In advanced outcome-based healthcare segments, insurers are reimbursing providers on the outcomes they deliver for their patients. Outcome-based reimbursements create better incentives for health services firms to effectively treat the growing population of patients with chronic diseases.

Opportunities for Croatia may lie in cultivating a private health sector focused on outcomes. Firms in this sector could compete for new patients in private insurance pools. Competitiveness will be determined by the quality of outcomes firms deliver, especially for “chronic needs” patients.
CROATIA: HEALTH SERVICES AND NEW METHODS OF PREVENTIVE MEDICINE AND DIAGNOSTICS

Croatia defines health care as a universal right. Croatia has a single-payer public health care system administered by the Croatian Institute for Health Insurance (HZZO for its name in Croatian). The system is funded by compulsory employee contributions.

A tiered system offers some added coverage. Croatia has two other insurance markets in addition to the mandatory market. One is a complementary public health insurance through HZZO, which covers the cost difference of services, products, and procedures not covered by the basic compulsory insurance. The second is private health insurance.

Because the public sector dominates health services, the number and size of private sector providers is small. All private health and residential care firms combined reported revenues of only EUR 354 million in 2015, compared to more than EUR 3.15 billion in public expenditures.

Private health service providers rely on dental tourism, which is driven by cost rather than quality. In this market, Croatian firms have a cost advantage over nearby Italian providers. However, sustained cost-led competition in dental services implies considerable risk and there is limited scope for growth.

The dental tourism market in Croatia could shrink as Italian and Austrian markets become more efficient due to recent equity investments. Dental tourism may not be a promising long-term opportunity. Instead, Croatian health service firms may have to rely on the expansion of private insurance markets in Croatia.

Health care innovation in Croatia lags international benchmarks. Furthermore, there may be a ‘brain drain’—Croatians are filing more patents for health industries outside of Croatia than inside the country.

Private health service providers rely on cost advantages, but this market is shrinking as Italian and Austrian providers become more efficient.

Croatia Medical Tourism Exports

Emerging strategic segments emphasize outcome-based payments. Advanced buyers—including insurance companies and public payers—are building outcome-based payments into their contracts. Firms have begun to compete for customers (insurers or individuals) based on the quality of outcomes.

Emerging outcome-based strategic segments share three key features:

- **Data collection.** Providers need to rigorously collect, manage, and secure evidence about the efficacy of their services.
- **Data analysis.** Beyond collecting data, providers, payers, and suppliers all need to analyze, operationalize, and commercialize it based on outcome and risk.
- **Demand for telehealth services.** Payers in emerging strategic segments encourage patients to seek care at telemedicine providers when possible.

Emerging outcome-based strategic segments have two main markets: “acute-needs” patients and “chronic needs” patients. “Acute needs” patients (such as those with a broken arm) and “chronic needs” patients (such as those with diabetes) require different care models. The markets therefore have different value chains.

The markets for “acute needs” and “chronic needs” patients therefore have different value chains.
“Acute Needs”
Shifting from a ‘general practitioner + emergency room’ model towards ‘Urgent care clinics + integrated Pharma Services’

The “acute needs” strategic segment will increasingly require:

- Changes in the point of care. Acute care is shifting from general practitioner clinics and emergency rooms at large hospitals to urgent care clinics increasingly integrated with pharmacies.
- Changes in form and usage. Consumers remain in control of decisions about where to seek acute care. However, payers are increasingly guiding customers to the most efficient points of care.

“Chronic Needs”
Shifting towards proactive primary care and integrated case management complemented by hyperspecialized points of care

The “chronic-needs” strategic segment will increasingly require:

- Hyperspecialized points of care. Outcome-based care for chronic conditions is becoming hyper-specialized in outpatient care clinics (e.g., clinics specifically for prostate cancer).
- Integrated care. Because providers are liable for the outcomes of their patients, they are increasingly integrating all relevant services in-house.
- Proactive primary care and integrated case management. Whereas previously, general practitioners coordinated all aspects of their patients’ care, now data-driven tech companies are increasingly managing care pathways to optimize outcomes.
- Personalized health care. Given the intensity of outcome measures, personalized health care—using case managers and exact time-release treatment—is becoming common.
- Self-management and behavioral health coaching. Health providers prioritize prevention and invest in patient self-management, which may include frequent personalized communications.
- Monitored device integration. Chronic health care is increasingly informed by monitored devices that give providers access to outcomes in real time.
MAKING CROATIA COMPETITIVE

Where Is the Value Chain Weak?

Certain aspects of the health services value chain constrain Croatia’s competitiveness:

- **Collecting, managing, and analyzing data on outcomes.** In Croatia, private insurance companies have not invested in collecting or analyzing outcome data. Moreover, Croatia lacks the innovative legal, institutional, and technological scaffolding necessary to promote the confidential collection and management of health-related big data.

- **Navigating new business models.** Croatian companies need to prepare for new models of healthcare focused on outcomes. Some actors in the value chain might not be eager to start the transition. Without the participation of health insurers, for example, movement by health service providers is unlikely.

- **Defining the role and scope of private insurance.** Croatia’s regulatory structure limits the sophistication of private insurance products and constrains insurers’ ability to deliver on outcomes.

- **Easing the financial transition.** The transition to an outcome-based health care system in Croatia will impose a temporary burden on firms. Firms may need to convince investors of the business case for the move and adopt new accounting and pricing systems.

Croatian companies need to prepare for new models of healthcare focused on outcomes.

Evolution in Healthcare Measurement


- **Biological & Medical Measures**
- **Cost Measures**
- **Patient Experience Measures**
- **Value Based Measures**
- **Structural Measures**
- **Process Measures**
- **Patient Outcomes**

Source: Adapted from 2016 presentation “Value-Based Health Care in Europe. What’s Next?” by Prof. Dr. F. Van Eenennaam
Areas for Reform

To improve its competitiveness in strategic segments, Croatia needs to strengthen parts of its health industry ecosystem:

Demand Conditions

Public providers constrain demand for private health services in Croatia. Basic, universal health insurance dominates most insurance markets. However, domestic demand for private health insurance is growing as incomes rise and patients want access to additional services.

Croatian firms need to orient toward EU markets. A few other EU countries have single payers that are moving quickly toward outcome-based payment systems. These payers (and others that will transition over time) could serve as sources of demand, but only if providers can demonstrate quality outcomes.

Factor Conditions

Capital is a constraint for Croatian health service providers. Croatian healthcare providers have about EUR 240,000 in assets on average, whereas specialist providers internationally have around EUR 70 million, and data-driven chronic care providers have about EUR 130 million. Croatian firms would need to match this investment through substantial financing.

Small and medium enterprises (SMEs) have limited access to finance. Banks in Croatia charge interest rates of approximately 4.7 percent for typical short-term loans, more than in comparable countries. (The Croatian Bank for Reconstruction and Development offers concessional loans with interest rates of 2 percent to SMEs investing in priority regions of the country.)

Croatia offers low wages compared to neighbors, but also lower labor productivity. Croatia has a higher rate of graduates in tertiary education in scientific and technical fields than many EU countries. However, the best graduates often find higher-paying jobs elsewhere in Europe. Thus, data and software intensive skills needed for outcome collection and analysis are missing.

Related and Supporting Industries

Delivering on health outcomes requires better collaboration. All actors in the value chain—including insurance companies, IT providers, pharmaceutical suppliers, and medical device manufacturers—need to cooperate.

Croatia’s health-related ICT industry is weak. Croatia lags the global average of 3.2 percent of health budget spent on IT development. With only around 200 IT specialists working in Croatian hospitals, the country is behind the global average of 2.9 percent of all hospital employees.

Strategy, Structure, and Rivalry

There is little vertical integration in private healthcare. Insurance firms, providers, and input suppliers operate independently. There is little coordination to manage the continuity of care or collaborate on innovations.
Recommendations

Specific actions could improve Croatia’s competitiveness in emerging strategic segments:

1. Developing institutions to systematically measure health outcomes. There is little in the way of outcome measurement in Croatia. Firms could collect this ‘big data’ on their own. However, it is often more efficient to create this resource as a club or public good. The government could facilitate the collection of outcome data at the national level using secured blockchain solutions.

   Estimated timeframe: 5 years.

2. Providing a partial risk guarantee. Croatian health service providers need to scale up investment in their operations. The government could incentivize investment through providing guarantees. Such a guarantee might cover 80 to 90 percent of a lender’s loss (on an accelerated payment scheme) in their health services sector portfolio. The maturity of the guarantee could be set at 15 years to allow firms to adjust to long-term structural changes.

   Estimated timeframe: 7 years.

3. Organizing a testbed pilot. Croatian providers need the opportunity to practice healthcare delivery on an outcome-driven basis. A first stage would target health firms specialized for chronic patients through a pilot. Relevant line ministries or government corporations could run the pilot through a public procurement. The longer-term aim would be to give all healthcare private providers the opportunity to evaluate the results of outcome-based payment systems.

   Estimated timeframe: 3 years.

4. Creating a mentoring program for the health industry. A mentoring program would provide support for (a) consultancy services to help firms transition to outcome-based business models, (b) expert mentoring from health services and advanced insurance companies that have implemented the new model, and (c) advice related to adopting technology for remote care or data management. MoEEC or the Croatian Chamber of Economy could implement the mentoring program (through a technical assistance program) as a matching grants scheme.

   Estimated timeframe: 2 years.

5. Adopting smart regulations that enable the functioning of insurance markets and protect patient confidentiality while allowing insurers and healthcare providers to use patient data fairly and productively. Smart regulations would expand the scope and role of private insurance to allow for patient choice, integrated care, and added benefits over the compulsory health insurance. Defining laws that enable competition on quality—not on cost—will be key to the success of private health providers. MoEEC and other relevant agencies could implement this recommendation through public institutions and government agencies.

   Estimated timeframe: 3 years.

NOTE
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