focus was given to the primary health care, due to its crucial "gatekeeper" role to the remaining of the health care (HC) system. The thesis argued that policy outcomes were affected by poor policy design. Failure to achieve reform goals of HC cost reduction lay in the path dependent policy design and series of incremental changes that achieve little change. Additionally, cost reduction design lowers budget expenditure on primary health care (PHC). It further increases expenses on other levels of care, as the investment in PHC can reduce expenses on the other levels of care.

By linking PHC reforms in Croatia to theory of historical institutionalism and four modes of incremental policy change: drift, conversion, layering and revision, interesting observation can be made. Out of four modes, revision and layering were observed clearly in the Croatian context. Policies that focus on cost reduction are simply joint together, without elimination of older policies. Overall, the analysis showed path dependent policy design that essentially does not change. From the continuous lack of change, Croatian HC suffers decline in patients' satisfaction and high amount of debt. This all influences provision of PHC. Three issues that PHC is facing in Croatia explained are: lack of PHC gatekeeping role fulfillment, insufficient focus on prevention, and lastly, lack of vertical communication among levels of care.

It is a challenge for decision makers to resolve these issues. However, increase in budget expenditures on PHC should be considered, as it lowers expenses on secondary and tertiary levels of care. Additionally, this research has shown how reforms often create new policies without elimination of the previous policy. This too should be amended. Finally, dangerous

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tendency of measuring efficiency only through expenses should be reconsidered. Instead, focus should be put on quality of service and achievement of positive outcomes.

Last challenge opened by this thesis is the one for the academia. The lack of literature that connects policy design study and reforms, not only in Croatia, opens room for further research. By enhancing the understanding of institutional change, contribution to successful policy making can be made.

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