ORIGINAL RESEARCH

Back to People's Health in Croatia – Generating new forms of collective agency

Snježana Ivčić, PhD; Lecturer Aleksandar Džakula, MD; Damir Martinović, MD; Valerija Žapčić,

Abstract

This paper concerns new forms of collective agency in the area of healthcare in Croatia from 2015 until 2018. These new forms developed in the midst of the growing privatization and commodification of health care and the simultaneous decrease in the accessibility to healthcare.

Privatization has taken place slowly, but continuously over the last 29 years. The traditional civil society organizations in the field of healthcare used to be characterized by a narrow set of activities, with vertical structures, and were frequently focused on a single-disease approach and collaboration with the pharmaceutical industry. Such practices produced limited results; hence improved forms of activism emerged.

In this research, we illustrate their development using the example of three case studies of collective agency. The first case study is looking at the policy analysis and the activist group started by the Organization for Workers' Initiative and Democratization (OWID); the second one focuses on the informal group of medical students called U3 formed at the Andrija Štampar School of Public Health with the aim of developing critical thinking; and the third case study considers the Karika Association, started as an attempt to rethink healthcare in the community.

The main research methods employed included process tracing analysis and research data comparison aimed at showing the differences between the traditional and the new forms of healthcare activism, in addition to the secondary sources of information such as scientific and professional literature. The results show that the new forms of collective agency in the healthcare area include various groups of citizens not necessarily connected with a specific disease, that they have a horizontal structure and are focused on the healthcare system in general. In conclusion, they represent the beginning of a paradigmatic shift in activism from a single-disease approach towards comprehensive health care that has the potential to deal with the growing issue of commercialization, commodification and inequalities in today's healthcare systems

.Key words: Croatia, public health, comprehensive health care, collective agency, active.

Snježana Ivčić, PhD,
Croatian Academy of Sciences and Arts, snjezana.
Email: ivcic@gmail.com

Lecturer Aleksandar Džakula, MD,
Škola narodnog zdravlja Andrija Štampar "/
School of Public Health „Andrija Štampar ",
Email: adzakula@snz.hr

Damir Martinović, MD,
Odjel za radiologiju, Opća bolnica Zabok i bolnica hrvatskih veterana /
Department of radiology, General Hospital Zabok and Hospital of Croatian Veterans ,
Email: dmartinovic.mef@gmail.com

Valerija Žapčić,
Nurse Educator, Udruga Karika /
Karika Association,
Email: udruga.karika@gmail.com

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Introduction

This paper is focused on a paradigmatic shift in the approach to the access to health care in Croatia. Historically speaking, there were three shifts. The first one occurred at the beginning of the 20th century, when Doctor Andrija Štampar introduced comprehensive health care in the then Yugoslavia invoking a transition from capitalism to social medicine.

Andrija Štampar, doctor and founder of the public healthcare system in this area, pointed out in his 1919 text *O zdravstvenoj politici* [*On Health Policy*] (1) the negative influence of the capitalist economy on human health: "the whole national economy is managed and flourishes to the detriment of the people's health and our overall health budget is in substantial deficit". Štampar warned against another very important fact, that capitalism comes down to purely physical/corporal strength, where sale is considered goods and people's health has no value, but is simply a consumable good: "In a capitalist economy the man provides some economic value, although he has no economic value himself; if he does not use his working power or loses it, he is like air and water." (1)

In his 1934 paper *10 godina unapređivanja narodnog zdravlja* [*Ten Years of Improving Public Health*], Andrija Štampar, wrote that the State was responsible for the citizens' health "…only the state-controlled health service can, in certain circumstances, provide adequate health care to the people" (2, p. 105). In addition, he was convinced that "Everybody should be equally committed to the issue of public health, affecting not only the health but also the progress of every individual. This is the only way that it can become an object of public concern." (2, p. 109).

Štampar's principles and approach to health care were implemented into the health policy of former Yugoslavia (1945-1991). The Yugoslavian healthcare system was based on solidarity and the principles of Andrija Štampar (3). Furthermore, it is worth noticing that health was defined by the Health Protection and Health Insurance Act (1980) (4) and treated as a public good (although this was not explicitly stated).

The outcomes of the Lalonde report (1974) (5), the Alma Ata Charter (WHO, 1978) (6) and the Ottawa Charter (WHO, 1986) (7) were in many ways complementary to the healthcare system in Yugoslavia at the time (8), which saw the health of the population as a concept made up of biological, social and economic components (1,9,10).

The second paradigmatic change occurred in the 1980s, its first sign being the 1973 oil crisis. In fact, these changes started back in the 1980s, when neoliberal politics dominated also health policies, especially in the south-eastern European countries (11), and Croatia was no exception (8, 12). In Croatia, however, privatization started to emerge in the 1980s (13).

Formally speaking, the second shift took place in Croatia at the beginning of the 1990s, with privatization in the healthcare system and the consequent replacement of the social economy by the free market economy over the next 29 years. The second change of paradigms in Croatia was introduced by a programme written by Andrija Hebrang in 1994 (14). He was not the first one to announce privatization, as it had already started at the end of the 1980s but he wrote a programme for it, advocating firmly the privatization of primary health care in Croatia. Subsequently, ministers of health and health experts continued along the same path, resulting however in today's deterioration of the healthcare system.

The third shift, which is the object of this research, started taking place very recently, only a few years ago. This new transition from the free market and commercialization and commodification of the healthcare system to universal/social and comprehensive healthcare is very interesting from several aspects. While a strong personality (A. Štampar) and the social state played a big role in the first transition, and in the second transition, international institutions (e.g., the International Monetary Fund and the World Bank) exercised a great influence in the newly formed state, the third, most recent transition began as a bottom-up shift to which civil society made a great contribution.

The third paradigmatic change was also marked by the global situation which contributed to the rethinking of the Croatian healthcare system and had influence on collective agency. Three concepts[1] need to be taken into consideration:

[1]There are some differences between the PHC and UHC approach. The PHC implies "primary healthcare

refocusing on the primary health care (PHC) as defined in the Alma Ata Chapter, global request for the universal health coverage (UHC) and promotion of the value-based health care (VBHC) defined by Michael Porter in 2010. This wave affected the OWID's group for health, the U3 group and the Karika Association.

This paper will try to answer the following research question: What factors led to the emergence of the third paradigmatic shift in the civil society area dealing with healthcare, and, more particularly, to a transition from a single-disease approach towards comprehensive health care in Croatia over the last decade. Furthermore, this paper focuses on the difference between traditional civil society organizations and the new forms of collective agency in the healthcare area as shown in three case studies.

The first case study is looking at the policy analysis and the activist group started by the Organization for Workers' Initiative and Democratization (OWID); the second one focuses on the informal group of medical students called U3 formed at the Andrija Štampar School of Public Health with the aim of developing critical thinking; and the third study considers the Karika Association, started as an attempt to rethink healthcare in the community.

practitioners working closely with their communities on the social and environmental determinants of health as well as in healthcare development" (15, p. 81) and the public sector dominates the economy. The UHC approach (the WHO version) is focused on the "financial protection and argues explicitly for public single payer financing (not care)". This approach strengthens the role of the private sector. Value in health was first explicitly mentioned in England in 2004 by the NHS, which published its first Annual Population Value Review in 2006. (16, p. 25). In 2010 Michael Porter (17, p. 2477) also defined value in health: "Value should always be defined around the customer, and in a well-functioning health care system, the creation of value for patients should determine the rewards for all other actors in the system. Since value depends on results, not inputs, value in healthcare is measured by the outcomes achieved, not the volume of services delivered, and shifting focus from volume to value is a central challenge. Nor is value measured by the process of care used; process measurement and improvement are important tactics but are no substitutes for measuring outcomes and costs. Since value is defined as outcomes relative to costs, it encompasses efficiency."

Methods

The main research methods employed in this study included process tracing analysis [2] and research data comparison aimed at showing the changes of paradigms and the differences between the traditional and the new forms of collective agency in the field of healthcare, in addition to the secondary sources of information such as scientific and professional literature.

Process tracing is the appropriate method for case studies based on qualitative data (18, p. 823), as was the case in this research. For the purpose of this research, Collier's definition of process tracing was used (18, p. 824): "Process tracing is an analytical tool for drawing descriptive and causal inference from diagnostic piece of evidence often understood as part of a temporal sequence of events or phenomena." Collier argues that process tracing "can contribute decisively both to describing political and social phenomena and to evaluating causal claims."

Bengtsson and Ruonavaara (19, p. 46) argue that if process tracing is understood in a broader context, it "refers to any research approach that is focused on tracing processes, that is, that looks at how various social and political outcomes are produced by events that result from actors' actions and interactions and various contextual factors." According to the two authors, "such a broad understanding of process tracing embraces both formal testing of hypotheses and more narrative approaches."

George and Bennett (20, p. 6) defined process tracing as the use of "histories, archival documents, interview transcripts, and other sources to see whether the causal process a theory hypothesizes or implies in a case is in fact evident in the sequence and values of the intervening variables in that case."

A timeline of the key events (Figure 1) [see text at the end] at the international and national level was created for the purpose of this research in order to help to understand the background of the above-mentioned paradigmatic shifts. The timeline has several purposes according to Ricks and Liu (21, p. 4): "…it helps clarify the

[2] https://en.wikipedia.org/wiki/Process_tracing

researcher's thought process, second, it establishes temporal precedence. Third, a timeline also provides what can be constituted as a "face validity" test for the argument. Fourth, timelines help us to identify major events that could have shaped the outcome of interests."

Beach and Pedersen (22, p. 838) argue that "on selecting cases that are as representative as possible of the rest of a causally homogeneous population, enabling us to infer that the mechanism that worked in the studied cases should also be present in the rest of the population of causally similar cases." Beach and Pedersen (22, p. 840) consider "tracing causal mechanisms using in-depth case study methods like process tracing can have two functions that result in the selection of different cases."

This study uses process tracing in order to compare the three qualitative case studies. The first case study is looking at the policy analysis and the activist group started by the OWID; the second one focuses on the informal group of medical students called U3 formed at the Andrija Štampar School of Public Health with the aim of developing critical thinking; and the third case study considers the Karika Association, started as an attempt to rethink health care in the community.

Results

I. Background and Context Settings of the healthcare system in Croatia

Figure 1 shows a timeline of the key events that led to the beginnings of the paradigm change in Croatia. Events were divided in those taking place at the international level and in Croatia only. A timeline of the last 100 years in Croatia shows the factors that enabled the paradigmatic shift and also how things change perpetually.

We focus on the third transition that started in 2008 in order to show the influence of the new forms of collective agency in the form of civil society activism. The year 2008 is significant for several reasons in the context of the emergence of new forms of collective agency in Croatia: the beginning of the economic crisis, the new version of the Health Care Act and the third wave of activism.

The first part of this section considers the broader context and the implications of the social, economic and political factors in Croatia for the healthcare system as a whole. Some international and domestic political, economic and social changes that happened over the last ten years influenced some events in Croatia, for example (see Figure 1), a new version of the Health Care Act was adopted in 2008 and at the same time another reform of the healthcare system was announced (23). The year 2008 was also significant because of another global economic crisis that affected Croatia, too. Many social policies, including health policies, were abolished and health care privatization and commodification was given a fresh impetus. Furthermore, Croatian accession to the EU in 2013 also had an impact on the healthcare system, considering some EU regulations and directives (for example, Regulation 883/04, Directive 2011/24/EU) needed to be implemented. Over the last 29 years, numerous healthcare reforms were adopted, almost one every year (24) and with each reform one part of the system was privatized or rendered ineffective (23).

The current situation in the public health system and the health system in general in Croatia is not very optimistic according to the report *State of Health: Croatia Country Health Profile 2019* (25). The profile provides a short synthesis of the health status in Croatia, focusing on risk factors, and an account of the health system. For example "health expenditure per capita, at EUR 1 272, was among the lowest in the EU in 2017, where the average was EUR 2 884. Croatia devotes 6.8 % of its GDP to health compared to an EU average of 9.8 %." The report identifies four main risk factors in Croatia: smoking, obesity, heavy alcohol drinking and low physical activity (25).

Table 1. Situation in Croatia in the last decade (2008-2018)

Current situation	
1. Poor public health indicators	**Public health crisis**
2. High share of spending on pharmaceuticals	
3. Reform efforts with limited success	

Source: OECD, 2019 (25)

Table 1 shows the current situation in Croatia according to the above-mentioned report. All three factors, i.e. poor public health indicators, high share of spending on pharmaceuticals, and reform efforts with limited success contributed to the recent public health crisis.

The report notes that Croatia "spends a much larger share of its health expenditure on pharmaceuticals and medical devices than many other EU countries, although in absolute terms (EUR 296 per person) it is below the EU average. […] In contrast, funds for long-term care only made up 3.1 % of health expenditure in Croatia, much lower than the EU average of 16.3 %, reflecting the fact that formal long-term care is still underdeveloped and mostly provided in institutional settings." (25, p. 10). Some other key findings from the profile are: "Croatia spent 6.8 % of its GDP on health in 2017, much less than the EU average of 9.8 %. […] Primary care is fragmented and seems to be underutilised compared to inpatient and hospital outpatient care. Long waiting lists for secondary and tertiary care are also a challenge." (25, p. 22).

In addition, numerous healthcare reforms proved to be unsuccessful and there is a need for the healthcare system to become more effective and consolidated in order to provide, first and foremost, comprehensive health care.

Table 2 Contemporary health trends in Croatia and worldwide

Trends in Croatia	
Providing health care / service	Commodification of health
Public health crisis	
"Selling sickness" /Disease mongering	Collective agency
Citizen participation	

Table 2 shows the current public health landscape in Croatia. There are four main trends; the first two, encompassing the provision of health care and the public health crisis, led to the commodification of health care, whereas the remaining two, called "selling sickness"[3] and citizen participation, contributed together to the emergence of (new) collective agency in Croatia. This confusing and demanding situation required a robust answer that the (new) collective agency was able to provide.

II. Civil Society Background

[3] By the term "selling sickness" we mean the ongoing trend, in Croatia and worldwide, of treating every disease as an event. Many civil society organizations are focused on single diseases and, in addition to helping their members/patients, they promote, consciously or unconsciously, these diseases and the medicines available to treat them, with a great help from the pharmaceutical industry. Tiner (26) explained that "…disease awareness campaigns are likely to expand the market for drugs for a given disease, but the market will expand for competitors' products as well as those of the sponsoring company. However, the real value of disease awareness campaigns is exactly what it says: making consumers aware that treatment may be available for their condition. Not infrequently, major disease is detected as a result of a patient seeking medical advice after contact with a disease awareness campaign." Moynihan, Heath and Henry (27) are of similar opinion: "Within many disease categories informal alliances have emerged, comprising drug company staff, doctors, and consumer groups. Ostensibly engaged in raising public awareness about underdiagnosed and undertreated problems, these alliances tend to promote a view of their particular condition as widespread, serious and treatable. Considering that these "disease awareness" campaigns are commonly linked to companies' marketing strategies, they operate to expand markets for new pharmaceutical products." Furthermore, Moynihan (28) gives the definition of selling sickness or disease mongering: "The problem of disease mongering is attracting increasing attention though an adequate working definition remains elusive. In our view, disease mongering is the selling of sickness that widens the boundaries of illness and grows the markets for those who sell and deliver treatments. It is exemplified most explicitly by many pharmaceutical industry-funded disease-awareness campaigns - more often designed to sell drugs than to illuminate or to inform or educate about the prevention of illness or the maintenance of health."

With regard to the development of civil society in Croatia, it needs to be said that since the 1990s, we witnessed three waves of activism in Croatia in the context of peace, human rights, gender equality and social justice (29). Stubbs examined the development of civil activism from 1991 on focusing mostly on human rights in the context of the Homeland War (1991-1995), and on women's rights. From the late 1990s to the late 2000s, the focus was on projectization and technocracy under the EU influence. The third wave of activism started in 2008 and was "differentiated in terms of the themes which were in focus, the more politicized discourses within which they are discussed and, not least, in the forms and processes through which they are expressed." (29, p. 22). It was characterized by different actions, by massive protests organized by associations and attended by the general public. Previously, protest had not focused on health but rather on environmental, women's rights and urban systems. The new approaches had a great impact, at a later date, on collective agency focused on healthcare systems.

According to the Register of Associations of the Ministry of Public Administration (30), there are 2657 associations in the field of healthcare in Croatia in 2020. They are grouped according to the field of expertise: cancer, diabetes, HIV, preventive activities, chronic diseases, heart diseases, patients' rights, etc. When searching the Register, it is almost impossible to find an association dealing with the healthcare system in general and some of the associations fall within social affairs.

The third wave of activism started to emerge in 2008 in Croatia according to Stubbs (29). This wave brought also some new approaches in the civil society organizations in the field of healthcare by then mostly focused on a single-disease approach and not the health care system in general. New approaches include more politicized discourses and networks among academic and local community and civil society. In this research, three approaches were used as a basis for a demonstration of collective agency: the academic community, the local community and the civil society perspective. They are illustrated by three case studies: OWID, U3 and Karika. Our focus here is on the new forms of collective agency, which had a considerable impact on the beginning of the paradigmatic change.

The first case study represents the civil society approach/perspective, embodied in the health research group established in 2015 as part of the OWID. OWID was originally established in 2012 (31) with the aim of influencing the healthcare system in general, promoting healthcare as an important aspect of social rights, researching healthcare reforms and healthcare accessibility, researching health marketization, working on the protection of public health and establishing a relationship with healthcare workers and their associations. The group's field of expertise encompasses primary health care, commercialization of the healthcare system, the union's work and EU health policy. Its main activities include organizing workshops, writing articles, conducting policy analysis, and research (32). The OWID is formally registered in the Register of Associations of the Ministry of Public Administration. The OWID has a horizontal management structure and several employees, but only one is dealing with healthcare. Other members of the group are volunteers. The OWID is not usually funded by the pharmaceutical industry or any other industry or organization that undermines human rights.

The second case study represented by the academic community, is the informal group U3 established in 2015. The idea behind U3 is to serve as a journal or academic club, as a platform for discussion of new phenomena (medical, political, social), book and article reviews, a place for critical thinking and promoting parrhesia[4] (33). It is a group where medical students, junior doctors, professors and public health professionals meet and discuss the current events in the healthcare sector. The U3 is a form of organization which is not strictly defined by place. It holds weekly meetings at Andrija Štampar School of Public Health, but it also takes part in the discussions organized by other organizations around Croatia. The U3 is based on academic foundations and gathers professors, students and associates. The group is characterized by a horizontal structure, with one or two coordinators and no employees. It is funded from donations. The group's main activities are journal club meetings, debates,

[4] free speech.

cooperation with other civil society organizations. The fields of expertise include public health, civil society, economic psychology, leadership and management of health services, human rights and ethics.

The third case study is the association called Udruga za unapređenje kvalitete života „Karika“ (*Association for the Improvement of the Quality of Life Karika*), established in 2017 in Karlovac. Karika is a local association focusing on the promotion of health in the local community (34). It focuses on three broad areas: healthcare protection, social issues as well as education, science, and research. The organization’s main activities include organizing lectures and workshops for children and parents in order to encourage parenthood, for people who want to adopt older children and for people with disabilities as well as organizing the Karlovac County Health Festival (Festival zdravlja Karlovačke županije) (35). Karika is a formal association entered in the Register of Associations of the Ministry of Public Administration. It is funded through membership fees, donations, sponsorships and project financing. Occasionally it collaborates with the pharmaceutical industry but this collaboration is limited to some specific events, and there is no influence of the pharmaceutical industry on the overall work or activities of the association.

Table 3. Three case studies

Organization	Short description	Approach
OWID	Policy analysis and activism Focus on labour rights and health Citizen perspective Bottom up approach	UHC, PHM
U3	Parrhesia Innovative approach Knowledge blocking Lack of evaluation Lack of knowledge transfer Academic setting	VBHC
KARIKA	Multisectoral approach Citizen participation Civil society Horizontal networking Community networking	PHM, UHC

Table 3 shows the similarities and differences among the three case studies. These associations are engaged in different forms of citizen activism and use different approaches. Their members are not only patients, but also ordinary citizens interested in the health system in general. In fact, a feature they all share is the citizen's participation. Furthermore, the associations are not focused on a single disease but rather work towards making analysis and activities available to all citizens.

All these approaches influenced and contributed, in some way, to the (re)thinking of the Croatian healthcare system and health policy in terms of collective agency. For example, the OWID’s group for health is under the strong influence of Andrija Štampar, PHC and UHC to a degree. The U3 is somewhat different because, in its work, it also takes VBHC into consideration. Karika's activities are also under the influence of Andrija Štampar. Together they helped to build a new strength which is able to advocate a progression from a single-disease approach towards comprehensive health care in Croatia.

Discussion

In this research, three approaches/perspectives were used as a demonstration of new collective agency: the academic community, the local community and the civil society approach/perspective. These three perspectives are illustrated by three case studies: OWID, U3 and Karika.

The traditional civil society organizations in the field of healthcare used to be characterized by a narrow set of activities, with vertical structures, and were frequently focused on a single-disease approach and very often collaboration with the pharmaceutical industry. In addition, focusing on a single disease helps the pharmaceutical industry to promote drugs for specific diseases and persuade (sick) people and their families to advocate the national financing of drugs. Furthermore, advocating for one group of patients and highlighting the problems of only one particular disease involves the exclusion of all other citizens with other types of health problems or diseases. All these approaches have influenced and helped in some way to (re)think the Croatian healthcare system and health policy in terms of collective agency.

The results show that the new forms of collective agency in the healthcare area included various groups of citizens not necessarily connected with a specific disease, that they had horizontal structures, that they were focused on the healthcare system in general (and that they were mostly independent of the pharmaceutical influence). Three case studies and their different approaches, which include the academic community (U3), the local community (Karika Association) and the civil society perspective (OWID's group for health), demonstrate that it is possible to start rethinking the Croatian healthcare system. The new collective agency includes active citizens (not necessarily patients), regardless of whether they are members of the formal or informal civil society and emphasizes the importance of their being aware of the meaning of an accessible healthcare system based on solidarity.

However, certain limitations should also be addressed as nothing is perfect and self-sustaining. All three groups face financing challenges, depend heavily on volunteers and enthusiastic individuals, and the lack of financial and human resources causes continuity problems.

The paradigmatic shift involved a progression from a single-disease approach towards comprehensive health care at a time when political, economic and social environment changes started to occur (Figure 1) from 2008 on in Croatia. The emergence of new forms of collective agency in the healthcare area in Croatia in the last decade enabled the beginning of the paradigmatic shift.

Conclusion

This paper explores the impacts of changing times on the forms taken by public health activism in Croatia, with specific attention to the political, economic and social changes that have characterized the past decade. In this research, a series of specific events leading to the current situation were chosen and the key steps in the process were analyzed, which eventually allowed for the changes and sequences to become visible.

The third paradigmatic shift is still an ongoing process and therefore no definite conclusions can be made as yet. Some events (Figure 1) show that changes in policy paradigms enabled the exploration of other possibilities. With the help of collective agency the focus has been slowly shifting towards the healthcare system in general.

Focusing on a single disease has some limitations, resulting in a restrictive approach to the healthcare system. Advocating on behalf of one group of patients and highlighting the problems of only one particular disease involves the exclusion of all other citizens with other types of health problems or diseases. In addition, this situation helps the pharmaceutical industry to promote drugs for specific diseases and persuade (sick) people and their families to advocate the national financing of drugs. On the other hand, a comprehensive healthcare approach tends to create a system that promotes the participation and inclusion in an ongoing battle for an accessible healthcare system based on solidarity.

The work and efforts of OWID, U3 and Karika need to continue in order to bring about changes. Without continuous action and reaction social cuts in the healthcare area will continue. The situation in Croatia may be improved further

and there are groups and collective agency that can make a change towards more social and comprehensive health care that has the potential to deal with the growing issue of commercialization, commodification and inequalities in the present healthcare systems.

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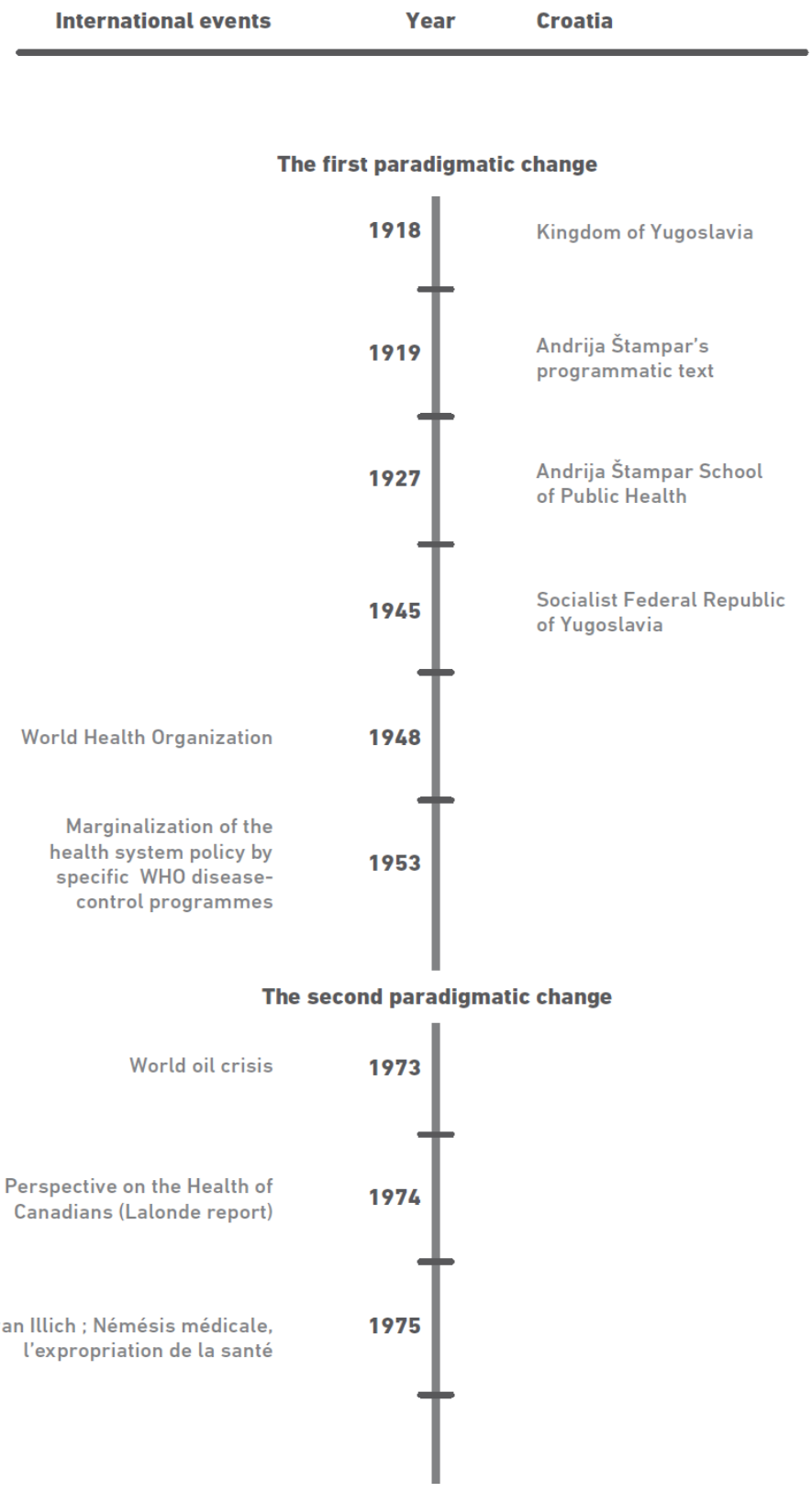
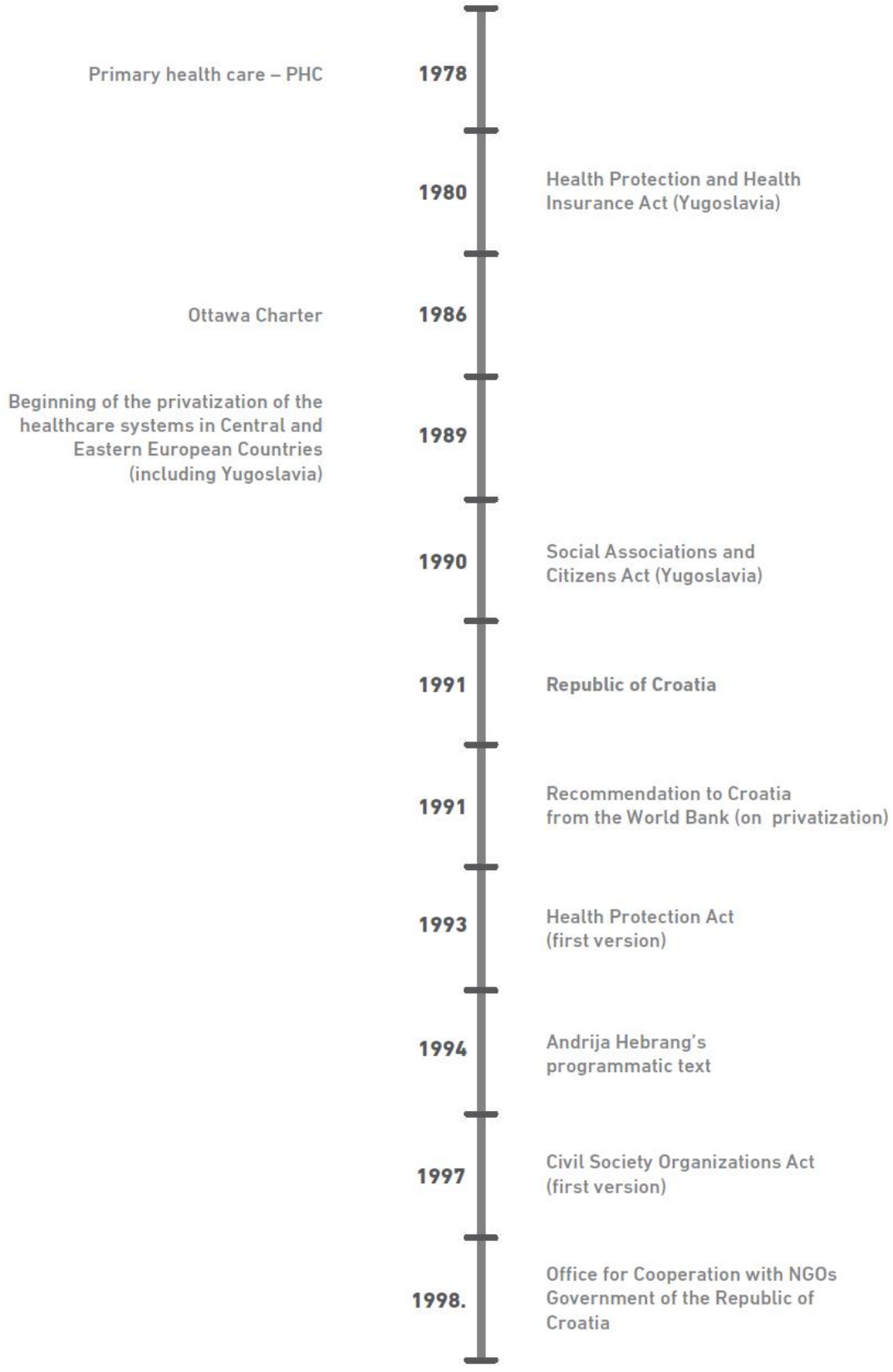
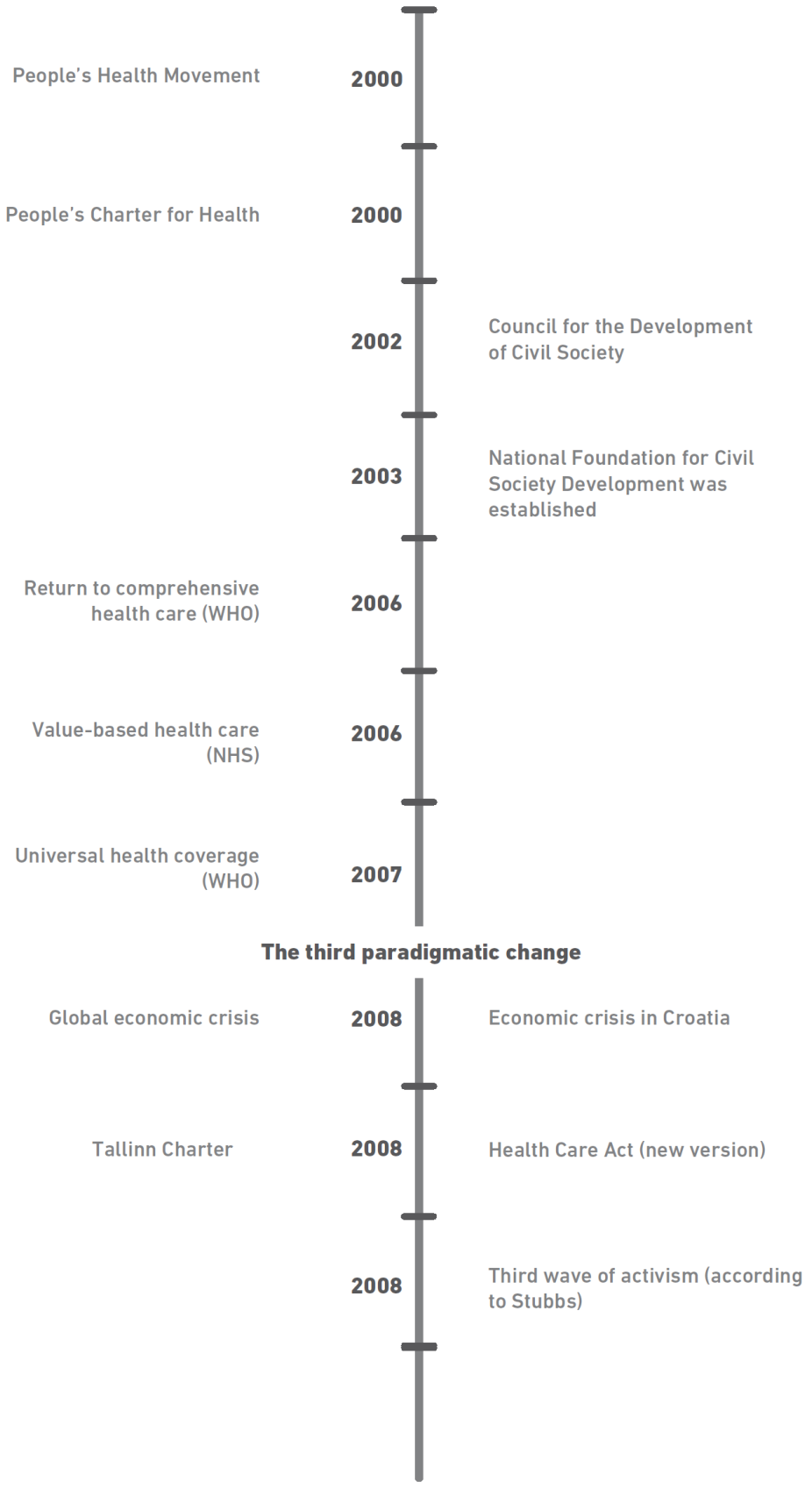
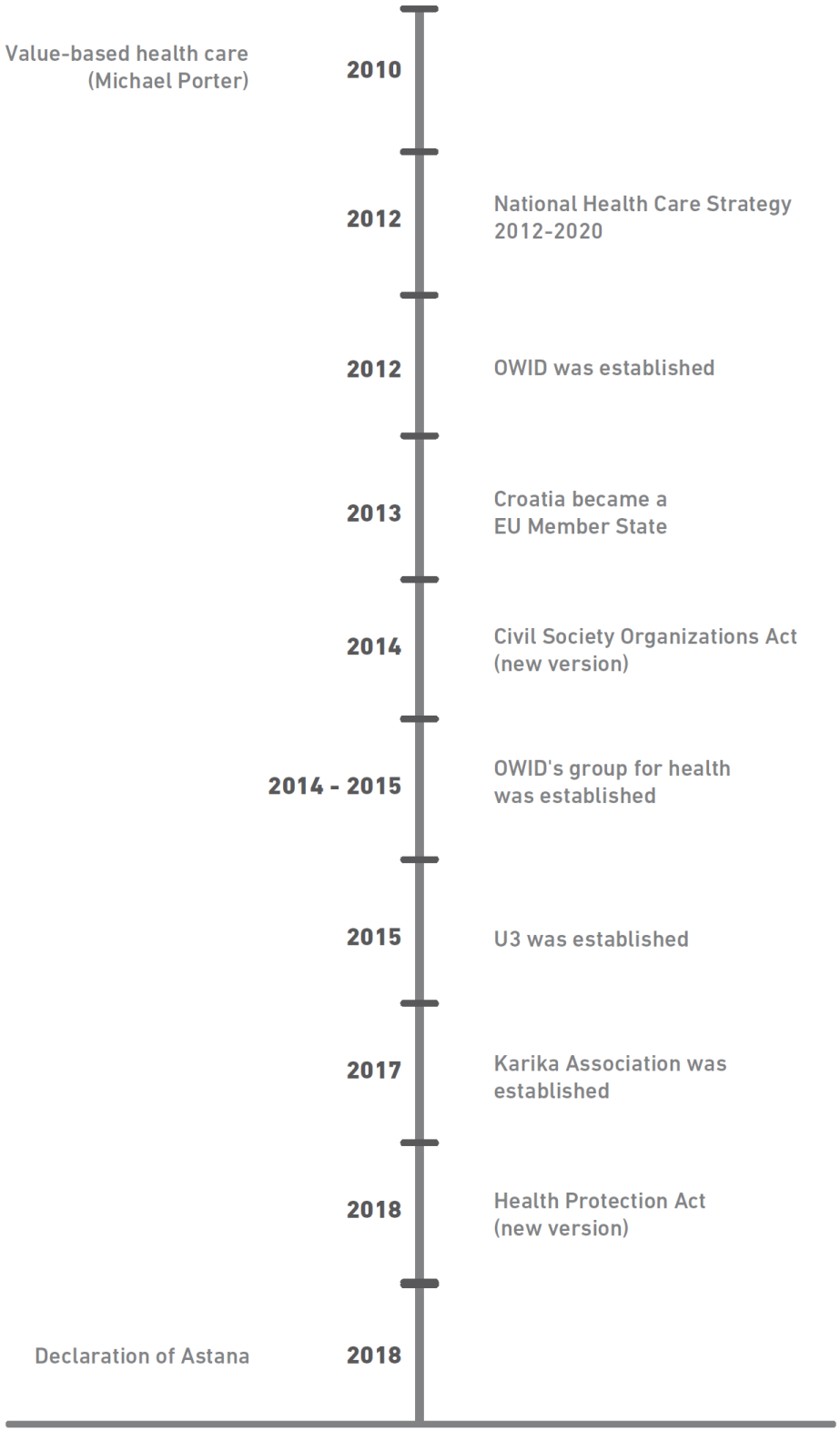
Figure 1. Timeline of the key events in the period from 1918 until 2018




Primary health care – PHC
1978
1980
Health Protection and Health Insurance Act (Yugoslavia)
Ottawa Charter
1986
Beginning of the privatization of the healthcare systems in Central and Eastern European Countries (including Yugoslavia)
1989
1990
Social Associations and Citizens Act (Yugoslavia)
1991
Republic of Croatia
1991
Recommendation to Croatia from the World Bank (on privatization)
1993
Health Protection Act (first version)
1994
Andrija Hebrang's programmatic text
1997
Civil Society Organizations Act (first version)
1998.
Office for Cooperation with NGOs Government of the Republic of Croatia


People's Health Movement
2000
People's Charter for Health
2000
2002
Council for the Development of Civil Society
2003
National Foundation for Civil Society Development was established
Return to comprehensive health care (WHO)
2006
Value-based health care (NHS)
2006
Universal health coverage (WHO)
2007
The third paradigmatic change
Global economic crisis
2008
Economic crisis in Croatia
Tallinn Charter
2008
Health Care Act (new version)
2008
Third wave of activism (according to Stubbs)


Value-based health care
(Michael Porter)
2010
2012
National Health Care Strategy
2012-2020
2012
OWID was established
2013
Croatia became a
EU Member State
2014
Civil Society Organizations Act
(new version)
2014 - 2015
OWID's group for health
was established
2015
U3 was established
2017
Karika Association was
established
2018
Health Protection Act
(new version)
Declaration of Astana
2018