Mission to Croatia

Franciscan Team Helps a New Nation Create Its Geriatric Care System

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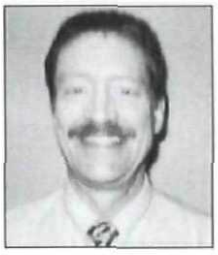

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In 1995 the Franciscan Health System (FHS), then based in Dayton, OH, received a $1.3 million grant from the U.S. Agency for International Development (USAID) to help Croatia improve its geriatric care system. An FHS geriatric team was to travel to that country and advise its government about establishing an educational system for geriatric care professionals, emphasizing core competencies for administrators, physicians, nurses, clinic and office managers, and fund-raisers.

Croatia, which seceded from Yugoslavia in 1990, was still a new nation at the time of the FHS team's first visit. A census conducted in 1991 had revealed a population of 4 million, 13 percent of whom were elderly. In 1995 Croatia's elderly were consuming 40 percent of the national healthcare budget (whose total was only a quarter of Ohio's annual healthcare budget).[1] Making matters even worse was the fact that because of war with Serbia, civil unrest, and flight to the West, the nation had lost a significant number of its younger citizens.[2] By 2000, according to Croatian government estimates, the country will have one of the proportionally largest over-65 populations in Europe.[3]

Unfortunately, Croatia, whose primary industry was tourism, had been forced to invest much of its limited resources in rebuilding its war-damaged tourism infrastructure. Help in setting up a national geriatric care system was therefore much needed. The FHS team made extended visits there in 1996, 1997, and 1998.

The Team and Its Challenges

FHS's geriatric team consisted of a retirement center administrator, a geriatrician, two physiatrists, a rehabilitation psychologist, and a home health nurse manager. Arriving in the city of Biograd na Moru in 1996, the team set up headquarters at a local orthopedic and rehabilitation hospital.

One of the team's goals was to establish the hospital as a center of excellence in gerontology, an underdeveloped specialty in Croatian medicine. Using the hospital as an educational and research base, the nation's healthcare system could efficiently develop and disseminate new policies and procedures in geriatric care.

Although the Croatian constitution guarantees access to basic healthcare for all citizens, the actual provision of care to the elderly faces several barriers. There is, for example, no central government agency coordinating geriatric care. The Ministry of Health, controlled by physicians, is responsible for hospital-based services. The Ministry of Labor and Social Welfare, controlled by social service professionals, directs long-term care services. The two ministries compete for funding. At the time the FHS team arrived, there was little cooperation between them.

One of the team's first practical tasks was enlisting the collaboration of care facilities overseen by each ministry. This was done on two levels. In Zagreb, Croatia's capital, the American International Health Alliance (AIHA), a USAID subcontractor, helped persuade members of the central government to cooperate. At the local level, the FHS team formed a coalition of healthcare professionals who were already eager for such cooperation. This coalition, which continues to operate, has proven to be invaluable in ensuring continuity of care between local hospitals and long-term care facilities.

The Rehabilitation Model

The FHS team's interdisciplinary nature ensured that it would take a broad view of the complex challenges involved in Croatia's system of geriatric care. Early in 1996 team members decided to

adopt a rehabilitation rationale and language in the recommendations they would make to the Croatian government.[4] The team had seven reasons for this decision:

- An estimated 60 percent of the world's over-60 population are mildly to severely disabled.[5]
- The care continuum is a basic assumption of the rehabilitation model.
- For the individual patient, rehabilitation effectiveness is defined in terms of the optimal functional level achieved in the community.
- In global terms, the model emphasizes evidence-based outcomes in a community context.
- Rehabilitation principles and technology translate easily into geriatric care policy language.
- Rehabilitation has a tradition of multidisciplinary research that can affect policymaking.
- In the model, individual patient, family, and community needs are routinely assessed to help focus the rehabilitation process.

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The rehabilitation model, developed by the World Health Organization,[6] was consistent with Croatian practice. The leaders of Biograd na Moru's hospital agreed to adopt the model in the care provided to their patients. And, in 1996-97, Croatia designated the hospital as the nation's first geriatric rehabilitation center. Although government funding of the project did not match expectations, this official recognition was a step forward.

The leaders of Biograd na Moru's hospital also agreed to adopt the standard manual for the accreditation of rehabilitation care facilities.[7] Although written by Americans, the manual is being adapted for use by professionals in other countries, including Canada, Sweden, and France. The fact that the manual's reputation is international made it appealing to Croatians, many of whom would like to see their country grow closer to Western Europe.[8]

International Links

To foster cooperation between the Ministry of Health and the Ministry of Labor and Social Welfare, the team got the help of AIHA and the U.S. State Department in arranging a November 1998 visit to the United States by top officials of the two Croatian ministries. A stop in Columbus, OH, introduced the visitors to U.S. healthcare at the state level, and another in Washington, DC, gave them a national perspective.

The Croatians' response was mixed. On one hand, they decided that the U.S. system had little relevance to Croatia's because it seemed wasteful of resources. (The visitors were especially appalled to find that the United States has more than 40 million uninsured citizens.) On the other hand, the Croatians did see opportunities for collaboration between the two countries, especially in long-term care.

In May 1998 the team helped the Croatians organize an eastern European conference on geriatric care policy in Biograd na Moru.[9] The participants—from Slovenia and Hungary, as well as Croatia and the United States—compared the geriatric healthcare systems of a number of nations, including Canada, Israel, France, the United Kingdom, Australia, Japan, and the United States. They decided that similarities generally outweighed differences except in one case: They saw the U.S. system as differing from theirs in its methods of financing, administration, policy setting and coverage.

Conference participants were particularly impressed by a study that had been conducted when France was planning its national geriatric policy.[10] Taking into account medical, cognitive, social, environmental, and community factors, the French researchers surveyed elderly care needs in multiple provinces, thereby enabling the government to make prudent use of its geriatric healthcare resources. By introducing the Croatians to the French program, the team hoped to encourage them to combine centralized policy making with strong local control of resource allocation.

As a result of the conference, Croatia decided to establish a geriatric curriculum based on international standards in its healthcare education.

Looking into the Future

During its five-year association with Croatia, the FHS team made four recommendations, three to the host country and one to other European nations.

Centralize Geriatric Policy and Services Following the

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Private investing would likely strengthen Croatia's geriatric care.

example of France and Canada, Croatia should merge the geriatric services currently divided between two government ministries. An effective continuum of geriatric care will require coordination at the highest government levels.

Encourage Private Investment Croatia's Ministry of Labor and Social Welfare would like to see private companies invest in that country's geriatric services. Unfortunately, though, its cumbersome funding/reimbursement system discourages investors. The ministry should consider adopting funding that encourages investors to build multitiered nursing/retirement communities, community care clinics, and hospice/home health agencies. Given centralized policymaking and localized resource allocation, private investing would likely strengthen the nation's geriatric care.

Create an International Exchange Program The Ministry of Labor and Social Welfare should fund an exchange program in which key leaders of Croatia's retirement services would study those in the United States and American leaders would do the same in Croatia.

View Croatia as a Laboratory Social scientists in other countries should view Croatia as a laboratory in national geriatric policymaking. The growth predicted in its elderly population there will be a preview of the explosion set to occur over the next 20 years in Western Europe. Surveys conducted in Croatia would be useful in planning geriatric healthcare for both that nation and its neighbors.

IMPROVING INTERNATIONAL HEALTHCARE

Croatia has agreed to fund a program to exchange healthcare leaders with the United States. Cheered by this and the other positive results of its association with that country, the FHS team urges the State Department to continue its healthcare grant program. A collegial effort rather than a political club, the program helps improve healthcare on the international level. □

For more information call Tom Kerkhoff, 352-338-0091, ext. 5820; or Brian Forschner, 513-825-9300.

NOTES

1. *Croatian Health Development Policy and Strategy Master Plan: Republic of Croatia Policy: Health for All by the Year 2005*, Zagreb, Croatia, 1996.
2. System Health Information Service, *Final Report: Health Surveillance Project*, University of Zagreb Medical School and United Nations High Command on Refugees, Zagreb, Croatia.
3. Republic of Croatia Ministry of Health, *Report of the Health System in the Republic of Croatia and Its Development: 1990-1995*, Zagreb, Croatia, 1996.
4. B. Forschner, T. Kerkhoff, and J. Labar, "The Challenge of Elder Healthcare in a Changing Croatia," *Medica Jadertina*, no. 27, 1997, pp. 1-4, 93-102.
5. H. Hoenig, N. Nusbaum, and K. Brummel-Smith, "Geriatric Rehabilitation: State of the Art," *Journal of the American Geriatric Society*, no. 45, 1997, pp. 1,371-1,381.
6. Hoenig, Nusbaum, and Brummel-Smith.
7. Commission on Accreditation of Rehabilitation Facilities, *Standards Manual and Interpretive Guidelines for Medical Rehabilitation*, Tucson, AZ, 1996.
8. Germany in particular has given Croatia a good deal of assistance, including medical technology, since 1990.
9. Money from the AIHA grant funded the conference.
10. D. Leibovici, S. Curtis, and K. Ritchie, "The Application of Disability Data from Epidemiological Surveys to the Development of Indicators of Service Needs for Dependent Elderly People," *Age and Aging*, no. 24, 1995, pp. 14-20.

STRUCTURES IN MINISTRY

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Sponsorship has also grown to include the idea of fidelity to mission and purpose. In many Catholic healthcare organizations, executive positions exist to promote and monitor the values of the sponsor. Most of these positions have a wider responsibility than the elements of canonical sponsorship.

What does the future hold for the adaptation of present juridic structures and the development of new structures for a Catholic healthcare ministry?

The exploration of the use of the structures described in the Code of Canon Law began almost immediately after its promulgation in 1983. The majority of Catholic healthcare sponsors in the United States are religious institutes of women. Since 1983 these institutes have focused their efforts on combining or jointly sponsoring their ministries. The recently established pontifical juridic persons, both public and private, have invested a large measure of authority in their lay members; however, the religious institutes have maintained control over who is a member of the juridic person. It remains to be seen if religious and lay cooperation is the final stage for these organizations or whether it is a step toward ultimate lay control.

There are diocesan private juridic persons and associations of the faithful that are true examples of lay sponsorship. At this time, however, they sponsor only a few facilities.

The immediate future appears to lie in lay and religious cooperation. One obvious question for the continuation of this partnership is the ability of religious institutes to contribute resources, especially personnel (which for most institutes is very limited), to partnerships. Another question is the interest and ability of laity to participate in the Catholic healthcare ministry. The dynamic quality and changing landscape of healthcare, including healthcare ministry, make it difficult to predict the future. □