PROGRAM-FOR-RESULTS INFORMATION DOCUMENT (PID)
APPRAISAL STAGE

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I. Country Context

Croatia's economy has been in recession for the fifth consecutive year and the outlook for growth remains weak. Croatia lost 12 percent of its output since the outbreak of the global crisis, with declines in personal consumption, exports, and investments. Results for the first nine months of 2013 are equally negative, with annual gross domestic product (GDP) falling by 0.7 percent. Although there are signs of bottoming out in 2013, the outlook for growth remains weak, given Croatia's dependence on the economic cycles of the European Union (EU) combined with slow progress in structural reforms. Unemployment rose to above 17 percent for survey-based unemployment by September 2013, the highest among the new EU member states, with the private sector bearing the brunt of the crisis, and jobs lost mainly in manufacturing, construction, and trade. The difficult external environment and deteriorating confidence at home, combined with slow progress in structural reforms and limited foreign direct investment inflows, will result in expected GDP contraction in 2013 as well, estimated at 0.8 percent.

Prolonged crisis led to a rise in poverty in Croatia. While, according to official data, the rise in the headcount poverty rate by 2010 was only 1.3 percentage points, micro-simulations based on the 2011 Household Budget Survey suggest that poverty incidence increased further in 2011 and 2012. Using an absolute poverty line fixed at 60 percent of median equivalent consumption, poverty increased by almost five percentage points (to 18 percent) between 2008 and 2012.

Croatia's recent entry into the EU brings new responsibilities and opportunities. Croatia joined the EU in July 2013 and is now aligning its health care strategy to fit with EU norms/regulations. Croatia's entry into the Excessive Deficit Procedure, with a requirement to bring the deficit under three percent and public debt under 60 percent of GDP by 2016 will necessitate increased fiscal tightening, including in the health sector. Meanwhile, as an EU member, Croatia now has access to significant, non-deficit creating EU funds with which to

support its investment and reform needs.

Demographic changes in Croatia will probably increase the future strain on public finances and health systems. The Croatian population has been declining since 1991, with a negative natural population growth rate of 0.5 percent (for the period 1991 to 2012). Since 2001, the 65-and-over age group has grown and is now larger than the population aged 15 and under. This has implications for public finances, since the proportion of working-age population is declining. Furthermore, international experience shows beyond a doubt that the demand for health services will increase in the future as the population ages. This could threaten the financial sustainability of the health system unless changes are made to improve its efficiency and effectiveness.

II. Sectoral (or multi-sectoral) and Institutional Context

The Croatian health system produces reasonably good outcomes, but at high costs that are difficult to sustain in an environment of fiscal constraints. Health sector reforms implemented over the last 20 years have gone a long way to improve the Croatian health system's performance, which produces robust results both in terms of health outcomes and public satisfaction. However, such results come at a high cost. With overall health spending at 7.8 percent of GDP, Croatia is near the top of the list compared to new EU members, and spends significantly more than countries with similar GDP per capita in the region. At 17.7 percent, the health sector's share of public expenditures (about EUR 3.1 billion) is higher than the 15.6 percent average for all EU countries (although some social security expenses beyond the strict health system, such as sick and maternity leave, are also included in that figure). In this fiscally constrained environment, the Croatian health system faces a mismatch among available public resources, growing expenditures, and increasing needs.

Health financing is organized according to social health insurance principles. A single fund, the Croatian Health Insurance Fund (HZZO), covers the entire population (about 4.4 million beneficiaries comprised by: 1.52 million active workers, 1.05 million pensioners, 1.15 million family members and 0.63 million individuals covered by special programs).

The needs that Croatia's health system must address have changed as a consequence of the demographic and epidemiological transition in the country. The disease burden in Croatia has shifted from being dominated by maternal and child health and communicable diseases to being dominated by chronic and non-communicable conditions. Heart and blood vessel diseases, for example, are the leading cause of death and account for 49 percent of deaths from all causes; cancer, the second-most-frequent cause, accounts for 26 percent. The two combined are responsible for three of every four deaths.

The institutional structure and capacity of the publicly funded health sector in Croatia has not kept pace with this changing landscape. Many health care services in Croatia continue to be delivered inefficiently. Hospitals continue to provide services that can be better and more cost-effectively provided in an ambulatory setting. Similarly, Long Term Social Care for the elderly is often provided in hospitals (at higher cost and inappropriate environment for the elderly) rather than in nursing homes or assisted living facilities. At the same time, primary care is not acting as an effective gatekeeper, and its role in preventive care needs strengthening.

Increased quality in services and facilities will be necessary for Croatia to sustain good health outcomes at lower cost. The Croatian Agency for Quality and Accreditation in Health Care (AQAHS) is an independent and not for profit public institution created in 2010 that acts as the national accreditation service in the Republic of Croatia. AQAHS was established in order to support implementation of the technical regulations which has been harmonized with the *acquis communautaire* of the European Union. Nevertheless, norms and protocols aligned with best international practice still need to be adopted. Standard practices for more frequent health services are not in place, there is a need to increase secondary prevention to reduce avoidable complications, the surveillance of negative outcomes (sentinel events) is not implemented and quality control mechanisms are not regular practices. A key illustration of this capacity gap is the failure to generate and use disaggregated data, for instance in monitoring and tracking county-level differences in quality and outcomes.

Croatia has started to implement important health sector reforms to improve efficiency and quality. Croatia recently introduced a number of long-term reform initiatives, including a new performance-based payment mechanism in hospitals, centralized purchasing for nonmedical equipment and consumables, new wide-ranging governance and management arrangements in health care institutions, and new regulations rationalizing pharmaceutical expenditures (which have been identified as regional best practice in a multi-country study conducted by the World Bank). Complementary and private insurance have also been implemented. As a result of reforms, Croatia now has fewer disparities between counties in term of funding and human resources.

Pharmaceutical sector reforms in Croatia have expanded access while reducing costs. The number of prescriptions in Croatia increased by 69.3 percent between 2005 and 2011. In 2012, the Ministry of Health introduced new regulations promoting the procurement of generics and centralizing procurement using competitive tendering and framework contracts for county hospitals. These reforms have already begun to yield savings; as a direct result of the first round of tenders, the estimated cost savings have been HRK 187 million (approximately EUR 24.5 million). At the same time, the average expenditure per insured individual and the average expenditure per issued prescription have decreased.

Nevertheless, there is still ample scope for reform: a key need is to optimize hospital capacity in Croatia. The average length of hospital stay in Croatia was 9 days in 2011, slightly over the EU average of 8 days. However, in the "EU15" countries it is lower (around 4.5 days in Norway and Sweden, 5.5 in France and the Netherlands, 6.5 in Spain and the United Kingdom). To achieve a shorter average hospital stay and so rationalize expensive hospital care, Croatia should provide alternative services for those who should ideally be treated in an ambulatory setting those who should be cared for in nursing homes or assisted living facilities and those who should, indeed, be treated as hospital inpatients. To accelerate the implementation of the hospital reform, the MoH recentralized management of hospitals to implement hospital management reforms that will facilitate future implementation of hospital rationalization.

III. Program Scope

Government Program

The Government of Croatia's National Health Care Strategy sets out development directions for the health sector and is the framework for making policy and operational decisions, including the distribution of budgetary resources. The Health Care Act forms the legislative framework of the National Health Care Strategy 2012–2020. This Strategy is the umbrella document determining the context, vision, priorities, and goals for health care in the Republic of Croatia over this period in the context of the social, legal, and economic framework of the EU. More specifically, the Strategy takes into account (a) Europe 2020, the EU strategy for growth; (b) Health 2020, the new health policy of the World Health Organization European Region; and (c) the Common Strategic Framework 2014–2020, which forms the basis for financing from EU funds.

The National Health Care Strategy 2012–2020 identifies the strategic problems and reform priorities for the health care sector. The strategic problems identified are: (a) poor connectivity and insufficient continuity of health care across levels (primary, secondary and tertiary) in the health system; (b) uneven or unknown quality of care; (c) inadequate efficiency and effectiveness of the health care system; (d) poor or uneven availability of health care across regions; and (e) relatively poor health indicators, particularly those related to risk factors and health behaviors.

The Government's reform program defines the following eight main priorities:

IV. **Developing a Health Information System and eHealth.** With a focus on: a) establish an electronic health record for patients, b) increase the use of health care and statistical information to support decision making, and establishing the reporting and warning system, c) generate a functional improvement, modernization and maintenance of the existing information systems in health care, d) increase standardization and certification, e) change management and training, and f) introduce new legal regulations for the sector (estimated EUR 45M).

V. **Strengthening and better using human resources in health care.** Developing a strategic plan of human resources, strengthening protection of health care workers, introducing vertical and horizontal mobility, improving specialization planning, adjusting regulations for work after mandatory retirement age (estimated EUR 12M).

VI. **Strengthening management capacity in health care**. The specific areas of focus include education and differentiation of management, data analysis, planning and researching the health care system, and strengthening the management authority of community health centers (estimated EUR 14M).

VII. **Reorganizing the structure and activities of health care institutions**. Improving integration and cooperation in primary health care and public health, supporting the establishment of group practices in primary care, and developing and implementing a hospital master plan to rationalize and modernize hospital services, increasing the continuity of care between hospital and out-of-hospital services, structural modifications to hospitals, and increasing centralized (joint) procurement for hospitals (estimated EUR 260M). The Ministry of Health initiated the production of a Hospital Master Plan that will analyze in detail the situation in the hospital system and will use the morbidity and

mortality data, as well as demographic and other projections, to recommend restructuring and reorganization, down to the level of individual institutions, including Hospitals Reshaping schemes or changes to the service profile. The hospitals reshaping scheme will introduce substantial adjustment in the way two or more hospitals are merged, organized, managed, and funded, and the necessary actions in the legal, financial, managerial, and other spheres to provide more efficient ambulatory care and a reduction in inpatient acute care.

VIII. **Fostering quality** in health care through (a) improving quality of monitoring, health worker education, and better public information for users; (b) developing, implementing, and monitoring clinical guidelines and accreditation; (c) introducing performance-based contracting and performance-based payments, with a specific emphasis on pay-for-quality initiatives; and (d) developing and implementing a formal Health Technology Assessment (HTA) (estimated EUR 40M).

IX. **Strengthening preventive activities** by increasing the budgetary share of preventive activities in the health budget, improving management of preventive activities and programs including the introduction of performance-based contracting for prevention and strengthening preventive care at the primary care level; strengthening systems to monitor harmful environmental factors and early warning/response systems (estimated EUR 24M).

X. **Preserving financial stability of health care** by focusing on strengthening the voluntary health insurance market, improving financial discipline in the health care system through greater accountability, improving the strategic allocation of health resources, and reducing corruption and informal payments (estimated EUR 10M).

XI. **Improving cooperation with other sectors and society in general** by Strengthening intersectoral cooperation (among ministries), with local and regional self-government and with civil society and media (estimated EUR 4M).

The Government's reform program is technically sound and oriented to addressing the reform priorities facing the Croatian health sector, that is, rationalizing the health facility network, improving quality of health care services, and promoting financial sustainability of the health sector. As the steward of the health sector, the Ministry of Health is uniquely positioned to design and implement the big-picture reforms currently needed in Croatia. While ambitious, the Government program has critical components and interventions required for delivering results, and the expected long term outcomes (2020) are achievable.

The Program

The proposed Program to be supported by the Bank is defined within the following boundaries: (a) Program duration (2013-2017); (b) Priorities supported; (c) Institutions involved. ***Priorities supported.*** To improve two critical areas of the health services (quality and efficiency) and considering the objectives of the Country Partnership Strategy it was agreed with the Government that the Program would include 5 out of the 8 priorities of the National Health Care Strategy 2012–2020. These priorities are oriented to addressing the main reform challenges

facing the Croatian health sector, that is, rationalizing the health facility network, improving quality of health care services, and promoting financial sustainability of the health sector. These include: **Priority iii Strengthening management capacity in health care** and **Priority iv Reorganizing the structure and activities of health care institutions**, including: Implementing the hospital master plan, Implementing hospital reforms and governance and management changes, promoting group practices for general practitioners, expanding secondary-level ambulatory services, including high-resolution ambulatory centers, redefining long-term health care services and palliative care; **Priority v Fostering quality in health care** and **Priority vi Strengthening preventive activities**, including: implementing of a hospital accreditation, implementing Health Technology Assessment (HTA) of all new health technologies, building a body of clinical protocols and care pathways, detecting and proper recording of specific "sentinel events for quality", implementing technical/clinical audits and payment mechanism to incentivize the use of clinical guidelines, using of the existing e-prescription system for quality control purposes; **Priority vii Preserving financial stability of health care**, including: further development of central procurement, outsourcing of nonmedical services, strengthening the performance-linked component in payments to hospitals and ambulatory services, developing the MoH capacity to develop and present proposals to be financed by EU structural funds.

XII. Program Development Objective(s)

The proposed PDO is ***to improve the quality of health care and efficiency of health services in Croatia***.

XIII. Environmental and Social Effects

The Environmental and Social System Assessment (ESSA) has taken into consideration the requirements of the OP 9.00 Program for Results Financing to identify any adverse environmental and social impacts that the Program could generate, including having an upfront risk screening of key potential environmental and social effects (benefits, impacts and risks).

The Program's social system was assessed as adequate without substantial negative impacts on the society. The overall risk profile is assessed as moderate as the Program is mainly focused on the improvements and better tailoring of the health care services to the needs of the Croatian citizens, increasing standards and quality control mechanisms of the health system, offering higher guarantees to users, and promoting the financial stability of the health sector.

There are no adverse social impacts associated with land acquisition and involuntary resettlement as the Program will not finance any construction of new facilities but rather small rehabilitation works within the existing hospital structures, if deemed necessary. Given the current political context, a potential social impact could result from planned health service rationalization which might meet a certain amount of resistance from different stakeholders. To that effect, the mitigation measures the ESSA underlines include transparency in the process, outreach and consultation with a wide range of stakeholders, a participatory approach, and public information campaigns to promote the benefits that the Program to the population.

Transparency, integrity and accountability of Program activities have been promoted through the development and adoption of the National Healthcare Strategy 2012–2020,

which underwent a broad consultation and consensus building process among all key stakeholders in an open and democratic way.

Mechanisms for grievance and appeals exist and are in use.

The initial environmental screening suggests that activities financed through the Program will generate a number of positive cumulative environmental impacts, covering the whole spectrum of nation-wide health improvements. Benefits include improved overall health status of the vast majority of citizens given improved access, quality and efficiency to essential health services.

The Program itself does not have explicit environmental management objectives. Yet, the Health sector in Croatia is being assessed through the ESSA process from two main environmental aspects: a) the health sector itself is a polluter and b) the health sector has an important role in national environmental protection and management. As a polluter, the sector is the producer of medical waste and point source of air pollution originating from its heating systems and incinerators. In addition, it is recognized as a sector that consumes significant amounts of energy and water. Two segments of the health care system have particularly important roles within the national environmental protection system: (a) Directorate for Sanitary Inspection of the Ministry of Health, and (b) Environmental Health Ecology Service within the Croatian National Institute for Public Health. These, under their jurisdiction, cover a number of tasks and responsibilities including ionizing and non-ionizing radiation, GMO related food safety, safe management of chemicals, biocides and other substances that present health hazard, safety of common use items (primarily cosmetics, detergents, toys and items that get in contact with food), sanitary safety of drinking water, and noise pollution.

XIV. Financing

Source	Amount (in million Euro)
Government of Croatia	105.0
IBRD	75.0
Total	180.0

XV. Program Institutional and Implementation Arrangements

The four most critical stakeholders involved in implementing the proposed Program are the Ministry of Health (MoH), the Ministry of Finance (MoF), the HZZO, and Agency for Quality and Accreditation in Health Care and Social Welfare (AQAHS) . In the context of the proposed Program, the MoH is the primary beneficiary that will be responsible for the implementation of the health sector reform and restructuring of the Croatian health care system according to priorities and directions defined in the Croatian National Health Care Strategy 2012–2020. The MoF will provide political and budget support to the MoH in implementing the Government's reform program and receive the transfers linked to the achieved DLIs. The HZZO is responsible for implementing reforms that will achieve the results targeted by the proposed Program. As the single payer in the mandatory health insurance system, the HZZO has a central role to play in achieving the proposed Program results (for example, contracting and payment based on Key Performance Indicators and Quality Indicators, stimulating ambulatory surgeries,

monitoring prescription patterns, auditing hospitals, and incentivizing GP group practices). The MoH is, however, responsible for supervising HZZO activities, and contributions to HZZO revenues for mandatory insurance constitute a part of the State Budget revenue. The MoH is currently also responsible for managing all (except one) hospitals. In the long term, however, once the financial rationalization of hospitals is completed, the MoH will once again decentralize management. The AQAHS is responsible for supporting the HZZO in ensuring the quality of contracted providers from whom the HZZO purchases mandatory health insurance services. The main contribution of the AQAHS is to facilitate and implement accreditation of health care institutions and ensure standards of quality in service provision.

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