The 4Cs of the Croatian public healthcare system: social marketing challenges at the dawn of EU accession

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Abstract: As a country nearing EU accession, Croatia faces many political, legal and economical challenges. Harmonisation with EU laws within the public sector is one of the most challenging steps in Croatia’s accession process. Under the rubric of public sector services, public healthcare is one of the most important as it supports the well being of individuals and society as a whole. The primary aim of this paper is to provide limited insight into Croatian public healthcare from the social marketing perspective. The exploration of the implementation of the social marketing principles is conducted following Lauterborn’s 4C marketing mix as the theoretical framework. Based on the literature review and primary research finding, this study provides an overview of the implementation of basic social marketing principles within the Croatian public healthcare system. Finally, the authors propose necessary changes to re-focus on user satisfaction and provide guidelines for further research.

Keywords: public healthcare; social marketing; healthcare services; Lauterborn 4C; Croatia.


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1 Introduction

Due to the process of EU accession, structural changes and harmonisation with EU legislation has been the Croatian *modus operandi* for the last five years. In such a dynamic and challenging environment, the Croatian public healthcare system participates in both mid- and long-term reforms, such as decentralisation. However, as Dzakula et al. (2008) suggested, the process of decentralisation, if poorly managed, could negatively impact the quality of healthcare, increase costs, delay development and structural changes. Poorly managed reforms could also result with unintended damage. While the reforms and decentralisation in the Croatian healthcare system are mainly focused on cost-cutting, rationing services and encouraging the provision of private health services, the level of satisfaction among users decreased because of increased inequality of access to healthcare (Mastilica and Kusec, 2005). Unfortunately, in Croatia, like in other Central and Eastern European countries, the quality of the healthcare system has rarely been evaluated from the user’s perspective (Mastilica and Chen, 1998). However, the implementation of marketing principles and focus on users could result in a more effective healthcare system and increased satisfaction among both providers and users (Dickinson, 1995; Evans, 2006). Therefore, the refusal to evaluate user satisfaction in Croatia and make reforms based on that information seems unreasonable.

The primary aim of this article is to provide limited insight into the Croatian public healthcare system from the social marketing perspective. In order to evaluate to what degree marketing principles are implemented, the focus of this exploratory research study is on the public healthcare providers and their understanding of marketing principles and related everyday practice. Furthermore, this article also provides an overview of the Croatian healthcare system from historical and political perspectives in order to establish background information needed for a better understanding of the current marketing related practice. Finally, based on empirical research findings and relevant body of marketing literature, an objective of this article is to provide suggestions for better implementation of marketing principles in the context of the Croatian public healthcare system.

2 Background: an overview of the Croatian public healthcare sector

In this section, a brief background, which includes a historical and political context, is provided. Since changes and reforms to Croatian public healthcare are closely related to changes in the political environment (Dzakula et al., 2008), it is necessary to also approach the topic of research from the historical perspective.

2.1 Brief historical and political background

Once an independent kingdom, in the period between 1102 and 1991, Croatia was incorporated into several unions and sustained varying degrees of political and cultural independence (Horvat, 1990). From the 16th century until the end of the First World War, Croatia formed part of the Austro-Hungarian Empire. Between the two world wars, Croatia was a part of the Kingdom of Serbs, Croats and Slovenes, which, in 1929, was renamed the Kingdom of Yugoslavia. In 1941, after the Axis powers seized Yugoslavia, most of the territory that today comprises Croatia was under the fascist regime of
The origins of today’s public healthcare system in Croatia could be tracked back to 1923 when the Epidemiological Institute was founded in Zagreb, as a successor to several institutes which were active in healthcare activities since 1893 (HZJZ, 2011). The greatest contributor to the institutionalisation and development of public healthcare efforts in Croatia was Andrija Stampar, one of the founders of the World Health Organization, and his vision of public health, with the basic role of prevention of diseases and promotion of health (Cvjetanovic, 1990).

Table 1  Decentralisations and centralisations of Croatian public healthcare

<table>
<thead>
<tr>
<th>Period</th>
<th>Development</th>
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<tr>
<td>1980s</td>
<td>Decentralisation (self-governing socialism)</td>
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<td>1990–1993</td>
<td>Centralisation (war, economic crisis, transition)</td>
</tr>
<tr>
<td>1993–2000</td>
<td>Re-decentralisation (reform of the system)</td>
</tr>
<tr>
<td>2000</td>
<td>Further decentralisation, legal harmonisation with EU</td>
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Source: Adapted from Dzakula et al. (2008)

The Croatian public healthcare system went through many transitions and structural changes in the last forty years (Table 1). Despite some western stereotypes, during the socialist era, the Yugoslav health system was considered innovative and committed to primary healthcare (Saric and Rodwin, 1993). Geographical, political and administrative circumstances prompted Croatia to decentralise its healthcare during the era of self-governing socialism (Dzakula et al., 2008). Due to the outbreak of war and economic crisis in early 1990s, the decentralised public healthcare system based on the concept of permanent development and total social safety proved unsustainable (Hebrang, 1994). During the war, Croatia also provided assistance to Bosnia and Herzegovina in terms of
medical supplies and securing the most basic level of healthcare for the parts of the country not occupied by Serbian forces and for the refugees stationed in Croatia (Rados et al., 2000). To tackle the emerging challenges and demands, public healthcare was reorganised and centralised in early 1990s, but the basic principles of universal coverage and mandatory health insurance were preserved (Kovacic and Sosic, 1998).

Despite the war, new reforms to the healthcare system were initiated in 1993. The reforms allowed patients to choose providers, expanded the privatisation of primary healthcare, organised financing the system through the Health Insurance Institute and transferred the ownership of hospitals and primary healthcare from state to local authorities (Hebrang et al., 1993). The reforms introduced a level of decentralisation but also raised some concerns, especially from an ethical perspective. For example, reforms enabled the establishment of private specialised polyclinics in which staff employed in the public sector could work part-time (Kovacic and Sosic, 1998). With inefficient structure and waiting lists in the public sector, users were simply forced to use expensive services in the private sector. Further attempts at decentralisation were made in 2000, but the process was introduced slowly and sporadically, due to the issue of competence and accountability on the part of local authorities and health providers (Dzakula et al., 2005). However, reforms were not well accepted by the public due to decreased coverage of the health insurance (Mastilica and Babic-Bosanac, 2002). With the start of the EU accession process, the Croatian public healthcare system went through the process of legal harmonisation with the EU. While this process went smoothly, the public healthcare system suffers from increasing issues with funding due to high expenditures, inadequate financial resources, continuous deficits of the state insurance fund, lack of transparency in funding, aging population, etc. (Voncina et al., 2007).

During the last 20 years the Croatian public healthcare system went through a series of changes due to a number of initiated reforms. While the goal of these reforms is almost always related to reducing the system’s costs, the users’ perspective seems to be neglected. Consequently, the level of satisfaction with the healthcare system among both participants and users has been in constant decline (Mastilica and Babic-Bosanac, 2002; Mastilica and Kusec, 2005).

3 Theoretical framework: marketing perspectives of public healthcare

In this section, a theoretical framework for the empirical research is established. Following the concept of social marketing, a basic link between marketing principles and public healthcare is explained.

3.1 An overview of the social marketing approach within the public healthcare system

The social marketing approach was first introduced in early 1970s by Kotler and Zaltman (1971) in their pioneering article on social marketing published in the *Journal of Marketing* and titled ‘Social marketing: an approach to planned social change’. In the article, the authors defined social marketing as:

“The design, implementation, and control of programs calculated to influence the acceptability of social ideas and involving considerations of product planning, pricing, communication, distribution, and market research [...] it is
According to a more recent definition, social marketing “is the use of marketing principles and techniques to influence a target audience to voluntarily accept, reject, modify, or abandon behaviour for the benefit of individuals, groups, or society as a whole” [Kotler et al., (2002), p.5].

Social marketing covers a broad area of marketing implications for non-commercial purposes. Following this idea, academic researchers largely grounded their theoretical considerations of social marketing on the theoretical foundations of commercial marketing (Grier and Bryant, 2005). In other words, social marketing utilises tools, techniques and concepts derived from commercial marketing in the pursuit of social goals (Andreasen, 1995). However, an overemphasis on the direct translation of commercial marketing principles and practices into social context could cause practical problems and confusion regarding the theoretical basis of social marketing (Peattie and Peattie, 2003).

As Willcocks (2008) noted, the application of marketing to healthcare has been the subject of some scepticism from various sources, not least healthcare employees, due to the following reasons:

- marketing is more about commercial as opposed to healthcare objectives
- the competition upon which marketing is based will bring about the pursuit of profit and not quality of care
- healthcare is different from other services/products, and is less amenable to the techniques and approaches of marketing
- healthcare is, to a large extent, an intangible service, while marketing primarily deals with tangible products
- healthcare is a unique service because of the individual freedom of clinicians
- healthcare operates with unpredictable demand
- it is ambiguous in terms of being unable to offer a precise definition of the ‘customer’.

However, as a concept, marketing could provide certain benefits to healthcare practitioners and the public. Advocating the marketing approach in public healthcare, Lotenberg and Siegel (2008, pp.621–623) suggested:

“The discipline of marketing offers public health organizations a variety of concepts and strategies for understanding and motivating behaviour change in specific populations of interest. Public health organizations use these techniques not only to influence individual health behaviour, but also to build public support for core public health policies and institutions. Using a marketing approach can therefore enable organizations to improve the effectiveness of specific health interventions and to strengthen the institutional capacity of the public health system as a whole. [...] The appropriate use of marketing can help public health practitioners be more effective in today’s environment.”
Table 2  The role of communication in performing the essential public healthcare services

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<td>1</td>
<td>Monitor health status and solve community health problems.</td>
<td>6</td>
<td>Enforce laws and regulations that protect and ensure safety.</td>
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<td></td>
<td>Communication role: Deliver relevant health status information</td>
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<td>Communication role: Share information with the regulated community</td>
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<td></td>
<td>to communities, particularly changes in rates that suggest the</td>
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<td>to facilitate the adherence to proper licensing and safety</td>
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<td></td>
<td>need for intervention; provide an opportunity for communities</td>
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<td>standards; ensure easy access (e.g., website availability) to the</td>
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<td></td>
<td>to voice concerns about perceived health problems.</td>
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<td>required forms and rules relating to licensing and regulation.</td>
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<tr>
<td>2</td>
<td>Diagnose and investigate health problems and health hazards in</td>
<td>7</td>
<td>Link people to needed personal health services and ensure the</td>
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<td></td>
<td>the community.</td>
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<td>provision of healthcare when otherwise unavailable.</td>
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<td></td>
<td>Communication role: Notify individuals and communities of</td>
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<td>Communication role: Inform medically underserved population</td>
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<td>potential health hazards (e.g., issue traveller’s advisories</td>
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<td>about opportunities for healthcare and the need for preventive</td>
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<td></td>
<td>in areas with known vector-borne disease transmission).</td>
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<td>services.</td>
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<td>3</td>
<td>Inform, educate, and empower people about health issues.</td>
<td>8</td>
<td>Ensure a competent public health and personal healthcare</td>
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<td></td>
<td>Communication role: Use multiple levels of communication,</td>
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<td>workforce.</td>
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<td></td>
<td>including social marketing and community education, to bring</td>
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<td>Communication role: Inform public health practitioners and</td>
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<td>about healthy lifestyles.</td>
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<td>healthcare providers about training opportunities, such as</td>
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<td></td>
<td>Communication role: Assist in the development of coalitions</td>
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<td>satellite video-conferences.</td>
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<td></td>
<td>and partnerships that will lead to collaborative action.</td>
<td>9</td>
<td>Evaluate effectiveness accessibility and quality of personal</td>
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<td></td>
<td>Communication role: Inform the public about new laws that</td>
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<td>and population-based health services.</td>
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<td></td>
<td>affect health; share draft planning documents with stakeholders</td>
<td></td>
<td>Communication role: Inform policy makers about the efficacy of</td>
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<td></td>
<td>as a means to receive input and generate investment and</td>
<td></td>
<td>population-based health services.</td>
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<td></td>
<td>outcomes.</td>
<td></td>
<td>Communication role: Publish results of applied research in</td>
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<td>4</td>
<td>Mobilise community partnerships and action to identify and</td>
<td>10</td>
<td>Research for new insights and innovative solutions to health</td>
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<td></td>
<td>solve health problems.</td>
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<td>problems.</td>
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<tr>
<td></td>
<td>Communication role: Use multiple levels of communication,</td>
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<td>Communication role: Publish results of applied research in peer-</td>
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<td>including social marketing and community education, to bring</td>
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<td>reviewed journals so that other agencies can translate findings</td>
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<td></td>
<td>about healthy lifestyles.</td>
<td></td>
<td>into more effective public health practice.</td>
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<tr>
<td>5</td>
<td>Develop policies and plans that support individual and</td>
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<td>Source: Harrell et al. (1994)</td>
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<td></td>
<td>community health efforts.</td>
<td></td>
<td>Medical care focuses on disease management and the act of curing</td>
</tr>
<tr>
<td></td>
<td>Communication role: Use multiple levels of communication,</td>
<td></td>
<td>while public healthcare efforts focus on health promotion and</td>
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|   | including social marketing and community education, to bring   |   | disease prevention (Nies and McEwen, 2011). As Evans (2006, p.1208) stated, “social marketing messages can aim to prevent risky behaviour through education or the promotion of behavioural alternatives”. Therefore, communication plays an important role in the context of public healthcare, especially for performing essential public healthcare services (Table 2). The organisation and management of such a vast number of communications with public and stakeholders definitely calls for a marketing approach. Some scholars consider social marketing solely a set of communicational activities (Hill, 2001). However, it should not be so limited. Social marketing is grounded in commercial marketing’s conceptual framework and includes exchange theory, market research, target audience segmentation, competition,
the marketing mix, consumer orientation, and continuous monitoring (Grier and Bryant, 2005).

The application of social marketing requires certain changes in approach to the target audience. Public healthcare, according to its definition, consists of organised health efforts directed to communities rather than to individuals, relying on a combination of science and social approaches (Novick and Morrow, 2008). On the other hand, commercial marketing focuses more on individuals, since it is considered “the art and science of choosing target markets and getting, keeping, and growing customers through creating, delivering, and communicating superior customer value” [Kotler and Keller, (2008), p.6]. However, social marketing calls for a shift from targeting everybody to targeting different segments or subgroups of the population who share needs, wants, lifestyles, behaviour and values that make them likely to respond in a similar manner to certain public healthcare marketing activities (Grier and Bryant, 2005).

3.2 4Cs as an alternative view of the classic 4P marketing mix

One of the long-standing fundamentals of marketing science is the classic 4P marketing mix. According to McCarthy (1964), the elements of the 4Ps are: product, price, promotion and place (distribution). Over time, the 4P approach received criticism and suggestions were made to expand the concept. One criticism of the 4P approach is that it does not focus on people (i.e., employees), even though people are important, especially in the context of personal selling in the business-to-business (B2B) market. Therefore, Judd (1987) suggested people as the fifth P. As Zineldin and Philipson (2007) echoed, the role of people as the fifth P gains additional importance in the context of relationship marketing and customer relationship management (CRM). On the other hand, Kotler and Keller (2008, p.392), reflect practitioners’ view with the suggestion of packaging as the fifth P. Packaging is commonly included as part of the product-P, but this approach ignores the communicative aspects of packaging and its role as a part of a brand (e.g., Löfgren et al., 2008; Underwood, 2003, Underwood et al., 2001). Therefore, the expansion of the classic 4P to include packaging is reasonable.

In addition to the 5P suggestions, there are also a few suggestions for a 6P marketing mix. Kotler (1999, p.95) suggests, for example, politics and public opinion as the two additional Ps. Knillans (2008) suggests people and planning, while Smith (2010) suggests people and performance as the extension of the 4Ps.

In the context of the service sector, Booms and Bitner (1981) suggest a 7Ps marketing mix, which represents the classic 4Ps extended to include process (of service delivery), physical evidence (of delivered service) and participants (involved in the service delivery). However, this approach should not be limited to services, but also take products into consideration, as Rafiq and Ahmed (1995) argue. There are also proposals to expand the 7Ps. For example, Goldsmith (1999) suggests personalisation (of product or service to the specific consumer preferences), while Melewar and Saunders (2000) include publications (e.g., corporative publications as part of the corporate PR) as the eighth P.

Constant criticism of the classic 4Ps and changes in business practice, led Lauterborn (1990) to offer a different perspective through the proposition of an alternative marketing mix consisting of 4Cs:
Consumer wants and needs, instead of product – consumers are educated and aware of various options available on the market. It is essential to understand their specific wants and needs towards products and services, because companies “can only sell what someone specifically wants to buy”.

Consumer’s cost to satisfy that want or need, instead of price – consumer perceives the total cost of acquiring a product or a service. Besides price, the total cost could include the cost of time, travel expenses, etc.

Convenience to buy, instead of place – due to changes in consumption behaviour and emerge of e-commerce, the focus should be on providing convenience to consumers through constant change and adaptation, rather than setting-up traditional and rigid distribution channels.

Communication, instead of promotion – while classic promotion mainly relays on one-way communication, the focus should be on dialogue with the consumer.

Instead of adding new elements, Lauterborn’s 4Cs model provides a different, contemporary view of the classic 4Ps marketing mix. Fundamentally, the 4Cs emphasises the importance of consumer focus with the approach to the marketing mix from the perspective of a modern and well-informed consumer faced with a vast choice of products and services in oversaturated markets.

3.3 Introducing the 4Cs in the context of social marketing

Since the corner stone of public healthcare is to address and satisfy public (and individual) needs related to (personal) health, the 4Cs seems to be an appropriate theoretical framework for the investigation of the marketing dimension of the public healthcare system. However, due to the specifics of social marketing, it is necessary to make certain adjustments. Adopting the suggestions by Peattie and Peattie (2003), Willcocks (2008) and partially by Rothschild (2010), the following modification to the interpretation of the Lauterbourns’s 4Cs in the context of social marketing could be suggested:

Consumer/user wants and needs – in the context of public healthcare, the user is often not aware of his/hers needs for better and healthier living and his/hers wants are usually not related with that. Therefore, it is the goal of social marketing to, from time to time, define those needs and to act in order to change a specific type of behaviour and to achieve desired behaviour.

Consumer’s/user’s cost – relates to the cost of behaviour change. However, this cost is mostly not related with the financial cost, but it mostly reflects time and effort spent by a person in the process of behaviour change. In this context, the goal of the marketer in social marketing is to minimise the cost of involvement for the user (Bloom and Novelli, 1981).

Convenience – refers to the accessibility of locations related to the process of behaviour consideration or interventions aimed at changing it.
Communication – consists of various types of marketing communications activities used to promote certain ideas and practice in the context of social marketing. Instead of a one-way dissemination of information, the focus of social marketing is on two-way communication through a multimodal transaction model of communication (Evans, 2006).

Bearing in mind these proposed modifications to the interpretation of the elements of the 4Cs, this alternative marketing mix could be used as a model for the assessment of the level of acceptance of social marketing within the public healthcare system. Furthermore, this approach should also provide aid to detect public healthcare efforts mislabelled as ‘marketing’ or ‘social marketing’ due to the neglect of many core marketing concepts.

4 Empirical research: in-depth interviews with experts

4.1 Methodology

Due to the explorative nature of this research study, a qualitative approach to the primary research was selected. Within the range of qualitative research methods, an in-depth or intensive interview has been selected. As Hesse-Biber and Leavy (2006, p.119) outlined, “in-depth interview uses individuals as the point of departure for the research process and assumes that individuals have unique and important knowledge about the social world that is ascertainable through verbal communication”. The goal of the in-depth interview is to yield information and to thoroughly explore a respondent’s point of view and perspective (Guion, 2001).

The in-depth interviews were conducted from a convenient sample of nine employees of the Croatian public healthcare institutions. Respondents were recruited among senior staff with a minimum of ten years experience in Croatian public healthcare. The in-depth interviews were unstructured in order to achieve a wider understanding of the implementation of marketing principles within the public healthcare system, without imposing any a priori categorisation, which might limit the field of inquiry (Punch, 2005). The in-depth interviews’ agenda was structured around the modified interpretation of the 4Cs marketing mix, as proposed in the previous section.

The data collected through the in-depth interviews was interpreted by content analysis. As Shapiro and Markoff (1997, p.14) suggest, content analysis refers to ‘any systematic reduction of a flow of text (or other symbols representing the presence, the intensity, or the frequency of some characteristics relevant to social science’). Since the in-depth interview is based on the open-ended questions and its overall approach could be characterised as explorative, the qualitative conventional content analysis was selected for data interpretation. Hsieh and Shannon (2005, p.1278) define qualitative content analysis as “a research method for the subjective interpretation of the content of text data through the systematic classification process of coding and identifying themes”.

4.2 Research findings

The first section of the in-depth interviews focused on consumers/users and their needs and wants. Overall, the interviews revealed a lack of market segmentation in the context of social marketing activities within the Croatian public healthcare sector. All
respondents agreed that the general public is the focus, rather than on particular segments. Therefore, individual needs and wants are not properly addressed. As an exemption, two respondents mentioned the breast cancer awareness and the prevention of cardiac diseases campaigns:

“The campaign targeted women in their 40s. During the campaign, I think women that didn’t even care about breast cancer got tested [...] I think we saved some lives. And not just that, I think women started thinking more about routine check-ups and prevention all together.” [Respondent 3]

“The campaign was intended for the population of certain age, gender neutral. And although everybody could have problems with heart, the most critical consumer group is over 45 years of age.” [Respondent 5]

One respondent also mentioned activities addressing the increasingly problematic issues associated with overweight and obesity. The activities are aimed at the general public, with occasional segmentation:

“Amongst others, children are one of the target groups. The plan is to provide better diet options to schools and kindergartens so that children would get used to healthier types of food, rather than fast food and candies. This way, they will develop their preferences towards healthier options at the early stage. [...] The idea came from England, where Jamie Oliver, a famous cook, tried to remove vending machines from schools and introduce a healthier diet to children.” [Respondent 2]

Respondents had difficulty understanding the context of consumer/user cost. Respondents focused their discussion mostly on the financial aspects. For example, the cost of primary healthcare is no longer fully covered by personal insurance, which was case in past. Furthermore, they noticed a decrease in the overall quality of the healthcare system, which provides fewer benefits to the users. Consequently, the increased financial cost of medical services did not result with an increase in the quality of services. The concept of the non-financial user cost is not that well recognised among respondents. Most of them find the cost of behaviour change as something that should be considered solely by users. In other words, users should be aware of the benefits which the change of behaviour will result with. Furthermore, some respondents suggested that users should not consider their effort as a cost since “all they do, they do for themselves”. However, a minority of respondents acknowledged the need for the healthcare system to communicate benefits of, for example, behaviour change in relation with the level of involvement and needed effort. For example, one respondent recognised the need for taking into account the user cost within the context of blood donation:

“A couple of years ago we had a very successful campaign where we promoted blood donation. First of all, we needed blood because, since the war, the blood banks needed [...] and the second reason was that we wanted to educate people from the age of 18 that donating blood is a normal and noble thing. Our goal was to move the focus from needles.” [Respondent 7]

Care about consumer/user convenience in the context of the Croatian public healthcare system also seems to be neglected. The majority of respondents consider the geographical dispersion of the primary healthcare institutions to be appropriate. However, they acknowledged the inequality of service among some institutions, which has a negative
impact on the overall user convenience. A minority of respondents tried to minimise the importance of convenience. According to them, users should show more initiative in, for example, finding relevant information about the healthcare system reforms and supplemental health insurance coverage:

“There was no need for providing more information to users on recent changes or to provide better access to information. All the needed information was published on the HZZO (Croatian Institute for Health Insurance) web page.”

[Respondent 1]

Respondents perceived communication as the most important aspect of social marketing or, in some cases, as the only marketing tool that is needed within the healthcare system. However, the majority of respondents described only one-way communication, with no clear idea about the benefits of two-way communication with users. Respondents also identified one of the structural problems within communication and the entire concept of social marketing within the Croatian public healthcare system – the lack of social marketing experts within the system. The majority of communication is managed and executed by staff with medical background and no formal education in marketing. Just a few, larger communication campaigns were handled by advertising agencies, like the anti-smoking campaign. Furthermore, management of communication activities is mostly treated as a side-job. As respondents noted, the Croatian public healthcare system’s primary channel of communication is internet, namely the official websites of various healthcare institutions. Due to limited funds, other types of media are used scarcely and mostly in cases of emergencies (e.g., epidemic outbreaks). However, all respondents recognised the need for better management of communication activities and the introduction of marketing experts within the healthcare system. Poorly managed communication could result in a serious crisis:

“One relatively recent example of poorly managed PR activities is the case of Rijeka hospital and the Maskarin incident. Miroslav Maskarin was a 20-year-old man who came to the hospital in Rijeka for a routine appendectomy. During the operation he nearly died. Additionally, his leg was amputated due to complications during the surgery. The hospital’s PR was managed and executed poorly. Although the doctors were exonerated by the Croatian Medical Association, the hospital took a hard blow when it came to its image and is now being sued by Maskarin. That is just one example of [what happens] when PR is not managed by experts [...] Doctors and the hospital board gave statements and communicated with the reporters themselves…And they are just not educated for something like that.” [Respondent 8]

Overall, all respondents agreed that the Croatian public healthcare system lacks a social marketing approach. First, there are almost no marketing experts employed within the system. More or less, all marketing labelled activities are handled by medical doctors, which respondents consider as a weakness. Second, marketing formally does not exist within the system. Second, the system is going through reforms initiated during the EU accession process. However, these reforms are aimed at the financial side of the system. As one of the respondents pointed, “the system is not focused on users, but on itself”. Finally, there is a huge impact of politics on the system. As some of the respondents mentioned, it is always about maintaining a balance between political demands and taking care about the users.
5 Conclusions

The Croatian public healthcare system went through a series of reforms during the last twenty years. As both the literature review and primary research revealed, these reforms were mostly focused on cutting costs, which resulted in a lower quality of the healthcare from the user’s perspective. Ironically, the overall quality of the Croatian healthcare system was much better before all of these reforms and decentralisation efforts (Dzakula et al., 2005). While the Croatian public healthcare system’s current focus on financial matters and budgetary issues could be partially justified from the perspective of the demands from the EU accession process and the need for cuts in public spending, there is an obvious need for the system to re-focus on user satisfaction.

As the primary research revealed, members of the Croatian public healthcare system do not understand the concept of social marketing. Similar to the reported discrepancy between the awareness of service marketing among Croatian surgeons and its application to medical care (Ozretic-Dosen and Bilic, 2009), members of the healthcare system mislabel certain communication activities as the marketing activities, while neglecting other important elements of the marketing mix in the context of social marketing, like focus on user satisfaction, user convenience, etc. Furthermore, there is a lack of social marketing experts within the healthcare system. Medical staff, with limited or no marketing education, manages social marketing activities, which is mostly limited to communication.

The Croatian public healthcare system will have to re-focus its efforts on user satisfaction in order to improve the quality of service. Implementation of the social marketing principles could provide an appropriate framework for further development and improvement. However, there is a need for specific adjustments before the new approach could be enacted. First, social marketing should be officially recognised by the system and implemented within the organisational structure. It is important to include the social marketing concept within development strategies and plans of the Croatian healthcare system to provide the critical mass needed for re-focusing on user satisfaction. Furthermore, the system should employ social marketing experts. Second, internal educational programmes should be designed for staff in charge for the social marketing activities and management. Since the implementation of the social marketing concept should result in the overall change of how the system treats users, a broader understanding of social marketing principles among healthcare staff is essential. Finally, the Croatian healthcare system needs to allocate sufficient funds for the implementation of social marketing principles, employment of social marketing experts and staff education. The implementation of the social marketing principles within the system is not possible without spending, but this should be considered as an investment into a better healthcare system and satisfied users.

This explorative study provides limited insight into the structural deficiency of the Croatian healthcare system and adaptation of social marketing principles. Some problematic issues and the lack of comprehension of the social marketing concept were revealed. Therefore, there is potential for further research in the field of the social marketing education for the healthcare staff. Furthermore, research focused on the user perspective should also be intensified, not only to measure the satisfaction level with healthcare services, but also to provide information needed for the development and execution of social marketing activities.
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References


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