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Integration processes within the Croatian palliative care model in 2014 – 2020

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A B S T R A C T

In Croatia, palliative care has been developing as an integral part of the health care system since 2014. This development is in line with the integrated care concept emerging in many countries. However, there are a number of implementation problems. The aim of this article was to identify positive and negative determinants for the integration of palliative care in Croatia. We identified policy processes or organizational changes within three key domains: the development of new organizational structures, stakeholders' empowerment, and removing barriers to the provision of integrated palliative care. The progress visible in these domains shows the sustainability of the palliative care model used in Croatia. However, there are also barriers hindering the integration of palliative care. We conclude that patient-centred and process-based change in health care can have a positive effect on the integration of care. Staff education and regulation of business processes are key for the sustainability of reforms. Lastly, it seems easier to achieve the integration of care when it develops as a bottom-up model and reflects the need for new processes, than when it is imposed from above as a single regional or national model.

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1. Background

In 2012, Croatia's decision to develop a strategic plan for palliative care started an intensive palliative care development process. The particularity and key challenge of this policy process has been the aim, stated in 2014, to develop the palliative care system as a comprehensive, integrated care model, encompassing both health care and social welfare [1].

The main goal was to achieve patient-centeredness, coordination and continuity of care, and to adopt a holistic interdisciplinary approach, all of which are necessary conditions for optimal palliative care [2–4]. The strong legacy of Croatian primary health care, combined with almost universal population coverage and a wide range of services covered by compulsory health insurance, provided many opportunities for improved integration.

1.1. Starting position

Until 2014 palliative care was mostly provided on a voluntary basis, with few professional mo bile palliative care teams. Although there had been a legal basis for the development of palliative care since 2003, no comprehensive framework for palliative care had been developed that would include the organized development of sufficient resources to meet a growing need [5]. The strategic development of palliative care as outlined in 2014 emphasized three key steps. First, improving conditions through the development of new organizational structures. Second, empowering all stakeholders to provide better palliative care through professionalization. Third, removing barriers to the provision of integrated palliative care and the systematic strengthening of stakeholders to provide optimal integrated palliative care in the future. These three steps represent the basis for the development of Croatia's integrated care model [6].

1.2. The importance of integrated care

The provision of health care is often fragmented, contributing to inconsistencies in procedures, difficulties in follow-up and inad-

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equate therapies, leading to poor health outcomes [7,8]. Although more and more people are suffering and dying from chronic diseases, health care systems are still orientated towards the episodic treatment of acute diseases [9].

Integrated care is generally seen as the opposite of fragmented care, driven by the improvement of patient's outcomes. It is a complex concept that comprises different dimensions and can take different forms, depending on the context and the perspectives shaping it [10].

Typically, integrated care can be distinguished by type, breadth, degree and process of integration, depending on the objectives of integration. Thus, it is important to reach a consensus on which purposes should be achieved by integrated care [11].

Common to all forms of integrated care are enabling factors to successful implementation, including policy and regulatory changes, funding mechanisms, organizational changes (both structural and functional), and the acceptance of shared norms, values and attitudes by the stakeholders involved [12,13].

1.3. The progress of palliative care reform in Croatia

The new integrated palliative care model in Croatia has been set up in two strategic planning and implementation periods, 2014–2016 and 2017–2020. The positive feedback and results of the period 2014–2016 have been acknowledged and the basic development concept and goals have been extended for the next three years [1,14].

The new palliative care model has been integrated within the health system, based on existing elements of health care. The principles of integrated care were in line with the principles in place for the health system as a whole, and so were familiar to health care providers, but years of fragmentation of health and social care had resulted in barriers to the integration of palliative care. Despite these challenges, the integrated palliative care model has been generally recognized as one of the few positive changes in the Croatian health system in recent years [15,16].

The aim of this paper is to explore the development and achievements of the new model of palliative care in Croatia in the period 2014–2020. Specifically, we evaluate integration processes within the new palliative care model and conduct a force field analysis for future integration, in regard to the health system as a whole.

2. Materials and methods

The analysis in this paper had been performed in two phases.

In the first phase, we identified changes in three prominent domains according to strategic documents on the development of palliative care: development of new organizational structures, empowering stakeholders, and removing barriers to the provision of integrated palliative care. For each domain, policy processes or organizational changes have been identified and described for the period 2014–2020.

In the second phase, we have undertaken a force field analysis of these integration processes, as well as other relevant changes in the health system.

The three main sources of information used for the analysis were: the national legislative and strategic framework [1,14,17,18,19]; national reports on the implementation of these frameworks; [20,21] international reports on the state of health and health care in Croatia [15,16,22-24].

3. Results

3.1. Development of organizational structures and resource allocation

The fragments of palliative care that existed before 2012 were mostly related to individual initiatives recognizing the most prominent needs of terminally ill patients and the lack of organized resources within the health and social welfare systems to respond to these needs.

Since the introduction of the Strategic Plan in 2014 until the beginning of 2020, organizational structures and services in palliative care increased continuously. Despite major differences between counties, each county has at least some palliative care resources (Table 1).

The new role of a county coordinator of palliative care has been introduced as a main integrating factor. It has been formalized in the 2019 Health Care Act and in the regulations for contracting providers within the statutory health insurance system, which define specific activities of the coordinator (see below). These activities include care coordination, collaboration with other stakeholders, and palliative care promotion and development [25].

In this way, planning and coordination within and between systems entered the payment and reporting system of the Croatian Health Insurance Fund. In addition to the increase in the number of coordinators, the number of mobile palliative care teams that provide home care services has also increased, as well as the annual financial allocation for these teams (Table 1) [20]. The annual remuneration for a standard palliative care coordinator has increased from 151,067 HRK in 2017 to 168,303 HRK in 2020. Similarly, the annual remuneration for a standard mobile palliative team has increased from 440,314 HRK to 486,376 HRK [26–28]. In terms of other providers of primary care, palliative care procedures are specified for family physicians, paediatricians, outpatient emergency medical services, community nurses, and home health care nurses [29].

In hospital care, the number of palliative care beds in all categories of hospitals has increased (Table 2) [21]. Moreover, special palliative care departments have been established, in line with the quality requirements set out in the Rulebook on minimum requirements regarding space, workers and medical and technical equipment, making the departments more home-like and family friendly [30–37]

Specifically for vulnerable groups, there has been an increase in the number of palliative care beds in psychiatric hospitals [38–41].

At the tertiary care level, in two out of four clinical hospital centres, a Department for Integration of Care and Palliative Care in Rijeka, and the Centre for Integration of Care in Split, have been established [42].

3.2. Regulation and professionalization

Until 2014, the development of care provision initiatives was parallel, yet complementary, to the health and social welfare systems. Being mostly informal, their scope was outside of the medical domain, aimed at various kinds of support to patients and their families. On the other hand, in health care settings palliative care emerged mostly from the relief of pain and other symptoms (as opposed to the active treatment of the underlying disease), as well as the psychological support of patients and their families.

Over time, more palliative care needs of patients had been recognized and there was a recognition that a significant gap in care existed, leading to the decision to develop a national palliative care strategy [43].

In the regulation of palliative care, changes have now been introduced to legal acts, reporting systems and payment methods, securing the sustainability of the palliative care reform (Table 3).

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Table 1
Development of palliative care resources, 2016 – 2020.

Minimum standard of palliative care resources per county	Actual palliative care resources	
	2016	2020
One county coordination centre	In 5 of 21 counties	In 17 of 21 counties[a]
Number of coordinators in palliative care, contracted by the Croatian Health Insurance Fund	29[b]	42
One county committee for palliative care	7/21	11/21
One palliative care mobile home team per county	10/21	14/21[a]
Number of mobile palliative teams, contracted by the Croatian Health Insurance Fund	21[b]	33
One mobility aid rental per county	21/21[a]	21/21[a]
One hospital palliative care team in each acute care hospital	16/31	16/31
80 palliative care beds per 1 million population	48 per 1 million	88 per 1 million
One hospital-based palliative pain clinic per county	19/21[a]	19/21[a]

Source: Authors based on the National program for the development of palliative care of the Republic of Croatia 2017–2020. [14], contracted contents of health care in the Republic of Croatia [20], and Croatian Health Statistics Yearbook [21].
[a] Some counties have developed more resources than the required minimum.
[b] In 2018.

Table 2
Number of palliative care beds, discharged patients and bed days in health care institutions in Croatia 2014 – 2020.

	General hospitals			Special hospitals and hospices			Health centre inpatient facilities		
Year	Beds	Discharged patients	Bed days	Beds	Discharged patients	Bed days	Beds	Discharged patients	Bed days
2014	43	294	5642	46	324	8580			
2015	108	1142	27,681	64	838	13,025			
2016	123	1514	25,981	62	864	20,175			
2017	169	1691	26,644	68	747	19,862			
2018	194	2602	37,396	71	990	24,462			
2019	199	2671	44,328	71	1340	41,706	16	58	1191
2020	216	2118	35,976	101	1476	49,017	55	325	5716

Source: Authors based on the Croatian Health Statistics Yearbook [21].

The 2019 Health Care Act acknowledged palliative care as both an integral aspect of health care and a service performed at the primary, secondary and tertiary level of health care [44].

The Rulebook on minimum requirements regarding space, workers and medical and technical equipment has set standards for providing palliative care, highlighting the need for collaboration of well-trained multi-professional teams and for rooms that enable more home-like conditions for both the patients and their families [45].

The Croatian Health Insurance Fund has defined diagnostic and therapeutic procedures to be performed by palliative care coordinators (12 procedures) and mobile palliative care teams (6 procedures). This served as a basis for contracting and paying palliative care services, enabling patients to receive palliative care covered by compulsory health insurance [46].

By the end of 2020, there were over 1000 professionals with additional education in palliative care. Following mandatory requirements for educated professionals to provide palliative care, professional organizations have defined the palliative care competencies for their respected profession and started developing educational courses as part of continuous professional education. Palliative care is included as a compulsory and elective subject in the secondary and university education of nurses and doctors (Table 4) [52–58].

National guidelines for coordinators have also been developed, including documentation for monitoring the work of the coordinators, aimed at achieving common standards of work. As the emergency services very often are the first point of care for palliative patients when their condition worsens, the National Institute for Emergency Medicine developed guidelines for the work of outpatient and inpatient emergency medical services with patients in need of palliative care [59].

Volunteer activities, formerly the basis of palliative care provision, are now complementary to professional care, and have increased in number, with 16 volunteer organizations orientated towards palliative care in 12 counties in 2020 [60–62].

With the involvement of local self-government and civil society, along with health care institutions, one county and two cross-border palliative care projects have been launched, involving Serbia, Bosnia and Herzegovina, and Montenegro [63–65].

3.3. Horizontal and vertical integration

The resources that were developed have provided the basis for both horizontal and vertical integration of care. Horizontal integration entails the integration of health and social care, as well as the integration of informal and formal care. Vertical integration refers to the integration of different levels of health care.

Mobility aid rentals are an example of the integration of home and community care in the new system of palliative care. Respite care, although still not officially recognized, is a step towards the integration of social and health care.

To achieve vertical integration, acute care hospitals are expected to form hospital palliative care teams. Their role is to implement the procedure of early identification of palliative care patients across the hospital and to involve them in the palliative care system.

In terms of types of integration, the emphasis has been on clinical and functional integration, which indicates that a patient-centred perspective has been taken. Functional integration includes integration of palliative care into the health system along with its non-medical components of care. IT software to support patient management also represents an element of functional integration. It has been in use in 12 health centres across 12 counties. In a way, this represents a stepping-stone in developing electronic health records accessible by care providers outside one institution. This had been in discussion since 2011, without ever reaching the stage of implementation. [66] The care coordinator has a facilitating role in the process of clinical integration.

The complex relationships between stakeholders and the spectrum of determinants influencing integration are presented by the force field analysis (Fig. 1).

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Table 3
Overview of key legislative changes to palliative care in Croatia.

Strategic documents	Legal acts and rulebooks		
Strategic development plan of palliative care in the Republic of Croatia for the period 2014–2016. National program for the development of palliative care of the Republic of Croatia 2017–2020.	Health care act		
	2003	2008	2018
	Palliative care for the terminally ill and dying included in health care measures and listed as an activity at the primary level of health care, under the health centres' stewardship A palliative care institution is defined with an obligatory interdisciplinary team for home visits, pain clinic, inpatient capacities and a living room	The health centres coordinate the provision of palliative care with private health workers who perform public health services on the basis of concessions	Palliative care is incorporated as part of the principle of a holistic approach to health care, with prevention, diagnosis, treatment and rehabilitation Besides health professionals, the provision of palliative care includes other professionals for specific issues Palliative care can be provided at the secondary and tertiary levels of health care The health centre provides a palliative care coordinator and mobile palliative care teams A palliative care institution is defined as an institution for the provision of inpatient palliative care
	Plan and program of health care measures from compulsory health insurance		
	2006	2020	
	Primary health care General care measures applicable to palliative care Providers: palliative care teams in cooperation with general practitioners, community nurses, home care nurses, hospital specialists	*Primary health care* Specific measures for palliative care Providers: palliative care coordinator of and mobile palliative team in cooperation with palliative care institutions, general practitioner, community nurse, home care nurse, social worker, psychologist, pharmacist, palliative care hospital teams, day hospital, palliative care hospital departments, individual specialists, volunteer organizations, civil society organizations, local government and self-government, social institutions; spiritual care providers; the media; the CHIF; competent ministries, institutes and agencies, medical schools, colleges, and universities *Secondary and tertiary health care* Providers: a team of at least three specialist doctors (specialties depending on the type of patient's disease), hospital palliative care team, bachelor / bachelor of nursing, doctor at hospital emergency service, health worker / health associate with appropriate training for supervision	
	Rulebook on minimum conditions regarding premises, workers and medical-technical equipment for performing health activities		
	2011	2015 changes and amendments	2018 changes and amendments
	Standards set for palliative care institution and health care institution providing inpatient palliative care (both on primary health care level) Requirements set for the working team – minimum education standard and number of professionals per patient	Standards added for health centres with inpatient capacities, hospital departments for palliative care, and other hospital departments' rooms with palliative care bedsThe room has to look home-like with place for family members to stay overnight. There also need to be: • an antidecubital mattress required • a kitchenette • a room for farewell from the deceased • a place for the palliative care coordinator and mobile palliative teams, including a meeting room • additional palliative care education for workers	Requirements set for the working team in hospital palliative care Occupational therapist with additional palliative care education added to the team

Source: Authors based on the national strategic and legislative documents [29,44-51].

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Table 4
Overview of the educational activities in palliative care in Croatia.

Guidelines	Education for professionals	Education for volunteers
Palliative care coordination centre/Palliative care coordinator in the county – a manual (Ministry of Health)	*Postgraduate* Postgraduate courses of continuous medical education of the I. category: Zagreb University, 2010 – 2021: “Fundamentals of palliative medicine”, twice a year, around 1000 students in total; “Communication skills in oncology and palliative care”, once a year, around 700 students in total “Psychological aspects in palliative care”, once a year, 350 students in total	In 2017 – 2020, over 200 people educated to volunteer in palliative care by La Verna volunteer organization and Croatian Catholic University
National guidelines for the work of outpatient and inpatient emergency medical services with patients in need of palliative care (Croatian institute of emergency medicine)	“Palliative care of war veterans”, 4 in total, 100 students in total Rijeka University: “Clinical Palliative Colloquium”, 10 courses, around 300 students in total Split University: “Basic knowledge of palliative medicine”, 2017 Osijek University: “Fundamentals of palliative care”, 2021, Osijek University, 25 students *Undergraduate and graduate level*	Until 2018, 26 two-month courses for non-health volunteers in palliative care were held by Croatian Association of Friends of Hospices
Tools and educational materials for professionals, for the implementation of palliative care (Rijeka University Hospital Centre and Andrija Štampar School of Public Health)	Palliative care introduced as a compulsory subject in undergraduate and postgraduate university and specialist nursing studies Palliative care introduced as a compulsory subject in 2/5 integrated undergraduate and postgraduate studies of medicine *High school* Palliative care introduced as a compulsory and an elective subject in high school education of nurses Numerous conferences on palliative care, with local, national and international participation, organized by professional societies, scientific institutions, health, and government institutions	I. Conference on Volunteers in Palliative Care held in 2019, organized by the Society for Hospice and Palliative Health Care of the Croatian Association of Nurses

Source: Authors based on publications, and announcements and reports on professional education [52–58].

A particularly important factor influencing the development of comprehensive and continuous palliative care is the existence of well-developed primary health care, community health programs, or a developed network of home services and good coordination of all stakeholders in primary care. The palliative care reform in Croatia has been based on the concept of care integrated within the health system, with care providers from both health care and other sectors, as palliative care is, by its nature, a multi-professional field. The novelty was that the reform was not a pilot project limited to certain institutions, but a system-level intervention implemented from 2014 onwards.

4. Discussion

4.1. Policy and integration implementation processes

The development of palliative care in Croatia can be compared with similar processes in other countries. Furthermore, the system was developed on the basis of international experiences and recommendations, taking into account the local situation. Several determinants are common to all of these reform processes. First, there is a continuous increase in needs and demands for palliative care because modern medicine prolongs life and allows palliative care to be included earlier in the course of the disease. Second, all societies are continuously improving forms of care aimed at helping seriously and chronically ill patients and their families. Third, the need to care for the most complex patients comprehensively and continuously has been recognized in many countries. Fourth, as a way to achieve the goals of optimal palliative care, the integration of all forms of care and putting the patient at the centre of care is considered necessary. In terms of challenges and barriers in the implementation and integration of palliative care in the health system, many similarities across countries can be identified. Most countries share a lack of resources, the fragmentation of care in terms of service delivery and payment, and regional disparities [67–69].

Croatia has developed a strategy, but not a special law regarding palliative care. Implementation was achieved through existing policies, management mechanisms, and payment systems. In addition, a unique national model was formed, which, using decentralized management, was adapted to local circumstances, leading to significant differences in progress across counties (Table 1).

4.2. Primary health care

Although there is a national plan and an overall legislative framework for the development of palliative care in Croatia, there are large differences between individual regions. The nuclei from which palliative care develops and spreads differ significantly. In some counties, these are hospitals where there are trained professionals and management initiatives for the development of palliative care, while other counties focus primarily on the development of coordination centres and mobile teams in primary health care. In some ways, these different approaches across counties are reminiscent of different approaches pursued across countries. Country examples of well-established primary and home-based palliative care services are Canada and the Netherlands [70,71].

In Croatia, there has been a trend towards the privatization of primary health care in recent years. This entails a weakening of the role of the publicly run health centre, which had been the fundamental bearer and coordination entity of primary care since 2008, and a strengthening of the position of private providers, with only up to 25% of employees remaining within health centres. The exception are several non-profitable services, including palliative care, which cannot be provided easily in private practices. The privatization process thus runs counter to the goal of integration. Combined with weak incentives for providing care to patients with complex health and social care needs, this leads to a reduced interest in the active management of palliative care patients [72]. Another challenge is that the distribution of health centres is uneven across counties (in terms of numbers of health centres per county), with no clear reasons for why this should be the case.

4.3. Hospital care

Depending on the stage of development, in some countries (Austria, Belgium, France, Germany, Portugal, and the United Kingdom) inpatient forms of palliative care are dominant [73]. This can be traced to hospital-centred health systems and the roots of pal-

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FORCES DRIVING INTEGRATION OF CARE	FORCES HINDERING INTEGRATION OF CARE
Policy process and resource allocation	
• Integrated care, community care, and home care are EU priorities • NGOs are developing innovative programs supporting integrated care • The European Association for Palliative Care (EAPC) White Paper on Palliative Care • Foreign reports (World Bank, European Commission) addressing the need for integrated care • Croatian Strategy on Palliative Care	• Lack of change management in health care • Division of resources between health and social care • Ignorance in the development of strategic and policy documents • Lack of system and process thinking in the planning of services
Professionalization	
• Physicians are recognizing the need for task-shifting • Institutions are interested in developing new education programs • There is a global skill-mix emphasis in health care	• Separate education for professionals from different fields • Division of competencies • Professional chambers not supportive of task-shifting • Resistance to the involvement of informal caregivers • Hierarchy-based teams and approach
Business process	
• Demand for higher quality demand • Demand for higher efficiency • IT solutions facilitating the flow of information	• Multi-level payment of services (CHIF, local and national authorities) • Separate ministries for health and social care • Lack of communication canals between different sectors • Ineffective management

Fig. 1. Force field analysis of integration processes in palliative care in Croatia from 2014 – 2020. *Source:* Authors based on the national legislative and strategic framework [1,14,17-19], and national and international reports on the state of health care in Croatia [15-16, 20-24].

liative care emerging from oncology and the care for cancer patients.

In Croatia, general palliative care, as conceived by the Strategic Plan, should be provided to each palliative care patient in hospital, and every healthcare worker should have the skill of recognizing and approaching palliative care patients. However, according to the National Plan of Development of Hospitals, the reorganization of hospitals should be based on their "functional integration". Described as is, it actually fits the definition of organizational integration, according to Lewis at al. [74]. Although this term refers to "integration", it is at odds with the integration process of palliative care. Functional integration with regard to hospitals in Croatia implies connecting hospitals in order to achieve better quality of health services, improved patient safety and satisfaction, and increased financial stability and sustainability of the health system. It means changing the modality in which activities are performed [75].

"Functional integration" is planned to place palliative care in certain hospitals, which would also be a modality of work (as opposed to acute treatment, day-case treatment, etc.). Although the hospital development plan has been formally adopted, the anticipated changes have so far occurred only at the legislative level, i.e. they have not yet been implemented. The national and regional strategies for the hospital system are not aligned, and as a result, the National Development Plan for Hospitals, based on their "functional integration", has not been implemented for almost a decade [76].

If it does get implemented, the danger is that this would neglect other needs of palliative care patients and their recognition in the overall health system. Moreover, it would move care from patients' homes to a specialized institution, something the palliative care reform aimed to avoid. The hospital development plan is, therefore, an example of system-centred integration, rather than a patient-centred one. Furthermore, the whole health system is al-

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ready orientated towards hospitals, while palliative care shifts the emphasis to the patient's home.

At the regional and local level, the establishment of palliative care project teams strengthens the further development of the new palliative care model. Counties are developing regional strategic plans for palliative care, as requested by the 2017 National Palliative Care Plan.

The recognition of palliative care and the extension of its scope to specific vulnerable groups was set out in the second strategic framework, covering 2017–2020. With the shift of palliative care from end-of-life care mainly for cancer patients to earlier interventions in the course of other non-communicable chronic diseases, there is a demand for the same shift from inpatient care to home care or as close to home as possible.

4.4. Social and cultural integration

The Croatian health system is still strongly hierarchical and physician-led. It is an innovation for nurses to have the responsibility for care coordination, as foreseen in the National Palliative Care Plan. Furthermore, a paternalistic relationship between physician and patient is still dominant in Croatia [77]. It poses an obstacle to the integration process, as the new palliative care model anticipates a strong partnership and active role of patients and their families.

Apart from the health system, palliative care also became more visible in the wider societal context. This is evident in the omnipresence of the topic in the public space, the increase of volunteers dedicated to the field, the representation of the palliative care topic in under- and postgraduate theses, as well as the emerging educational curricula covering palliative care in under- and postgraduate education.

In countries such as Poland and the United Kingdom, the first initiatives and roots of palliative care emerged from humanitarian programs outside the health system that helped the patients and their families [78]. The same was witnessed in Croatia, which is why civil society has been involved formally in the strategic plan. Volunteering in health and social care is an important component for the successful development of palliative care. However, the volunteering culture is still underdeveloped in Croatia. It poses another challenge, especially in face of the lack of health professionals. Hungary reports similar challenges, as opposed to Austria and the Netherlands, which have a high enrolment of volunteers and where civil society is a key component of care provision [71,79-80].

The processes of social and structural integration, besides reflecting the existing health care culture, have been affected by years of fragmentation of the health and social care systems. The increase of the health system's complexity due to medical and technological developments has not been followed by more efficient governance and management. So far, the framework for the structural integration of palliative care has largely been set by strategic plans and, later, by changes in the regulation of palliative care. However, its full implementation will also require social and cultural integration.

4.5. Efficiency and quality

Systematic evidence on efficiency and quality of palliative care in Croatia is so far limited, due to the lack of a national monitoring system. However, quality improvements are likely to have occurred in recent years in view of the increased resources provided, an increase in the number of palliative care beds, an increase in the number of health professionals providing palliative care, the new training courses they have undergone, and new palliative care guidelines.

Access to palliative care is likely to have improved, as palliative care services have been brought closer to where people live. Not only were hospital beds converted to palliative care beds, but departments underwent complete refurbishment, making them more suitable for palliative care patients and their carers, which is likely to have improved quality of palliative care.

The new projects targeting specific local needs for palliative care, which involve regional governments and non-governmental organizations, show an overall increased awareness of the need for defined palliative care processes.

5. Conclusions

Croatia's palliative care model, based on the integration of health and social care, is undergoing a process of continuous change in terms of developing and reorganizing structures, and developing and linking processes of care. Achievements of these processes were confirmed by the EU and national authorities, and have been set as a priority for the period 2021–27. However, more research needs to be undertaken to explore specific efficiency and quality issues and other indicators that have to be improved.

5.1. Implications for policy and resource allocation

A patient-centred and process-based change in health care can have a positive effect on the integration of care. This development could be supported by the demand for greater system efficiency, which includes the shortening of hospital stays and the prioritization of outpatient care. Demands for the specialization of services and the consolidation of institutions providing palliative care, on the other hand, can negatively affect the integration and quality of palliative care.

5.2. Regulation and education

Under- and postgraduate education in palliative medicine can help to promote the integration of care, but staff education and regulation of business processes are key for the sustainability of reforms. Attitudes towards horizontal and vertical integration and how to achieve those in primary care have a direct bearing on palliative care.

5.3. Integration

The basic principles of the Croatian health system are supporting integrated care, but due to strong top-down governance and the lack of managerial capacities at all levels, are often not reflected in the organization of the health system. The important over-arching lesson from the Croatian experience is that it seems easier to achieve the integration of care when it develops as a bottom-up model and reflects the need for new processes, than when it is imposed from above as a single regional or national model.

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and conducting scientific research in the field of identified social change.

Conflict of interest statement

The authors declare that they have no conflict of interests.

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