Croatia

Croatia (Hrvatska) covers an arc of territory from the Danube River in the east to Istria in the west and down the Adriatic coast to Dubrovnik in the south. The borders of the country are with Bosnia and Herzegovina, Slovenia, Hungary and the Federal Republic of Yugoslavia. The land area in 1993 was 56,500 km2 ...The capital is Zagreb.

Northern Croatia united with Hungary in the 12th century, turned to the Austrian Habsburg Empire in the 16th Century and remained part of the Habsburg Empire until 1918. With the dissolution of this empire in the First World War, Croatia became part of the kingdom of Serbs, Croats and Slovenes, renamed Yugoslavia in 1929. After the Second World War, Croatia became a republic within the Yugoslav Federation under Marshal Tito.[1]

[1] *Health Care Systems in Transition: Croatia* (1999) Copenhagen: The European Observatory on Health Care Systems: 1.

1 Palliative care service provision

1.1 Current services (last updated: May 2002)

The following palliative care services are known to exist in Croatia:

		Existing services (2002)
Adult	Inpatient - Freestanding	0
	- Hospital unit	0
	- Hospital mobile team	0
	Nursing home	0
	Home care	1
	Day care	0
	Total	**1**
Paediatric	Inpatient	0
	Home care	0
	Day care	0
	Unspecified	0
	Total	**0**
	Grand total	**1**

Current projects (last updated: May 2002)

The following palliative care projects are known to exist in Croatia; these are not yet operational services:

		Known hospice/ palliative care projects (2002)
Adult	Inpatient - Hospital	0
	- Hospice	0
	Home care	0
	Unspecified	7
	Total	**7**
Paediatric	Hospital	0
	Hospice	0
	Home care	0
	Unspecified	0
	Total	**0**
	Grand total	**7**

The only current palliative care service in Croatia is a hospice home care team based in Zagreb and run by members of the Croatian Society for Hospice/Palliative Care. Soon to move to its own premises in a health care home in the east of the city, it will then also establish a day care service. Volunteer doctors, nurses and social workers make up the home care team, working evenings, weekends and in holiday time. This service began in January 2000. During its first year, with the services of a total of 18 volunteers, 771 visits were made to 57 patients; visits lasted between 1-4 hours and were sometimes overnight. Help was also given through a substantial number of telephone consultations with doctors (1,000) and nurses (691). The service holds a stock of special beds, portable toilets and other aids and equipment. The group also provides a visiting service to patients in a local nursing home. It has not yet received any financial support from the state or from the HZZO (the Croatian insurance fund).

There are examples of other, less developed, groups with palliative care interests in Karlovac, Virovitica, Varazdin, Kopvrinica, Osijek, Split and Pula.

Development project

In Koprivnica Kizevci County, Croatia, which has 326 deaths per year from cancer, 65% of which occur at home, there is a primary health care development project funded by the World Bank and directed by the BIS Health Care Group. Most unusually, the project has produced a needs assessment for palliative care in the county[2] and made recommendations for local palliative care service provision.

1.2 Reimbursement and funding for services

The only current palliative care service in Zagreb, Croatia, run by members of the Croatian Society for Hospice/Palliative Care, has not yet received any financial support from the state or from the HZZO (the Croatian insurance fund).

[2] *Copyright © 2001 BIS Healthcare Group, All Rights Reserved*. Report No 21336/3/A10 Revision 1.4, 12 June 2001. Prepared by Dr Jeremy Keen.

1.3 Opioid availablity and consumption

Morphine chloride; morphine sulphate (continuous); pethidine; pentazocine; fentanyl; tramadol; methadone; and codeine are all registered for use in Croatia. There is no immediate release morphine. Morphine consumption in Croatia is low at 0.7398 mg/capita[3] in 1999 and had remained relatively stable for some years. Then in 2000 the Ministry of Health made an estimated morphine requirement for 12 kg of the drug; in 2002 the estimate had risen 313% to 50 kg. Opioid prescriptions are made out in duplicate; prescribing physicians keep a separate book of details of patients receiving opioid analgesics; prescriptions are valid for five days; the amount per prescription is limited, though the duration of treatment is not.[4]

INCB data on opioid consumption in Croatia between 1994 and 1998 are available for codeine, morphine, pethidine and cocaine. In that time codeine consumption almost doubled from 291 kg to 505 kg; morphine consumption increased over the same period only from 1 kg to 5 kg. Pethidine consumption fell during these years from 9 kg to 6 kg. Methadone consumption was relatively stable: 32 kg consumed in 1994, compared to 35 kg in 1998. A small amount of cocaine was consumed in 1995-97, 4 kg in total. The average daily consumption of defined daily doses of these drugs per million inhabitants between 1994-98 was: codeine (1883); morphine (32); methadone (527); pethidine (7).[5]

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[3] *Availability of Opioid Analgesics in Eastern Europe and the World* prepared for WHO/OSI Workshop on Assuring Availability of Opioid Analgesics for Palliative Care, Budapest, Hungary, 25-27 February 2002, by Pain and Policy Studies Group, WHO Collaborating Center for Policy and Communications in Cancer Care, University of Wisconsin Comprehensive Cancer Center, Madison, Wisconsin, USA.

[4] Bilusic Marinko MD. *Opioid Availability in Croatia.* Presentation to WHO/OSI Workshop on Assuring Availability of Opioid Analgesics for Palliative Care, Budapest, Hungary, 25-27 February 2002.

[5] International Narcotics Control Board (2000) *Narcotic Drugs: Estimated World Requirements for 2000. Statistics for 1998*. New York: United Nations.

In February 2002 issues relating to the use of opioids in Croatia were summarised by an expert group[6] as follows, and an action plan was formulated to address them:

(1) Does national policy require the use of a special prescription form?
Yes, duplicate for opioids

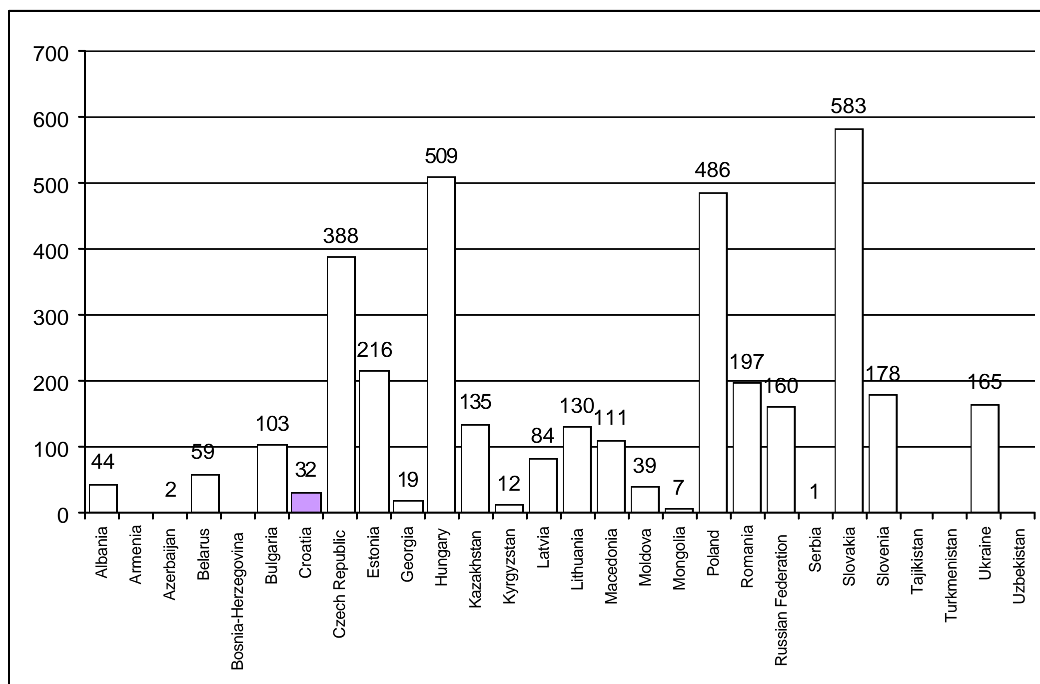
(2) Does the physician or institution have to pay for the special prescription form? *No*

(3) Does national policy establish a validity period for opioid prescriptions?
Yes
If so, what is the period? *5 days*

(4) Does national policy establish a maximum amount that can be prescribed at one time? *Yes*
If so, what amount? *2 g morphine, 0.05 g fentanyl patch,*
0.2 g methadone per prescription

(5) Does national policy limit the length of time that a patient may be treated with an opioid? *No*

Average defined daily doses of morphine, Central and Eastern Europe (1994-1998)



Source: Clark D, Wright M (2002) *Transitions in End of Life Care: Hospice and Related Developments in Eastern Europe and Central Asia*. Buckingham: Open University Press

[6] WHO/OSI Workshop on Assuring Availability of Opioid Analgesics for Palliative Care, Budapest, 25-27 February 2002.

1.4 National and professional associations

The Croatian Society for Hospice/Palliative Care was founded in wartime, in 1994 as part of the Croatian Medical Association. Its principle aim is to promote hospice ideas through professional education and development; branches were created in Virovitca in 1997 and Koprivica in 2001. The society received funding support from the Open Society Institute in 2001 and 2002, in particular for its work as a national educational resource in palliative care. It has organised some local fund-raising events and has the support of a private benefactor. In 1997 the Friends of Hope Society was formed for fund-raising purposes within Zagreb, followed by the Croatian Society of Hospice Friends, with branches elsewhere. In 2000 a Croatian Society for Pain Treatment was founded, as part of the Croatian Medical Society.

1.5 Palliative care 'coverage'

There is a service providing palliative care for every 4.6 million people in Croatia.

Ratio of hospice/palliative care services per million population, Central and Eastern Europe (2002)

	Ratio 1:
Estonia	1: 0.14m
Poland	1: 0.15m
Slovenia	1: 0.32m
Bulgaria	1: 0.36m
Hungary	1: 0.37m
Latvia	1: 0.48m
Lithuania	1: 0.62m
Czech Republic	1: 1.02m
Albania	1: 1.03m
Romania	1: 1.07m
Slovakia	1: 1.33m
Macedonia	1: 1.98m
Bosnia-Herzegovina	1: 2.00m
Croatia	1: 4.60m
Serbia	1: 10.50m

Source: Clark D, Wright M (2002) *Transitions in End of Life Care: Hospice and Related Developments in Eastern Europe and Central Asia*. Buckingham: Open University Press

1.6 Palliative care workforce capacity

Croatia currently has 20 physicians (including 3 family doctors) and 4 nurses with some form of palliative care training, together with 2 psychologists, 3 social workers and 59 volunteers working in the field.[7]

[7] Questionnaire data (Observatory)

2 History and development of palliative care in Croatia

2.1 Narrative history of palliative care in Croatia

Since 1994, the retired neurologist, Professor Anica Jusic, from a base in her own apartment in Zagreb has led a team of activists seeking to promote palliative care in Croatia. Their chief focus has been on raising public and professional awareness through a programme of conferences, lectures and symposia, many of which have involved the participation of experts from outside the country. The group is involved in the translation and publication of key palliative care texts into Croatian and has promoted numerous study and educational visits abroad for Croatian doctors, nurses, social workers and volunteers. There is a particular link with Hospice Buffalo, New York State, USA and with Pilgrims Hospice in Kent, UK and the Kent Institute for Medicine and Health Sciences, at the University of Kent.[8] The group produces its own newsletter, *Bilten* [Bulletin], which by its 10th issue at the end of 2001 had grown to 40 pages in length. It has obtained publicity through the Croatian mass media, for example by participating in the international event *BT Voices for Hospices*.

The key strategy of this group has been awareness raising, education and lobbying of the Croatian Ministry of Health. It has established a working party to promote inter-faculty collaboration in palliative care education at the University of Zagreb and to educate a team of future experts. The Croatian Society for Hospice/Palliative Care is working closely with the Croatian Society of Oncology (established 2001) and special sessions on palliative care have been held at recent oncological conferences.

In March 2002 Professor Jusic was asked to chair a multi-disciplinary and multi-agency working group on palliative care, to report to the Minister of Health, which will focus on establishing palliative care within Croatian health law, on funding and service development across the country, and on a national education strategy. There is a particular concern to have hospice/palliative care defined as the responsibility of both the Ministry of Health *and* the Ministry of Work and Social Welfare

[8] Murtagh FEM (2002) 'Palliative care teaching in Croatia'. *Hospice Information Bulletin* 1(1).

2.2 Hospice/beacon case studies

No information currently available.

2.3 Life/oral histories

No information currently available.

3 Public Health Context

3.1 Population

The population of Croatia in 2001 was 4,381,352 : a decrease from the 2000 figure of 4.6 million.

3.2 Epidemiology

Croatian health status is better than that of many Central and Eastern European countries, with life expectancy at birth in 1997 of 76.5 for females and 68.6 for males. Figures for 2000 indicate an increase to 77.7 for females and 69.8 for males.

In the year 2000 deaths (50,246) exceeded births (43,746). Ischaemic heart disease was the major cause of death. There were 11,278 cancer deaths in 1999, making it the second most common cause of death after cardiovascular disease. Deaths in health care institutions have been steadily rising, from 25.4% in 1970 to 45.7% in 1998, though there are said to be major local variations in the rates of home death.

Population and life expectancy, Central and Eastern Europe (2000)

	Population	*Life expectancy*	
	Millions	*Male*	*Female*
Albania	3.1	64.3	72.9
Bosnia- Herzegovina	3.9	68.7	74.4
Bulgaria	7.9	67.4	74.9
Croatia	4.6	69.8	77.7
Czech Republic	10.2	71.5	78.2
Estonia	1.3	65.4	76.5
Hungary	9.9	66.3	75.2
Latvia	2.4	64.2	75.5
Lithuania	3.7	66.9	77.2
Macedonia	2.0	70.2	74.8
Poland	38.6	69.2	77.7
Romania	22.4	66.2	73.5
Serbia	10.5		
Slovakia	5.3	69.2	77.5
Slovenia	1.9	71.9	79.4

Source: World Health Report 2001

WHO age standardised death rates per 100,000 population,
Central and Eastern Europe (1995-1998)

	Year	*All causes*	*Cancer*
Albania			
Bosnia- Herzegovina			
Bulgaria	1998	958.9	123.3
Croatia	1997	836.0	174.2
Czech Republic	1998	706.6	182.9
Estonia	1998	907.7	157.8
Hungary	1998	917.8	219.4
Latvia	1998	955.2	152.1
Lithuania	1997	817.2	149.4
Macedonia	1997	809.1	126.6
Poland	1996	812.2	165.2
Romania	1998	933.9	130.6
Serbia			
Slovakia	1995	820.9	172.3
Slovenia	1997	666.1	167.5

Source: World Health Organisation: World Health Statistics 1997-1999

3.3 Health care system

Social ownership of health facilities in Croatia is being replaced with state, county and private ownership. The Croatian Health Insurance Institute was established in 1993 in place of more limited schemes and it determines the available resources for health by setting and collecting insurance contributions. It is also responsible for setting the normative standards fro health care provision. However, the Ministry of Health produces an annual national health plan with defined objectives. 'The Croatian health reforms have been marked by a distinctive approach to privatisation of primary care and some secondary care. The decision was to lease health care facilities at subsidised rates rather than sell them in order to provide stability in difficult economic times. The debts of the previous system have been eliminated and in 1995 a surplus was accumulated to pay for new capital equipment.'[9]

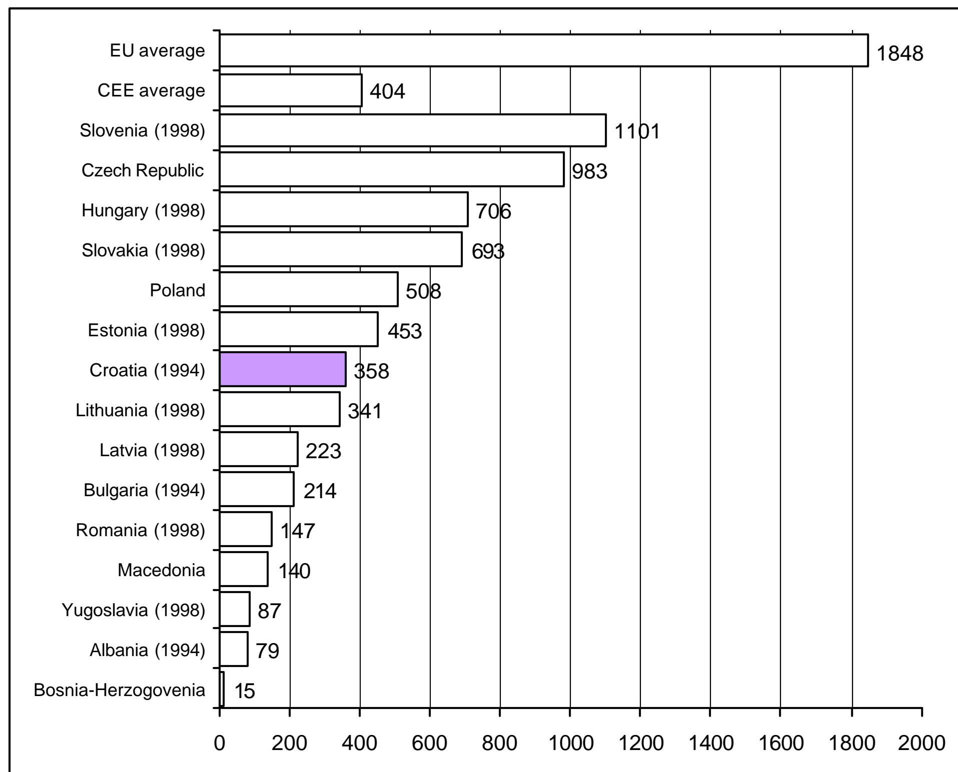
[9] *Health Care Systems in Transition: Croatia* (1999) Copenhagen: The European Observatory on Health Care Systems: 46.

Despite some apparent improvements in the overall health care system, a group of palliative care innovators in the country have stated:

> 'The number of beds in hospital is reduced, even for cancer patients, the outpatient services are limited so that you have to wait for months to get some kind of examination in the social/governmental sector. You might go to the private units but their services are too expensive for most patients, and the additional health insurance does not work as yet. The hospital admissions for dying or old patients are difficult and due to limits the ward discharges early.'[10]

Health care expenditure (US$) per capita, Central and Eastern Europe

Health care expenditure (US$) per capita, CEE and the CIS



Source: WHO Regional Office for European Health for All database and HiTs

[10] Desa Grubic-Jakupcevic; Marijana Persoli-Gudelj, Anica Jusic, Biserka Valjak, Silvia Missoni response to ECEPT questionnaire.

3.4 Political economy

Croatia became an independent country when the Yugoslavian federation collapsed and its first democratic and multi-party elections took place in 1990. Independence was announced in June 1991. This promoted a declaration of independence from Croatia of the Serbian enclave of Krajina, which led to war. The Dayton peace agreement finally brought hostilities to a close in December 1995. In emerging from these four years of conflict (1991-95), Croatia has been suffering from major social and economic problems.

In 1999, 1,001,064 inhabitants in Croatia were recorded as retired. Unemployment in the year 2000 was 21%.

4 Ethics and ethnography

4.1 Ethical issues

No information currently available.

4.2 Ethnographic studies

No information currently available.

5 References and further reading page

5.1 References

1: *Health Care Systems in Transition: Croatia* (1999) Copenhagen: The European Observatory on Health Care Systems: 1.

2: *Copyright © 2001 BIS Healthcare Group, All Rights Reserved*. Report No 21336/3/A10 Revision 1.4, 12 June 2001. Prepared by Dr Jeremy Keen.

3: *Availability of Opioid Analgesics in Eastern Europe and the World* prepared for WHO/OSI Workshop on Assuring Availability of Opioid Analgesics for Palliative Care, Budapest, Hungary, 25-27 February 2002, by Pain and Policy Studies Group, WHO Collaborating Center for Policy and Communications in Cancer Care, University of Wisconsin Comprehensive Cancer Center, Madison, Wisconsin, USA.

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7: Questionnaire data (Observatory)

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9:*Health Care Systems in Transition: Croatia* (1999) Copenhagen: The European Observatory on Health Care Systems: 46.

10: Desa Grubic-Jakupcevic; Marijana Persoli-Gudelj, Anica Jusic, Biserka Valjak, Silvia Missoni response to ECEPT questionnaire.