Influence of international organisations on social policy making in vulnerable countries: The case of Croatian healthcare financing policy

A thesis submitted for the degree of
Doctor of Philosophy
in
Political Science

by
Ante Malinar

[Bremen, April 2024]
Date of defence: 28.08.2024

Dr. Monika Ewa Kaminska
Prof. Dr. Heinz Rothgang
Prof. Peter Starke

Bremen International Graduate School of Social Sciences
University of Bremen
Constructor University

Acknowledgements

This dissertation has been informed by the work carried out in Project B08: "Transformation of Health Care Systems in Central and Eastern Europe," situated within the Collaborative Research Centre 1342, at the University of Bremen. I would like to thank my supervisors Monika Ewa Kaminska, Heinz Rothgang and Peter Starke. Their guidance and support, especially that of my first supervisor Monika Ewa Kaminska, were indispensable to the completion of this dissertation. Without their help this work would not have been possible. I would also like to acknowledge the Deutsche Forschungsgemeinschaft for the financial support, as well as faculty and fellows of the Bremen International Graduate School of Social Sciences (BIGSSS). Finally, I am grateful to my wife Ava, family and friends for their encouragement.

Table of contents

Abbreviations

CDU – Croatian Democratic Union

CEE – Central and Eastern Europe

CHI – Complementary Health Insurance

EU – European Union

GSP – Global Social Policy

IFIs – International Financial Institutions

IMF – International Monetary Fund

IOs – International Organisations

LMICs – Low- and middle-income countries

SHI – Social Health Insurance

SIZ – Samoupravne interesne zajednice [Self-managing interest communities]

WB – World Bank

WHO – World Health Organisation

Part I: Dissertation Overview

1. Introduction

Healthcare policy is one of the most important social policies in modern welfare states as it aims to "improve health and strive for the highest possible health status of the entire population, taking both morbidity and mortality into account" (Franken & Koolman, 2012, p. 29). To provide health services and goods to designated population (healthcare beneficiaries), healthcare systems need to be financed and regulated (to avoid market failures stemming from asymmetry of information). Therefore, three basic dimensions of healthcare systems can be distinguished: provision, regulation and financing (Rothgang et al., 2010). Financing is one of the most important dimensions of the healthcare system as it largely influences the performance of the healthcare system, both in terms of quality of healthcare services, but also in terms of its outcomes (Davis, 2010; Phelps, 2002). The main focus of the financing dimension involves exploring various choices for collecting revenue (Rothgang et al., 2010), pooling the collected revenue, purchasing healthcare services, and determining the extent of coverage, including its breadth, scope, and depth (Kutzin, Cashin, & Jakab, 2010).

There is a large body of literature which analyses social policy making, including healthcare financing, by focusing on national constellations alone (e.g., functionalism, institutionalism, and power resources framework). However, strong focus on national states alone has been "subject to criticism and blamed for its methodological nationalism" (Zürn 2005, as cited in Obinger et al., 2013, p. 112). Much broader focus is needed to sufficiently comprehend changes in the making of social policy. There is a growing scholarship which tries to explain developments in social policy by taking into account the relationship between the national domain and the international domain. For instance, the global social policy (GSP) approach argues that social policy development is influenced by global developments beyond nation-state and in particular by global actors such as international organisations (IOs) (Deacon, 2007; Deacon, Hulse, & Stubbs, 1997; Kaasch, 2015; Obinger et al., 2013). The focus of GSP is the analysis of the role of global actors in the making of social policy, their power and the strategies they use to influence national policy making, as well as global discourse surrounding social policy (Deacon, Hulse, & Stubbs, 1997; Kaasch, 2015).

Similarly, the policy transfer framework emphasises that policy choices of nation states are being "borrowed" from other nation-states and/or that IOs play a significant role in disseminating policy knowledge across borders (Deacon, 2007; Dolowitz & Marsh, 2000). The idea behind this framework is that policy ideas are increasingly transcending national borders, with nation-states either voluntarily adopting these ideas or being coerced into their adoption (Dolowitz & Marsh, 2000). In this process, the impact of specific national factors should not be excluded because they can facilitate or impede the process of policy transfer (e.g., Evans, 2009; Joachim et al., 2008).

It is often suggested that low- and middle-income countries (LMICs) or countries facing crises find themselves in a weak bargaining position when dealing with powerful IOs. Such countries usually have limited resources or policy expertise and as a result they are considered to be more receptive to IOs' policy prescriptions (Batley, 2004, p. 55; Deacon, Lendvai, Stubbs, 2007, p. 226; Laurell & Arellano, 1996, p. 13; Noy, 2017; Woods, 2006, p. 72). However, the literature on this subject is inconclusive as some studies have shown that this is not always the case. The influence of IOs in such countries is rarely straightforward because specific national conditions and actors interact with external pressures (e.g., Kaminska et al., 2021; Kpessa & Béland, 2012; Foli, 2023; Heinrich et al., 2021; Orenstein, 2008; Weyland, 2006). Moreover, the literature about whether and how IOs adapt their strategy and advice in response to specific country-level developments is less developed (some examples of research that touch upon this topic include Druga, 2022; Noy, 2018; Wireko & Béland, 2017).

The aim of this dissertation is to fill these gaps and address the inconsistencies in the above-mentioned literature by analysing the involvement of IOs in a country potentially susceptible to external pressures. To achieve these goals, the dissertation relies on a qualitative case study of Croatia and the role of IOs in the development of its healthcare financing policy in the 1990-2019 period. The focus on a country case study allows for a comprehensive account of how IOs influence national policy making and how they respond to specific national conditions. It is important to note that while this study focuses on influence of IOs, it also recognises that international linkages can extend horizontally, involving the transfer of policies between countries (Dolowitz & Marsh, 2000). Therefore, during the research and data collection process, effort was made to identify and include this dimension as well.

Croatia is a noteworthy case study as it is located in Central and Eastern Europe (CEE), a region that has been increasingly influenced by IOs (Cerami, 2005; Deacon, Hulse, & Stubbs, 1997; Kaasch, 2015; Nemec & Lawson, 2008; Pop-Eleches, 2008). Given Croatia's unique historical trajectory, which includes post-communist transition, the War of Independence, and nation-building, it has been potentially very susceptible to the impact of IOs. Therefore, Croatia is an excellent case study for examining the interplay between the national and global domains in policy development, particularly in the context of power asymmetries (please refer to section four for a detailed discussion of case selection). By selecting Croatia as a case study, the dissertation will also contribute to the literature on Croatian healthcare financing reforms, as well as shed more light on the literature about the role of IOs in CEE. Previous studies (e.g. Džakula, Sagan, Pavić, et al., 2014; Stubbs & Zrinščak, 2007; Zrinščak, 2007), and the empirical research that forms the basis of this dissertation show that the World Health Organisation (WHO), the International Monetary Fund (IMF) and in particular the World Bank (WB) have been the most relevant IOs involved in shaping Croatian healthcare financing policy. Therefore, this dissertation focuses on these three IOs.

The dissertation addresses the following research questions:

1. Why and how did IOs get involved in the development of Croatian healthcare financing policy?
2. What instruments did IOs use to influence Croatian healthcare financing policy?
3. What were the contents of their policy prescriptions and advice?
4. Did IOs adapt to specific country-level developments and, if so, how?

The dissertation consists of four distinct yet interconnected research papers (A, B, C and D) that collectively address the aforementioned research questions.

Paper A: Malinar, A. (2022). Anti-Communist Backlash in the Croatian Healthcare System. In J. Kuhlmann & F. Nullmeier (Eds.), *Causal Mechanisms in the Global Development of Social Policies* (pp. 239-270). Cham: Palgrave Macmillan.

The paper examines the role external influences had on shaping the Croatian healthcare financing reforms in the 1990-1993 period. During this period Croatia was extremely vulnerable to external

pressures and the expectation was that IOs would figure prominently in mentioned reforms. Interestingly however, empirical findings have shown that IOs had limited influence. Instead, reforms were driven by domestic actors who engaged in drawing policy lessons from other CEE and Western countries.

Paper B: Malinar, A. (2022). The role of the World Bank and the International Monetary Fund in the healthcare financing reforms in Croatia: Transfer of ideas and limited coercion. *Global Social Policy*, *22*(3), 540-559.

The paper focuses on the second significant set of Croatian healthcare financing reforms which occurred in the 2000-2002 period and investigates the influence of IOs on said reforms. The paper challenges the perception of IOs as inflexible and hegemonic organisations. On the one hand, the evidence shows that IOs prefer to adjust to national conditions and rely on non-coercive strategies of influence. On the other hand, Croatia was able to contest their policy prescriptions despite potentially being in a weak bargaining position.

Paper C: Malinar A. (n.d.) Healthcare financing reforms in post-communist Croatia and the role of International Organisations. B08 project book

The paper examines the healthcare financing reforms implemented in Croatia from 1990 to 2019 and explorers how interactions between IOs and national conditions and actors shaped the country's healthcare financing policy. The paper extends the analysis by examining a broader time frame and adopting a broader analysis of healthcare financing policies including the dimensions of pooling, coverage and purchasing alongside revenue collection. It builds upon the findings of Paper A, revealing that although the influence of IOs was initially limited during the 1990-1993 period, the transition from the communist regime facilitated the establishment of IO offices in Croatia, leading to their growing influence on healthcare financing policies. Moreover, it corroborates and expands upon findings of Paper B, showing that throughout the entire period of observation, IOs adapt to national conditions and prefer to use non-coercive instruments of influence.

Paper D: Malinar, A., & de Carvalho, G. (2004). International organisations as policy bricoleurs: An analysis of the World Bank's healthcare financing recommendations for Argentina and Croatia. *Contemporary Politics*, 1–24

The paper takes into account the findings from paper B and C i.e., the importance of the WB and its non-coercive strategies utilised to influence Croatian healthcare financing policy. It investigates how the WB formulated its policy recommendations in Argentina and Croatia during the 1987-2007 period. The study contributes to the literature on the role of the WB and its modus operandi within the specific context of middle-income countries in CEE and Latin America. By including a comparative perspective between countries in different world regions, the paper extends the analysis beyond the CEE region towards the global level. Consequently, the arguments presented in the dissertation are further strengthened by the evidence found in a different world region (Latin America). The findings suggest that the WB does not dogmatically follow a particular policy paradigm. Instead, the WB formulates healthcare financing recommendations by reinterpreting prevailing policy paradigms in the light of specific national conditions, namely economic and political circumstances, as well as healthcare system performance. In doing so, it engages in *policy bricolage*, a process in which policy actors draw on multiple sources of knowledge to piece together contextualised policy solutions.

This cumulative dissertation is structured into two parts. In the first part, the second chapter elaborates on the key concepts and theoretical framework used, while the third chapter discusses the state of the art on the role of IOs in healthcare and their influence in vulnerable countries and CEE. This discussion is focused solely on the IOs covered in the four contributions of the dissertation: the WHO, the WB and the IMF. This is then followed by a literature review of healthcare financing policy development in Croatia i.e., historical perspective and post-communist transition reform process, as well as the role of IOs. The fourth chapter explains the case selection and outlines the data and methodology used in the dissertation. The fifth chapter provides an overview of the four papers, discussing their research questions, results, contribution to the literature, and how they fit together in the dissertation as a whole. The sixth chapter presents the discussion and conclusions of the dissertation, including the main findings, implications, and contributions to the field of study, as well as the limitations of the research and possible avenues for future research. Finally, in the second part of the dissertation, manuscripts of the four papers are provided.

2. Theoretical framework

2.1 Global Social Policy and Policy Transfer

As noted in the introduction, a large body of the literature focuses on developments within nation states alone to explain changes in social policy. Frequently used theoretical approaches include functionalism, power resource theory and institutionalism. The functionalist perspective sees the policy change as a response to common problem pressures and rising social needs caused by different historical processes (Myles & Quadagno, 2002). Compared to functionalist perspective, power resource theory argues that politics matter in the development of social policy and emphasises the role of policy actors such as political parties, voters and trade unions therein (Hicks & Swank 1992; Myles & Quadagno, 2002). For instance, many scholars within this tradition argue that welfare policy development can be attributed to the success of left-wing parties and strong trade unions (Kangas, 1991; Korpi, 1989; Myles & Quadagno, 2002). While power resource theory puts emphasis on agency, institutional theory scholars argue that institutions are a crucial factor in social policy making because they constrain agency. For instance, even when left-wing parties associated with expansion of welfare state lose power, the already established welfare institutions can develop vested interest which preserve the status quo (Streeck & Thelen, 2005). Institutional theory tends to emphasise continuity and incremental change, and relies on the notion of path dependency to stress that past policy choices constrain future ones (Djelic & Quack, 2007; Streeck & Thelen, 2005; Wilsford, 1994).

The above-mentioned theories are very important for the analysis of social policy development. However, one of the major shortcomings is that they focus solely on developments within the nation state, ignoring the transnational or international influences that are increasingly evident in contemporary social policy (Deacon, 2007; Yeates, 2014). Migration and interconnectedness of economy, emergence of global private markets in service provision and global actors such as supranational or international organisations have an impact on social policy (Deacon, 2007; Yeates, 2014). Considering the latter, it is important to employ a framework which takes into account the relationship between the national and the global sphere.

This dissertation relies on a conceptual framework that draws on GSP and policy transfer theories. These theories provide suitable concepts to analyse the processes and actors that are external to nation-states and their influence on social policy development, as well as the interplay between

national and international factors. GSP approach argues that social policy development is influenced by global developments beyond nation-state and in particular by global actors such as IOs (Deacon, 2007; Deacon, Hulse, & Stubbs, 1997; Kaasch, 2015; Obinger et al., 2013). Due to increasing globalisation, social policy making is no longer a nation-state isolated phenomenon. Instead, social policy development is explained by the interaction between national, international and transnational linkages (CRC, 2018; Deacon, 2007; Obinger et al., 2013; Yeates, 2014). In other words, developments across different territorial levels have an impact on social policy development (de Carvalho et al., 2021, p. 4).

Deacon argues that GSP consists of social policy prescriptions advocated by global actors such as IOs, as well as "emerging supranational social policies and mechanisms of global redistribution, global social regulation and global social rights" (Deacon 2007, p. 1). One of the main research interests in the field of GSP is the analysis of policy recommendations disseminated by IOs and other global actors, as well as the study of the various instruments used by these actors to disseminate their policy prescriptions to nation states (Deacon, Hulse, & Stubbs, 1997). Within this approach, IOs are seen as particularly important actors able to substantially influence national social policy (Deacon, Hulse, & Stubbs, 1997; Deacon, 2007; Yeates, 1999; 2014).

Healthcare is one of the policies which has emerged as a significant topic in GSP agendas and discussions (Kaasch, 2015). Besides setting global health goals (e.g., the 2000 UN Millennium Development Goals) or fighting against specific diseases, the issues such as sustainable financing of healthcare and access to healthcare services are discussed at the global level (Kaasch, 2015). Moreover, IOs such as the WHO or the WB have developed their own healthcare agenda in order to aid countries with their healthcare system related problems. These IOs can influence national healthcare policy making by providing recommendations for healthcare policy reform, as well as conditioning their aid with implementation of specific policies (Kaasch, 2015, Schmitt, 2020; see also section 2.2 for a detailed review of instruments IOs use to influence policy).

To analyse whether and how recommendations of IOs are adopted on the national level, the dissertation draws further insight from the policy transfer framework. While some concepts are shared between the two frameworks (e.g. coercion and non-coercion as instruments IOs use to influence policy), the policy transfer framework can provide additional conceptual, analytical, and methodological tools to investigate the impact of IOs on nation-states compared to GSP alone

(Kaasch, 2015, p. 7). Dolowitz and Marsh (2000) define policy transfer as a "process by which knowledge about policies, administrative arrangements, institutions and ideas in one political system (past or present) is used in the development of policies, administrative arrangements, institutions and ideas in another political system" (p. 5). Compared to policy diffusion literature which emphasises structural, interest-based and non-intentional processes, the policy transfer literature is a more suitable framework to investigate IOs and their influence on national social policy as it emphasises the role of agency, i.e., it investigates international policy actors and instruments they use to disseminate knowledge about policies, as well as the role of national policymakers in their search for, or rejection of, foreign policy ideas (Marsh & Sharman, 2009; Obinger et al., 2013). The focus is on investigating how, what, when and from whom policy makers adopt foreign policies. Consequently, the policy transfer literature primarily relies on qualitative methods, often involving a smaller number of cases or even case studies and a detailed analysis of policy actors, as well as other variables involved in the process of policy transfer (Hassenteufel et al., 2017; Marsh & Sharman, 2009, p. 270).

In general, the framework argues that policies can be transferred across nation state borders voluntarily or coercively and that the direction of policy transfer can be horizontal (e.g., from one country to the other) or vertical (e.g., from IOs to countries) (Deacon, 2007; Dolowitz & Marsh, 1996, 2000; Kuhlmann et al., 2020; Marsh & Sharman, 2009; Obinger et al., 2013). In a voluntary (non-coercive) policy transfer, policy makers decide if they want to adopt policies coming from abroad without exogenous pressure. It usually implies positive or negative lesson drawing from other countries (Dolowitz & Marsh, 2000; Dolowitz, 2021; Klein 1997; Rose 1991; Stone, 1999) or policy learning facilitated by IOs, either through global norm diffusion or by their active involvement in the countries (Deacon, 2007; Deacon & Stubbs, 2007; Paloni & Zanardi, 2006; Orenstein, 2008; Yilmaz, 2017). Coercive policy transfer, on the other hand, implies that policies transferred from abroad are imposed onto nation states by other powerful states such as the USA or by IOs which condition their financial aid with adoption of specific policies (Bazbauers, 2018; Deacon, 2007; Deacon, Lendvai, Stubbs, 2007; Dolowitz & Marsh, 2000; Killick, 1998; Paloni & Zanardi, 2005).

Whether involving coercive or non-coercive policy transfer, the framework acknowledges the dynamic interplay between national conditions, actors, and external influences. National factors

such as path dependency, electoral cycles and government turnovers, economic and political resources, level of demand, policy resistance by vested interests and veto players, cultural, political and economic context, as well as domestic public opinion can enable, constrain or modify the process of policy transfer (Bache & Taylor, 2003; Benson & Jordan, 2011; Dolowitz & Marsh, 1996; Evans, 2009; Joachim et al., 2008; Marsh & Sharman, 2009; Minkman et al., 2018; Weyland, 2006; Yeates, 1999). The interactions between national factors and external influences can play a pivotal role in shaping the content of transferred policies or potentially result in the rejection of foreign policies altogether (Kuhlmann et al., 2020). Therefore, IOs do not operate in a vacuum and are constrained by developments within nation states. Consequently, IOs have to employ various instruments to shape policy on the national level. The next section conceptualises IOs as autonomous actors which can use coercive and non-coercive instruments to influence policy at the national level.

2.2 IOs and their instruments of influence: coercive and non-coercive influence

Different types of global actors which are operating within and beyond national borders have gained significant importance in shaping social policy across the world (Deacon, 2007; Deacon, Hulse, & Stubbs, 1997; Kaasch, 2015). Among the variety of global actors, this dissertation focuses on international governmental organisations. Scholars are increasingly adopting a social constructivist perspective on IOs, which considers them to be legitimate and independent actors, rather than sole extensions of states and their interests (Barnett & Finnemore, 2004; Barkin, 2013; Dijkzeul & Beigbeder, 2003)

In line with the mentioned literature, this dissertation assumes that IOs are autonomous actors that can formulate their own strategies and independently exert influence. To influence policy, IOs have to be perceived as legitimate. Barnett and Finnemore (2004) argue that IOs derive their legitimacy from different sources: the rational and legal authority that is put forward in their charters; state delegated legitimacy, moral legitimacy which is reflected in their mission to aid countries and finally, the expert legitimacy which is based on their extensive policy knowledge (p. 25). Legitimate and powerful IOs such as the WB, the IMF, International Labour Organization or the European Union (EU) are engaged in defining the content of social policy and its implementation (Deacon 2007; Kaasch, 2015). In other words, IOs act as agents of policy transfer and facilitate the exchange of policy knowledge (Stone, 2004; Stone et al., 2020). They diffuse

and enforce norms and in some cases sanction member states which are not conforming or complying (Escribà-Folch & Wright, 2010; Finnemore, 1993; Jakobi, 2009).

From the GSP and policy transfer literature it can be deducted that IOs can directly influence national policy making by using coercive (hard power) and/or non-coercive (soft power) means (Dolowitz & Marsh, 2000, Schmitt 2020). This dissertation conceptualises coercive means of influence as the first dimension of power in which "A has power over B to the extent that he can get B to do something that B would not otherwise do" (Dahl, 1957, pp. 202-203). This dimension of power is limited to visible behaviour in decision-making processes where preferences are overtly conflicting (Lukes, 2005). In the context of the relationship between IOs and the country receiving their financial assistance, a considerable portion of the literature emphasizes the significance of policy lending conditionalities, where IOs are seen as coercive actors attempting to impose policies they advocate (Brunswijck, 2019; Cerami, 2005; Deacon, 2007; Deacon, Hulse, & Stubbs, 1997; Deacon, Lendvai, Stubbs, 2007; Paloni & Zanardi, 2006). In this view, IOs will only provide financial assistance if the recipient country fulfils their conditionalities; therefore, in order to gain access to funding, countries are forced to take actions that they might not otherwise have willingly taken.

Such coercive means are associated with IOs that provide financial aid, most notably the IMF and the WB (Deacon, 2007; Dolowitz & Marsh, 2000; Kaasch, 2015; Killick, 1998; Obinger et al., 2013; Paloni & Zanardi, 2005). For instance, Hadjiisky (2021) notes that if the IMF and the WB observe the receiving countries' failure in complying with IOs policy conditions, "they are liable to lower its amount or to delay it" (p. 124). In effect, conditionality limits the policy autonomy of aid – receiving countries as it imposes a particular model of development (Yeates, 1999). One of the most prominent examples of the use of conditionality includes structural adjustment policies advocated by the IMF and the WB, such as the promotion of free markets, privatisation, trade liberalisation, reduction of public sector debt, tight fiscal and monetary policies etc. (F. Noorbakhsh & S. Noorbakhsh, 2005; Yeates, 1999).

However, Killick (1998) has argued that the IMF and the WB do not always insist on "hard core conditionalities" which are formulated only at the insistence of the lender, but have also negotiated "pro forma conditionalities" which are mutually agreed upon between the lender and the recipient (pp. 9-11). In this sense, conditionalities can have characteristics of both coercion and non-

coercion (see below). The point of such conditionalities is to instil government identification with and ownership of the lending programme, and to increase the success of loan programmes (Bazbauers, 2018; Killick, 1998). The WB, for instance, has argued that this leaves a larger space for country-grown policies while following the minimum standards of the donor (WB, 2005).

With that said, the effectiveness and enforcement of conditionalities has been disputed. As Orenstein (2008) argues, IOs do not hold a formal veto power over national policymaking (p. 55). In addition, IOs such as the WB were found to be lenient in enforcing conditionalities due to perverse incentives within the IO itself, such as country lending targets or staff promotion system based on negotiated loans (Mosley et al., 1995, p. 47). Larmour (2002) extends this argument further by noting that the international financial institutions (IFIs) have a long-term interest to influence national policy. To achieve this, they are eager to keep lending money to aid recipient countries (p. 259). Similarly, Joachim et al., (2008) argue that while coercion can achieve short-term success, it can also undermine IOs reputation and their long-term influence. All these factors might explain why organizations like the WB have frequently shown limited concern regarding non-compliance with conditionalities by recipient countries (Weyland, 2006) and why these conditionalities are frequently and intentionally left vague (Noy 2017, p. 13).

Clearly, conditions attached to loans are not always a guarantee of successful policy transfer, and IOs have to rely on other non-coercive strategies to influence policy. Non-coercive influence can be conceptualised as the second and third dimension of power. These dimensions of power operate by influencing the government's agenda (by including or excluding policy issues and solutions), the difference being that the second dimension is visible in observable conflict, while the third dimension of power operates more subtly when "A exercises power over B... by influencing, shaping or determining B's desires" (Lukes, 2005, p. 27). IOs can exert non-coercive influence through their policy expertise, technical assistance (training and education of national civil servants and representatives), policy knowledge production and its dissemination (Bazbauers, 2018; Béland & Orenstein, 2013; Deacon, Lendvai, Stubbs, 2007; Evans, 2009; Hadjiisky, 2021; Heneghan & Orenstein, 2019; Kaasch, 2015; Kelley, 2004; Orenstein, 2008). Policy knowledge is produced and disseminated through various channels: international conferences, publications, data collection and analysis, evidence-based policy studies etc. (Bazbauers, 2018; Hadjiisky, 2021; Kaasch, 2015; Ruger & Yach, 2009). It is important to mention that policy ideas prescribed by IOs

are in constant flux and are often contested in the international space, “to the extent that policy consensus within international organisations may be the exception, not the rule” (Béland, Orenstein, 2013, p. 126). Ideational changes within IOs have important consequences for which policy advice is given to the aid recipient countries and thus affect the direction of domestic policy making (Béland & Cox, 2011; Mahon, 2009; Mahon & McBride, 2009; Skogstad, 2011; True & Mintrom, 2001).

Policy expertise and long-term experience of IOs can result in global norm setting about desirable policies countries should enact. Indeed, Evans (2009) states that “the content of policy transfer is often informed by notions of best practice disseminated by international organisations, KIs [Knowledge Institutes] and think-tanks in the international domain” (p. 260). Thus, IOs can also be seen as an international epistemic community. Such a community can claim authority to policy relevant knowledge (Haas, 1992, p. 3). To establish such authority, IOs rely on “comparative advantage: their universal reach, derived from their institutional missions and official rules, but also the politically neutral nature of their knowledge” (Hadjiisky, 2021, p. 133). However, policy knowledge is rarely neutral and policy recommendations can be framed within “hegemonic consensus” (St. Clair, 2006) such as neoliberalism which is usually associated with the WB (Appel & Orenstein, 2018; Orenstein, 2008; Plehwe, 2007). The authority and legitimacy that IOs have enables them to take control of policy-related knowledge production, shape policy discourses, identify and frame policy problems and solutions, and appear as very powerful agenda-setters (Béland & Orenstein, 2013; Deacon, Lendvai, Stubbs, 2007; Hadjiisky, 2021; Larmour, 2002; Orenstein, 2000; Robertson, 1991).

3. State of the art

3.1 The role of IOs in healthcare

With regards to healthcare, the WHO has traditionally been one of the most influential IOs relying on "soft power" and non-coercive influence, spreading healthcare policy norms across the globe since its inception in 1948. The WHO primarily relies on international norm setting and knowledge dissemination. To this end, it publishes studies on best practices and reform models, healthcare data and statistics, organises international workshops and conferences (such as the conference held in Alma-Ata in 1978) and creates a knowledge exchange platform between healthcare experts (Kaasch, 2015; Kaasch & Martens, 2015). One of the most important WHO publications containing healthcare policy evaluations and recommendations include the 1978 Alma Ata Declaration, World Health Reports and Health for All strategies (Kaasch, 2013, 2015). The WHO policy focus is on promoting universal healthcare coverage, primary healthcare, abolishing health inequalities, establishing healthcare financing based on solidarity, collective funding and risk pooling (Kaasch, 2013, 2015). Moreover, the WHO has a long history of advancing public health programs and helping developing countries and enjoys a great international legitimacy (Ruger & Yach, 2009; Weyland, 2006). However, compared to IFIs, the WHO is portrayed as a weaker institution which can exert only minimal pressure on the countries where it is involved due to its lack of financial resources and inability to impose conditionalities (Weyland, 2006, p. 171).

IFIs such as the WB and the IMF have been increasingly broadening their competencies and the scope of their activities beyond their initial domains of interest. Their focus now embraces issues connected to global poverty, health, pensions and the like (Deacon, 2007; von Gliszczynski & Leisering, 2016; Kaasch, 2015; Kaasch et al., 2019; Orenstein, 2008). Consequently, the WB, together with the WHO, has become to be seen as one of the two global ministries of health (Deacon, 2007). As Walt et al., (2004) put it:

> The relative power of the international organizations shifted from the 1980s onward, with WHO losing some of its authority and legitimacy at least within the international community, less so among developing countries. WHO was also challenged by those relatively new to health, such as the World Bank, which had considerably more financial and analytical power. (p. 195)

Thus, the transfer of health policies has increasingly been dominated by the WB, at the expense of the WHO, even though health was not the initial domain of the WB expertise (Hadjiisky, 2021, p. 135). For instance, in the 1990s, the WB was the leading institution in diffusing health norms and policies and the largest external funder of global health (Noy, 2017, p. 56; Ruger 2005). Nevertheless, the WB viewed "the WHO as a complementary agency and collaboration as mutually beneficial" (Noy, 2017, p. 48). The WB has been involved in healthcare since the 1970s (Tichenor & Sridhar, 2017) and has published numerous studies on healthcare policy. Among others, some prominent examples include "Financing Health Services in Developing Countries: An Agenda for Reform" (WB, 1987), "World Development Report: Investing in Health" (WB, 1993) and "Health, Nutrition and Population Sector Strategy" (WB, 1997).

It has been argued that the WB promotes neoliberal agenda in healthcare. This includes a focus on efficiency, decreasing the role of the state, introduction of market mechanisms, privatisation and promotion of individual responsibility in health, curtailing public expenditure on health and promoting health only in terms of developing the human capital (Brunet-Jailly, 1999; Cerami, 2005; Deacon, 2000, 2007; Deacon & Hulse, 1997; Kaasch, 2015; Laurell & Arellano, 1996; Lehrer & Korhonen, 2004; Nemec & Kolisnichenko, 2006; Noy, 2017; Stuckler & Basu, 2009). This neoliberal agenda provoked controversy due to its emphasis on the role of user fees and privatisation (Kaasch, 2015, p. 38). Moreover, Structural Adjustment loans often had "detrimental effects on welfare states and social policy more generally" (Noy, 2017, p. 11). However, the focus of the WB and its ideas regarding healthcare have changed (Deacon, 2007; Kaasch, 2015; Noy, 2017).

The WB's 1997 "Health, Nutrition and Population Strategy" advocated for a greater flexibility of the WB, abandoning rigid policy prescriptions in the healthcare sector, adapting aid according to specific contexts of the countries, greater role of the state, social sensitivity, advancing risk protection, establishment of pooling mechanism and mobilisation of additional resources (Deacon, 2007; Kaasch, 2015; WB, 1997). The 2007 "Health, Nutrition and Population Report" is similar in its goals to "ensure people's access to essential services and financial protection by raising stable, sufficient, long-term public and private financial resources, predictable, equitable, efficient and in a way that minimizes economic distortions" (WB, 2007, p. 112). Noy (2017) argues that the WB started to put more emphasis on equity and increased access to healthcare, instead of just

focusing on efficiency, even though it still advocated neoliberal policy instruments (such as performance-based management or targeting) to achieve said goals.

Compared to the WB, the IMF has been less involved in social and healthcare sector policies due to its lack of expertise in the area (Odling-Smee, 2006, p. 182). Nevertheless, the IMF prescriptions on macroeconomic policy usually incorporated austerity measures which led to a decrease in social spending (Bajpai, 1990; Deacon, 2007; Deacon & Hulse, 1997; Heinrich, 2021; Kaasch, 2015; Odling-Smee, 2006; Orenstein, 2008; Stuckler & Basu, 2009; Wohlmuth, 1984).

3.2 IOs and their influence in vulnerable countries

The literature suggests that power asymmetries between countries and IOs play a major role in explaining the extent of influence IOs have over countries. Vulnerable countries i.e. low – and middle – income countries, as well as countries which find themselves in crisis, are potentially in a weak position to bargain and are more prone to be influenced by IOs and their policy prescriptions. Such countries usually have a lower degree of development, resources, policy expertise or higher debt which in turn makes them vulnerable and more reliant on external aid provided by IOs, be it in the form of financing or policy expertise (e.g. Aina et al., 2004; Batley, 2004; Laurell & Arellano, 1996; Marsh & Sharman, 2009; Mosley et al., 1995; Paloni & Zanardi, 2006; Weyland, 2006; Woods, 2006). Moreover, the influence of IOs can be further emphasised in the field of healthcare as literature has shown that LMICs often lack institutional capacity, adequate infrastructure, resources, as well as policy expertise in such a complex policy field (Kohlmorgen, 2005; Ruger, 2007; Weyland, 2006).

Power asymmetries are particularly relevant in the case of IFIs. National governments usually invite IOs such as the WB or the IMF as a measure of last resort, when they no longer have the ability to access other sources of funding (Hadjiisky, 2021). Evans (2009) has argued that "the influence of these global economic institutions has been particularly pronounced in developing countries, transition states and states emerging from conflict, which all depend heavily on external aid, loans and investment" (p. 256). As a result of power asymmetries and aid dependency, scholars have asserted that in order to gain access to new funding sources, developing and low- and middle-income countries, particularly those facing crises, frequently find themselves with little option but to comply with the policy-related conditionalities imposed by the WB and the IMF (Batley, 2004, p. 55; Mosley et al., 1995, p. 41; Paloni & Zanardi, 2006, p. 3; Tomson & Biermann, 2015, p. 171).

Empirical evidence from diverse countries and regions, including Europe, Africa, and Latin America, as well as across various policy sectors like labour policy, pensions, healthcare, etc., seem to provide support for these arguments. For instance, the economic crisis that hit sub-Saharan Africa in the 1980s and its dependence on foreign aid led most countries in the region to accept policies imposed by IFIs (Aina et al., 2004; Foli, 2023; Loxley, 1990; Ndulu, 2008). In a similar vein, de Carvalho (2021) contends that in Latin America, countries with the least developed economies, a high rate of foreign debt, and low GDP per capita, such as Bolivia and Peru, along with those receiving the highest amount of foreign aid, like Colombia, adhered most closely to the WB's healthcare recommendations. Further evidence was found in Europe. In their investigation of the role of IOs in Southeast Europe, Deacon, Lendvai and Stubbs (2007) have found that weakness of the economy and the state, as well as lack of active civil society, enable IOs to have a much stronger influence on social policy in recipient countries.

Clearly, a large body of literature provides arguments that IOs are more influential in vulnerable countries. However, some scholars argue that despite structural constraints or significant power asymmetries, the transfer of policies from IOs to vulnerable countries is rarely a straightforward process. The basic idea of such scholars is that countries should not be viewed as mere passive recipients of policy prescriptions, but rather as active participants in the process of policy transfer (e.g. Bache & Taylor, 2003; Heinrich, 2021; Heinrich et al., 2021; Loxley, 1990; Mosley et al., 1995). As Heinrich et al. (2021) argue, the influence of IOs and their policy prescriptions does not depend only on the approach they take in a particular country, but also on the strategies national governments use to interact with IOs. Even in less developed countries, IOs cannot rely on coercion alone (Ağartan, 2007). Instead, they have to cooperate with and take into account the position of domestic policy makers in order to make sure the transfer of policies is successful (Orenstein, 2008). In this process, the transfer of policy prescriptions from IOs can be impeded or the content of their policy prescriptions can be altered because specific national conditions and actors interact with external pressures (Asensio & Popic, 2019; Foli, 2023; Heinrich et al., 2021; Kaminska et al., 2021; Kpessa & Béland, 2012; Orenstein, 2008; Weyland, 2006; Yeates, 2002).

Many scholars have investigated the influence of IOs on various policy sectors in different world regions and provided empirical evidence which supports the latter argument. F. Noorbakhsh and S. Noorbakhsh (2006) argue that the WB itself acknowledged that several African countries failed

to adhere to the conditions attached to their loans and implemented counteractive measures or eventually rolled back the reforms at a later time. Loxley (1990) found that the WB and IMF lost their influence in Zambia after their reform programme to address the high debt problem failed and that the Zambian government created its own programme independent of the two IFIs. Further evidence provided by Wireko and Béland (2017) shows that the WB displayed willingness to align with the government's policy stance on Social Health Insurance (SHI) in Ghana and even endorsed it on an international level. Similar evidence was found in Latin America and in CEE (Druga, 2022; Kaminska et al., 2021; Noy, 2017, 2018; Weyland, 2006). For instance, Noy (2017) found that Costa Rica was able to resist some of the neoliberal policies proposed by the WB. Moreover, the Costa Rican government was able to convince the WB to support its initiative towards universalistic healthcare policies "despite economic, financial, and demographic pressures over this time period" (Noy, 2017, p. 167). Kaminska et al. (2021) and Druga (2022) discovered that in CEE, amidst the early post-communist transition, characterised by economic and political turmoil, Poland and Albania demonstrated the ability to diverge from the WB's counsel advocating tax-based healthcare financing. Instead, they opted for SHI as their preferred healthcare financing model. With regards to more recent events, Asensio and Popic (2019) have found that as a result of Portugal's severe financial crisis, in 2011, the healthcare reforms were initiated by the Troika (the European Commission, the European Central Bank, and the IMF) and its bail-out programmes. However, the reforms were ultimately shaped by domestic actors and their strategies.

From the above summary it can be observed that the literature on influence of IOs in vulnerable countries is inconclusive. Some scholars argue that IOs possess the capability to exert significant influence on vulnerable countries, resulting in severe restrictions on their freedom to choose policy decisions. Other researchers argue to the contrary and indicate that vulnerable countries can preserve policy autonomy and that IOs have to rely on domestic policy makers to implement their policy prescriptions (Dion, 2008; Kuhlmann et al., 2020). Consequently, this view posits that interdependence between these actors is created, no matter how asymmetric the power between them might be (Bache & Taylor, 2003) and that national factors, such as the political and institutional context, interact with and mediate external pressures. This dissertation contributes to the mentioned literature by providing evidence in support of the latter position. It shows that even in countries which are considered vulnerable, the influence of IOs is mediated by national conditions and national policymakers.

3.3 The role of IOs in healthcare (financing) policy in CEE

The literature suggests that the post-communist transition opened up CEE countries to external influences such as IOs. During this time of political and economic crises, CEE countries were in need of financial aid, as well as technical assistance and policy expertise to reform the institutions inherited from the communist regime (Brada et al., 1995). IOs such as the WB, the IMF, the EU or the WHO saw this as an opportunity to exert influence and push their policy agenda in a region previously closed by the "iron curtain" (Cerami, 2005; Deacon, Hulse, & Stubbs, 1997; Kaasch, 2015; Nemec & Lawson, 2008; Pop-Eleches, 2008). Brada et al. (1995) point out that IFIs were the largest suppliers of financial assistance in CEE countries (p. 52).

The influence of IOs such as the IMF and the WB on economic and macro-economic stabilisation policies has been well documented (Cerami, 2005; Greskovits, 1998; Sachs, 1994; Wallich, 1995). For instance, Fultz (2002) and Müller (2002) argue that high external debts and presence of IOs were crucial in influencing the CEE policy agenda and implementation of neoliberal reforms. Similarly, with regards to social policies, Deacon, Hulse and Stubbs (1997) argue that transformation of social policies in CEE countries was heavily influenced by IOs. One of the most prominent social policy reforms in CEE influenced by the WB was the pension policy where the WB advocated for the introduction of three-pillar pension systems (Müller, 1999; Orenstein, 2008).

With regard to healthcare policy in CEE, Davis (2010) notes that many IOs have been involved in health projects in the region (p. 56). The WB in particular was seen as one of the most influential organisations in CEE. Besides policy expertise and technical assistance, the WB offered substantial financial aid in the region (Cerami, 2005; Deacon, 2007; Kaasch, 2013; Orenstein, 2008). Radin (2003, 2008) notes that the WB was one of the most involved IOs in CEE healthcare reforms as it was the only organisation that gave direct loans and support for the healthcare sector. However, in contrast to the pension reform, the WB lacked a consensus on appropriate health policy recommendations and therefore had no real blueprint for successful health reform (Nelson, 2001, pp. 259-261; Radin, 2003, p. 32; Wallich, 1995, p. 75).

Nevertheless, some authors argue that the WB's preferred model for healthcare financing reform was the SHI system, and that the shift from tax-based financing to the SHI system that occurred in

almost all CEE countries during the post-communist transition was largely the result of pressure from the WB and the IMF (Cerami, 2005; Kaasch, 2015; Nemec & Lawson, 2008, p. 29). Cerami (2005) argues that the main goals of the WB and the IMF were to support macroeconomic stabilisation by prescribing neoliberal policies in the CEE welfare states. This was reflected in austerity measures and the promotion of private sector activity. For instance, according to Cerami (2005), the introduction of SHI in CEE countries was regarded as the first step towards facilitating privatisation policies (pp. 53, 59, 89). This argument is supported by Nemec and Kolisnichenko (2006) who argue that ideas for marketisation and privatisation policies in CEE healthcare systems were being prescribed by the WB and the IMF (p. 15). This policy agenda included an increase of individual responsibility for health, adoption of user charges for health services, reduction of healthcare expenditures and healthcare benefits, developing private insurance schemes and decentralisation (Cerami, 2005; Deacon, 2000, 2007; Deacon & Hulse, 1997; Kapstein & Milanović, 2001; Laurell & Arellano, 1996; Lehrer & Korhonen, 2004; Stuckler & Basu, 2009).

With regards to the WHO, Cerami (2005) notes that it had a limited influence in CEE region. Even though the WHO had been active in CEE since the transition from the communist regime started, it did not have a clear policy preference and consequently did not favour nor promote any specific healthcare model (Cerami, 2005, p. 64). Nevertheless, the WHO provided technical assistance, policy expertise, analyses of the CEE healthcare systems and their reforms, and established a comprehensive set of healthcare data and statistics (Cerami, 2005, p. 64).

In contrast to the influence of IOs on healthcare policy in CEE, some scholars have put emphasis on national factors as the main drivers of change (Jacoby, 2004; Radin, 2003; Rechel & McKee, 2009; Roberts, 2009; Sitek, 2008). For instance, Rechel and Mckee (2009) and Sitek (2008) argue that reforms towards new healthcare financing policies were driven by negative healthcare policy experiences in the communist system. In contrast to Cerami (2005) who argues that IOs played a major role in diffusing the SHI model in CEE, the study by Kaminska et al. (2021) shows that the early transition period in Albania, Latvia and Poland was characterised by an anti-communist backlash. Consequently, communist policies were widely rejected, especially by medical professionals who played a major role in advocating SHI and reinstitution of Bismarckian principles (Kaminska et al., 2021; Lawson & Nemec 2003; Rechel & Mckee, 2009). Interestingly enough, anti-communist backlash in Poland and Albania was strong enough to reject the WB's

advice of instituting tax financing (Kaminska et al., 2021). Rechel and Mckee (2009) explain that although IOs were indeed present, their role in the reform process should not be overstated. Similarly, Roberts (2009) and Sabbat (2010) argue that the WB lacked the influence to promote SHI in CEE region.

Besides the strong influence of medical professionals in some CEE countries, Sitek (2008) stresses the role of first multiparty elections, party politics and institutions in explaining the direction of health policy changes. For instance, healthcare financing reforms in the Czech Republic between 1990 and 1993 resulted from a clash between neoliberals advocating radical privatisation and social liberals advocating universal healthcare access (Orenstein, 1995, pp. 187-188). Furthermore, many scholars agree that path dependent structures and historical legacies of the interwar period served as a model for healthcare financing reforms in CEE countries (Inglot, 2008; Marrée & Groenewegen, 1997; Kutzin, Jakab, & Cashin, 2010). For instance, it is suggested that Bismarckian principles instituted during the interwar period heavily influenced the direction of post-communist healthcare reforms decades later (Cerami, 2005; Inglot, 2008). Most of CEE countries shifted their Semashko model towards contribution-based SHI (Kutzin, Jakab, & Cashin, 2010; Marrée & Groenewegen, 1997). In this sense, the dissolution of communist regimes did not create a political vacuum (Beyer & Wielgohs, 2001). Rather, the implementation of new policies was influenced by historical legacies (Hausner et al., 1995; Stark, 1991; Stark & Bruszt, 1998, 2001). As a result, CEE countries produced a hybrid mix of welfare policies based on interwar and communist historic legacies, as well as new marketisation policies (Inglot, 2008).

Another important factor accounting for the direction of healthcare policy changes in CEE involves horizontal policy transfer. Domestic policy makers looked up to the "Western-style insurance system" (Jacoby, 2004, p. 48) and wanted to "emulate the apparent success of models used in Germany and Austria" (Rechel & Mckee, 2009, p. 1187). For instance, Poland and Latvia relied on German experts in their quest to introduce SHI, while Albania drew lessons from the French SHI system (Kaminska et al., 2021). It was considered that the SHI system would collect additional funds, contain costs, improve transparency, reduce the role of the government, increase the autonomy of medical profession and their salaries, and improve the quality of healthcare services delivered to patients (Rechel & Mckee, 2009; Kaminska et al., 2021).

In summary, it is clear that IOs were present in post-communist CEE countries, providing technical expertise, advice, and financing (Cerami, 2005; Deacon, Hulse, & Stubbs, 1997; Kaasch, 2015). However, the findings on their role and the extent of their influence on healthcare financing policy in CEE remain inconclusive. The scholarship is often divided into two camps (exogenous vs. endogenous) focusing either on the role of IOs or the role of domestic actors. This dissertation bridges this knowledge gap. By focusing on the case of Croatia, it shows that national and international spheres are interrelated and that healthcare policy developments in CEE can only be explained by analysing their interaction.

3.4 Croatia

3.4.1 Historical background and healthcare financing reforms

After the end of the Second World War, Croatia was incorporated into a new Yugoslav federal state. Socialist Federal Republic of Yugoslavia (hereinafter referred as Yugoslavia) was a communist state which was governed by the communist party under the leadership of Josip Broz Tito. It consisted out of six federal republics (Montenegro, Serbia, Bosnia and Herzegovina, Slovenia, Macedonia and Croatia) and two autonomous regions (Kosovo and Vojvodina). Yugoslavia had a high degree of independence from the Soviet Union, especially after the so-called Tito-Stalin split in 1948. The split had consequences for the political organisation of Yugoslavia as the country was not forced to introduce Soviet socialist policies. Instead, Yugoslavia started to introduce a distinct type of socialism called self-management socialism (Ramet, 2002).

The formal goals of self-management were devolution and decentralisation of decision making. To this end, self-managing interest communities (SIZ – samoupravne interesne zajednice) were introduced whereby workers could participate in the management of their enterprises. Moreover, self-management was also introduced in social policies such as education, social welfare or healthcare (Ramet, 2002). Consequently, healthcare and its financing reflected self-management ideals, although more so in theory than in practice. Usually referred to as the Štampar model, the healthcare system in Yugoslavia was organised on self-management and Bismarckian principles[1] with a heavy emphasis on primary care and public health (Džakula, Šogorić & Vončina, 2012;

[1] The origins of the SHI and Bismarckian principles can be traced back to the period when Croatia was still part of the Austro-Hungarian empire (Zrinščak, 2003, p. 3007)

Parmelee, 1985; Šarić & Rodwin, 1993). Instead of centralisation which characterised the Soviet Semashko model, the healthcare system in Yugoslavia was heavily decentralised and the authority for decision making was devolved to municipalities. Financing of the healthcare system was organised according to the Bismarckian principles. Health funds were organised at the municipal level, and they were structured as SIZs. Decisions in such SIZs were formally being made according to the interests of users and providers of healthcare services.

Despite this, Yugoslav healthcare system shared many of the characteristics found in other CEE communist countries. Self-management was never fully realised. The communist party and its members had a crucial influence on any major decisions to be taken. Sunić (1995) describes the system as "democratic centralism" (p. 67) while Ramet (2002) notes that it was mocked as SIZ-ophrenia whereby "two parallel structures exercised jurisdiction in the same area" (p. 9). SIZs were dominated by the communist party members and had little autonomy from the central authorities and the government (Davis, 2010; Šarić & Rodwin, 1993). Resources for healthcare were scarce and their allocation was primarily driven by political decisions. Therefore, the decentralisation and devolution of authority was overshadowed by the influence of the communist party.

The healthcare system suffered from disorganisation, as well as significant discrepancies between different regions in terms of financing, quality and access to services (Chen & Mastilica, 1998; Džakula, Sagan, Pavić, et al., 2014; Šarić & Rodwin, 1993). The Croatian healthcare system in Yugoslavia faced similar problems as in other CEE countries. Funding was inadequate, physicians were underpaid, there was excess demand for services, lack of pharmaceuticals and medical devices, non-existent control of expenditures and no economic incentives to improve the performance of the healthcare system (Chen & Mastilica, 1998; Šarić & Rodwin, 1993). Primary care was not entirely efficient and the healthcare system relied heavily on hospital services (Bredenkamp & Gragnolati, 2008; Šarić & Rodwin, 1993).

In the 1980s, Yugoslavia started to experience severe economic and political crisis. After Tito's death, national interests of the federal republics started to emerge. Eventually, Yugoslavia disintegrated when Slovenia and Croatia proclaimed independence in 1991. During this time Croatia started its transition from communism towards democracy, liberalism and market economy, a process which was hindered by the outbreak of the War of Independence (1991-1995). The war had severe negative consequences for the economic and political development of Croatia

(Hebrang, Ljubičić & Baklaić, 2007; Ramet 2013). The 1990s in Croatia were marked by economic and political crises, nation building, war, post-war rebuilding and social claims making, as well as authoritarian tendencies and crony capitalism (Bičanić & Franičević, 2003; Ramet, 2010, 2013; Stubbs & Zrinščak, 2007; Zakošek, 2002). These processes had a strongly negative effect on the healthcare system and its financing, and reforms started as early as 1990.

The healthcare financing reforms during and after the transition from the communist regime shared many similarities with other CEE countries e.g., introduction of market-based instruments, private insurance, co-payments etc. (Chen & Mastilica, 1998; Kovačić & Šošić, 1998; Vončina et al., 2007). The main difference from other CEE countries was that Croatia centralised the previously highly decentralised financing system. The Bismarckian insurance-based system was retained but multiple SHI funds were replaced by a single national SHI fund which was strictly controlled by the government (Kovačić & Šošić, 1998; Vončina et al., 2007; Zrinščak, 2007). As in other CEE countries, part of the funding came from the state budget, mostly for public health and for covering non-contributing persons (for instance, pensioners, children, students, unemployed). However, the latter subsidies were not paid prospectively. Rather, the government retroactively covered health insurance deficits from the government budget (Vončina et al., 2007). After the early transition from the communist regime, later reforms in healthcare financing included broadening of the contribution base, a reduction in benefits, an expansion of co-payments, which increased in both rate and scope, and the introduction of complementary health insurance (CHI) to cover the latter. Moreover, Croatia partially developed a private insurance market. Substitutive private insurance was introduced in 1993 (then abolished in 2002), and supplementary private insurance, which covers additional services and better quality care, was also introduced in 1993. Finally, since 2004, private insurance companies have been able to offer CHI (Chen & Mastilica, 1998; Džakula, Sagan, Pavić, et al., 2014; Kovačić & Šošić, 1998; Vončina et al., 2007; Zrinščak, 2007).

3.4.2 The role of IOs in Croatian healthcare: what is already known?

The literature on the involvement of IOs in Croatian healthcare is scarce. Most of the studies on Croatian healthcare analyse the policy changes that have occurred in the system since Croatian independence (e.g., Broz & Švaljek, 2014; Chen & Mastilica, 1998; Džakula, Šogorić & Vončina, 2012; Džakula, Sagan, Pavić, et al., 2014; Kovačić & Šošić, 1998; Mihaljek, 2006; Vončina et al., 2007; Zrinščak, 2007). Only a few studies analyse the role of IOs and foreign policy ideas in

Croatian healthcare (e.g., Hebrang, 1994; Hebrang, Ljubičić & Baklaić, 2007; Stubbs & Zrinščak, 2007, 2009), but none does so in detail. Deacon, Lendvai and Stubbs, (2007) have argued that the post-war stabilisation process in Croatia and the other countries involved in the Yugoslav succession wars opened up significant opportunities for the involvement of IOs (p. 226). The existing literature shares the view that the IMF and in particular the WB were actively involved in Croatian healthcare reforms (Džakula, Sagan, Pavić, et al., 2014; Stubbs & Zrinščak, 2007, 2009; Vončina et al., 2007; Zrinščak, 2007).

The WB's involvement began only after Croatia introduced major healthcare reforms in 1993. The WB provided Croatia with financial support, technical assistance, policy advice, analytical services and healthcare policy studies that evaluated the healthcare system and recommended reforms (Džakula, Sagan, Pavić, et al., 2014; Stubbs & Zrinščak, 2007). As in other CEE countries, the WB did not have an "overall reform package" for health system in Croatia and instead tried to support and extend the 1993 reforms (Stubbs & Zrinščak, 2007, p. 96). To this end, the first healthcare project (started in 1995) funded new medical equipment and informatisation of healthcare administration (Zrinščak, 2007, p. 203).

Despite the 1993 reforms, the healthcare system soon became financially unstable and new healthcare reforms were initiated in the early 2000s, this time under the tutelage of the IMF and the World Bank (Stubbs & Zrinščak, 2007, p. 90; Vončina et al., 2007). Croatia and the WB agreed on the second healthcare project (2000 – 2005) which was reform-oriented and determined to achieve "more effective, efficient and financially sustainable health system" (Stubbs & Zrinščak, 2007, p. 96) Pilot projects were initiated, with main components being reorganisation and rationalisation of hospitals and establishment of primary care group practices (Stubbs & Zrinščak, 2007; Zrinščak, 2007). However, the results of the pilot projects were not adequately evaluated and consequently were not used as a template for broader reform (Zrinščak, 2007, p. 203). Stubbs and Zrinščak (2007) argue that unlike the pension reform, where the WB was successful in promoting three pillar pension system, healthcare system has proved to be much more resilient to change (p. 96).

With regards to other IOs, only a few studies mention the advisory role of the WHO, primarily in the context of early transition reforms which occurred in 1993 (Hebrang, Njavro & Mrkonjić, 1993; Hebrang, Ljubičić & Baklaić, 2007). For instance, the WHO urged Croatia not to rush into

privatisation of the system due to negative experiences of some other CEE countries such as Hungary (Hebrang, Njavro & Mrkonjić, 1993, pp. 17-18). Based on the literature, it can be concluded that IOs, and primarily the WB, were indeed present in shaping Croatian healthcare policy. However, relatively little is known about how IOs interacted with Croatian national stakeholders, what ideas they promoted and how influential they were. To fill the gap in the literature, this dissertation addresses exactly these issues by analysing the influence of IOs in Croatia, their policy ideas and their interaction with the national policymakers.

4. Methodology

4.1 Case selection

Case studies focus on small number of cases or a single case (Gerring, 2017). This dissertation focuses on a single case which has the advantage of providing highly focused, in-depth analysis of the reform processes and a wide range of case-based evidence which are not easily available for a larger sample (Gerring, 2017). Only by adopting a qualitative case study focused on a long-term perspective can we get a full picture of the healthcare financing reform processes in Croatia and the ways in which IOs operated and tried to shape healthcare policy.

There are multiple reasons why Croatia and its healthcare financing policy provide a good case to study the interplay of international and national factors in the development of healthcare policy during the 1990-2019 period. First, Croatia is situated within CEE, a region in which the study of IOs and their impact on healthcare policies has grown increasingly important since the fall of the communist regimes. Scholars have argued that the post-communist transition which was accompanied by political, economic and healthcare system crises opened up CEE countries to the influence of IOs and new policy ideas from abroad. IOs such as the WB, the IMF, the EU or the WHO saw post-communist transition in CEE as an opportunity to exert their influence and push their policy agenda in the region (Cerami, 2005; Deacon, Hulse, & Stubbs, 1997; Kaasch, 2015; Nemec & Lawson, 2008; Pop-Eleches, 2008). However, as already discussed, the extent of influence these IOs had on healthcare reforms in the region is disputed, as some scholars emphasise the role of national factors (e.g. Kaminska et al., 2021; Rechel & McKee, 2009; Sitek, 2008).

Second, in the early 1990s, Croatia embarked on a political, economic and social transition from the communist regime, which was accompanied by political and economic crises and a nation-building process (see Ágh, 1998). However, compared to other countries in the CEE region, Croatia also experienced a devastating war in 1991-1995, which followed its independence from Yugoslavia, as well as the post-war reconstruction of the country (Ramet, 2010). After the early years of transition, Croatia experienced economic crises in the late 1990s and at the end of 2000s. Moreover, the transition to liberal democracy was lagging behind. Croatian politics in the 1990s was dominated by Croatian Democratic Union (CDU) which established a defected democracy characterised by authoritarian tendencies and crony capitalism (Bičanić & Franičević, 2003; Ramet, 2010, 2013; Stubbs & Zrinščak, 2007; Zakošek, 2002). Only when a loose coalition spearheaded by the left-wing Social Democratic Party and the centrist Croatian Social Liberal Party

came to power in 2000 did Croatia consolidate democracy and start to move closer towards the West (Bičanić & Franičević, 2003). It started negotiations to join multiple supranational organisations such as the EU and North Atlantic Treaty Organization (Bičanić & Franičević, 2003). Due to these circumstances, Croatia can be characterised as a vulnerable country, finding itself in a weak bargaining position vis-à-vis IOs. Consequently, it can be argued that Croatia was susceptible to policy ideas coming from powerful IOs. Thus, it provides a good case to study the role of IOs in social policy making and their influence on a country which has been undergoing significant transformations and is vulnerable to external pressures.

Third, since its independence and breakaway from Yugoslavia, Croatian healthcare financing policy has undergone significant changes which are well documented in the literature (e.g. Džakula, Sagan, Pavić, et al., 2014; Vončina et al., 2007; Zrinščak, 2007). However, the existing literature provides scarce analysis of Croatian healthcare reform processes and the influence of policy ideas coming from international domain (see for instance Hebrang, 1994; Hebrang, Ljubičić & Baklaić, 2007; Stubbs & Zrinščak, 2007, 2009). It shares the view that IFIs, the IMF and primarily the WB, were actively involved in Croatian healthcare reforms (Džakula, Sagan, Pavić, et al., 2014; Stubbs & Zrinščak, 2007, 2009; Vončina et al., 2007; Zrinščak, 2007). However, as already indicated in section three, relatively little is written on the exact role these IOs had, the content of their policy prescriptions or the extent of their influence.

In sum, the case of Croatia - marked by post-communist transition, war and economic crises - provides a valuable case for understanding the influence of IOs on policy development in a vulnerable country. Although Croatia's experience is distinctive, especially with the added burden of the Croatian War of Independence, its situation is similar to other countries that have faced the challenges of nation-building after the collapse of a larger political entity, as seen in many parts of Central and Eastern Europe and the post-Soviet region (see, for example, Ágh, 1998; Rutland, 2021). Moreover, like many countries in the Global South (see Huntington, 1991), Croatia has experienced a prolonged political dictatorship followed by a multifaceted crisis, making it potentially more vulnerable to external influences on policymaking. Thus, by focusing on Croatia, the study also contributes to broader discussions on the role of IOs in shaping healthcare reforms in similar contexts.

4.2 Data

The dissertation relies on a large amount of qualitative data gathered during the research process. The data cover the period from 1990 to 2020 and consist of publicly available documents and interviews. The documents were collected from a wide range of sources in order to increase the reliability of the evidence. They include 134 parliamentary minutes, 91 legal acts, 9 government strategies, 48 medical journals and 228 media publications relevant to Croatian health financing policy. In addition, 124 documents from IOs operating in Croatia during the period under observation were collected, including project and loan reports, evaluation reports, publications, loan agreements and studies related to healthcare financing policy. The documents were collected from both physical and online archives of the Croatian government and parliament, Croatian national library, Croatian National Bank and media outlets, and from online archives of the IMF, the WB, and the WHO. In addition, paper D included the collection of WB documents related to the healthcare financing policy in Argentina in the 1987-2007 period. These were collected from online archives of the WB.

To complement the data derived from public documents, 20 semi-structured interviews were conducted with a wide array of experts knowledgeable of the subject, such as ministers of health and their assistants, healthcare administration staff from policy relevant institutions (Ministry of Health, Croatian Institute for Health Insurance and Croatian Institute of Public Health), medical professionals active in the Croatian Medical Chamber, representatives of NGOs involved in healthcare, such as the Coalition of Health Associations in Croatia, politicians involved in the healthcare system as well as journalists who wrote about the Croatian healthcare system, academics and IO experts. Therefore, the interviewees included both the individuals who were directly involved in healthcare financing reform processes and external observers. Interviews were arranged through personal contacts and a snowball approach in which the respondents introduced the author to other potential respondents, up to the point where no new data were being revealed.

It is important to note some limitations in data collection. The search in the physical archives of the WHO Office in Croatia and the WHO online archives did not yield any significant results, i.e. there were no documents to determine the content of WHO advice during the period of its involvement in Croatian healthcare financing policy. In addition, informants who could provide more information on the latter, as well as general information on WHO's involvement during this period, could not be interviewed due to their decease. Finally, some potential respondents declined to be interviewed. However, alternative respondents were found to fill this gap. This significantly reduced the potential influence non-participation could have had on research outcomes.

4.3 Methods

For each of the four papers the collected data were analysed using qualitative content analysis supported by MAXQDA software. Initially, a thorough review of the entire data collection was conducted. In instances where documents addressed broader issues than healthcare alone, terms such as “health", “healthcare”, "health financing" and “healthcare financing” were employed to seek out text segments pertinent to the research topic. Afterwards, the data were coded. Coding was, for the most part, consistent across papers and focused on ideas and position of IOs and domestic policy actors regarding healthcare financing policy; role of IOs in the healthcare financing sector (advice, education, financing, imposition); position of domestic policy actors towards IOs and vice versa (co-operation, contention). In addition, Paper A included the position of domestic policy makers towards policies from other countries (negative, positive).

Besides qualitative content analysis, Paper A also relied on process tracing, a method by which the black box between independent and dependent variables is illuminated and causal mechanisms are established (Baker & Kay 2015, p. 2; George & Bennett 2005, p. 206). Following the work of Nullmeier and Kuhlmann (2022), causal mechanisms were divided into elementary and complex mechanisms. Elementary causal mechanisms explain the production of activities by individual or collective actors (e.g. programmes, protests, decisions) that comprise only one causal step, while complex causal mechanisms contain multiple elementary causal mechanisms, creating a chain of causation with several sequential steps (Nullmeier & Kuhlmann, 2022, p. 16).

5. Contribution of research papers

5.1 Paper A: Anti-Communist Backlash in the Croatian Healthcare System

The paper investigates the most comprehensive Croatian healthcare financing reforms which occurred during the early transition period (1990-1993) and established a hybrid healthcare financing system combining Bismarckian and Beveridgean elements, and imbued with neoliberal principles. As described in the previous sections, the literature on the influence of IOs in the CEE region during the post-communist transition is inconclusive. Some scholars emphasise the role of IOs and how they seized the "policy vacuum" to advance their agenda, while others emphasise the role of national factors. During the reform period, Croatia started its post-communist transition accompanied by economic and political crisis which culminated in the 1991-1995 War of Independence. This made Croatia an extremely vulnerable country in dire need of international aid and consequently it was expected that IOs played a major role in reform process. The aim of the paper is to investigate how and why the healthcare financing reforms occurred and whether the interplay between national and global sphere played any significant role. The paper addresses two research questions: (1) How and why did reforms in the financing of Croatian healthcare move towards a hybrid system in the 1990–1993 period? And (2) what was the role of policy transfer processes in those reforms?

To answer the research questions, the paper relies on qualitative data i.e. media publications, medical journals, laws, and parliamentary minutes. In total, 125 newspaper articles were collected. In addition, 48 medical journals, 10 healthcare laws and minutes of 26 parliamentary debates were collected and analysed. Furthermore, 13 interviews were conducted with experts knowledgeable of the subject, such as ministers and their assistants, healthcare administration staff from the institutions relevant to policy (Ministry of Health, Croatian Institute for Health Insurance and Croatian Institute of Public Health), politicians involved in the healthcare system, but also academics, experts and journalists. The research started with a review of all available secondary literature and then proceeded with the interviews. In the next step, process tracing and qualitative data analysis were used to establish the causal mechanisms behind the healthcare financing policy reforms. Causal mechanisms were divided into elementary and complex mechanisms (see Nullmeier & Kuhlmann, 2022).

The empirical findings show that healthcare financing reforms were driven by domestic actors, primarily medical professionals. The reform process was underpinned by three complex causal mechanisms: the doctors enter politics mechanism, the old system departure mechanism and the seeking solutions abroad mechanism. After the communist party lost the first multiparty elections to the CDU, medical professionals occupied key healthcare policy venues and were crucial actors in formulating new healthcare policies, including financing (i.e. the doctors enter politics mechanism). In doing so, medical professionals set themselves up as an epistemic community because they had the relevant expertise and authority in a complex field such as healthcare. The basic idea of the reform was to move away from the previous communist policies (i.e. the old system departure mechanism) and towards the perceived successes of Western policies. To achieve the latter, domestic policy makers initiated horizontal policy transfer and drew positive and negative lessons from Western and CEE countries, e.g., learning from countries such as the Czech Republic and Germany (i.e., seeking solutions abroad mechanism).

These mechanisms explain the perceptions and interpretations of key policy actors and consequently their action orientation towards reforming the health system in Croatia. Taken together they form the complex causal mechanism of anti-communist backlash which explains the dominant perception of previous communist policies as a failure, particularly by medical professionals, and searching for new policy solutions abroad. The mechanisms are composed of different elementary causal mechanisms, namely, emotional orientation (prevailing feelings of dissatisfaction towards the communist regime and its policies), rational orientation (strategic actions of doctors, cost and benefit analysis of new policy solutions) and comparative orientation (emulating the perceived success of Western European countries, avoiding policy failures of other CEE countries).

In contrast to domestic actors, the role of IOs in the reform process was very limited. IOs such as the WB or the EU were wary of getting involved in a country which was not recognised by the international community and in which there were high security concerns after the disintegration of Yugoslavia and the War of Independence. Despite this, one IO did get involved. Due to the personal connections of the Director of the WHO Regional Office for Europe and the Croatian Minister of Health, the WHO representatives set up an informal office at the Croatian Ministry of Health. Although the direction of reforms was set by domestic policy makers, the WHO experts

provided advice in the formulation of the 1993 healthcare laws. Other IOs such as the WB only became involved in 1995, after their security concerns related to the war were alleviated. The WB, alongside the WHO, praised the introduced reforms and supported them further with material and financial aid in the scope of the 1995 Health Project. The latter findings show the importance of linkages between international and national sphere and how national conditions and actors enable and/or constrict the process of policy transfer.

In the case of Croatia, IOs did not play a crucial role in the reform process during the early post-communist transition period (1990-1993). This contradicts the literature which suggests that IOs took advantage of the policy vacuum in CEE countries (e.g. Deacon, Hulse, & Stubbs, 1997). Croatia's extremely vulnerable position actually hindered the presence of IOs. These findings support the argument that the healthcare policy changes in the early 1990s in CEE were primarily driven by endogenous processes, with limited role of IOs. Domestic actors, such as medical professionals, negative policy experiences during the communist period, first multiparty elections, and the influence of Western policies were deemed more important (Davis, 2010; Jacoby, 2004; Kaminska et al., 2021; Rechel & McKee, 2009; Sitek, 2008).

5.2 Paper B: The role of the World Bank and the International Monetary Fund in the healthcare financing reforms in Croatia: transfer of ideas and limited coercion

The paper focuses on the second phase of significant healthcare financing reforms that occurred in Croatia during the 2000-2002 period. During this period, Croatian government turned to the WB and the IMF to help stabilise the macroeconomic situation, curb high budget deficits and rising public debt, and reform the social sector, including healthcare. Although Croatia faced numerous problems and was in a weak bargaining position vis-à-vis the IOs, it was able to introduce healthcare financing policies that differed from the recommendations of the IOs. The paper focuses on analysing the process of vertical policy transfer, i.e. the interaction of the WB and the IMF with domestic policy makers in the context of power asymmetries.

The paper puts forward the following research questions: (1) To what extent and in which ways did the WB and the IMF influence Croatian healthcare financing policies? and (2) Why did the WB not use the leverage it had to compel Croatia to implement its policy prescriptions, despite it being in a weak bargaining position at the time?

The case study is based on qualitative data which included 32 media publications, six legal acts, minutes of 54 parliamentary sittings, three government strategies and 48 IO documents such as project and loan reports, evaluation reports, publications, letters of intent, loan agreements, and studies related to Croatia. These data were collected from online archives of the WB and the IMF, and both physical and online archives of the Croatian government and parliament, Croatian national library, Croatian national bank and media outlets and cover the period from 1997 to 2006. Moreover, 14 interviews were conducted with experts knowledgeable of the subject and those who were directly involved in the reform process, such as ministers and their assistants, healthcare administration staff from the institutions relevant to policy (Ministry of Health, Croatian Institute for Health Insurance and Croatian Institute of Public Health), politicians involved in the healthcare system as well as academics and IO experts. Qualitative content analysis of the collected data was conducted using MAXQDA software.

In contrast to the first phase of reforms where (as discussed in paper A) IOs involvement was very limited, this paper shows that IOs were extensively involved in Croatian healthcare financing policy during the 2000-2002 period. At that time, the WB provided a first loan which included healthcare financing conditionalities while the IMF negotiated a Stand-by Arrangement with the Croatian government. However, the IMF primarily focused on macroeconomic policies and delegated healthcare issues to the WB due to its own limited expertise in that domain. In comparison to the IMF, the WB was heavily involved using both coercive and non-coercive instruments to influence Croatian healthcare financing policy. Non-coercive instruments included the production of healthcare financing studies, provision of technical assistance as well as consulting and persuading the government. The WB evaluated Croatian healthcare system and its financing, disseminated policy ideas, and defined problems and solutions based on Croatia's specific national conditions and its own long-term experience. In this way, the WB assumed the role of an epistemic community and its recommendations were considered to be a legitimate source of knowledge. Consequently, the WB was able to influence the healthcare financing policy agenda, and Croatia implemented most of its policy recommendations. These recommendations, among others, included diversifying revenue collection, decreasing the payroll tax, reducing the sick pay and maternity leave and increasing the rate and scope of co-payments for a range of services.

However, some of the policies recommended by the WB were contested (e.g. exempting only vulnerable groups from co-payments) and moreover, Croatia was able to introduce policies which were opposed by the WB (e.g. state-run complementary health insurance). This finding shows that the coercive influence of the WB was limited. Even though Croatia was in a weak bargaining position vis a vis IOs, the WB's conditionalities actually had a non-coercive and voluntary character. In fact, these pro-forma conditionalities were negotiated with the Croatian government and mutually agreed upon. Instead of acting as a top-down institution, prescribing and forcing rigid policies, the WB was flexible and lenient. It considered the preferences of domestic policy actors, as well as the already achieved reform progress and Croatian political and economic context. As a result, the WB adapted its stance to the Croatian government's policy preferences, allowing the government to introduce policies that would limit political opposition and prevent social backlash. Such flexibility and leniency on the part of the WB can be explained by its benevolent interest in assisting Croatia in its development, as well as by its self-interest in lending money and prolonging its influence in the future by staying in the reform game. To this end, the WB has been willing to negotiate and compromise with the recipient government.

The paper shows that even countries which find themselves in a vulnerable position are able to resist the pressures from powerful IOs. In the case of Croatia, the WB did not act as a hegemon which tried to unilaterally prescribe policies. Instead, it mostly relied on non-coercion and pro-forma conditionalities. Moreover, the WB was willing to adjust its standpoint according to the developments within the country, but also to domestic policy makers which do not always passively accept policy prescriptions provided by IOs. Consequently, WB's influence was determined by the interplay of endogenous political and economic factors, interests of the recipient country and interests of the WB itself, which is, under certain circumstances, willing to soften its demands in return for the prospect of a long-term relationship.

5.3 Paper C: Healthcare financing reforms in post-communist Croatia and the role of International Organisations

The paper describes the healthcare financing reforms in Croatia since 1990 until 2019 and analyses to what extent linkages between IOs and domestic policy makers shaped healthcare financing policy in Croatia. It builds on paper A and shows that even though the influence of IOs was limited during the 1990-1993 period, the transition from the communist regime enabled IOs to open their

offices in Croatia and to start influencing its healthcare financing policy in the future. It complements and extends the findings of paper B and addresses the limitations of papers A and B i.e., influence of IOs on one country at one point in time and the focus on revenue collection only (Rothgang et al. 2010). It does so by expanding the period of observation and the definition of healthcare financing which includes additional healthcare financing dimensions as defined by Kutzin, Cashin, & Jakab, (2010): pooling, coverage and purchasing.

The paper answers the following research questions: (1) How and to what extent did IOs shape policy changes in Croatian healthcare financing? (2) What was the rationale for IOs involvement in Croatian healthcare financing reforms? (3) What was the rationale for Croatia to seek aid from IOs? (4) What was the content of IOs policy advice in Croatian healthcare financing reforms and did it change over time? (5) Was the interaction between IOs and domestic policy makers cooperative or contentious and did it change over time? (6) Which policy changes occurred in Croatian healthcare financing in the period of analysis?

The paper is based on qualitative data and combines in-depth semi structured interviews and document analysis. Documents include 103 media publications, 83 legal acts, 108 parliamentary minutes, 9 government strategies and 124 IO documents such as project and loan reports, evaluation reports, publications, loan agreements and studies related to Croatia and its healthcare policy. The data were collected from online archives of the WHO, the WB and the IMF, and both physical and online archives of the Croatian government and parliament, Croatian national library, Croatian national bank and media outlets. The data cover the period from 1990 until 2020. Furthermore, 17 interviews were conducted with experts knowledgeable of the subject, such as ministers and their assistants, healthcare administration staff from the institutions relevant to policy (Ministry of Health, Croatian Institute for Health Insurance and Croatian Institute of Public Health), politicians involved in the healthcare system as well as academics, journalists and IO experts. The data was analysed using qualitative content analysis supported by MAXQDA software.

Empirical findings show that three IOs, the WHO, the IMF and the WB were involved in the reforms of healthcare financing in Croatia. The influence of the WHO in the healthcare financing dimension was limited to its advisory role during the formulation of the 1993 healthcare laws. Since then, the WHO reoriented its work and focused on the issues concerning public health policy.

The IMF was focused on macroeconomic policy and its involvement in the healthcare financing policy was confined to pressuring the government to cut healthcare expenditures. However, the IMF did not recommend any specific policy to achieve the latter but rather delegated this task to the WB, which was the most influential IO in Croatian healthcare financing policy since the end of the 1991-1995 War of Independence.

To influence Croatian healthcare financing policies, the WB relied on both coercive and non-coercive instruments of influence. Similar to findings in Paper B, this paper shows that non-coercive instruments of influence relied on the WB's extensive policy knowledge and expertise in the healthcare financing field. This expertise was able to influence the government agenda and bring in new policy ideas for domestic policy makers to consider, particularly because the WB tailored its policy advice to the developments within the country. Moreover, the paper finds that the WB acted as a horizontal policy transfer intermediary and that the advice of the WB was informed by positive and negative policy experiences found in other countries such as the Czech Republic, Slovenia, or the UK. At the same time, the WB also hired external consultants with expertise in specific areas which aimed to develop particular policy models in Croatia. For instance, British consultants were involved in developing a primary care model inspired by the group practice primary care and fund holding purchasing models found in the UK.

Coercion, however, had limited impact because the WB did not impose strict conditionalities. During the whole period of observation, the WB did not act as a hegemon trying to unilaterally define healthcare financing policy. Instead, the WB often adjusted its position and advice according to the developments within the country, thus allowing Croatia to adopt policies which fell short of WB's initial preferences. Moreover, the Croatian case shows that the loans in the healthcare sector often addressed policy slippages of the previous loans. For instance, during the 2005 Programmatic Adjustment Loan, policy actors within the CDU-led government vetoed the requests of the WB to shift the CHI to the private insurance market. In order to continue the loan disbursements in the healthcare sector, the WB recommended alternative policies acceptable to the CDU government.

The latter finding suggests that the WB is not particularly interested in rigidly enforcing the implementation of the policies it recommends. Instead, it is content with the loan progress as long as its recommendations are partially adopted. This allows the WB to include unresolved issues

from previous loans into subsequent ones and to push for a more comprehensive adoption of its policy recommendations in the future. Therefore, rather than trying to tackle all the issues in a single loan, the WB takes a more gradual and incremental approach to influence policy changes in the recipient country. Indeed, the paper shows that the interaction between domestic actors and IOs resembles a bargaining process. At the outset, the WB takes a firm stance and demands extensive policy changes. However, as the process unfolds, it appears to compromise on its demands, accepting fewer policy changes or policies proposed by the national government itself. Therefore, this paper shows that findings in paper B were not just an isolated case where the WB gave in to preferences of domestic policy makers. Rather, this pattern is ingrained in the WB's modus operandi. After all, if the WB were to simply cancel the loan and withdraw, it would not be able to sell future loans nor would it be able to retain its influence over the country and stay in the reform game. As a result, even in the context of power asymmetries between IOs and a vulnerable country, domestic policymakers can gain more room for manoeuvre and resist powerful IOs such as the WB.

5.4 Paper D: International organisations as policy bricoleurs: An analysis of the World Bank's healthcare financing recommendations for Argentina and Croatia

The previous papers show the importance of the WB in Croatian healthcare financing, in particular, its non-coercive instruments of influence, i.e., its reliance on policy expertise to influence the development of healthcare financing policy. Therefore, this paper analyses how the WB formulates healthcare financing recommendations by examining the cases of Argentina and Croatia, two representative cases of socio-political transformations in, respectively, Latin America and CEE during the 1987-2007 period.

Both countries experienced political and economic transformations during the period of observation. They shared a preceding statist regime (rightist military dictatorship in Argentina and communism in Croatia) and their transition to democracy and market-based economy involved significant and comprehensive policy changes. These transformations featured active participation of the WB in restructuring social policy, including healthcare financing. During the 1987-2007 period, the recommendations of the WB were informed by two prominent paradigms, the Washington Consensus (WC) (1987–1997) and the post-Washington Consensus (post-WC) (1997–2007). Although the WB was guided by these paradigms, the understanding of the WB's

preferences for healthcare financing reform is limited, especially compared to pension policy, where the WB had a defined reform blueprint (Orenstein, 2008).

By means of a dual twofold comparison (Argentina vs. Croatia, WC vs. post-WC periods), this paper aims to provide a better understanding of IOs' healthcare policy recommendation making. The paper answers the following research questions: (1) Does the WB provide healthcare financing policy advice based on top-down, one-size-fits-all solutions? (2) Or does the WB adjust general, established blueprints in view of concrete national conditions?

The paper combines qualitative data from two sources: Secondary scholarship and the WB. The former was used to outline internal national conditions in each country, namely, political and economic conditions and healthcare system performance. To analyse the WB's healthcare financing recommendations, WB documents concerning Argentina (1987–2007) and Croatia (1993–2007)[2] were collected. These documents were systematically identified through structured searches within the WB's public database, using filters such as "Argentina" OR "Croatia" AND "Health Systems Development and Reform" in English and Spanish/Croatian equivalents. Furthermore, a non-indexed search was carried out to include additional documents that might not have been covered by structured searches. 14 publications related to Argentina and 11 to Croatia were identified for analysis. Methodologically, the study employed a literature review and qualitative content analysis of WB documents.

The paper shows that, during the WC and post-WC periods, the WB did not have a uniform approach in each country and that it tailored its healthcare financing recommendations to country-specific conditions. Both Argentina and Croatia received different recommendations which were, from the standpoint of the WB, aligned with their economic and political circumstances, as well as healthcare system performance. For instance, during the WC period, both countries received recommendations which were generally in line with the neoliberal principles. However, the recommendations were contextualised to national conditions and furthermore, some recommendations completely diverged from the WC and its neoliberal principles.

[2] The variations in the timeframe can be attributed to the respective WB membership dates: Argentina became a member in 1956, while Croatia joined in 1993.

During the post-WC period, the same pattern in how the WB formulates recommendations was observed. However, compared to the previous period, where the WC principles were primarily contextualised to different national conditions, the WB formulated its recommendations by taking inspiration from two different paradigms simultaneously, WC and post-WC. At the time, neoliberal rhetoric underwent changes in both countries, with certain recommendations being discarded or losing prominence (e.g., decreasing the state's involvement in Argentina), while others became more nuanced (e.g., the co-payment policy in Croatia). Moreover, in Argentina, neoliberal instruments such as targeting were utilised to advance post-WC goals (e.g. coverage expansion) rather than promoting cost saving.

These findings suggest that the WB did not consider the WC and post-WC as paradigms whose dogmas should be strictly followed. Rather, they were considered as toolkits providing different tools to respond and adjust to the concrete circumstances in Argentina and Croatia. In doing that, the WB acted as a policy bricoleur, an actor who draws on multiple sources of knowledge and existing ideas to piece together contextualised policy solutions, rather than relying on textbook blueprints or predefined solutions (Carstensen, 2011). Therefore, the paper provides further evidence and corroborates the findings of the previous two papers (B and C). It shows that the WB is a rather flexible actor and that instead of acting as a neoliberal hegemon, it is willing to adjust to specific country conditions. Moreover, the paper contributes to the theory of policy bricolage by creating an analytical framework to measure policy bricolage in IOs' policy recommendation making.

6. Discussion and conclusions

The aim of this dissertation was to analyse the involvement of IOs in Croatia in order to understand how IOs operate in a country susceptible to external pressures. The dissertation posed the following research questions:

1. Why and how did IOs get involved in the development of Croatian healthcare financing policy?
2. What instruments did IOs use to influence Croatian healthcare financing policy?
3. What were the contents of their policy prescriptions and advice?
4. Did IOs adapt to specific country-level developments and, if so, how?

This section will address these research questions and present a summary of findings as well as their implications for academic scholarship. Moreover, limitations of the study and potential areas for future research will be explored.

The work on the dissertation produced several significant findings which contribute to our understanding of GSP and the policy transfer processes in the context of a country susceptible to external pressures. It also sheds light on the dynamics of healthcare policymaking in Croatia and the CEE region. Drawing on the existing body of GSP literature, this dissertation supports the notion that IOs are increasingly influencing the making of social policy, including healthcare (Deacon, 2007; Kaasch, 2015; Obinger et al., 2013; Yeates, 2014). The dissertation identified three IOs which were involved in the development of Croatian healthcare financing policy, the WHO, the IMF and the WB. Of these three, the WB stood out as the most influential IO, while the WHO and the IMF had a limited role in shaping healthcare financing policy. This is not surprising considering that since 1987, the WB has increasingly focused on systemic reforms of health systems rather than providing infrastructural and technical support for health services in the context of population control and primary care (Noy, 2017; Tichenor & Sridhar, 2017). This finding is consistent with earlier scholarship, which highlights the diminishing prominence of the WHO as the primary IO in the field of healthcare policy (Hadjiisky, 2021; Walt et al., 2004). Compared to the WB and the WHO, the IMF lacks a dedicated mandate in the field of healthcare, leading to its limited engagement in this area. Similarly to Russia in the 1990s (see Odling-Smee,

2006, pp. 159,182), the IMF entrusted healthcare-related matters to the WB in Croatia due to a lack of expertise in the field of healthcare.

The impetus for the involvement of IOs in Croatian healthcare financing policy came during the first years of Croatian independence. During this period, Croatia was an extremely vulnerable state, and the power imbalance between IOs and the country was at its highest. The Croatian government, led by the CDU, invited IOs to collaborate in addressing healthcare system issues, including financing. Based on the previous scholarship (e.g. Aina et al., 2004; Batley, 2004; Deacon, Hulse, & Stubbs, 1997; Evans, 2009; Laurell & Arellano, 1996; Mosley et al., 1995; Paloni & Zanardi, 2006), it can be argued that this situation should prompt IOs to get involved and use such a window of opportunity to leverage their influence and shape healthcare financing policy. However, IOs were wary of getting involved in healthcare policy as Croatia was engulfed in a military conflict and lacked international recognition. Consequently, the influence of IOs was limited. This finding shows that in contrast to the above-mentioned scholarship, the vulnerability of a country can impede the influence exerted by IOs. This might not be that surprising, especially if one considers IOs which wield substantial financial means. Indeed, it is difficult to imagine IOs, particularly IFIs such as the WB, becoming involved in a country plagued by conflict and initiating costly healthcare projects without assurance of the country's survival. This uncertainty makes it even more challenging to ensure the successful implementation of the project and eventual repayment of borrowed funds.

Because the IOs' involvement was limited at the time, the reform process was driven by domestic actors and their motivations. Nevertheless, ideas from abroad still had an impact. Medical professionals occupied important policy venues and acted as an epistemic community which engaged in the process of horizontal policy transfer and drew positive and negative policy lessons from abroad. These findings suggest that there was no policy vacuum in the initial period of post-communist transition (1990–1993), thus contradicting the assertion made by some scholars that IOs took advantage of the lack of policy ideas in CEE (e.g. Deacon, Hulse, & Stubbs, 1997). Instead, the findings from the reform process in the early transition period are consistent with the literature which states that the impetus for reform was endogenous (Radin, 2003; Rechel & McKee, 2009; Roberts, 2009; Sitek, 2008) and that the CEE countries wanted to emulate policy models used in Western countries (Jacoby 2004; Rechel & Mckee 2009). However, this early

transition period in Croatia can be seen as an anomaly due to specific national conditions at that time. Once the conflict subsided, IOs became increasingly involved and started to exert their influence on the making of healthcare financing policy. Since then, IOs and in particular the WB proved to be instrumental in influencing the healthcare financing reforms, similar to the case in some other CEE countries (Cerami, 2005; Deacon, Hulse, & Stubbs, 1997; Kaasch, 2015; Nemec & Kolisnichenko, 2006).

To influence Croatian healthcare financing policy, IOs relied on coercive and non-coercive instruments of influence. Of course, the instruments employed depend on the IO itself. For instance, the WHO is not a financial institution such as the WB and it does not offer loans. Therefore, it does not use coercion in the form of conditionalities attached to loans and it primarily relies on non-coercive influence. The involvement of the WHO in Croatian healthcare financing was limited to early transition reforms when the WHO sent healthcare policy experts to participate in the process of policy formulation. These experts supported and worked in line with the agenda set by the government. They provided policy advice and consultations to domestic policymakers who could either accept or reject their advice. Due to limited empirical evidence, it is not possible to ascertain the exact extent to which these policy experts were influential.

On the other hand, the IMF and the WB are IFIs that could rely on both coercive and non-coercive instruments of influence. The IMF, however, was not particularly involved in healthcare financing reforms. Although the IMF and the Croatian government negotiated Stand-by Arrangements, the IMF did not institute conditionalities related to healthcare financing policies. Instead, the IMF gave only general advice, such as to cut healthcare expenditures. Nevertheless, it could be argued that IMF prescriptions on macroeconomic policy and its advocation of austerity measures indirectly pressured the Croatian governments to consider reducing the scope and depth of healthcare coverage. Such a finding would be consistent with prior literature which investigated similar topics (e.g. Bajpai, 1990; Kaasch, 2015; Odling-Smee, 2006; Orenstein, 2008; Stuckler & Basu, 2009; Wohlmuth, 1984).

Compared to the WHO and the IMF, the WB combined both coercive and non-coercive influence. The use of coercion revolved around conditions which were to be fulfilled before the disbursement of loans. However, compared to literature which emphasises that IOs use conditionalities to impose policies which countries would not otherwise implement (e.g. Brunswijck, 2019; Cerami, 2005;

Deacon, 2007; Deacon, Hulse, & Stubbs, 1997; Hadjiisky, 2021; Paloni & Zanardi, 2006), this dissertation provides evidence of a more nuanced view of conditionalities. The observed conditions do not necessarily represent a true form of coercion, i.e. the first dimension of power (see Dahl, 1957; Lukes, 2005). Instead of imposing "hard core conditionalities" which are solely dictated by the lender, the WB opted to use "pro forma conditionalities" (see Killick, 1998). Such conditions are negotiable and involve a bargaining process between the lender and recipient, i.e. conditions which are the result of mutual agreement. Therefore, their use blurs the line between coercion and non-coercion. Considering that Croatia was a vulnerable country which could presumably easily succumb to dictated conditions, such a finding is likely to evoke some surprise, especially because the WB was often lenient in negotiating and enforcing conditionalities. Nevertheless, "pro forma conditionalities" do play a role in the power dynamics between IOs and aid-receiving countries. Such conditionalities can be situated within the second or third dimension of power (Lukes, 2005) because they are able to influence the agenda of loan negotiations and frame what will be discussed during the bargaining process, thus limiting the policy autonomy of the aid-receiving country (Yeates, 1999).

Such an outcome is similar to the use of non-coercive instruments of influence, instruments on which the WB primarily relied. Non-coercive influence included data collection and analysis of Croatian healthcare financing policy, producing healthcare financing studies, technical assistance and frequent consultations with government officials. The WB "took a seat at the government table" and positioned itself as an epistemic community (see Haas, 1992) that provided continuous policy advice.

Compared to pension and education policy, where scholars have argued that the WB promoted one-size-fits-all solutions, e.g. a three-pillar pension system (Orenstein, 2008), or the education model derived from the WB's Systems Approach for Better Education Results initiative (Seitzer et al., 2023), the evidence provided in this dissertation suggests that the content of the WB's advice was not based on a specific blueprint. Instead, in formulating the policy recommendations, the WB acted as a policy bricoleur and considered multiple sources of knowledge to formulate recommendations. This process involved the WB taking stock of existing ideas found within the Washington and post-Washington consensus. It then reinterpreted or deviated from them in order to tailor the content of policy recommendations to the Croatian national conditions, which

encompass political and economic conditions as well as healthcare system performance. This accommodation to national conditions sometimes went as far as letting domestic policymakers decide which components to include in the WB project (e.g. 1995 Health Project). These findings are consistent with the literature which argues that the WB does not offer a single blueprint for healthcare reforms and that it takes specific national conditions into account (Noy, 2017; Weyland, 2006).

In addition, the WB also considered policy lessons and solutions from other CEE and Western countries which it considered as potentially capable of addressing the challenges identified in Croatia. In some cases, the WB delegated and outsourced the transfer of such foreign policies to external consultants with expertise in specific areas. In doing so, the WB acted as a horizontal policy transfer mediator facilitating lesson drawing from other countries, thus confirming the notion that the direction of policy transfer can go both ways, from countries to IOs and from IOs to countries (Kuhlmann et al., 2020).

Due to its comprehensive knowledge of healthcare policy and its ability to provide country-tailored advice, Croatian governments considered the WB's advice as relevant and legitimate. By frequently interacting with domestic policymakers and disseminating policy knowledge over various channels, the WB was able to influence the government's healthcare financing policy agenda. Therefore, it can be argued that the WB primarily exercised the second and third dimensions of power by attempting to influence the agenda through the inclusion or exclusion of particular policy issues and solutions (see Lukes, 2005). These findings are similar to those put forth by other scholars, contending that IOs like the WB wield significant influence in influencing the government agenda and framing policy discussions in a way that suits their interests (Deacon, Lendvai, Stubbs, 2007; Killick, 1998; Larmour, 2002; Noy, 2017; Orenstein, 2000; Robertson, 1991; St. Clair, 2006; Weyland, 2006).

Clearly, the influence of IOs such as the WB goes beyond the use of coercion and conditionalities, as they combine coercive and non-coercive instruments of influence. Such a finding is consistent with the notion that the WB presented itself as the knowledge bank and that one of its main functions became to sell policy ideas alongside loans (Stone, 2000; Stone & Wright, 2007). Moreover, coercion was not a dominant instrument of influence and its use was limited. Even in the context of large power asymmetries between the country and the IO, the lenient approach of

the WB enabled Croatia to resist the pressures from the powerful IO on multiple occasions and, moreover, to turn the direction of the healthcare financing reforms in its own favour, at least to a certain degree. Not only was the WB lenient in enforcing conditionalities, but it also adjusted its policy recommendations to Croatian national conditions, and more often than not took domestic policymakers' preferences into account. Therefore, instead of acting as a hegemon, the WB appears as a pragmatic, reflexive, lenient and flexible actor that prefers to use non-coercive instruments of influence and collaborate with domestic policymakers in order to shape their policy preferences. This finding is in sharp contrast to scholars who argue that vulnerable countries often encounter limited or no alternatives when it comes to adhering to the policy prescriptions mandated by IOs (Batley, 2004, p. 55; Mosley et al., 1995, p. 41; Paloni & Zanardi, 2006, p. 3; Tomson & Biermann, 2015, p. 171). On the contrary, the dissertation supports the arguments of scholars providing evidence that the influence of IOs is mediated by national conditions and actors, even in vulnerable countries (Asensio & Popic, 2019; Foli, 2023; Heinrich et al., 2021; Kaminska et al., 2021; Kpessa & Béland, 2012; Orenstein, 2008; Weyland, 2006; Yeates, 2002). The Croatian case demonstrates that vulnerable countries cannot be viewed as mere passive recipients of IOs' policy prescriptions. Instead, such countries should be viewed as active participants in the policy transfer process because they interact with IOs, they can bargain and negotiate the terms and the contents of loans and even reverse policies previously agreed with IOs. In other words, even in vulnerable countries, domestic policymakers are able to exercise their veto power. Moreover, the dissertation provides additional evidence and corroborates the conclusions from other scholars which found that IOs do not even want to unilaterally impose policies, but actively engage and collaborate with domestic policymakers and even accommodate their positions (Druga, 2022; Noy, 2017, 2018; Wireko & Béland, 2017).

There are multiple reasons why IOs such as the WB opt for such an approach, even in countries that are susceptible to its influence. First of all, instead of forcing rigid policy prescriptions, the WB has a genuine interest in supporting the development of the countries it operates in. Moreover, in publications such as the Health, Nutrition and Population Strategy (1997) and Assessing Aid (1998), the WB itself recognised the limitations of conditionalities, acknowledging that depending solely on them, without obtaining domestic support and government ownership, lacks effectiveness in achieving meaningful policy change (WB, 1997, 1998, pp. 51–52). One of the major shortcomings of conditionalities is rooted in the mandate of IOs. As Orenstein (2008)

argues, IOs are unable to exercise formal veto power over countries in which they operate. In other words, IOs cannot directly interfere in the national policymaking process by vetoing a bill which goes against their recommendations. Moreover, the case of Croatia shows that IOs are not particularly concerned with the enforcement of conditionalities. Within IOs such as the WB, perverse incentives are evident, encompassing aspects like predefined country lending targets and a staff promotion system based on the number of negotiated loans. These incentives foster a lenient approach in evaluating the fulfilment of conditionalities, leading to a smoother approval of loan disbursements (see also Mosley et al., 1995). Furthermore, IOs are not content with mere short-term success gauged by the fulfilment of policy-related conditions. Instead, they act strategically; they bargain, offer concessions and make trade-offs in return for the prospect of providing future loans which, as the Croatian case shows, often deal with previous loan shortcoming and/or policy reversals. Although such a lenient approach means that some policies IOs advocate will not be implemented by the recipient country, it enables them to stay in the reform game and ensures their long-term influence. In this way, IOs can also try to push for policies which were not initially implemented and influence their adoption in the future. Larmour eloquently articulated this perspective when he suggested that IOs "do not like to seem to be pushing governments around. They seek influence, rather than control" (Lamour 2002, p. 259).

This influence, then, primarily stems from non-coercive instruments which revolve around persuasion (Béland & Orenstein, 2013). By relying on non-coercive instruments as well as pro forma conditionalities, IOs hope to generate support from domestic policymakers for new policy proposals, promote government ownership and in turn to increase the success of loan programmes (Bazbauers, 2018; Foli, 2023; Killick, 1998; Orenstein, 2008; WB, 2005). This could also be one of the reasons why IOs tailor their recommendations to country needs. It can be argued that country-tailored advice can find greater acceptance among domestic policymakers and provide better policy solutions for a particular country than a one-size-fits-all solution (Foli, 2023). If the advice proves valuable to a country, IOs can preserve and even extend their authority and expert legitimacy (Barnett & Finnemore, 2004). The above-mentioned findings indicate that IOs do adapt to specific country-level developments, either through tailored advice or by accommodating the preferences of domestic policy actors. IOs have a vested interest in doing so, even when operating in vulnerable countries. Therefore, vulnerability does not seem to be the sole determining factor in the extent of IO influence in a given country.

To conclude, this dissertation shows that IOs play a prominent role in the development of social policy. As the GSP approach argues, IOs are important actors in social policy and they bring policy ideas from the global to the national level. To achieve the latter, IOs use a variety of instruments which are defined here as coercive and non-coercive. However, the dissertation shows that the use of coercion is limited, even in vulnerable countries. Moreover, exclusive emphasis on coercion oversimplifies and provides an inaccurate understanding of how IOs influence the policymaking process. While it might seem reasonable that vulnerable countries could be easily influenced or compelled to follow specific conditions due to power imbalances, the actual situation is more complex. The lack of formal veto power and the existence of perverse incentives create a situation where IOs are more than willing to bargain with and accommodate to the aid-receiving country. Instead of imposition, IOs prioritise securing a consistent presence at the government's decision-making table. With this approach, IOs influence the government's policy agenda gradually and incrementally, steering policy changes in the desired direction predominantly through the use of non-coercive methods. By staying in the reform game, IOs are able to maintain their lending activities and expand their influence over time. This approach is beneficial for both the IOs and the countries receiving aid. IOs can consistently offer loans and exert influence over national policymaking, while the aid-receiving country gains access to funds with negotiable conditions, along with valuable policy advice. Therefore, the dissertation shows that for global influences to have an impact, they have to engage with national conditions and actors which interact with and mediate such influences. This confirms the argument of Bache and Taylor (2003) who assert that in the process of policy transfer, interdependency between IOs and the aid-receiving country is created, no matter how asymmetric the power between them might be. Therefore, both national and global level factors are inextricably linked and, in many ways, dependent on each other. Consequently, to understand GSP and policy transfer processes, both national and global factors have to be taken into account. In other words, the global influences the local while the local influences the global.

Finally, it is important to mention the limitations of the dissertation and propose avenues for further research. First of all, the collection of empirical data for the involvement of the WHO in the early transition period was limited (refer to section four for more information). Second, most of the findings refer to the WB because it was practically the only IO that had a significant influence on Croatian healthcare financing policy. Third, the findings are for the most part limited to a case

study of Croatia (except for the fourth paper which includes findings from Argentina) and healthcare financing policy. Considering these points, future research dealing with the same or similar topics could focus on investigating different countries and regions, different policy sectors, but also the influence of other IOs such as the OECD. In addition, future studies could also investigate whether the recommendations given by IOs provide effective solutions for the problems countries are facing.

7. References

Ağartan, T. İ. (2007). Turkish health policy in a globalizing world: The case of 'Transformation of Health' program. *ISA Research Committee 19 Annual Academic Conference*. Florence: ISA.

Ágh, A. (1998). *The politics of Central Europe*. SAGE Publications Ltd.

Aina, T., Chachage, C., & Annan-Yao, E. (2004). *Globalisation and social policy in Africa*. CODESRIA.

Appel, H., & Orenstein, M. A. (2018). *From Triumph to Crisis: Neoliberal Economic Reform in Postcommunist Countries*. Cambridge University Press.

Asensio, M., & Popic, T. (2019). Portuguese healthcare reforms in the context of crisis: External pressure or domestic choice? *Social Policy & Administration, 53*(7), 1003–1017. https://doi.org/10.1111/spol.12480

Bache, I., & Taylor, A. (2003). The Politics of Policy Resistance: Reconstructing Higher Education in Kosovo. *Journal of Public Policy, 23*(3), 279–300.

Baeten, R., & Vanhercke, B. (2017). Inside the black box: The EU's economic surveillance of national healthcare systems. *Comparative European Politics, 15*(3), 478–497. https://doi.org/10.1057/cep.2016.10

Bajpai, N. (1990). World Bank's Structural Adjustment Lending: Conflicting Objectives. *Economic and Political Weekly, 25*(15), 791–794. http://www.jstor.org/stable/4396166

Baker, P., & Kay, A. (2015). What Can Causal Process Tracing Offer to Policy Studies? A Review of the Literature. *Policy Studies Journal, 43*(1), 1–21.

Barkin, J. S. (2013). *International Organization: Theories and Institutions*. Palgrave Macmillan.

Barnett, M., & Finnemore, M. (2004). *Rules for the World: International Organizations in Global Politics*. Cornell University Press.

Batley, R. (2004). The politics of service delivery reform. *Development and Change, 35*(1), 31–56.

Bazbauers, A. R. (2018). *The World Bank and Transferring Development*. Springer.

Béland, D., & Cox, R. H. (2011). *Ideas and politics in social science research*. Oxford University Press.

Béland, D., & Orenstein, M. A. (2013). International organizations as policy actors: An ideational approach. *Global Social Policy, 13*(2), 125-143. https://doi.org/10.1177/1468018113484608

Benson, D., & Jordan, A. (2011). What have we Learned from Policy Transfer Research? Dolowitz and Marsh Revisited. *Political Studies Review, 9*(3), 366–378. https://doi.org/10.1111/j.1478-9302.2011.00240.x

Beyer, J., & Wielgohs, J. (2001). On the Limits of Path Dependency Approaches for Explaining Postsocialist Institution Building: In Critical Response to David Stark. *East European Politics and Societies, 15*(2), 356-388. https://doi.org/10.1177/0888325401015002007

Bičanić, I., & Franičević, V. (2003). *Understanding reform: The case of Croatia* (GDN/WIIW Working Paper). https://wiiw.ac.at/understanding-reform-the-case-of-croatia-dlp-3287.pdf

Brada, J. C., Schönfeld, R., & Slay, B. (1995). The role of international financial institutions in Central and Eastern Europe. *Journal of Comparative Economics, 20*(1), 49–56. https://doi.org/10.1006/jcec.1995.1003

Bredenkamp, C., & Gragnolati, M. (2008). Sustainability of health care financing in the western Balkans: An overview of progress and challenges. *SEER: Journal for Labour and Social Affairs in Eastern Europe, 11*(2), 151–184.

Broz, T., & Švaljek, S. (2014). Financiranje zdravstva u Hrvatskoj: Od reforme do reforme [Financing healthcare in Croatia: From reform to reform]. In M. Vehovec (Ed.), *O zdravstvu iz ekonomske perspective* [About healthcare from the economic perspective] *(*pp. 51-75). Ekonomski institut.

Brunet-Jailly, J. (1999). Has the World Bank a strategy on health? *International Social Science Journal*, *51*(161), 347–361. https://doi.org/10.1111/1468-2451.00203

Brunswijck, G. (2019). *Flawed Conditions: The Impact of the World Bank's Conditionality on Developing Countries* (Briefing Paper). European Network on Debt and Development. https://assets.nationbuilder.com/eurodad/pages/520/attachments/original/1590688379/Flawed_conditions.pdf?1590688379

Carstensen, M. (2011). Paradigm man vs. the bricoleur: Bricolage as an alternative vision of agency in ideational change. *European Political Science Review, 3*(1), 147–167.

Cerami, A. (2005). *Social policy in Central and Eastern Europe: The emergence of a new European welfare regime*. [Doctoral dissertation, Universität Erfurt]. Electronic Text Center der Universitäts- und Forschungsbibliothek Erfurt/Gotha.

Chen, M., & Mastilica, M. (1998). Health care reform in Croatia: For better or for worse? *American Journal of Public Health, 88*(8), 1156–1160.

Collaborative Research Center 1342 [CRC 1342]. (2018). *Global dynamics of social policy, summary of the research programme*. University of Bremen, Collaborative Research Center 1342. https://www.socialpolicydynamics.de/f/6ddf0e8df8.pdf

Dahl, R. A. (1957). The concept of power. *Behavioral Science, 2*(3), 201–215.

Davis, C. (2010). Understanding the legacy: Health financing systems in the USSR and central and eastern Europe prior to transition. In J. Kutzin, C. Cashin, & M. Jakab (Eds.), *Implementing health financing reform* (pp. 25–63). World Health Organization, on behalf of the European Observatory on Health Systems and Policies.

de Carvalho, G. (2021). The World Bank and Healthcare Reforms: A Cross-National Analysis of Policy Prescriptions in South America. *Social Inclusion, 10*(1). https://doi.org/10.17645/si.v10i1.4734

de Carvalho, G., Polte, A., Scherf, K., Mahmoud, M., & Frisina Doetter, L. (2021). Trends in time: Identifying healthcare system introductions worldwide. *SOCIUM SFB 1342 Working Papers, 16*, 1-59.

Deacon, B. (2000). Globalization and social policy: The threat to equitable welfare (Geneva 2000 Occasional Paper No. 5). United Nations Research Institute for Social Development (UNRISD), Geneva. (Working Paper).

Deacon, B. (2007). *Global Social Policy and Governance*. Sage.

Deacon, B., & Hulse, M. (1997). The making of post-communist social policy: The role of international agencies. *Journal of Social Policy, 26*(1), 43–62. https://doi.org/10.1017/s0047279496004898

Deacon, B., & Stubbs, P. (2007). *Social Policy and International Interventions in South East Europe*. Edward Elgar.

Deacon, B., Hulse, M., & Stubbs, P. (1997). *Global Social Policy: International Organizations and the Future of Welfare*. Sage.

Deacon, B., Lendvai, N., & Stubbs, P. (2007). Conclusions. In B. Deacon & P. Stubbs (Eds.), *Social Policy and International Interventions in South East Europe* (pp. 221–243). Edward Elgar.

Dijkzeul, D., & Beigbeder, Y. (2003). *Rethinking International Organizations: Pathology and Promise*. Berghahn Books.

Dion, M. (2008). International Organizations and Social Insurance in Mexico. *Global Social Policy, 8*(1), 25-44.

Djelic, M. L., & Quack, S. (2007). Overcoming path dependency: Path generation in open systems. *Theory and Society, 36*(2), 161–186.

Dolowitz, D. (2021). Learning and transfer: Who learns what from whom? In O. P. De Oliveira (Ed.), *Handbook of Policy Transfer, Diffusion and Circulation* (pp. 26-43). Edward Elgar.

Dolowitz, D. P., & Marsh, D. (2000). Learning from abroad: The role of policy transfer in contemporary policy-making. *Governance, 13*(1), 5–23. https://doi.org/10.1111/0952-1895.00121

Dolowitz, D., & Marsh, D. (1996). Who Learns What from Whom: A Review of the Policy Transfer Literature. *Political Studies, 44*, 343-357. https://doi.org/10.1111/j.1467-9248.1996.tb00334.x

Druga, E. (2022). Against All Odds: Introducing Social Health Insurance in Albania. An Actor-Centred Approach to Causal Mechanisms. In J. Kuhlmann & F. Nullmeier (Eds.), *Causal Mechanisms in the Global Development of Social Policies* (pp. 271–302). Palgrave Macmillan. https://doi.org/10.1007/978-3-030-91088-4_9

Džakula, A., Šogorić, S., & Vončina, L. (2012). Decentralization in Croatia's health system. In Bartlett, W., Bozikov, J., Rechel, B., et al. (Eds.), *Health Reforms in South East Europe* (pp. 64–75). Palgrave Macmillan.

Džakula, A., Sagan, A., Pavić, N., Lončarek, K., & Sekelj-Kauzlarić, K. (2014). *Croatia: Health System Review*. World Health Organization. Regional Office for Europe.

Escribà-Folch, A., & Wright, J. (2010). Dealing with Tyranny: International Sanctions and the Survival of Authoritarian Rulers. *International Studies Quarterly, 54*(2), 335–359. http://www.jstor.org/stable/40664170

Evans, M. (2009). Policy transfer in critical perspective. *Policy Studies, 30*(3), 243–268. https://doi.org/10.1080/01442870902863828

Finnemore, M. (1993). International Organizations as Teachers of Norms: The United Nations Educational, Scientific, and Cultural Organization and Science Policy. *International Organization, 47*(4), 565–597. http://www.jstor.org/stable/2706939

Foli, R. K. (2023). *The Making of Anti-Poverty Policies in Ghana. Transnational Actors, Processes and Mechanisms*. Palgrave Macmillan.

Franken, M., & Koolman, X. (2013). Health system goals: A discrete choice experiment to obtain societal valuations. *Health Policy, 112*(1–2), 28–34. https://doi.org/10.1016/j.healthpol.2012.12.013

Fultz, E. (2002, November 13). Social security reforms in Central and Eastern Europe: How effective, equitable, and secure? European regional meeting. New and revised approaches to social protection in Europe, Budapest. https://www.issa.int/pdf/budapest02/2fultz.pdf

George, A. L., & Bennett, A. (2005). *Case Studies and Theory Development in the Social Sciences*. MIT Press.

Gerring, J. (2017). *Case Study Research: Principles and Practices* (2nd ed.). Cambridge University Press.

Greskovits, B. (1998). *The political economy of protest and patience: East European and Latin American transformations compared*. Central European University Press.

Haas, P. (1992). Introduction: Epistemic communities and international policy coordination. *International Organization, 46*(1), 1–35.

Hadjiisky, M. (2021). International organizations as complex agents in policy transfer processes. In O. P. De Oliveira (Ed.), *Handbook of Policy Transfer, Diffusion and Circulation* (pp. 121-155). Edward Elgar.

Hassenteufel, P., Benamouzig, D., Minonzio, J., & Robelet, M. (2017). Policy diffusion and translation: The case of health agencies. *Novos Estudos - Cebrap, 36*(1), 77–98. https://doi.org/10.25091/s0101-3300201700010004

Hausner, J., Jessop, B., & Nielsen, K. (1995). *Strategic Choice and Path-Dependency in Post-Socialism: Institutional Dynamics in the Transformation Process*. Edward Elgar.

Hebrang, A. (1994). Reorganization of the Croatian health system. *Croatian Medical Journal, 35*(3), 130-136.

Hebrang, A., Ljubičić, M., & Baklaić, Ž. (2007). Izvješće o stanju i razvoju hrvatskog zdravstvenog sustava od 1990. do 1995. godine [Report on the State and Development of the Croatian Health Care System from 1990 to 1995]. *Hrvatski časopis za javno zdravstvo, 3*(10), 1–9.

Hebrang, A., Njavro, Đ., & Mrkonjić, I. (1993). *Komentar Zakona o zdravstvenoj zaštiti i Zakona o zdravstvenom osiguranju* [Comments on Healthcare Act and Health Insurance Act]. Zagreb: Privredni biro.

Heinrich, A. (2021). International knowledge transfer and learning in social policy: The case of the post-Soviet region. *Global Social Policy, 21*(1), 3-8. https://doi.org/10.1177/1468018121996077

Heinrich, A., Isabekova, G., Müller, A., Pleines, H., & Brink, T. T. (2021). The Agency of Recipient Countries in Transnational Policy-Related Knowledge Transfer. *Communist and Post-communist Studies, 54*(3), 51–72.

Helderman, J. (2015). The crisis as a catalyst for reframing health care policies in the European Union. *Health Economics, Policy and Law, 10*(1), 45-59. doi:10.1017/S1744133114000231

Heneghan, M., & Orenstein, M. A. (2019). Organizing for impact: International organizations and global pension policy. *Global Social Policy, 19*(1-2), 65-86. https://doi.org/10.1177/1468018119834730

Hicks, A., & Swank, D. (1992). Politics, Institutions, and Welfare Spending in Industrialized Democracies, 1960–82. *American Political Science Review, 86*(3), 658–674. https://doi.org/10.2307/1964129

Huntington, S. P. (1991). *The Third Wave: Democratization in the Late Twentieth Century.* University of Oklahoma Press.

Inglot, T. (2008). *Welfare States in East Central Europe, 1919-2004*. Cambridge University Press.

Jacoby, W. (2004). *The enlargement of the European Union and NATO: Ordering from the menu in Central Europe*. Cambridge University Press.

Jakobi, A. P. (2009). Global education policy in the making: International organisations and lifelong learning. *Globalisation, Societies and Education, 7*(4), 473–487. https://doi.org/10.1080/14767720903412275

Jenson, J. (2010). Diffusing ideas for after neoliberalism. *Global Social Policy, 10*(1), 59–84. https://doi.org/10.1177/1468018109354813

Joachim, J., Reinalda, B., & Verbeek, B. (2008). *International Organizations and Implementation: Enforcers, managers, authorities?* Routledge.

Kaasch, A. (2013). Contesting contestation: global social policy prescriptions on pensions and health systems. *Global Social Policy, 13*(1), 45-65.

Kaasch, A. (2015). *Shaping Global Health Policy: Global Social Policy Actors and Ideas about Health Care Systems*. Palgrave Macmillan.

Kaasch, A., & Martens, K. (2015). *Actors & agency in global social governance*. Oxford University Press.

Kaasch, A., Koch, M., & Martens, K. (2019). Exploring theoretical approaches to global social policy research: Learning from international relations and inter-organisational theory. *Global Social Policy, 19*(1-2), 87-104. https://doi.org/10.1177/1468018119845570

Kaminska, M. E., Druga, E., Stupele, L., & Malinar, A. (2021). Changing the healthcare financing paradigm: Domestic actors and international organizations in the agenda setting for diffusion of social health insurance in post-communist Central and Eastern Europe. *Social Policy & Administration*, *55*(6), 1066–1081. https://doi.org/10.1111/spol.12724

Kangas, O. (1991). *The Politics of Social Rights: Studies on the Dimensions of Sickness Insurance in OECD Countries*. Swedish Institute for Social Research.

Kapstein, E. B., & Milanović, B. (2001). Responding to globalization. *Global Social Policy, 1*(2), 191–212. https://doi.org/10.1177/146801810100100203

Kelley, J. (2004). International Actors on the Domestic Scene: Membership Conditionality and Socialization by International Institutions. *International Organization, 58*(3), 425–457. doi:10.1017/S0020818304583017

Killick, T. (1998). *Aid and the Political Economy of Policy Change*. Routledge.

Klein, R. (1997). Learning from Others: Shall the Last be the First? *Journal of Health Politics, Policy and Law, 22*(5), 1267–1278.

Kohlmorgen, L. (2005, December 5-8). International organisations and global governance: The role of the World Health Organisation, World Bank and UNAIS [paper presentation]. *Salzburg Seminar on the Governance of Health, Salzburg, Austria*.

Korpi, W. (1989). Power, Politics, and State Autonomy in the Development of Social Citizenship: Social Rights during Sickness in Eighteen OECD Countries since 1930. *American Sociological Review, 54*(3), 309–28.

Kovačić, L., & Šošić, Z. (1998). Organization of Health Care in Croatia: Needs and Priorities. *Croatian Medical Journal, 39*(3), 249–255.

Kpessa, M., & Béland, D. (2012). Transnational actors and the politics of pension reform in Sub-Saharan Africa. *Review of International Political Economy, 19*(2), 267-291.

Kuhlmann, J., González de Reufels, D., Schlichte, K., & Nullmeier, F. (2020). How social policy travels: A refined model of diffusion. *Global Social Policy, 20*(1), 80-96. https://doi.org/10.1177/1468018119888443

Kutzin, J., Cashin, C., & Jakab, M. (2010). *Implementing Health Financing Reform: Lessons from Countries in Transition*. World Health Organization Regional Office for Europe, on behalf of the European Observatory on Health Systems and Policies.

Kutzin, J., Jakab, M., & Cashin, C. (2010). Lessons from health financing reform in central and eastern Europe and the former Soviet Union. *Health Economics, Policy and Law, 5*, 135–147. https://doi.org/10.1017/S1744133110000010

Larmour, P. (2002). Conditionality, coercion and other forms of 'power': International financial institutions in the Pacific. *Public Administration and Development, 22*(3), 249–260.

Laurell, A. C., & Arellano, O. L. (1996). Market commodities and poor relief: The World Bank proposal for health. *International Journal of Health Services, 26*(1), 1–18.

Lawson, C., & Nemec, J. (2003). The political economy of Slovak and Czech health policy: 1989-2000. *International Political Science Review, 24*(3), 219–235. https://doi.org/10.1177/0192512103024002004

Lehrer, D., & Korhonen, A. (2004). Postcommunist aid negotiation: a review of recent research. *Cambridge Review of International Affairs, 17*(3), 593-616. DOI: 10.1080/0955757042000298192

Loxley, J. (1990). Structural adjustment in Africa: Reflections on Ghana and Zambia. *Review of African Political Economy, 17*(47), 8–27. https://doi.org/10.1080/03056249008703845

Lukes, S. (2005). *Power: A Radical View*. Palgrave Macmillan.

Mahon, R. (2009). The OECD's Discourse on the Reconciliation of Work and Family Life. *Global Social Policy, 9*(2), 183-204. https://doi.org/10.1177/1468018109104625

Mahon, R., & McBride, S. (2009). Standardizing and disseminating knowledge: The role of the OECD in global governance. *European Political Science Review, 1*(1), 83–101. doi:10.1017/S1755773909000058

Marrée, J., & Groenewegen, P. P. (1997). *Back to Bismarck: Eastern European health care system in transition*. Avebury.

Marsh, D., & Sharman, J. C. (2009). Policy diffusion and policy transfer. *Policy Studies, 30*(3), 269–288. https://doi.org/10.1080/01442870902863851

Mihaljek, D. (2006). Health care policy and reform in Croatia: how to see the forest for the trees. In K. Ott (Ed.), *Croatian accession to the European Union. Vol. 4, The challenges of participation* (pp. 277-320). Institute of Public Finance, Zagreb.

Minkman, E., Van Buuren, A., & Bekkers, V. (2018). Policy transfer routes: an evidence-based conceptual model to explain policy adoption. *Policy Studies, 39*(2), 222–250.

Morrissey, O. (2004). Conditionality and aid effectiveness re-evaluated. *The World Economy, 27*(2), 153–171. https://doi.org/10.1111/j.1467-9701.2004.00594.x

Mosley, P., Harrigan, J., & Toye, J. (1995). *Aid and Power: The World Bank and Policy-Based Lending*. Routledge.

Müller, K. (1999). *The political economy of pension reform in Central-Eastern Europe*. Edward Elgar.

Müller, K. (2002). From the state to the market? Pension reform paths in Central–Eastern Europe and the former Soviet Union. *Social Policy & Administration, 36*(2), 142–155. https://doi.org/10.1111/1467-9515.00277

Myles, J., & Quadagno, J. (2002). Political Theories of the Welfare State. *Social Service Review, 76*(1), 34-57.

Ndulu, B. J. (2008). The Evolution of Global Development Paradigms and their Influence on African Economic Growth. In B. J. Ndulu, S. A. O'Connell, R. H. Bates, P. Collier, & C. C. Soludo (Eds.), *The Political Economy of Economic Growth in Africa, 1960–2000* (pp. 315–347). Cambridge University Press.

Nelson, J. M. (2001). The Politics of Pension and Health-Care Reforms in Hungary and Poland. In J. Kornai, R.R. Kaufman, and S. Haggard (Eds.), *Reforming the State: Fiscal and Welfare Reform in Post-Socialist Countries* (pp. 235–266). Cambridge University Press.

Nemec, J., & Kolisnichenko, N. (2006). Market-based Health Care Reforms in Central and Eastern Europe: Lessons after Ten Years of Change. *International Review of Administrative Sciences, 72*(1), 11–26.

Nemec, J., & Lawson, C. (2008). Health Care Reforms in CEE: Processes, Outcomes and Selected Explanations. *NISPAcee Yearbook, 1*, 27–50.

Noorbakhsh, F., & Noorbakhsh, S. (2006). The Effects of Compliance with Structural Adjustment Programmes on Human Development in sub-Saharan Africa. In A. Paloni & M. Zanardi (Eds.), *The IMF, World Bank and Policy Reform* (pp. 138–155). Routledge.

Noy, S. (2017). *Banking on Health: The World Bank and Health Sector Reform in Latin America*. Palgrave Macmillan.

Noy, S. (2018). Healthy targets? World Bank projects and targeted health programmes and policies in Costa Rica, Argentina, and Peru, 1980–2005. *Oxford Development Studies, 46*(2), 164-183. https://doi.org/10.1080/13600818.2017.1346068

Nullmeier, F., & Kuhlmann, J. (2022). Introduction: A Mechanism-Based Approach to Social Policy Research. In J. Kuhlmann & F. Nullmeier (Eds.), *Causal Mechanisms in the Global Development of Social Policies* (pp. 3–29). Palgrave Macmillan. https://doi.org/10.1007/978-3-030-91088-4_1

Obinger, H., Schmitt, C., & Starke, P. (2013). Policy diffusion and policy transfer in comparative welfare state research. *Social Policy & Administration, 47*(1), 111-129. https://doi.org/10.1111/j.1467-9515.2011.00843.x

Odling-Smee, J. (2006). The IMF and Russia in the 1990s. *IMF Staff Papers, 53*(1), 151–194.

Orenstein, M. A. (1995). Transitional Social Policy in the Czech Republic and Poland. *Czech Sociological Review, 3*(2), 179–196. http://www.jstor.org/stable/41133092

Orenstein, M. A. (2000). How Politics and Institutions Affect Pension Reform in Three Postcommunist Countries (SSRN Scholarly Paper 630682). https://papers.ssrn.com/abstract=630682

Orenstein, M. A. (2008). *Privatizing Pensions: The Transnational Campaign for Social Security Reform*. Princeton University Press.

Paloni, A., & Zanardi, M. (2006). Introduction and overview. In: Paloni, A., & Zanardi, M. (Eds.), *The IMF, World Bank and Policy Reform* (pp. 1–23). Routledge.

Parmelee, Donna E. (1985). Whither the State in Yugoslav Health Care? *Social Science & Medicine, 21*(7), 719–728.

Phelps, C. E. (2002). *Health Economics* (3rd Edition). Addison Wesley.

Plehwe, D. (2007). A global knowledge bank? The World Bank and bottom-up efforts to reinforce neoliberal development perspectives in the post-Washington consensus era. *Globalizations, 4*(4), 514–528.

Pop-Eleches, G. (2008). *From economic crisis to reform: IMF programs in Latin America and Eastern Europe*. Princeton, NJ: Princeton University Press.

Preker, A., Jakab, M., & Schneider, M. (2002). Health financing reforms in central and eastern Europe and the former Soviet Union. In E. Mossialos, A. Dixon, J. Figueras, & J. Kutzin (Eds.), *Funding Health Care: Options for Europe* (pp. 80–109). Open University Press.

Radin, D. (2003). The impact of the World Bank on health care reform in transitional economies. *Politička misao, 40*, 30–51.

Radin, D. (2008). World Bank funding and health care sector performance in Central and Eastern Europe. *International Political Science Review, 29*(3), 325–347.

Ramet, S. P. (2010). *Central and Southeast European Politics since 1989*. Cambridge University Press.

Ramet, S. P. (2013). Croatian Politics since 1990. In R. Lukić, S. P. Ramet, & K. Clewing (Eds.), *Hrvatska od osamostaljenja: Rat, politika, društvo, vanjski odnosi* (pp. 33-59). Golden marketing-Tehnička knjiga.

Ramet, S. P. (2002). *Balkan Babel: The Disintegration of Yugoslavia from the Death of Tito to the Fall of Milošević*. Westview Press.

Rechel, B., & McKee, M. (2009). Health reform in central and eastern Europe and the former Soviet Union. *The Lancet, 374*, 1186–1195.

Roberts, A. (2009). The politics of healthcare reform in Postcommunist Europe: The importance of access. *Journal of Public Policy, 29*, 305–325.

Robertson, D. B. (1991). Political Conflict and Lesson-Drawing. *Journal of Public Policy, 11*(1), 55–78. doi:10.1017/S0143814X00004931

Šarić M. & Rodwin V.G. (1993). The once and future health system in the former Yugoslavia: Myths and realities. *Journal of Public Health Policy, 14*(2), 220–237.

Rose, R. (1991). What is Lesson-Drawing? *Journal of Public Policy, 11*(1), 3–30. https://doi.org/10.1017/s0143814x00004918

Rothgang, H., Cacace, M., Frisina, L., Grimmeisen, S., Schmid, A., & Wendt, C. (2010). *The State and Healthcare: Comparing OECD Countries*. Palgrave Macmillan.

Ruger, J. P. (2005). The changing role of the World Bank in global health. *American Journal of Public Health, 95*(1), 60–70. https://doi.org/10.2105/AJPH.2004.042002

Ruger, J. P. (2007). Global health governance and the World Bank. *The Lancet, 370*(9597), 1471–1474. https://doi.org/10.1016/s0140-6736(07)61619-5

Ruger, J. P., & Yach, D. (2009). The Global Role of the World Health Organization. *Global health governance: The scholarly journal for the new health security paradigm, 2*(2), 1–11.

Rutland, P. (2021). Introduction: nation-building in the Baltic states: thirty years of independence. *Journal of Baltic Studies*, *52*(3), 419–424.

Sabbat, J. (2010). Different view of Polish health policy. *BMJ*, *341*, c3593. https://doi.org/10.1136/bmj.c3593

Sachs, J. (1994). *Poland's jump to the market economy*. MIT Press.

Schmitt, C. (2020). External actors and social protection in the Global South: An overview. In C. Schmitt (Ed.), *From colonialism to international aid* (pp. 3-18). Palgrave Macmillan.

Seitzer, H., Baek, C., & Steiner-Khamsi, G. (2023). Instruments of lesson-drawing: Comparing the knowledge brokerage of the OECD and the World Bank. *Policy Studies*, 1–21. https://doi.org/10.1080/01442872.2023.2220282

Sitek, M. (2008). Politics and Institutions in the Reforms of Health Care in the Czech Republic, Hungary and Poland. *Polish Sociological Review, 1*(161), 39–53.

Skogstad, G. (2011). *Policy Paradigms, Transnationalism, and Domestic Politics*. University of Toronto Press.

St. Clair, A. L. (2006). The World Bank as a transnational expertised institution. *Global Governance, 12*(1), 77–95.

Stark, D. (1991). Path Dependence and Privatization Strategies in East Central Europe. *East European Politics and Societies, 6*(1), 17-54. https://doi.org/10.1177/0888325492006001003

Stark, D., & Bruszt, L. (1998). *Postsocialist Pathways: Transforming Politics and Property in East Central Europe*. Cambridge University Press.

Stark, D., & Bruszt, L. (2001). One Way or Multiple paths: for a Comparative Sociology of East European Capitalism. *American Journal of Sociology, 106*(4), 1129–1137. https://doi.org/10.1086/320301

Stepan, M., & Anderson, K. M. (2014). Pension reform in the European periphery: The role of EU reform advocacy. *Public Administration and Development, 34*(4), 320–331. https://doi.org/10.1002/pad.1690

Stone, D. (1999). Learning Lessons and Transferring Policy across Time, Space and Disciplines. *Politics, 19*(1), 51-59. https://doi.org/10.1111/1467-9256.00086

Stone, D. (2000). *Banking on Knowledge: The Genesis of the International Knowledge Banks in Education: Catalysts for Global Development Network*. Routledge.

Stone, D. (2004). Transfer agents and global networks in the 'transnationalization' of policy. *Journal of European Public Policy, 11*(3), 545–566. https://doi.org/10.1080/1350176041000169429 1

Stone, D., & Wright, C. (2007). Introduction – The currency of change: World Bank lending and learning in the Wolfensohn era. In: Stone D. & Wright C. (Eds.), *The World Bank and Governance: A Decade of Reform and Reaction* (pp. 1–27). Routledge.

Stone, D., De Oliveira, O. P., & Pal, L. A. (2020). Transnational policy transfer: The circulation of ideas, power, and development models. *Policy and Society, 39*(1), 1–18. https://doi.org/10.1080/14494035.2019.1619325

Streeck, W., & Thelen, K. (2005). *Beyond continuity: Institutional change in advanced political economies*. Oxford University Press.

Stubbs, P., & Zrinščak, S. (2007). Croatia. In Deacon, B., & Stubbs, P. (Eds.), *Social Policy and International Interventions in South East Europe* (pp. 85–103). Edward Elgar.

Stubbs, P., & Zrinščak, S. (2009). Croatian Social Policy: The legacies of war, state-building and Late Europeanization. *Social Policy & Administration, 43*(2), 121–135. https://doi.org/10.1111/j.1467-9515.2009.00651.x

Stuckler, D., & Basu, S. (2009). The International Monetary Fund's effects on global health: before and after the 2008 financial crisis. *International Journal of Health Services, 39*(4), 771–781.

Sunić, T. (1995). *Titoism and Dissidence: Studies in the History and Dissolution of Communist Yugoslavia*. Peter Lang.

Tichenor, M., & Sridhar, D. (2017). Universal health coverage, health systems strengthening, and the World Bank. *BMJ*, 358, j3347. https://doi.org/10.1136/bmj.j3347

Tomson, G., & Biermann, O. (2015). Health Policy Reform in Low-Income and Lower Middle-Income Countries in Southeast Asia. In E. Kuhlmann, R. H. Blank, I. L. Bourgeault, & C. Wendt (Eds.), *The Palgrave International Handbook of Healthcare Policy and Governance* (pp. 171–187). London: Palgrave Macmillan. https://doi.org/10.1057/9781137384935_11

True, J. M., & Mintrom, M. A. (2001). Transnational networks and policy diffusion: The case of gender mainstreaming. *International Studies Quarterly, 45*, 27–57.

von Gliszczynski, M., & Leisering, L. (2016). Constructing new global models of social security: How international organizations defined the field of social cash transfers in the 2000s. *Journal of Social Policy, 45*(2), 325–343. doi:10.1017/S0047279415000720

Vončina, L., Džakula, A., & Mastilica, M. (2007). Health care funding reforms in Croatia: A case of mistaken priorities. *Health Policy, 80*(1), 144–157.

Wallich, C. I. (1995). What's Right and Wrong with World Bank Involvement in Eastern Europe. *Journal of Comparative Economics, 20*, 57-94.

Weyland, K. G. (2006). *Bounded Rationality and Policy Diffusion: Social Sector Reform in Latin America*. Princeton University Press.

Wilsford, D. (1994). Path Dependency, or Why History Makes It Difficult but Not Impossible to Reform Health Care Systems in a Big Way. *Journal of Public Policy*, *14*(3), 251–283.

Wireko, I., & Béland, D. (2017). Transnational actors and health care reform: Why international organizations initially opposed, and later supported, social health insurance in Ghana. *International Journal of Social Welfare, 26*(4), 405–415.

Wohlmuth, K. (1984). IMF and World Bank structural adjustment policies: Cooperation or conflict? *Intereconomics, 19*, 226-234.

Woods, N. (2006). *The Globalisers: The IMF, the World Bank, and Their Borrowers*. Cornell University Press.

World Bank. (1987). *Financing Health Services in Developing Countries: An Agenda for Reform*. World Bank.

World Bank. (1993). *World Development Report 1993: Investing in Health, Volume 1*. World Bank.

World Bank. (1997). *Health, Nutrition and Population Sector Strategy*. World Bank.

World Bank. (1998). *Assessing Aid: What Works, What Doesn't, and Why*. World Bank.

World Bank. (2005). *Conditionality Revisited: Concepts, Experiences, and Lessons Learned*. World Bank.

World Bank. (2007). *Healthy Development: The World Bank Strategy for Health, Nutrition, and Population Results*. World Bank.

Yeates, N. (1999). Social politics and policy in an era of globalization: Critical reflections. *Social Policy & Administration, 33*(1), 372-393.

Yeates, N. (2002). Globalization and Social Policy: From Global Neoliberal Hegemony to Global Political Pluralism. *Global Social Policy, 2*(1), 69-91. https://doi.org/10.1177/1468018102002001095

Yeates, N. (2014). *Understanding Global Social Policy*. Policy Press.

Yılmaz, V. (2017). The impact of the World Bank on healthcare reform in Turkey. In V. Yılmaz (Ed.), *The Politics of Healthcare Reform in Turkey* (pp. 117–149). Palgrave Macmillan.

Zakošek, N. (2002). *Politički sustav Hrvatske*. Fakultet političkih znanosti, Zagreb.

Zrinščak, S. (2003). Social Policy in the Context of Thorough Social Transformation of Post-Communist Countries. *Revija za socijalnu politiku, 10*(2), 135–159.

Zrinščak, S. (2007). *Zdravstvena politika Hrvatske. U vrtlogu reformi i suvremenih društvenih izazova* [Croatian health policy. In the whirlwind of reforms and contemporary social challenges]. *Revija za socijalnu politiku, 14*(2), 193–220.

Part II: Paper Manuscripts

1. Paper A: Anti-communist Backlash in the Croatian Healthcare System

8

Anti-communist Backlash in the Croatian Healthcare System

Ante Malinar

1 Introduction

During the transition, in 1993, the Croatian healthcare system underwent profound changes demarking it from the system established in the communist period. Reforms took place in all three dimensions of healthcare: financing, regulation and provision. This chapter focuses only on reforms in the financing dimension and its regulation (Rothgang et al. 2010). Healthcare financing in the communist period was characterised by formally established social ownership, self-management and decentralisation based on Bismarckian principles. The reforms in the early 1990s tackled the deficiencies of the communist system. They departed radically from its

This chapter is a product of the research conducted in the Collaborative Research Centre 1342 "Global Dynamics of Social Policy", funded by the Deutsche Forschungsgemeinschaft (DFG, German Research Foundation)—Projektnummer 374666841—SFB 1342.

A. Malinar (✉)
University of Bremen, Bremen, Germany
e-mail: malinar@uni-bremen.de

J. Kuhlmann, F. Nullmeier (eds.), *Causal Mechanisms in the Global Development of Social Policies*, Global Dynamics of Social Policy,
https://doi.org/10.1007/978-3-030-91088-4_8

principles and established a mix of financing policies stemming from the experiences of other Western and Central and East European countries, providing evidence for horizontal policy transfer and learning (Dolowitz and Marsh 2000; Klein 1997). This policy mix established a hybrid system of healthcare financing combining Beveridgean, Bismarckian and market principles as well as radically changing the role of the state. Schmid et al. (2010, 455) argue that healthcare systems are becoming hybrid. Hybridisation of healthcare policies occurs through policy transfer, "the cross-national diffusion of ideas about policy concepts and instruments" (Schmid et al. 2010, 460). Although their research includes only OECD countries, the Croatian case confirms that the trend of hybridisation is present even in non-OECD countries.

Croatia is a case worth investigating for several reasons. First, it is an example of one of the few countries in Central and Eastern Europe (CEE) which had a Bismarckian system during the communist regime. Healthcare financing was decentralised and involved multiple social health insurance (SHI) funds managed by providers and users (Džakula et al. 2014; Parmelee 1985; Šarić and Rodwin 1993). Second, while the idea of implementing SHI diffused across CEE, the reforms in Croatia took the opposite direction. SHI was retained, but it was centralised with the creation of one national health fund closely controlled by the government. At the same time, formal out-of-pocket payments (co-payments and self-medication payments) (Kaminska and Wulfgramm 2019) and two different forms of private insurance were instituted. This has effectively created a hybrid financing system (Chen and Mastilica 1998, 1157; Vončina et al. 2007; Kovačić and Šošić 1998). And third, transition accompanied by war has made Croatia an extremely vulnerable country in dire need of international aid where, consequently, one would expect international organisations to have greater bargaining power and leverage. However, the direction and ideas for reform were defined by domestic actors, while international organisations had only a minor influence or none at all.

This chapter answers two research questions: (1) How and why did reforms in the financing of Croatian healthcare move towards a hybrid system in the 1990–1993 period? And (2) what was the role of policy transfer processes in those reforms? The chapter answers the research questions by referring to the elementary and complex causal mechanisms adopted in

this volume (Chap. 1). Elementary causal mechanisms explain the production of activities by individual or collective actors that comprise only one causal step, while complex causal mechanisms contain several elementary causal mechanisms which form a causal chain of several causal steps (Chap. 1). Thus, process tracing is used to illuminate the black box between independent and dependent variables (George and Bennett 2005, 206) while holding "the promise of a rich account of how a complex political phenomenon like public policy emerges" (Baker and Kay 2015, 2). In this case, the independent variable is a high level of attention to the issue stemming from the mismatch in healthcare policies and the changing environment (economic and political crisis and its culmination in the early 1990s), while the dependent variable is the 1993 health policy output.

Three complex causal mechanisms are identified: the *doctors enter politics mechanism*, the *old system departure mechanism* and the *seeking solutions abroad mechanism*. The first mechanism explains how doctors occupied key political positions in the healthcare policymaking domain. The second mechanism explains how negative perceptions of the communist healthcare system and intermediary policy solutions led to a departure from the old system. The third mechanism explains how, during the reform process, Croatia scanned policy solutions and drew on lessons learnt abroad. Combined, these three mechanisms form the complex causal mechanism of *anti-communist backlash*. It explains how the prevailing dissatisfaction with the communist healthcare system, particularly among medical doctors, pushed the reforms in a new direction towards hybridisation of financing. What is more, in all four complex causal mechanisms, different elementary causal mechanisms are identified, such as an emotional orientation, a rational orientation and a comparative orientation.

To reconstruct the reform process, the chapter analyses qualitative data such as media publications, medical journals, laws and parliamentary minutes.[1] Furthermore, 13 interviews were conducted with experts

[1] The majority of the newspaper articles analysed come from the most influential newspapers at that time: *Vjesnik*, *Večernji list*, *Slobodna Dalmacija* and *Glas Slavonije* (Ramet 2013), but the analysis also included newspaper articles from non-mainstream media such as *Radničke novine* and *Sindikalna javnost*. In total, 125 newspaper articles were collected. In addition, 48 medical journals (*Liječnički vjesnik* and *Liječničke novine*), 10 healthcare laws and minutes of 26 parliamentary debates have been collected and analysed.

knowledgeable of the subject, such as ministers and their assistants, healthcare administration staff from the institutions relevant to policy (Ministry of Health, Croatian Institute for Health Insurance and Croatian Institute for Public Health), politicians involved in the healthcare system, but also academics, experts and journalists. The research started with a review of all available secondary literature and then proceeded with the interviews. This chapter is based on an analysis of the collected data using a qualitative content analysis methodology. The mechanisms derived in this chapter were inspired by existing theories and concepts from policy process research, most notably the concept of epistemic communities, the policy transfer literature and punctuated equilibrium theory (Baumgartner and Jones 2009; Haas 1992; Dolowitz and Marsh 2000).

The chapter starts with a literature review on healthcare reforms in CEE countries and Croatia, while also providing an explanation of the role of policy transfer processes in these countries. Subsequently, in Sects. 3 and 4 the chapter explains the context of and the trigger for the reforms. Section 5 identifies the actors involved, their interaction and the activities that produced the reforms. Moreover, it offers explanations for how the reforms produced a hybrid system of healthcare financing in Croatia. The concluding section relates the mechanisms that were identified in this chapter to policy process research and draws some broader conclusions.

2 Healthcare Reforms in CEE and the Role of Policy Transfer

The transition of CEE[2] countries from the communist regime, which started in 1989, had a profound impact on their health systems. During the communist regime, the majority of CEE countries had a centralised healthcare system named after Semashko. It was characterised by state control of the system, tax-based financing, universal coverage, free

[2] In this chapter, the CEE region is understood as post-communist countries, excluding the post-Soviet ones (except the Baltic states).

provision of health services at the point of use, informal payments, over-reliance on hospital services and underfunding (Lawson and Nemec 2008). CEE countries underwent a major paradigm shift and introduced market and liberal reforms into their systems, such as decentralisation by establishing social health insurance (SHI) funds, allowing a free choice of practitioners, privatisation and introducing out-of-pocket payments, while also reducing the hospital sector and developing primary care (Lawson and Nemec 2008; Rechel and McKee 2009).

Although there were many similarities with other CEE countries, the so-called Yugoslav *Štampar* model was organised on distinctly Yugoslav communist values of self-management and Bismarckian principles whose formal goals were to establish democratic governance through decentralisation and devolution of authority in the decision-making process. The reforms in the early 1990s followed similar principles as in other CEE countries, although Croatia centralised the system and retained the SHI.

In general, the literature on policy transfer processes in CEE countries is inconclusive, suggesting that the ideas for reforms were either exogenous or endogenous. A first strand of literature explains that healthcare reforms in CEE were a result of the influence and pressures of international organisations. It suggests that early transition created a policy vacuum in the CEE countries and that international organisations such as the World Bank (WB), the World Health Organization (WHO), the International Monetary Fund (IMF) or the European Union (EU) seized the opportunity to exert their influence through financing and policy advice (Deacon et al. 1997; Cerami 2006; Kaasch 2015). For instance, Nemec and Kolisnichenko (2006, 15) argue that the World Bank and the IMF were instrumental in providing ideas on marketisation reforms in CEE healthcare systems.

On the other hand, it is suggested that the reform processes were mostly endogenous and that other factors beyond the influence of international organisations accounted for the policy changes (Rechel and McKee 2009; Sitek 2008; Radin 2003; Roberts 2009). Sitek (2008) argues that the direction of change was influenced by the interaction of political institutions, party politics and in some cases professional organisations such as medical chambers. Moreover, the majority of CEE countries wanted to move away from communist policies and looked to

Western systems. This suggests horizontal interdependencies in that CEE countries wanted to "emulate the apparent success of models used in Germany and Austria" (Rechel and McKee 2009, 1187) by moving towards "a Western-style insurance system" (Jacoby 2004, 48).

3 The Political and Economic Context of Croatia

After the end of the Second World War, Croatia became a federal republic within Yugoslavia governed by the Communist regime led by Tito. In 1948, after Tito–Stalin split and its culmination in 1952, Yugoslavia embarked on a different path of socialism than that of the other countries in the Eastern bloc—the path of self-management socialism (Ramet 2002). Self-management introduced social ownership and self-managing interest communities (SIZ—*samoupravne interesne zajednice*) in which workers could participate in the management of their enterprises. This type of governance was also reflected in public services such as healthcare, education and social welfare (Ramet 2002). However, there was a discrepancy between the formal authority of SIZs and the authority of provincial and republic governments. This "democratic centralism" (Sunić 1995, 67) "in which two parallel structures exercised jurisdiction in the same area, was mocked as SIZ-ophrenia" (Ramet 2002, 9).

After Tito's death in 1980, different ideas emerged on the future organisation of Yugoslavia. Serbia wanted to maintain its hegemony in a centralised federation, while Croatia and Slovenia were favouring a loose confederation or independence (Žižmond 1992). Moreover, a severe economic crisis plagued Yugoslavia during the 1980s and already in 1981, foreign debt amounted to $19.2 billion (Ramet 2002, 10). The economic crisis came to a head at the end of the decade. GNP and labour productivity decreased, while unemployment increased and hyperinflation ensued (Žižmond 1992). As the pressures of political and economic crisis were mounting, the Communist Party was losing its legitimacy and was pushed into holding the first multiparty elections in 1990. The elections established a new party in power, the Croatian Democratic Union

(*Hrvatska demokratska zajednica*, HDZ). HDZ was a pro-reform right-wing party oriented towards breaking with the communist past, independence for Croatia, democratisation, liberalism, pluralism and transition to a market economy (Milanović 2011; Dunatov 2010).

Due to the perceived political and economic crisis, HDZ opted for the introduction of a semi-presidential political system with a strong presidential figure (Boban 2008). After coming to power, HDZ purged policy venues and appointed people loyal to them in public administration and the judiciary, facilitating even more control over policy processes at the time (Ramet 2013, 37). Therefore, the transition to liberal democracy was severely limited. In the 1990s, Croatia was a defected democracy with limited pluralism, dominance of the president and widespread corruption (Ramet 2010, 259).

The ground was set for the dissolution of Yugoslavia when Croatia and Slovenia proclaimed independence in 1991. However, the dissolution was followed by the war in 1991 which lasted until 1995. At the end of 1991, Croatia lost control of 30% of its territory, 40% of industry was destroyed, income from tourism dropped by about 80% and inflation and unemployment increased (Ramet 2013, 38). Between 1991 and 1993, Croatia experienced a decline of about 31% in GDP (World Bank 1995). Moreover, a large population of refugees from occupied Croatian and Bosnian territories came to Croatia (Hebrang et al. 2007). For all these reasons, the financial revenue of the healthcare system dropped considerably. Compared to 1991, the revenue dropped by 62% in 1992 (Hebrang 2015).

4 Financing of Healthcare in Croatia: Historical Background

The history of SHI in Croatia can be traced back to the times when Croatia was part of the Austro-Hungarian empire. A first form of SHI was introduced already in 1891, although its coverage was very limited. Afterwards, SHI went through a number of changes in 1907, 1922 and 1937, mostly expanding the coverage to a wider range of workers and

including more health services (Zrinščak 2003). In Yugoslavia, Croatia followed a similar path to other CEE countries by abolishing SHI and instituting tax financing from local, district, republic and federal levels (Parmelee 1985, 720). However, SHI was reintroduced, thus supporting a new "third way" of self-management socialism.

The model of social ownership and self-management was most explicitly defined after the passage of the 1974 Constitution, which was followed by the 1976 and 1980 Healthcare Acts (Ivčić et al. 2017). During that time, healthcare was heavily decentralised and inefficient. It was organised on socialist principles of expanding health services, "free" healthcare and solidarity (Šarić and Rodwin 1993; Džakula et al. 2012). These formal goals could not be achieved with the financial organisation of a system governed by 113 self-managing interest communities which acted as SHIs, collecting funds according to the Bismarckian model of payroll taxes (Parmelee 1985). In theory, "every local and republican self-governing medical unit managed its own affairs, with a high level of financial independence" (Džakula et al. 2012, 69). However, there was a discrepancy between the self-management component and the influence of the Communist Party.

Parmelee (1985, 725) notes that "SIZ professional administrative staffs are almost constantly accused of usurping the decision-making prerogatives of the self-managed SIZ assemblies, and acting little better than the state bureaucrats they were meant to replace". There was

> a fairly established practice of political interfering in the internal organisation of health care institutions and in particular with personnel policy. It has often been the case that these authorities impose administrative staff who have been unable to find employment elsewhere. (Popović and Škrbić 1968, 89)[3]

The power and influence of the Communist Party permeated all levels of governance, be it local, republic or federal with only a few exceptions. This kind of system was also reflected in the position of medical professionals in the healthcare system. Following the establishment of the

[3] Throughout the chapter, all Croatian quotes were translated.

Yugoslav state, all professional associations (except lawyers) were disbanded due to ideological reasons. As a representative of the professional interests of doctors, the Croatian Medical Chamber was banned and its properties seized already in 1946 (Ivaničević 2015). The position of the doctor was equated with the position of a regular worker in service to society, the regime and the economy. With the expansion of self-management in the late 1960s and early 1970s, medical professionals could exert more influence in medical facilities and SIZs, mostly because of the asymmetry of information between users and providers (Ivčić et al. 2017), but again no major changes could have been made without the approval of the Communist Party.

> We [*the doctors*; my emphasis] assessed this attitude towards the tendency to develop self-government as quickly as possible in our country as negative, and still believe that the responsibility for healthcare management often goes hand-in-hand with a certain monopoly which ignores the growing demands of reducing the dominance of public administration in decision-making. (Ferber and Knežević 1969, 133)

> No one could work in SIZ, there were some exceptions, if one was not a member of the Party because everything was conducted through the Party so that there would be no rebellion or any protests. One received a position along the Party line from which one had some material gain and had to be *silent regarding the issues* (emphasis mine). On paper … you said it yourself, patients, the population was electing people to those governing bodies, but the list had only Communist Party members. (Hebrang, interview 2019)

Doctors voiced concerns about low salaries, difficulty to find employment despite the lack of doctors in the system, emigration of doctors, accusations of taking bribes and difficulties of retired doctors (Ferber and Knežević 1969). It was emphasised that "doctors should be more involved in health policy, especially in relation to staffing and funding, which, in the current framework, makes full self-management impossible" (Ferber and Knežević 1969, 142). The result was a disoriented system which suffered from disorganisation and bordered on anarchy (Džakula, interview 2019; Mastilica, interview 2019). Moreover, there were huge

discrepancies between different regions in terms of financing, quality and access to services (Šarić and Rodwin 1993; Chen and Mastilica 1998). With the culmination of the economic and political crisis these problems became highly apparent and a radical reorganisation of the healthcare system followed in the 1990–1993 period. Prevailing dissatisfaction among medical professionals with their position within the healthcare system pushed them to become involved in politics where they figured prominently, being key actors during the transition period and healthcare reforms of the early 1990s.

5 The Croatian Healthcare Reform Process 1990–1993

In the 1980s, the economic crisis severely decreased the pooling of funds for healthcare. During this time, the discourse in healthcare slowly started to change. Several publications started to introduce new terms into healthcare discourse which also permeated the media, such as "co-payments", "supply and demand", "efficiency" or "cost benefits" (Ivčić et al. 2017; Ivčić and Vračar, interview 2020). The period of the late 1980s and early 1990s marked a turning point in Croatian healthcare for which only 3.6% of GDP was allocated (Hebrang 1990a, 10). In 1989, a new communist government led by Ante Marković initiated economic reforms to curb growing inflation and national debt while at the same time introducing aspects of a market economy and limited privatisation. The new minister of health, Mladen Radković, started to prepare a major reorganisation of healthcare and initiated a programme called Basis (*Osnova*). The idea was to introduce individual responsibility for health through an expansion of co-payments and to reorganise the financing of the system by establishing a two-tier insurance. The first tier would provide financing through a general government budget for basic health services and a second tier would act as a worker's additional health insurance which was to be covered by the employer (Radković 1990, 7).

Although the discourse was changing and gaining traction, the reform proposal from the new communist government encountered many

obstacles. "The reorganisation of SIZs has been under discussion for two years and all these attempts have shown the egoism of the municipalities expressed in the demand for having their own SIZ, that much energy, paper and money has been spent on elaborating the new organisation" (Cvitkušić 1990, 1). Yet, nothing was implemented after the new government came into power (Cvitkušić 1990). Individuals who were benefiting from the existing organisation of the system and who were organised around the Communist Party at different government levels blocked the reform attempts. Despite the mounting problem pressures and an obvious need to reform the system, it was not possible to overcome the resistance, thus preventing any large-scale reorganisation of the system. Once HDZ won the elections and came to power, the new government had different ideas on how to reform the system. The *Osnova* programme was discontinued and suffered a dismal fate.

5.1 The Doctors Enter Politics Mechanism

The elections and breakdown of the Communist Party and its influence served as a trigger for the whole causal mechanism underpinning the changes. It created a space for new actors and ideas in Croatian policy-making. The doctors enter politics mechanism explains how doctors entered the political stage and occupied key political positions in the healthcare domain. It consists of several elementary causal mechanisms, more specifically an emotional and a rational orientation. On the one hand, the emotional orientation explains that the dominant feelings of dissatisfaction, frustration and marginalisation of medical professionals drove them to become involved in politics.

As Poljak notes in an interview:

> Since the war [Second World War], the Croatian Medical Association has had to serve the ruling politics and even work against the interests of its members. One received support from above [The Communist Party] in proportion to one's obedience … Thanks to the new political opportunities, the Association now has the freedom to oppose and criticise. (Šimunić 1990, 5)

On the other hand, the rational orientation explains the strategic action in which medical professionals seized their opportunity, joined the HDZ and consequently occupied powerful positions in the government, enabling them to exercise influence on health policy. "Although unprepared for the nuances of politics and governance, doctors filled the political vacuum by replacing the ousted lawyers in the new government" (Blaskovich 1997, 81). A considerable number of medical professionals occupied positions in the government, parliament and municipal councils. Medical professionals not only began to be involved in the formal decision-making venues, but also influenced policymaking through the Medical Association and a newly formed Croatian doctor's union which was established in 1990 (M. V. 1990, 9). The decision-making process in healthcare shifted from being dominated by the Communist Party to being dominated by doctors. Thus, the doctors had assumed the most important political positions and had a significant influence on healthcare decision-making, for example, in the Ministry of Health and later in the national health fund. Besides occupying political positions, doctors acted as an epistemic community (Haas 1992) which had the knowledge and competence to deliberate on the healthcare system, its problems and policy solutions.

> A large number of doctors ran for the state parliament and for the municipal councils, parliaments. Why? The doctor is ahead of the great majority in his social environment and understands what is going on and how. Many got involved in it and I encouraged them strongly. (Hebrang, interview 2019)

> Count up how many HDZ ministers are medical doctors, all right. From Mate Granić, I mean the medical lobby and by medical lobby I mean top surgeons … professorial level doctors. (Stubbs, interview 2019)

> It is no coincidence that in the political life of Croatia, and I do not know if it is the same in other transition countries, but it seems to me that there are many medics, doctors. Even at the highest functions. You see, there was Foreign Minister Mate Granić, a doctor, a professor of the faculty and today Reiner … doctors were very much involved as ministers. (Mastilica, interview 2019)

5.2 The Old System Departure Mechanism

Although many doctors were involved, the most important one was the Minister of Health Andrija Hebrang, as his ideas were largely implemented. Hebrang was a person with a turbulent history and a strong resentment towards the communist regime.[4] The old system departure mechanism explains the first changes which were introduced in the health system. It consists of an emotional and a rational orientation of policy actors. At the time, negative feelings towards and perceptions of the communist healthcare system were prevalent in the government, parliament and media outlets. This meant that the policies under consideration were quite dissimilar to those of the communist system (Anonymous expert, interview 2019; Mastilica, interview 2019). The media and policymakers discussed the policy failures of the communist system, evaluating its policies not only through emotional, but also through rational appeals, such as lack of accountability, coordination and expenditure controls, heavy involvement of politics or corruption. The following quotes illustrate this:

> The self-management dislocated way of financing and decision-making, as well as the incompetence of the staff, is the cause of anarchy in the management of the Croatian healthcare system, which is why we did not achieve an adequate health standard. (Hebrang 1990b, 6)

> The legacy of the old system is still in people's minds. The term used in this law proposal is actually reminiscent of the term healthcare worker. And that sounds just like a port worker, a railroad worker, a foreman and so on and so forth … I ask that doctors should not fall under that Bolshevik phrase. (Štanfel 1993, 6)

Moreover, the crisis in healthcare meant that the policies had to be based on rational solutions that would alleviate its deficiencies, most importantly contain its costs. The mix of the rational and the emotional orientation thus produced policies dissimilar to the communist system

[4] Hebrang's father Andrija Hebrang had advocated Croatian national interests and was accused of Croatocentrism (Banac 1988, 90). He was thus perceived as a threat to Tito who ordered his imprisonment and assassination.

which were at the same time based on the rational deliberation of the situation in which

> the money to cover health services and accumulated debts was non-existent. Rather, the Communists had funded healthcare by issuing government bonds which had no real value. The value was given by the legitimacy of the Party, but as soon as the Party lost legitimacy it became obvious that debts had to be paid with sound money for the system to survive. (Hebrang, interview 2019)

According to Hebrang, the only rational and fast solution for resolving the situation and departing from the previous system was to introduce centralisation which "goes in terms of financial control, primarily financial because we have come into the situation that without it, we would not have a chance for better days" (Hebrang 1990a, 10). Therefore, the authority of SIZs over financing was disbanded, users and providers no longer had a say in the way financing of healthcare was to be conducted in their municipalities and the responsibility for financing was taken over by one fund called The Republic Health Fund managed by another physician, Mate Granić. Former SIZ authorities now worked under strict control of the SHI fund which established an equal contribution rate[5] for payroll taxes across the whole country.

SHI lost its Bismarckian principles of decentralised multiple funds and corporatist governance (however limited it was in Yugoslavia) and the government had strict control of the SHI fund by appointing its directors and board of directors; at the same time, it had the authority to dismiss them (Vončina et al. 2007, 147; Pezo, interview 2019). Individuals in SIZ assemblies could no longer rely on the power and legitimacy of the Communist Party to push their agenda and block the reforms. Coupled with the government's heavy determination towards reforming the sector, the context of policy processes changed and enabled a fast-sweeping reform. A new law was passed after only four months after new government came into power.

[5] Set at 11.6% in 1991, changed to 20% in 1992 and 16% in 1999 (Croatian Parliament 1991, 1992; WHO 1999).

5.3 The Seeking Solutions Abroad Mechanism

Centralisation and rationalisation of financing was only a stepping stone which prevented the collapse of the system. Once this burning issue was resolved, policymakers oriented themselves towards introducing new policies which would bring the healthcare system into line with the perceived successes of Western European countries.[6] Here the seeking solutions abroad mechanism, consisting of an emotional, a rational and a comparative orientation, can provide an explanation. The mechanism explains how policymakers wanted to move away from the communist policies by scanning the policy solutions abroad and implementing those that were best suited for the Croatian context. The emotional orientation explains the role of the media and the policymakers in propagating dissatisfaction with the communist system and a need to further depart from it. It can be said that such a perception of the communist system was prominent in all three causal steps.

Moreover, the comparative orientation reflects the position of policymakers to emulate the perceived success of the West, look for policy solutions elsewhere and draw lessons from other countries. Here it is important to note that the Minister of Health (Andrija Hebrang) had, as a physician in Yugoslavia, travelled to Western countries to attend medical conferences. During his time abroad, he learned about the organisation of healthcare in these countries, most notably the USA and Germany (Hebrang, interview 2019). Learning from his experiences abroad, the minister favoured a radically different organisation of healthcare financing which would introduce neoliberal[7] policies based on market principles which had already been introduced in many European countries (Šimunić 1990, 7).

[6] A common theme in the newspapers at the time and in the interviews with relevant policy actors was the perception of Western European healthcare systems as a success story and a role model to which Croatia has to strive, which entailed introducing policies that would bring Croatia closer to these countries.

[7] Neoliberal policies in healthcare include commodification of health services, individual responsibility for health, introduction of market principles such as privatisation, competition and private insurances, deregulation and decentralisation (McGregor 2001; Rotarou and Sakellariou 2017). Obviously not all neoliberal ideas were implemented in Croatia.

As other CEE countries were also in the process of transition, the Ministry of Health had set up an office for evaluating and comparing the policies which were being introduced in countries facing similar problems. This facilitated the process of gathering experiences from other countries. Thus, in the third step, the rational orientation explains how different policy solutions were being evaluated according to their costs and benefits and how they could fit into the Croatian context. The transfer of policy experiences from other countries initiated by the Ministry of Health sought to, on the one hand, avoid the negative consequences of the reforms implemented in other countries and, on the other hand, implement the reforms that proved useful, thus taking into consideration the consequences of alternative courses of action.

The minister's experiences abroad and the designated office in the Ministry of Health enabled the process of horizontal policy transfer by evaluating policies in other countries, be it CEE or Western ones, in order to draw positive and negative lessons. For example, the experiences and adverse effects in the Czech Republic (Hebrang et al. 2007, 2), which established a "pluralistic semi-competitive insurance-based system" (Earl-Slater 1996, 16), and the USA, where "small business employees are completely unprotected from the negative side of the healthcare market" (Hebrang 1993, 7), have served as a lesson to approach marketisation and privatisation policies carefully. On the other hand, positive learning stemmed from Western Europe.

> Among the many organisational forms that are possible in the financing of the health system, we have selected those which have the most favourable ratings in the world based on the experience of others. (Hebrang et al. 2007, 3)

> In Europe, there is a sensible combination of the state or SHI funds and private initiatives. Why is that important? Because it brings competition while keeping solidarity. That is the most delicate balance a healthcare system should have. Competition increases quality, lowers service prices, and at the same time you have to keep that social component. (Hebrang, interview 2019)

Individual responsibility for health, co-payments and private insurance schemes appeared on the agenda. Despite heavy criticism in the media, a law which increased co-payments up to 10% for selected healthcare services (Kovačić and Šošić 1998, 4) was supported by the government and was passed by parliament in 1991. The law established co-payments for drugs, visits to primary care, specialists, diagnostic and hospital treatments, among others, while parts of the population such as children or the elderly were exempted (Kovačić and Šošić 1998, 4). Such policies increased the trend of commodification of healthcare. A survey conducted by Mastilica and Chen (1998) shows that over half of the respondents had great or very great problems with out-of-pocket expenses. At the same time, the introduction of private insurance schemes was postponed due to the ever-increasing political crisis and the expected dangers of war. The healthcare system was turned into an integrated military-civilian system. Many doctors were mobilised into the army or were required to serve in reoriented war hospitals. At the same time, the system had to provide healthcare services to civilians in areas not affected by war (Hebrang 2015).

Once the Serbian aggression and advance subsided in the 1992–1993 period, the ground was laid for the formulation of two encompassing healthcare laws. These laws established the Croatian Institute for Health Insurance with 21 regional branches, replacing the former Republican Fund and completely eradicating former SIZ bodies. The perception was that "the state insurance principle … has given the best results in Western countries" (Hebrang et al. 2007, 3). Moreover, a limited space for private insurance market operations was introduced. One form of private insurance was supplementary, covering additional and better quality of health services on top of the mandatory SHI, for which citizens could apply in the private insurance market. The second form, according to the German model, was entirely private health insurance. Eligibility for coverage of citizens was determined by an income above a threshold specified by the Minister of Health and entailed opting out from the mandatory SHI.

Thus, two types of private insurance were reserved for people with high incomes who wanted to have a better standard and coverage of health services. The government introduced market policies and limited competition in the private insurance market while at the same time

preserving solidarity and access to healthcare for a majority of population which was insured by mandatory SHI operating under the Croatian Institute for Health Insurance. Again, both the comparative and the rational orientation is evident as the Ministry of Health tried to avoid "the traps of sudden privatisation, which has yielded very poor results in the healthcare of some post-communist countries" (Hebrang et al. 2007, 3). The goal was to slowly expand the private health insurance market which would have an increased role in the years to come.

> My idea was to make eighty to ninety percent of the system social, and ten to twenty percent which would go to the market in order to level it all together, and that's why supplementary insurance and co-payments were the first attempts, and it worked until the 2000s when we lost the election to the leftist parties. (Hebrang, interview 2019)

The goal was never achieved and the private insurance market was only used by few people. For instance, almost ten years after the reforms, "in 2002, private health insurers reported annual revenues of HRK 962 million (EUR 130 million) or roughly 6% of total health expenditure" (Vončina et al. 2007, 151). However, the institution of a single SHI fund managed to curb healthcare expenditures, pool additional funds and save the system from collapsing. "The debts of the previous system have been eliminated and in 1995 a surplus was accumulated to pay for new capital equipment" (WHO 1999, 46).

Apart from implementing horizontal policy transfer, the Ministry of Health sought help from international organisations as well. However, due to the severe political crisis the presence and influence of international organisations were limited.[8] These organisations were extremely careful not to engage in healthcare projects in a country that was at war and not recognised by the international community (Stubbs and Zrinščak 2007; Hebrang, interview 2020). This was especially the case with the World Bank, IMF and the EU PHARE programme because they offered financial aid for development projects. Ironically enough, this extreme

[8] However, it is important to note that a lot of international organisations and NGOs were indeed present in the early years of transition, such as the UN, Red Cross and alike which were very active in offering humanitarian aid (Stubbs and Zrinščak 2007).

vulnerability actually inhibited the presence of international organisations in the country.

Nevertheless, the minister wanted advice for the initiated reforms and the only possible venue he could turn to was the WHO because its expertise is not reliant on financial aid or strong conditionalities (Kaasch 2015; Deacon 2007). The WHO and its general message of abolishing health inequalities, achieving universal coverage, solidarity and risk pooling was a perfect match since the minister did not want to risk solidarity with the introduction of market and private initiatives. The problem was that the WHO recognised only Yugoslavia as a partner and not Croatia. Thus, the minister used informal connections to meet with the WHO president of the European Regional Office, Jo Asvall, who agreed to set up a small office in the Croatian Ministry of Health in 1991.

> [Asvall] tasked one of his men to communicate with us: "I said I don't need you for money, I only need you for advice. I'll tell you a problem, you give me advice. Whether or not I will listen to it depends on the situation." And this man was phenomenal, coming once a month for two to three days. I would invite my co-workers, we talked and filtered out a lot of our uncertainties. (Hebrang, interview 2019)

A working group consisting of domestic and WHO experts was established to work on the formulation of new healthcare laws which were passed by parliament in 1993. Other international organisations were not present in the reform process, while the World Bank only became involved in 1995, supporting the initiated reforms with financial aid and a healthcare project. The World Bank and the WHO praised the introduced reforms and even admitted they could serve as a model for other Eastern European countries (Hebrang et al. 2007; World Bank 1995).

5.4 The Anti-communist Backlash Mechanism

To recapitulate, the dynamics of the reform process can be explained by three complex causal mechanisms: the doctors enter politics mechanism, the old system departure mechanism and the seeking solutions abroad

mechanism. The first mechanism explains how the prevailing dissatisfaction towards communist policies drove doctors to get involved in the reform process by joining the new ruling party and occupying key political positions in the healthcare domain. The second mechanism explains the first part of the reform process in which the newly introduced policies were as dissimilar as possible to the communist system while at the same time providing a rational foundation for resolving the deficiencies of the healthcare system. The third mechanism explains the second part of the reform process, namely, the departure from the negatively perceived communist legacies by looking to Western Europe, drawing lessons from other countries and implementing policies which suited the Croatian context according to their perceived costs and benefits. These three complex causal mechanisms form the combined mechanism of anti-communist backlash. It explains how the prevailing dissatisfaction with the communist healthcare system, particularly among medical doctors, pushed reforms in the opposite direction and initiated a search for "non-communist" policies abroad.

5.5 Hybridisation of Healthcare Financing as the Output of the Reform Process

The output of the described reform process was a hybrid model of healthcare financing and its regulation. SHI insurance accounted for most of the revenue in healthcare (93% in 1994), more than in 1980 (74%). A negligible number of people signed up for the two types of private insurance, while co-payments remained constant at around 2%. However, the revenue from co-payments is understated and "not necessarily included in the national accounts" (WHO 1999, 13). Other sources were subsidised by the state budget (prevention, education, statistics, etc.) and county budgets (special programmes and healthcare for elderly peasants) (Kovačić and Šošić 1998, 4). Table 8.1 represents the sources of income for Croatian healthcare during the 1990s.

Although the revenue from SHI increased, there are arguments to be made that Croatia actually moved away from the SHI model,

Table 8.1 Financing sources for the Croatian healthcare system

Source of finance	1980	1990	1991	1992	1993	1994	1995	1996	1997
Public									
State budget	–	13%	28%	28%	9%	7%	10%	7%	5%
SHI	74%	74%	70%	70%	91%	93%	90%	93%	95%
Private									
Out-of-pocket	2%	1%	2%	2%	2%	2%	2%	2%	2%
Private insurance	–	–	–	–	–	–	–	–	–
Other									
External sources	7%	12%	–	–	3%	3%	3%	1%	1%

Source: WHO (1999, 13)

introducing Beveridgean and neoliberal principles. First, self-governance where users and providers negotiated the scope and price of healthcare services through SIZ assemblies was abolished. Second and inextricably linked to the first argument, the decentralised and fragmented health system consisting of 113 health funds was abolished in favour of one national SHI fund, the Croatian Institute for Health Insurance, which holds a monopoly in the SHI market. In theory, the Croatian Institute for Health Insurance established a form of corporatist governance as the managerial board consisted of representatives of employers, medical professionals and patients (Croatian Parliament 1993).

However, professional organisations or unions in Croatia are largely underdeveloped and their influence in decision-making is marginal. The medical professionals' organisations are an exception (Škaričić, interview 2019; Rukavina, interview 2019; Radin, interview 2019; Belina, interview 2019). Thus, corporatism is severely limited and in practice the Croatian Institute for Health Insurance is just an extension of government politics as the fund implements policies already agreed upon at the governmental level (Vončina, interview 2019; Anonymous expert, interview 2019). "The observation that everything happens in one place is only partially correct. Everything is happening in one place, which is the government, i.e., the Ministry of Health. The Croatian Institute for Health Insurance only implements a specific policy" (Hebrang 1996, 4).

Third, although the system was stabilised, once the debts started accumulating again, the government has, more often than not, covered these debts through government budget transactions.

> Every year we are 2 to 3 billion kuna [HRK, Croatian currency] in deficit and while I was a minister, I always covered it from the budget so I made this mixed Beveridge model … and then I would come to the Government session: now look people I have rationalised this, introduced controls and records. I did everything and cannot go any further. Expenditures are higher because prices are expensive … Every year I have managed to transfer 2 to 2.5 billion HRK from the budget to the health fund and this is how we covered the debts. (Hebrang, interview 2019)

Therefore, incentives to rationalise and curb expenditures are lacking (Anonymous expert, interview 2019) since the government eventually pays for the accumulated debts from the general budget—a form of retrospective tax financing (Mossialos et al. 2002, 69). Thus, the "principle of stable contribution rate" (Giaimo 2001, 351) in an SHI, where equalising revenue and expenditures should figure prominently, is actually non-existent.

Fourth, an explicit basket of services to which insurees are entitled was not defined (Vehovec, interview 2019). Rather similarly to general taxation systems, the Ministry of Health and the Croatian Institute for Health Insurance produced an annual health plan containing "regulations on health insurance entitlements" which had to be approved by parliament (WHO 1999, 10). Although limited, neoliberal principles were also introduced in the healthcare financing dimension, such as a move towards individual responsibility for health, setting up healthcare services as a commodity by instituting co-payments and self-medication payments to private providers and opening a private insurance market.

Thus, a hybrid system of healthcare financing incorporating Beveridgean, Bismarckian and neoliberal principles was created. Practically, the only difference between a true Beveridge system was that the funds were mainly collected by payroll taxes and pooled into an extra-budgetary SHI fund. The arguments mentioned above confirm Steffen's (2010) conclusions which show that categorisations of healthcare systems are rather difficult and that every country has its own specific policies borrowed from various healthcare models.

6 Discussion and Conclusions

Three causal mechanisms explain the perceptions and interpretations of key policy actors and consequently their action orientation towards reforming the health system in Croatia: the doctors enter politics mechanism, the old system departure mechanism and the seeking solutions abroad mechanism, which together form the combined causal mechanism of anti-communist backlash. It explains the dominant perception of communist policies as a failure, particularly by medical doctors, and searching for new policy solutions abroad. The mechanisms are composed of different elementary causal mechanisms, namely, emotional orientation (prevailing feelings of dissatisfaction towards the communist regime and its policies), rational orientation (strategic actions of doctors, cost and benefit analysis of new policy solutions) and comparative orientation (emulating the perceived success of Western European countries, avoiding policy failures of other CEE countries).

Taken together, this has created a hybrid system of healthcare financing and its regulation based on Bismarckian, Beveridgean and neoliberal principles. In sum, analysing the causal process by dividing it into several causal mechanisms and linking them together into a complex causal mechanism proves to be a useful tool for tracing and explaining the reform process. Moreover, the causal mechanism approach can work across and link different theoretical traditions which aim to explain policy changes, thereby contributing to the existing literature.

The mechanisms in this chapter were inspired by theories and concepts such as punctuated equilibrium theory, policy transfer and epistemic communities. Despite the external pressures of a growing economic crisis during the 1980s, healthcare policy in Croatia remained stable, leading to the accumulation of policy errors which created a mismatch or friction between a changing environment and unchanging policy (Zehavi 2012; Baumgartner and Jones 2009). Baumgartner and Jones (2009, 25, 31) argue that increasing policy failures and increasing problem pressures modify policy images or shared "public understandings of policy problems" which are then coupled to policy venues or "institutions or groups in society" that "have the authority to make decisions". This process leads

to positive feedback which punctuates the equilibrium of policymaking and results in major policy change. In Croatia the same process can be observed.

Policy change in Croatian healthcare was only possible once the policy monopoly (Baumgartner and Jones 2009) of the Communist Party at different levels of government was dissolved. After the communists lost the elections in 1990, a causal mechanism which underpins the changes was triggered. Doctors who were unsatisfied with their position joined the new ruling party and occupied relevant policy venues, while veto actors in the municipalities lost their legitimacy and could no longer exert their influence and block the reforms. The exogenous crisis and endogenous problem pressures within the healthcare system were only a sufficient condition for change, while elections and the installation of a new party in the power structures provided a necessary condition for change. Indeed, Walgrave and Varone (2008, 370) argue that "if parties adopt a new policy image and control the new institutional venue, then it will translate into a major policy change". After the elections, the negative policy image was able to be coupled with new policy venues which pushed for a reorganisation of the healthcare system.

Doctors figured prominently in the reforms, acting like an epistemic community, "a network of professionals with recognized expertise and competence in a particular domain and an authoritative claim to policy relevant knowledge within that domain or issue area" (Haas 1992, 3). The influence of such an epistemic community was obvious as doctors did not have any competition in the policymaking field. Moreover, doctors occupied key political positions and were crucial actors in formulating new healthcare policies. As they wanted to move away from communist legacies and towards the perceived successes of Western policies, policymakers were involved in policy transfer, a "process by which knowledge about policies, administrative arrangements, institutions and ideas in one political system (past or present) is used in the development of policies, administrative arrangements, institutions and ideas in another political system" (Dolowitz and Marsh 2000, 5). It can be either voluntary or coercive, revolving around a "continuum that runs from lesson-drawing to the direct imposition of a program, policy or institutional arrangement on one political system by another" (Dolowitz and Marsh 2000, 13).

Besides setting up an office within the Ministry of Health tasked with drawing policy lessons from other CEE countries, the Minister of Health already had knowledge about Western policies acquired during his travels abroad. The transfer of policies was completely voluntary and consisted of mostly horizontal lesson drawing from other countries. It was both negative (e.g., CEE, USA) and positive (Western Europe), which served to either avoid the mistakes of others or to add potential policy tools to the repertoire (Klein 1997, 1270). Moreover, it was also a "symbolic act whereby politicians seek to enhance their status, credibility or modernity" (Stone 2017, 61). Therefore, contrary to the literature which states that international organisations exploited the policy vacuum in CEE countries, the Croatian case offers evidence that international organisations were not crucial for the reform process at all. Although the WHO was involved in the formulation of new healthcare laws by providing advice, it has not enforced any conditionalities. The World Bank, however, was involved in the reform process only after the new laws were passed and agreed on health projects with the government in 1995 in order to support the new government agenda.

Such a comparative orientation among key policy actors established a mix of policies, thus radically changing health financing and its regulation from self-management and Bismarckian principles towards hybrid policy. The Croatian case has indeed demonstrated that policy transfer plays a major role in hybridisation of healthcare systems (Schmid et al. 2010; Steffen 2010). As policymakers respond to problem pressures by searching for compatible solutions elsewhere, they develop "distinct policy responses" and "new elements that are not system specific" (Schmid et al. 2010, 460). Croatian policymakers considered policy solutions irrespective of their ideological background except for dismissing anything resembling communism. Therefore, a hybrid model consisting of Bismarckian, Beveridgean and neoliberal principles of financing was introduced. Although financing from SHI contributions has expanded, its regulation was heavily in line with the Beveridgean system. The state has assumed a major role in the regulation of financing, controlling the SHI fund. At the same time, neoliberal principles were introduced. Individual responsibility for health was introduced by establishing formal co-payments and self-medication payments (Kaminska and Wulfgramm

2019), while market principles were introduced in the health insurance field by establishing two forms of private insurance.

To conclude, the Croatian case provides insights on the dynamics of reform in healthcare policy in one CEE country by using process tracing as a method and establishing causal mechanisms underpinning the changes. It provides evidence that key actors in the reform process were domestic doctors, similarly to other CEE countries (Kaminska et al. 2021), thereby supporting the literature which states that healthcare reforms in CEE were mostly endogenous (Rechel and Mckee 2009; Sitek 2008; Radin 2003; Roberts 2009). On the other hand, it contradicts the literature which claims that exogenous actors such as international organisations were instrumental in directing the reform processes in CEE countries (Deacon et al. 1997; Cerami 2006; Kaasch 2015; see Nemec and Kolisnichenko 2006). Nevertheless, the WHO and the World Bank were present at different stages of the reform process, mostly supporting the initiated reforms rather than initiating themselves. Although the impetus came from the inside, policy ideas were influenced by the experiences of other countries, be it CEE ones or Western ones like Germany, thus supporting the literature which states that CEE countries wanted to emulate policy models used in Western countries (Rechel and Mckee 2009; Jacoby 2004), Therefore, the chapter contributes to the literature on healthcare policy changes in CEE during the transition period and provides a piece of the puzzle which helps us understand how and why changes in healthcare happened in those countries. Furthermore, it contributes to future research on international interdependencies in social policymaking in CEE countries.

References

Baker, Phillip, and Adrian Kay. 2015. What Can Causal Process Tracing Offer to Policy Studies? A Review of the Literature. *Policy Studies Journal* 43 (1): 1–21.

Banac, Ivo. 1988. *With Stalin Against Tito: Cominformist Splits in Yugoslav Communism*. Ithaca: Cornell University Press.

Baumgartner, Frank R., and Bryan D. Jones. 2009. *Agendas and Instability in American Politics*. 2nd ed. Chicago: University of Chicago Press.

Blaskovich, Jerry. 1997. *Anatomy of Deceit: An American Physician's First-Hand Encounter with the Realities of the War in Croatia*. New York: Dunhill Publishing.

Boban, Davor. 2008. Konsenzus i sila u ustavotvornim procesima: Hrvatska, Rusija i Poljska [Consensus and Power in Constitutional Processes: Croatia, Russia and Poland]. In *Politička i konstitutcionalna integracija duboko podeljenih društava*, ed. Milan Podunavac, 67–82. Beograd: Fondacija Heinrich Boll.

Cerami, Alfio. 2006. *Social Policy in Central and Eastern Europe: The Emergence of a New European Welfare Regime*. Berlin: LIT Verlag.

Chen, Meei-shia, and Miroslav Mastilica. 1998. Health Care Reform in Croatia: For Better or for Worse? *American Journal of Public Health* 88 (8): 1156–1160.

Croatian Parliament. 1991. Zakon o zdravstvenoj zaštiti i zdravstvenom osiguranju (pročišćeni tekst) [Law on Health Care and Health Insurance (consolidated text)]. *Narodne Novine* 12: 1–51.

———. 1992. Zakon o izmjeni Zakona o zdravstvenoj zaštiti i zdravstvenom osiguranju [Law on Amendments to the Law on Health Care and Health Insurance]. *Narodne Novine* 18: 1–2.

———. 1993. Rješenje o imenovanju Upravnog vijeća Hrvatskog zavoda za zdravstveno osiguranje [Decision on the Appointment of the Management Board of the Croatian Health Insurance Institute]. *Narodne Novine* 110: 1.

Cvitkušić, Dragan. 1990. SIZ-ovi [SIZ's]. *Glas Slavonije*, June 7.

Deacon, Bob. 2007. *Global Social Policy and Governance*. London: SAGE.

Deacon, Bob, Michelle Hulse, and Peter Stubbs. 1997. *Global Social Policy: International Organizations and the Future of Welfare*. London: Sage.

Dolowitz, David P., and David Marsh. 2000. Learning from Abroad: The Role of Policy Transfer in Contemporary Policy-Making. *Governance* 13 (1): 5–23.

Dunatov, Šime. 2010. Začeci višestranačja u Hrvatskoj 1989. godine [The Beginnings of Multiparty Politics in Croatia in 1989]. *Radovi Zavoda za povijesne znanosti HAZU u Zadru* 52: 381–397.

Džakula, Aleksandar, Selma Šogorić, and Luka Vončina. 2012. Decentralization in Croatia's Health System. In *Health Reforms in South East Europe*, ed. Will Bartlett, Jadranka Bozikov, Bernd Rechel, and Maria Rohova, 64–75. London: Palgrave Macmillan.

Džakula, Aleksandar, Anna Sagan, Nika Pavić, Karmen Lonćčarek, and Katarina Sekelj-Kauzlarić. 2014. Croatia: Health System Review. *Health Systems in Transition* 16 (3): 1–162.

Earl-Slater, Alan. 1996. Health-Care Reforms in the Czech Republic. *Journal of Management in Medicine* 10 (2): 13–22.

Ferber, Edvin, and Stojan Knežević. 1969. Liječnik i njegov položaj u našem društvu [Doctor and His Position in Our Society]. *Liječnički vjesnik: glasilo Hrvatskoga liječničkog zbora* 2 (91): 133–145.

George, Alexander L., and Andrew Bennett. 2005. *Case Studies and Theory Development in the Social Sciences*. Cambridge: MIT Press.

Giaimo, Susan. 2001. Who Pays for Healthcare Reform? In *The New Politics of the Welfare State*, ed. Paul Pierson, 334–368. Oxford: Oxford University Press.

Haas, Peter M. 1992. Introduction: Epistemic Communities and International Policy Coordination. *International Organization* 46 (1): 1–35.

Hebrang, Andrija. 1990a. Bivši system je varao narod [The Former System Deceived the People]. Interview by Dragan Cvitkušić. *Glas Slavonije*, September 22.

———. 1990b. Zdravstveni dinar dobio tutora [The Health Dinar Got a Tutor]. Interview by R. Cigler. *Večernji list*, October 11.

———. 1993. Interview by Diana Glavina. *Večernji List*, August 17.

———. 1996. Dvostruki intervju: ministar zdravstva—predsjednik komore [Double Interview: Minister of Health—President of the Chamber]. Interview by Petar Pavković. *Liječničke novine* 23 (127): 1–8.

———. 2015. *Hrvatski sanitet tijekom srpsko-crnogorske agresije na Republiku Hrvatsku 1990–1995* [Croatian Medical Corps During the Serbian-Montenegrin Aggression on the Republic of Croatia 1990–1995]. Zagreb: Medicinska naklada: Udruga hrvatskih liječnika dragovoljaca 1990–1991.

Hebrang, Andrija, M. Ljubičić, and Ž. Baklaić. 2007. Izvješće o stanju i razvoju hrvatskog zdravstvenog sustava od 1990. do 1995. godine [Report on the State and Development of the Croatian Health Care System from 1990 to 1995]. *Hrvatski časopis za javno zdravstvo* 3 (10): 1–9.

Ivaničević, Nedjeljko. 2015. Pravni položaj Hrvatske liječničke komore od 1945. do 2005. godine [Legal Status of the Croatian Medical Chamber from 1945 to 2005]. In *Hrvatska liječnička komora 1903–1995–2005. Spomenknjiga u povodu desete obljetnice obnove Hrvatske liječničke komore*, ed. Željko Poljak, 143–149. Zagreb: Hrvatska liječnička komora.

Ivčić, Snježana, Ana Vračar, and Lada Weygand. 2017. Primarna zdravstvena zaštita u Hrvatskoj od samoupravljanja do tranzicije: korijeni ideja privatizacije [Primary Health Care in Croatia from Self-Management to Transition: The Roots of the Idea of Privatisation]. In *Zbornik odabranih radova s Drugog međunarodnog znanstvenog skupa Socijalizam na klupi. Socijalizam: Izgradnja*

i Razgradnja, ed. Chiara Bonfiglioli and Boris Koroman, 99–128. Pula-Zagreb: Srednja Europa.

Jacoby, Wade. 2004. *The Enlargement of the European Union and NATO: Ordering from the Menu in Central Europe*. Cambridge: Cambridge University Press.

Kaasch, Alexandra. 2015. *Shaping Global Health Policy. Global Social Policy Actors and Ideas about Health Care Systems*. Basingstoke: Palgrave Macmillan.

Kaminska, Ewa M., and Melike Wulfgramm. 2019. Universal or Commodified Healthcare? Linking Out-Of-Pocket Payments to Income-Related Inequalities in Unmet Health Needs in Europe. *Journal of European Social Policy* 29 (3): 345–360.

Kaminska, Ewa M., Ertila Druga, Liva Stupele, and Ante Malinar. 2021. Changing the Healthcare Financing Paradigm: Domestic Actors and International Organizations in the Agenda Setting for Diffusion of Social Health Insurance in Post-Communist Central and Eastern Europe. *Social Policy & Administration* 55 (6): 1066–1081.

Klein, Rudolf. 1997. Learning from Others: Shall the Last be the First? *Journal of Health Politics, Policy and Law* 22 (5): 1267–1278.

Kovačić, Luka, and Zvonko Šošić. 1998. Organization of Health Care in Croatia: Needs and Priorities. *Croatian Medical Journal* 39 (3): 249–255.

Lawson, Colin, and Juraj Nemec. 2008. Health Care Reforms in CEE: Processes, Outcomes and Selected Explanations. *NISPAcee Yearbook* 1: 27–50.

M. V. 1990. Liječnicima vratiti ugled [Restore the Reputation of Doctors]. *Slobodna Dalmacija*, September 27.

Mastilica, Miroslav, and Meei-shia Chen. 1998. Health Care Reform in Croatia: The Consumers' Perspective. *Croatian Medical Journal* 39 (3): 256–266.

McGregor, Sue. 2001. Neoliberalism and Health Care. *International Journal of Consumer Studies* 25 (2): 82–89.

Milanović, Toni. 2011. Kriza 1980-ih u Jugoslaviji i međunarodni pogledi [The Crisis of the 1980s in Yugoslavia and International Views]. *Rostra: Časopis studenata povijesti Sveučilišta u Zadru* 4 (4): 85–92.

Mossialos, Elias, Anna Dixon, Josep Figueras, and Joe Kutzin. 2002. *Funding Health Care: Options for Europe*. Buckingham: Open University Press.

Nemec, Juraj, and Natalya Kolisnichenko. 2006. Market-based Health Care Reforms in Central and Eastern Europe: Lessons after Ten Years of Change. *International Review of Administrative Sciences* 72 (1): 11–26.

Parmelee, Donna E. 1985. Whither the State in Yugoslav Health Care? *Social Science & Medicine* 21 (7): 719–728.

Popović, Boško, and Škrbić, Milan. 1968. *Samoupravljanje u zdravstvu* [Self-Management in Healthcare]. Zagreb: Zbor liječnika Hrvatske.

Radin, Dagmar. 2003. The Impact of the World Bank on Health Care Reform in Transitional Economies. *Politička misao* 40 (5): 30–51.

Radković, Mladen. 1990. Interview by Jasna A. Petrović. *Radničke novine*, March 12.

Ramet, Sabrina P. 2002. *Balkan Babel: The Disintegration of Yugoslavia from the Death of Tito to the Fall of Milošević*. Colorado: Westview Press.

———. 2010. *Central and Southeast European Politics since 1989*. Cambridge: Cambridge University Press.

———. 2013. Politika u Hrvatskoj od 1990. godine [Croatian Politics since 1990]. In *Hrvatska od osamostaljenja: Rat, politika, društvo, vanjski odnosi*, ed. Reneo Lukić, Sabrina Petra Ramet, and Konrad Clewing, 33-59. Zagreb: Golden marketing-Tehnička knjiga.

Rechel, Bernd, and Martin McKee. 2009. Health Reform in Central and Eastern Europe and the Former Soviet Union. *The Lancet* 374 (9696): 1186–1195.

Roberts, Andrew. 2009. The Politics of Healthcare Reform in Postcommunist Europe: The Importance of Access. *Journal of Public Policy* 29 (3): 305–325.

Rotarou, Elena S., and Dikaios Sakellariou. 2017. Neoliberal Reforms in Health Systems and the Construction of Long-Lasting Inequalities in Health Care: A Case Study from Chile. *Health Policy* 121 (5): 495–503.

Rothgang, Heinz, Mirella Cacace, Lorraine Frisina, Simone Grimmeisen, Achim Schmid, and Claus Wendt, eds. 2010. *The State and Healthcare. Comparing OECD Countries*. New York: Palgrave Macmillan.

Šarić, Muhamed, and Victor G. Rodwin. 1993. The Once and Future Health System in the Former Yugoslavia: Myths and Realities. *Journal of Public Health Policy* 14 (2): 220–237.

Schmid, Achim, Mirella Cacace, Ralf Götze, and Heinz Rothgang. 2010. Explaining Health Care System Change: Problem Pressure and the Emergence of "Hybrid" Health Care Systems. *Journal of Health Politics, Policy and Law* 35: 455–486.

Šimunić, Mijo. 1990. Primarna zdravstvena zaštita danas [Primary Healthcare Today]. Interview by Željko Poljak. *Liječničke novine* 19 (91–92): 4–7.

Sitek, Michał. 2008. Politics and Institutions in the Reforms of Health Care in the Czech Republic, Hungary and Poland. *Polish Sociological Review* 1 (161): 39–53.

Štanfel, Željko. 1993. AMANDMANI na Konačni prijedlog zakona o zdravstvenoj zaštiti (Prijedlog zakona broj 140) [AMENDMENTS to the Final Bill on Health Care (Bill No. 140)]. *Županijski dom Sabora RH*, 26 July.

Steffen, Monika. 2010. Social Health Insurance Systems: What Makes the Difference? The Bismarckian Case in France and Germany. *Journal of Comparative Policy Analysis: Research and Practice* 12 (1–2): 141–161.

Stone, Diane. 2017. Understanding the Transfer of Policy Failure: Bricolage, Experimentalism and Translation. *Policy & Politics* 45 (1): 55–70.

Stubbs, Paul, and Siniša Zrinščak. 2007. Croatia. In *Social Policy and International Interventions in South East Europe*, ed. Bob Deacon and Paul Stubbs, 85–103. Cheltenham and Northampton: Edward Elgar Publishing.

Sunić, Tomislav. 1995. *Titoism and Dissidence: Studies in the History and Dissolution of Communist Yugoslavia*. Frankfurt: Peter Lang.

Vončina, Luka, Aleksandar Dzakula, and Miroslav Mastilica. 2007. Health Care Funding Reforms in Croatia: A Case of Mistaken Priorities. *Health Policy* 80 (1): 144–157.

Walgrave, Stefaan, and Frédéric Varone. 2008. Punctuated Equilibrium and Agenda-Setting: Bringing Parties Back In: Policy Change after the Dutroux Crisis in Belgium. *Governance* 21 (3): 365–395.

WHO (World Health Organisation). 1999. *Health Care Systems in Transition: Croatia*. Copenhagen: WHO Regional Office for Europe.

World Bank. 1995. *Memorandum and Recommendation of the President of the International Bank for Reconstruction and Development to the Executive Directors on a Proposed Loan in an Amount Equivalent to US$40.0 Million to Republic of Croatia for a Health Project. Report No. P-6580-HR*. http://documents1.worldbank.org/curated/en/559441468244221414/pdf/multi0page.pdf. Accessed February 14, 2021.

Zehavi, Amos. 2012. A Reform Less Ordinary? Historical Institutionalism, Punctuated Equilibrium, and Mental Health Care Privatization. *Administration & Society* 44 (6): 731–753.

Žižmond, Egon. 1992. The Collapse of the Yugoslav Economy. *Soviet Studies* 44 (1): 101–112.

Zrinščak, Siniša. 2003. Social Policy in the Context of Thorough Social Transformation of Post-Communist Countries. *Revija za socijalnu politiku* 10 (2): 135–159.

2. Paper B: The role of the World Bank and the International Monetary Fund in the healthcare financing reforms in Croatia: Transfer of ideas and limited coercion

Article

Global Social Policy
2022, Vol. 22(3) 540–559

DOI: 10.1177/14680181221108017
journals.sagepub.com/home/gsp

The role of the World Bank and the International Monetary Fund in the healthcare financing reforms in Croatia: Transfer of ideas and limited coercion

Ante Malinar
University of Bremen, Germany

Abstract

The paper investigates the influence of policy ideas from the World Bank and the International Monetary Fund (IMF) on healthcare financing policy in Croatia during the 2002 reform. It contributes to the global social policy literature by providing evidence that the influence of international organisations primarily stems from non-coercive instruments to control the policy agenda, for example, dissemination of ideas, technical assistance and consultations with the recipient government. Even though Croatia was facing economic and political difficulties which weakened its bargaining position vis a vis IOs, the paper shows that impact of coercion and conditionalities attached to international aid was limited. It explains the lenient stance of international organisations by their mission to aid and adjust to a country's needs as well as their self-interest to lend money, to stay in the reform game and to prolong their influence in the future. Consequently, international organisations are willing to bargain and make trade-offs with the recipient government.

Keywords

Central and Eastern Europe, Croatia, healthcare financing policy, international organisations, coercion, non-coercion

Corresponding author:
Ante Malinar, Collaborative Research Centre 1342, University of Bremen, Mary-Somerville-Straße 7, 28359 Bremen, Germany.
Email: malinar@uni-bremen.de

Introduction

After the collapse of the communist regimes in Central East Europe (CEE), countries in the region faced major challenges due to political, economic and social transition. Post-Yugoslav countries were under particular strain because of the additional task of nation building (Ramet, 2010). Furthermore, some post-Yugoslav countries like Croatia suffered severe damage during the 1991–1995 war which followed the disintegration of Yugoslavia. This made Croatia heavily reliant on international aid and consequently susceptible to international organisations' (IOs) influence.

The existing literature suggests that IOs such as the World Bank (WB), the World Health Organization (WHO), the International Monetary Fund (IMF) or the European Union (EU) were heavily involved in reforming the different sectors of social policy in post-communist CEE, including healthcare (Cerami, 2006; Deacon et al., 1997; Deacon and Stubbs, 2007; Grabbe, 2006; Grielen et al., 2000; Kaasch, 2015). The WB and the IMF appear as the most influential organisations to have shaped social policy in post-communist countries (Deacon et al., 1997). They seized the opportunity to offer policy advice, technical expertise and money (Cerami, 2006; Deacon et al., 1997; Kaasch, 2015). Regarding healthcare, the goal of the WB and the IMF was to improve the efficiency, productivity and financial sustainability of the healthcare systems in CEE (De Beyer et al., 2000). The same is observed in Croatia where the WB and the IMF were the most important IOs involved in the transition reforms and post-war reconstruction effort in the aftermath of the 1991–1995 war (Stubbs and Zrinščak, 2007).

Healthcare was one of the sectors severely affected by transition processes and war. The financial problems in healthcare were temporarily addressed by wide-ranging reforms in 1993, but resurfaced in the late 1990s because of low healthcare insurance contribution levels, increased unemployment, a large informal economy, population aging and large general budget deficits. In the early 2000s, major reforms were initiated, focusing on the three healthcare dimensions: financing, provision and regulation (Rothgang et al., 2010). The reforms were prepared and coordinated together with the IMF and the WB. However, some of the policies introduced differed from the IOs' recommendations. The paper focuses only on the financing dimension in the 2000–2002 period since this provides a clear case of contestation between domestic and international policy actors. The paper argues that the WB and IMF chose the approach of adjustment rather than trying to unilaterally shape Croatian healthcare financing. It contributes to the literature on healthcare financing policy changes and the interaction of the WB and the IMF with the national governments in CEE.

The paper will answer the following research questions: (1) To what extent and in which ways did the WB and the IMF influence Croatian healthcare financing policies? and (2) Why did the WB not use the leverage it had to compel Croatia to implement its policy prescriptions, despite it being in a weaker bargaining position at the time?

The paper reports on a case study that produced a rich account of the WB/IMF role in Croatia, a country which was facing major challenges posed by post-communist transition and 1991–1995 war. The case study is based on qualitative data, gained from combining in-depth semi-structured interviews with documentary analysis, which allows for a detailed insight into the reform process and actors involved. The data (including 32

media publications, six legal acts, minutes of 54 parliamentary sittings, three government strategies and 48 IO documents such as project and loan reports, evaluation reports, publications, letters of intent, loan agreements, and studies related to Croatia) were collected from online archives of the WB and the IMF, and both physical and online archives of the Croatian government and parliament, Croatian national library, Croatian national bank and media outlets. The data cover the period before, during and after the 2002 reform, from 1997 to 2006.

Fourteen interviews were conducted with experts knowledgeable of the subject and those who were directly involved in the reform process, such as ministers and their assistants, healthcare administration staff from the institutions relevant to policy (Ministry of Health, Croatian Institute for Health Insurance [CIHI] and Croatian Institute for Public Health), politicians involved in the healthcare system as well as academics and IO experts. Interviews were arranged through personal contacts and a snowball approach in which the respondents introduced the author to other potential respondents, up to the point where additional data revealed no new information. The data were triangulated using multiple sources to enhance the credibility of findings.

The data were analysed using qualitative content analysis and MAXQDA software. First, the entire data collection was carefully read. When documents included broader issues rather than healthcare alone, the keywords health and health financing were used to search for text segments relevant to the research topic. In the ensuing step the data were coded by focusing on: ideas and position of IOs and domestic policy actors about healthcare financing policies; role of IOs in the healthcare financing sector (advice, education, financing, imposition); position of domestic policy actors towards IOs (co-operation, contention).

The next section offers a literature review on the instruments the WB and IMF use to influence policymaking. The subsequent section analyses economic and political difficulties, as well as problems in healthcare system performance Croatia was facing at the time of healthcare financing reforms that is, its political and economic context and a short overview of Croatian healthcare financing policies. The fourth section focuses on the interaction between the IMF, the WB and the domestic actors and analyses how Croatia could introduce policies that were not completely aligned with the IOs' recommendations. Finally, a discussion and conclusions of the study are presented.

The World Bank and the IMF: coercive and non-coercive influence

Two different approaches to influencing policy in countries where the WB and the IMF offer aid can be deducted from the literature: a coercive and a non-coercive approach. Much of the literature stresses the importance of policy lending conditionalities, whereby the WB and the IMF act as coercive actors who try to unilaterally introduce policies they advocate (Cerami, 2006; Deacon, 2007; Deacon et al., 1997, 2007; Paloni and Zanardi, 2006). Thus, coercion represents the first dimension of power (see Dahl, 1957; Lukes, 2005), forcing countries to do what they otherwise would not do. The IMF conditions focus on macroeconomic issues (Kaasch, 2015; Odling-Smee, 2006), while the WB also

includes 'detailed microeconomic conditionality' with direct implications for other sectors such as healthcare (Deacon, 2007; Paloni and Zanardi, 2006: 2). Nevertheless, the IMF's policy prescriptions can indirectly influence healthcare policies or 'at least have implications for choices and decisions about health policy' (Kaasch, 2015: 56) since the healthcare sector constitutes a large part of government budget expenditure.

Some studies argue that adjustment loans and the related conditionalities have not always been effective in securing desired policy change (Killick, 1998; Larmour, 2002; Mosley et al., 1995). Weyland (2006) argues that the WB was not particularly concerned with countries fulfilling conditionalities while Noy (2017) notes that conditionalities are 'often purposefully vague' (p. 13). Moreover, non-compliance with conditionalities frequently went unpunished due to the systemic pressures within the WB to continue lending money (Killick, 1998; Mosley et al., 1995). Such pressure was internalised by setting country lending targets, staff promotion based on negotiating new loans, guaranteed repayment of loans by aid receiving countries and incentives to secure the future relationship with aid recipient countries (Killick, 1998; Larmour, 2002; Mosley et al., 1995). The WB itself recognised these problems and stated that conditionalities can be difficult to enforce (WB, 1998, 2005).

Due to conditionality limitations and the inability to exercise formal veto power (Orenstein, 2008), the WB and the IMF often choose to act in a non-coercive way (Deacon, 2007; Deacon and Stubbs, 2007; Paloni and Zanardi, 2006: 19; Yılmaz, 2017). Non-coercion entails technical assistance, survey missions, training institutes and policy advice disseminated through research publications and consultations with the governments (Bazbauers, 2018: 40). By persuading countries to follow their advice, IOs act as an epistemic community, which has been defined as a network of experts with an 'authoritative claim to policy-relevant knowledge' (Haas, 1992: 3). Positioned as 'The Knowledge Bank', the WB appears as the legitimate source of policy expertise which is based on accumulated cross-country evidence and its project experience in other countries (Bazbauers, 2018: 239; Paloni and Zanardi, 2006; Stone and Wright, 2007; Yılmaz, 2017: 121). Expertise frames policy discourse in recipient countries, moulds the knowledge of domestic actors and biases their choices (Deacon et al., 2007: 226). St. Clair (2006) argues that WB's framing of policy is influenced by 'hegemonic consensus' which is not independent from political and social set of values (see, for instance, Appel and Orenstein, 2018; Orenstein, 2008; Plehwe, 2007 which describe pervasiveness of neoliberal policy framing within the WB). Thus, non-coercion can heavily influence the agenda-setting process by including or excluding policy issues and solutions (Bazbauers, 2018; Larmour, 2002; Noy, 2018; Orenstein, 2008; Weyland, 2006). Such influence can be situated in the second and third dimension of power (see Lukes, 2005).

However, coercion and non-coercion can be regarded as an ideal type heuristic. In reality, the distinction is blurred as elements of non-coercion can be present in coercion. Conditionalities can have a partially non-coercive character. Such 'pro forma conditionalities' are consensual, mutually agreed between the lender and recipient and emerge as the 'outcome of often long periods of consultation and discussion' (Killick, 1998: 9). The point of the latter is to instil government identification with and ownership of the lending programme, and to increase the success of loan programmes (Bazbauers, 2018;

Killick, 1998; WB, 1997c, 1998). The WB has argued that this leaves a larger space for country-grown policies while following the donor's minimum standards (WB, 2005). In contrast to 'hard-core conditionalities', coercive influence is effectively reduced because 'pro forma conditionalities' are not 'made only at the insistence of the lender' (Killick, 1998: 11).

Regarding healthcare policy, scholars suggest the IMF and the WB promoted policies associated with the Washington consensus e.g. increasing individual responsibility, user charges for health services, marketisation, reduction of healthcare expenditures and healthcare benefits and the like (Cerami, 2006; Deacon, 2007; Laurell and Arellano, 1996; Stuckler and Basu, 2009: 771). Since the 1997 Health, Nutrition and Population Sector Strategy, the WB has advocated for social sensitivity in health, a greater role for the state, increased flexibility and avoidance of rigid policy prescriptions (Deacon, 2007; Kaasch, 2015; WB, 1997c). In general, the discourse shifted towards universal healthcare, expanded coverage, equity and increased access, especially for the poor (Kaasch, 2015; Noy, 2017). Unlike pension reform, for which the WB advocated the three-pillar pension system (Orenstein, 2008), the WB did not have a readily available blueprint for healthcare financing reforms (Radin, 2008). Rather, it tailored its assistance to different political, economic and institutional environments (Noy, 2017, 2018; Yılmaz, 2017: 124). Moreover, the policy prescriptions varied due to the different WB staff across countries and time (Noy 2017: 13).

Theoretically, the literature states that coercive or non-coercive influence is more powerful in countries which are less developed, where the state and the economy are weaker, or find themselves in a crisis (Deacon et al., 2007: 226; Noy, 2017; Woods, 2006). Such countries have less bargaining power vis a vis IOs (Batley, 2004: 55; Laurell and Arellano, 1996: 13; Woods, 2006: 72) and often had no choice but to accept conditionalities in order to access new sources of funding (Paloni and Zanardi, 2006: 3). Moreover, they sometimes lack the policy-relevant knowledge and rely on WB/IMF expertise (Paloni and Zanardi, 2006: 20; Weyland, 2006). Such expertise is not neutral and often translates into exercising non-coercive power (Bazbauers, 2018; St. Clair, 2006).

However, even countries which faced economic or political difficulties were able to resist the pressures from powerful IOs. Noy (2017: 173, 2018: 17) argues that in Peru, Argentina and Costa Rica, the WB aligned its health strategy to the recipient countries and 'worked with governments to support their initiated reforms'. Weyland (2006) comes to very similar conclusions in other Latin American countries, such as El Salvador, Bolivia, Brazil or Costa Rica. Wireko and Béland (2017) show that the WB was willing to accommodate to the government policy position towards Social Health Insurance (SHI) in Ghana, and even promote it internationally. Although the influence of IOs can be expected to be greater in countries which find themselves in unfavourable position, the mentioned literature suggests this is not always the case. This paper provides a case study on Croatia which challenges the view of the IMF and the WB as rigid and hegemonic organisations. It shows that the IMF and particularly the WB did not unilaterally shape healthcare financing reforms in Croatia which was in a politically and economically challenging position and was still able to contest some of their policy prescriptions.

Croatia: context of healthcare financing reforms

Political and economic context

The early 2000s marked a major point of discontinuity in Croatian politics (Bičanić and Franičević, 2003). The strongest party since Croatian independence, the Croatian Democratic Union (CDU), was severely weakened when the most influential figure in the party and the Croatian president, Franjo Tuđman, passed away in 1999 (Stubbs and Zrinščak, 2007). The elections organised in 2000 were won by a coalition of six parties spearheaded by the Social Democratic Party (SDP) and the Croatian Social Liberal Party (CSLP) (Bičanić and Franičević, 2003: 24). The weakening of the CDU and the new SDP/CSLP government's support for change from a semi-presidential to a parliamentary system resulted in more open and deliberative policy processes. The new reform-oriented government and 'its explicit stance of openness to all forms of international co-operation, was quickly seized upon by the World Bank and others' (Stubbs, 2008: 370). To further increase its openness to the West, the new government started negotiations to join the EU and North Atlantic Treaty Organization (NATO), joined the World Trade Organization (WTO) and Central European Free Trade Agreement (CEFTA) and co-operated with the International Criminal Tribunal for the former Yugoslavia (Bičanić and Franičević, 2003).

However, the coalition between ideologically diverse parties suffered from 'internal struggles, blackmailing, and deliberate politicization of particular reform policies and moves' (Bičanić and Franičević, 2003: 24). In addition, the government was heavily criticised by the media and public opinion for pushing 'neoliberal reforms' under the tutelage of the IMF and the WB (Bičanić and Franičević, 2003) and for willingness to cooperate with the International Criminal Tribunal for the former Yugoslavia (Kasapović, 2005). All of this led to the destabilisation of the government, frequent changes of ministers (including the Minister of Health) and eventually the exit of two parties (most importantly CSLP) from the coalition government in 2002 (Kasapović, 2005). Policymaking under such conditions was 'difficult, slow, and often without an easily recognizable pattern, but with a serious negative public relations effect' (Bičanić and Franičević, 2003: 24).

Moreover, Croatia was still recovering from the devastating 1991–1995 war which disrupted trade flows, tourism and foreign investments (WB, 2001a), and slowed the development of the economy.[1] For instance, gross domestic product (GDP) only reached pre-war 1990 growth levels in 2003 (Bebek and Santini, 2013). Also, the war and post-communist transition influenced social policymaking, including healthcare. Disempowered groups such as war veterans and to an extent pensioners successfully claimed social benefits, justified by the unfairness of privatisation processes (Puljiz et al., 2008: 39; Stubbs and Zrinščak, 2007: 91). Although the economy grew in the 1995–1998 period (WB, 2001a), Croatia still had to tackle excessive trade deficits, rising unemployment, insolvencies of banks and state-owned enterprises, and excessive public sector employment (Bičanić and Franičević, 2003: 18; International Monetary Fund (IMF), 2001: 4; WB, 2001d). At the same time, social policy reforms continued, including healthcare, pensions, social protection and assistance among others (Stubbs, 2008;

Stubbs and Zrinščak, 2007). To stabilise the macroeconomic situation, curb large fiscal deficits, rising public debt, and reform its social sector, the Croatian government turned to the World Bank and the IMF.

The Croatian healthcare system in the 1990s

Croatia inherited a heavily decentralised system that had been established when it was part of Yugoslavia. It produced unfavourable outcomes and could neither control expenditure nor collect adequate revenue to finance healthcare services (Chen and Mastilica, 1998; Džakula et al., 2012; Rodwin and Šarić, 1993). The 1993 healthcare reforms centralised healthcare financing. Payroll taxes were pooled into one national health fund, the CIHI. Co-payments for selected services and two forms of private insurance were introduced. One form was full private insurance, which persons above a certain income threshold could opt for instead of the SHI offered by the CIHI. The second form was supplementary insurance, which offered better access and quality of healthcare. In addition to SHI, the government's budget financed care for vulnerable groups and bailed out CIHI deficits when necessary. The reforms curbed healthcare expenditure and pooled additional funds in the healthcare system (European Observatory on Health Care Systems, Regional Office for Europe, World Health Organization, 1999: 46).

However, in the late 1990s, problems of rising expenditure and lack of funding started to re-emerge. High expenditure was related to inadequate primary care, overreliance on hospital and specialist care, generous benefits and extensive exemptions from co-payments which generated moral hazard (Vončina et al., 2007; WB, 2004). Payroll taxes did not provide adequate funding due to the ever-growing older population (about 20% of the population was older than 60 years in 2003), increased unemployment and a large informal sector (roughly 7% of GDP) (Vončina et al., 2007). All of this created financial deficits in the CIHI from 1998 until 2001. In 2000, total healthcare expenditure amounted to 10.2% of GDP (Croatian Parliament, 2006) and the CIHI debts were HRK 4.2 billion (about EUR 0.55 billion) (Zrinščak, 2007). To sustain its operations, the CIHI required sizable financial infusions from the government budget, which was already under severe strain (WB, 2001b). Taken together, these problems created an urgency for reform.

Reforms introduced in the early 2000s

In the early 2000s, full private insurance was abolished, which resulted in pooling more insurers into the SHI. The CIHI was incorporated into the government budget, losing its extra-budgetary status and the limited autonomy it previously had. The idea was to achieve more control over expenditures, debt collection and management (Vončina et al., 2007: 150). To reduce reliance on payroll taxes, reforms focused on diversifying revenue collection, which included lowering the payroll contribution rate from 18% to 15.5% (WB, 2004: 40), increasing the scope and rates of co-payments (Vončina et al., 2007) and reducing exemptions from co-payments from 80% to 50% of the population (WB, 2004). Moreover, voluntary complementary health insurance (CHI) was introduced, which covered the above-mentioned co-payments. The premium was set as a lump sum to be paid monthly, HRK 80 and HRK 50 for retired persons (about EUR 10.5 and EUR 6.5).

However, the government *in principle* subsidised CHI premiums for large parts of the population such as children under 18, war veterans or people with disabilities (Vončina et al., 2007). The CIHI was given the exclusive right to initially offer CHI while private insurers could only enter the market after 2 years.

Throughout the reform process, the Croatian government was co-operating with the WB in the healthcare sector (and to a lesser extent with the IMF). However, insufficient co-payment exemptions and the introduction of CHI clashed with the WB recommendations. Although the WB was initially not in favour of such policies, its adjustment and the prescription of pro forma conditionalities enabled Croatia significant room for manoeuvre in ignoring the WB's recommendations. The next section analyses the involvement of the WB and IMF in Croatian healthcare policy, including their advice, conditionalities, interaction with the Croatian government and the reasons for the WB's adjustment towards the Croatian government.

The interaction of the Croatian government with the IMF and the WB

Non-coercion: advancing the WB agenda

Croatia's co-operation with the IMF and the WB started during the 1990s, after Croatia joined the IMF in 1992 and the WB in 1993. Both organisations offered economic stabilisation programmes, loans, technical assistance and expertise (Croatian National Bank, 2021; WB, 2021 Interview 1, 2020[2]). The IMF was focused on macroeconomic policies to reduce inflation and stabilise the currency while the WB focused on sectoral policies, particularly pensions and health (Interview 1, 2020; Stubbs and Zrinščak, 2007). This engagement enabled the WB and the IMF to occupy a seat at the government table and gain access to the most important policy actors and institutions to promote their policy ideas.

The co-operation continued when the new SDP/CSLP government came to power in 2000. The government requested support from the WB and the IMF to resolve the economic crisis and emerging issues in social policy, including healthcare (Stubbs and Zrinščak, 2007). However, the IMF was not particularly involved in the healthcare discussions even though it negotiated a Stand-by Arrangement (SBA) with the government in 2001. The IMF SBA was focused on reducing public sector employment and government deficits, privatising state-owned enterprises, and establishing price and currency stability (Croatian Government 2001, 2002; IMF, 2002b: 21–22). IMF Staff Country Reports (IMF, 2000, 2002a) stated that healthcare benefits were generous and that expenditures were unsustainable and should be reduced. However, the IMF did not promote specific healthcare policies. Instead, the WB took the lead in healthcare policy dialogue with the government (IMF, 2002a: 38). The WB experts involved in the process stated that:

> As far as health, pension and social policies are concerned, we [the WB] would mostly lead a dialogue . . . and the IMF in principle then takes over our reform proposals and has to align with us . . . (Interview 2, 2020[3])

> We [the WB] have the technical experts who can discuss the health package, what should go into the publicly-financed package and what should not. The IMF does not have that expertise. (Interview 1, 2020)

The WB had already been engaged in the healthcare sector during the tenure of the CDU government through consultations, producing healthcare studies and the conclusion of the Health Project in 1999 (Zrinščak, 2007). The WB continued the same practice with the SDP/CSLP government. The WB experts participated in government meetings (Interview 1, 2020) and positioned themselves as part of the epistemic community (Haas, 1992) which exerted non-coercive influence on domestic policymakers. Compared to Croatian pension reform, where the WB promoted a Chilean model and eventually settled for Argentinean one (Stubbs and Zrinščak, 2007), the WB did not rely on any specific reform model regarding healthcare financing. Rather, it tailored its assistance to the country-specific context. Policy ideas were based on WB studies which contained evidence-based analyses of the Croatian healthcare system, and also on the WB's long-term experience of working in other countries (Interview 1, 2020; Interview 2, 2020; Interview 3,[4] 2020).

In 'The Reform of Health Care in Croatia' document, the WB stated that healthcare financing policy was inadequate and that 'changes in revenue sources and revenue collection efficiency are needed' (Croatian Ministry of Health and World Bank, 2000: 1). Moreover, in 'Public Sector Financing, Health Care Reform and Pension Reform in Croatia' it stated that public expenditures were too high, and argued in favour of introducing cost-containment policies and policies that would moderate demand (WB, 1997b). These WB studies, alongside others such as 'Croatia Beyond Stabilization' (WB, 1997a), 'Country Assistance Strategy' (WB, 1999), 'Croatia: A Policy Agenda for Reform and Growth' (WB, 2000) and 'Regaining Fiscal Sustainability' (WB, 2001b) recommended diversifying revenue collection and decreasing the payroll tax, enhancing debt and payroll contribution collection through increased government control over the health fund, increasing the rate and scope of co-payments for a range of services, exempting only vulnerable groups such as poor or chronic patients from co-payments, explicitly defining a publicly-financed basket of health services, reducing the overly generous sick pay and maternity leave and, finally, supporting the development of a private insurance market.

The WB's presentation of ideas and its direct access to the government and relevant policy actors proved to be very influential in educating the domestic policymakers and shaping the way in which they thought about healthcare policy. The WB was seen as a legitimate source of expertise and at the same time Croatia lacked healthcare policy experts in the fields of health economics and health system management (Interview 4,[5] 2020; Interview 5,[6] 2019; Interview 6,[7] 2019; Croatian Ministry of Health and World Bank, 2000). The following quotes confirm the latter.

> [The WB] actually had an extremely beneficial impact because they brought in expertise, consultants, who steered the healthcare policy in a direction which, at that time, was considered to be the right one. (Interview 7,[8] 2020)

> . . . We [the WB] could master a critical body of researchers, top experts, experienced people to go through this process and create a report which we discussed with our counterparts. This process itself is very influential . . . (Interview 1, 2020)

> Through such analytical studies, governments simply get the opportunity to look at the same system through a different focus, we usually do it with comparisons of good practices in the world, which then gives them [the domestic policymakers] a different way of thinking and sometimes the studies alone are enough to incentivise the government to make policy changes. (Interview 2, 2020)

At this point, the government did not contest the WB advice and relied on the WB expertise to decide which were the best policies to consider and implement. Arguably, this reflects the notion of the third dimension of power (Lukes, 2005) as the WB was able to influence the government's agenda and control issue attention in healthcare without contestation. The government's healthcare strategies adopted in 2000 and 2002 largely reflected WB ideas, emphasising the need to reduce healthcare expenditure through stricter financial discipline, introduce a standard basket of services covered by SHI, increase the use of co-payments, reduce exemptions to co-payments and support the development of a private insurance market (Croatian Government, 2000: 30; Croatian Ministry of Health, 2003: 36; Croatian Ministry of Health and World Bank, 2000; Croatian Office for Development Strategy, 2002).

Coercive influence: a deliberately blunt knife

To support the government agenda, the WB provided financing and included healthcare policy components into the 2001 Structural Adjustment Loan which focused on structural reforms, supporting economic growth, market competition, enhancing flexibility in the labour market, reducing investment barriers, strengthening social protection and improving the health and pension systems (WB, 2001d). The WB's non-coercive influence was complemented by coerciveness when the WB demanded prior fulfilment of policy actions in order to release the loan.[9] To disburse the loan, the WB insisted on increasing the scope and rate of co-payments, exempting only vulnerable groups such as poor or chronic patients from co-payments, and levying contributions on income from non-wage labour.

However, such a co-payment policy would have greatly eroded the generous benefits people were already entitled to. It was heavily contested by the opposition in parliament, trade unions, media and the public which criticised the proposed reforms as being unfair, shifting the burden of financing from the state to the citizens and blindly following the 'neoliberal' logic of the IMF and the WB (Đuretek et al., 2001; Rebić, 2002; Interview 1, 2020; *Večernji list*, 2001, 2003). At this point, the interests of the WB and the government started to diverge. Although the government was initially in favour of the WB policies as outlined in its agenda, once the backlash from the opposition started, it gave in to this pressure. Already unpopular and suffering from internal disputes, the government adjusted its standpoint in order to appease the public, prevent social backlash and increase its prospects in future elections.

To mitigate the domestic pressure and satisfy the WB at the same time, the government remained open to increasing the rate and scope of co-payments. However, it proposed much broader co-payment exemption policy compared to the one favoured by the WB. Among others, groups eligible for co-payment exemptions included war veterans, unemployed, disabled, frequent blood donors etc. (WB, 2004). Moreover, the government proposed voluntary complementary health insurance (CHI), which would be offered exclusively by the CIHI for the duration of 2 years. CHI premiums would be set as a fixed lump sum with an additional discount for pensioners (Croatian Parliament, 2002; Vončina et al., 2007). The idea was 'to reduce the adverse effects on financial protection' (Vončina et al., 2010: 228) and to increase the CIHI's revenue (Interview 8,[10] 2019; Interview 9,[11] 2019; WB, 2004). A member of the government who worked in the Ministry of Health at the time stated,

> IOs asked for the introduction of co-payments, we [the government] then introduced the reform in which the citizens themselves would not directly pay out of pocket, but would rather be insured through the CHI, thus exempting them from co-payments. (Interview 10, 2019)

The WB (2004) argued that the role of co-payments was negligible in moderating demand for health services and that broader co-payment exemptions and CHI would re-introduce the moral hazard problem (p. xi). Moreover, the WB (2004) stated that CHI would introduce the problem of adverse selection because 'it is likely to be purchased by beneficiaries with highest medical cost' (p. xi). The WB experts involved in the reform claimed,

> We [the WB] focused on increasing co-payments . . . but then they [the government] exempted the unemployed, veterans, children, voluntary blood donors, everyone who is below a certain income threshold, and then the question arose as to whether such a policy made any sense. (Interview 2, 2020)

> Co-payment has a corrective factor to prevent overuse of health services . . . For this reason, Akiko Maeda [WB consultant] objected to the introduction of complementary insurance because she wanted to instil . . . the cognitive feeling that there is economic value behind the individual health service. (Interview 11,[12] 2019)

However, the WB acknowledged that many of the proposed reforms which 'aim to dismantle Croatia's generous welfare state' would be very difficult to implement as they 'threaten significant vested interests and could engender a social backlash, particularly in an environment of already high unemployment' (WB, 2001d: 34). Moreover, the WB (2004) was satisfied with the government's progress in reducing the payroll tax, increasing control over the health fund by incorporating it into the general government budget, reducing sick pay and maternity leave, and broadening the contribution base to non-wage labour incomes. In turn, the WB softened its demands and adjusted its standpoint towards co-payment exemptions and CHI. It approved the Structural Adjustment Loan and concluded that Croatia fulfilled the necessary conditions concerning the increased price, scope and reduced exemptions from co-payments, and the broadened contribution base (WB, 2001c: 8).

Clearly, the WB did not have a firm stance on the conditionalities and was open to discussing them with the government. The coercive influence was limited to pro forma conditionalities which are open for negotiation and mutually agreed between the lender and the recipient (Killick, 1998). The WB experts indicated that

> The Bank has its desires, what it considers to do, the right sort of conditionality for a specific project and then it is a matter of negotiations with the country . . . they [the WB] send you a list and say this is what it is going to be, we can talk about it but this is our starting point. (Interview 3, 2020)

> First of all, there has to be volunteerism in cooperation . . . We made and published policy studies where we analysed healthcare financing and what the problems were, and then we defined policies based on that. But then of course we have negotiations with the government where we determine what is possible and what is not possible to introduce . . . The government says: ok within such a political economy we can or can't do this, we can introduce it in this way, in two steps in three steps etc. (Interview 2, 2020)

Rather than forcing explicit and rigid conditionalities beforehand, the WB took into account the position of the Croatian government in determining the loan disbursement conditions, as long as it considered it viable to reach the loan objectives (e.g. financial sustainability of healthcare) (Interview 1, 2020; Interview 3 2020; WB, 2001d). The main goal of the WB was to provide different instruments for supporting the country's development, and create balanced priorities in open and deliberative negotiations with the government (Interview 1, 2020; Interview 2 2020; Interview 3, 2020; Interview 12,[13] 2019; Interview 13,[14] 2019). Such an approach reflected the changing discourse within the WB (1997c) itself, stemming from the 1997 Health, Nutrition and Population Strategy which highlighted the adaptation of 'lending policies and procedures to client needs' and 'participatory approaches' that encourage government ownership (p. 16). Similar notions have been elaborated in its 1998 Assessing Aid publication (WB, 1998).

Besides the changing approach within the WB, another factor for the WB's adjustment to the Croatian government's position follows from the perverse incentives within the WB. After all, if the WB were to cancel the loan and leave the country, it would lose its influence and the potential to lend money in the future. As Mosley et al. (1995) argue, the system for promoting WB staff based on country lending targets creates perverse incentives to approve the loan despite deviations from the originally planned policies. The interviewed WB experts who worked in Croatia confirmed this:

> We [the WB] want to lend so we work with the governments, that is our mandate . . . The point is that we make our living as an institution by lending, so yes, if anything, we often end up being not too tough, but too lenient . . . I think the real concern with us is that probably we should be tougher. (Interview 1, 2020)

> Money out the door is what counts, that is what gets you promoted and there are perverse incentives in the Bank and you will not get promoted for denying the funds because the programme in the country was bad, ok . . . You failed, there is no money out the door. And that is a huge problem, that is absolutely a huge problem. (Interview 3, 2020)

Similarly, one CIHI board member at the time noted that despite policy slippages, the WB wanted the reform processes to continue and that it was willing to adjust 'either by changing goals or changing a plan, etc. So, let's say there has never been such a firm stance [of the WB] . . . It should not be forgotten that they make money on it' (Interview 14,[15] 2019). When a new government led by the CDU came to power in 2003, the WB (2004) encouraged it 'to explore alternative solutions' which would avoid 'the problems associated with adverse selection and moral hazard' (p. xi). The CDU government was open to restructuring CHI and co-payment exemptions, and in turn the WB offered policy lending and support by including the above-mentioned components in the future Programmatic Adjustment Loan (Independent Evaluation Group, 2006: 3). Clearly, the WB has a long-term interest to stay in the reform game and continue influencing the policymaking process in the future. To achieve this aim, the WB adjusted to the government's position regarding co-payment policy and eventually offered a new loan. Staying in the game allows the WB to act as a constant policy advisor shaping the government agenda and trying to correct previous policy setbacks while pressing demands for further changes.

Discussion and conclusions

The study explored the influence of the IMF and the WB in Croatian healthcare financing reforms in the early 2000s. During this time, Croatia was in an unfavourable political and economic position and its healthcare system was inefficient and experienced a sharp rise in expenditure. To initiate reforms in healthcare it turned to the IMF and the WB, who provided expertise and financial support. As in some other countries, the IMF delegated the healthcare issues to the WB due to their own lack of expertise (Odling-Smee, 2006: 182). In comparison to the IMF, the WB was heavily involved and mostly relied on its non-coercive influence such as producing healthcare financing studies, providing technical assistance, consulting and persuading the government.

The WB acted as an epistemic community (Haas, 1992), helping domestic policymakers to evaluate healthcare policies, and to define issues and solutions based on evidence. Its expertise and policy advice were tailored to the country-specific context and based on evaluation of the Croatian healthcare system and evidence from other countries. Similar observations have been made in other countries (see Druga, 2022; Noy, 2017, 2018; Weyland, 2006; Yılmaz, 2017). In this way, the WB was able to control the government agenda and 'derive power through classifying the world, ordering information so that it is known and interpreted in a certain way' (Heneghan and Orenstein, 2019: 68; see also Lukes, 2005 for a discussion of the third dimension of power). It can be argued that the WB was mostly successful in this endeavour as Croatia indeed implemented most of its policy recommendations.

Although the WB formally imposed conditionalities, it is hard to categorise the latter as a form of true coercion. Instead of 'hard-core conditionalities' that are made only at the insistence of the lender, conditionalities had a non-coercive and voluntary character as they were negotiated and mutually agreed with the government (Killick, 1998). By opting for 'pro forma conditionalities' (Killick, 1998: 9), the WB provided the SDP/CLSP government with significant room for manoeuvre to introduce policies which were

not recommended by the WB, for example, CHI and broader co-payment exemptions. The question is why did the WB not use the leverage it had to impose its policies on a country whose political and economic position weakened its bargaining power?

The first argument stems from the WB's benevolent interest in supporting Croatia in its development. Instead of acting as a top-down institution prescribing rigid policies, the WB was flexible and took the Croatian political and economic context into account as well as already achieved reform progress and preferences of domestic policy actors. The WB adjusted its standpoint and allowed Croatia to introduce policies which would lessen the resistance from the opposition and prevent social backlash. This reflects the changing approach within the WB as outlined in the 1997 Health, Nutrition and Population Strategy and in its 1998 Assessing Aid publication. The new approach highlighted that relying on conditionalities without domestic support and government ownership is not effective in securing policy change (WB, 1997c, 1998: 51–52). Hence, the desire to shift to pro forma conditionalities (Killick, 1998) and adapt to client needs (WB, 1997c). Other scholars have come to similar conclusions. Kaminska et al. (2021) show that in Albania and Poland, the WB did not unilaterally shape healthcare financing policies and that the role of domestic policymakers should not be understated. Also in Peru, Costa Rica, and Ghana, the WB adjusted to respective government priorities and supported their policy ideas (see Noy, 2017, 2018; Weyland, 2006; Wireko and Béland, 2017).

Other arguments which explain the WB's leniency include systemic pressures within the WB to lend money (Killick, 1998; Mosley et al., 1995). The WB had an interest to stay in the reform game and provide financing and policy advice in the future. However, it is not only about future prospects for contracting loans, it is also about prolonging influence. Aware of conditionality limitations (Killick, 1998; Larmour, 2002; Mosley et al., 1995; Orenstein, 2008; WB, 1998, 2005), the WB focuses on non-coercive influence which is more likely to take hold by ensuring long-term access to the most important policymaking actors and institutions. To this end, the WB is receptive to positions held by domestic policymakers, it is willing to bargain, make trade-offs and offer new loans. As Larmour (2002) argues, IOs 'do not like to seem to be pushing governments around. They seek influence, rather than control' (p. 259).

This was evident in Croatia as the WB did not only disburse the money for the 2001 loan, but also offered a new loan in 2005 which encompassed similar healthcare financing components. Similar processes can be observed in other countries. In Albania, Druga (2022) explains the WB's 'attempts to stay in the reform game even though the reform is not in line with its preferences, and after it failed to convince the Government of its preferred choice' (p. 3). In the Pacific, Larmour (2002) notes that the WB wanted a 'long-term relationship: the loan buys them a seat at the table, and they are usually happy to roll over another one to stay in the game' (p. 259).

To conclude, the study shows that the WB's main mode of influence in Croatia was non-coercive. Croatian policymakers were influenced by the WB's expertise and in the most part, followed its advice. However, some of the policies introduced differed from the policies initially advocated by the WB. This shows that coerciveness played a limited role. Indeed, the WB did not impose strict conditionalities and force Croatia to introduce all of its policy prescriptions. Moreover, it has been shown that the use of pro forma conditionalities blurs the line between coercion and non-coercion and that the WB

prefers a less coercive approach which avoids unilateral policy prescriptions. The latter findings support more recent literature which suggests a move away from coerciveness or imposition towards the WB's readiness for collaborative interaction and accommodation (Noy, 2017, 2018; Wireko and Béland, 2017);

In contrast to the literature which states that countries which find themselves in unfavourable position have little or no leverage against the WB, this case study supports the literature which provides evidence that the WB does not act as a hegemon and that even such countries can steer the direction of policy changes in their favour. It can be argued that the WB's influence is determined by the interplay of endogenous political and economic factors, interests of the recipient country and interests of the WB itself, which is, under certain circumstances, willing to soften its demands in return for the prospect of a long-term relationship. Finally, it is important to note that the findings of the paper are limited to a case study of Croatia at one period in time. Future research should offer insights on this topic by focusing on longer time frames and different countries and regions. Nevertheless, the study offers valuable insight on the interaction of IOs and aid recipient countries and different ways IOs can exert influence. At the same time, it shows that a country which was facing many challenges was able to bargain and make trade-offs with powerful IO.

Funding

The author disclosed receipt of the following financial support for the research, authorship, and/ or publication of this article: "Deutsche Forschungsgemeinschaft (DFG,German Research Foundation), Grant/AwardNumber: Projektnummer 374666841 - SFB1342".

ORCID iD

Ante Malinar https://orcid.org/0000-0002-9793-3098

Notes

1. The study by Praljak (2006) estimates direct war damages at $56 billion and indirect war damages at $86 billion in the period from 1991–2004. Other studies are more modest and do not make the distinction between direct and indirect war damages e.g. $27.5 billion (WB, 2001a)
2. WB expert involved in the reform process.
3. WB expert involved in the reform process.
4. External consultant of the Croatian Ministry of Finance managing the World Bank social sector loan.
5. Croatian healthcare expert, external observer.
6. Croatian healthcare expert, external observer.
7. Croatian healthcare expert, external observer.
8. WB consultant, Croatian healthcare expert and assistant Minister of Health (2012–2014), external observer.
9. Besides healthcare financing, they included amendments to the pension law, market competition law, reducing barriers to foreign direct investment, reducing direct subsidies in the economy, and so on (WB, 2001c).
10. Croatian healthcare expert involved in Coalition of Health Associations in Croatia, external observer.

11. Croatian healthcare expert, external observer.
12. WB and Croatian healthcare expert involved in the reform process.
13. WB expert involved in Croatian healthcare.
14. WB expert involved in Croatian healthcare.
15. CIHI 2000–2002 board member.

References

Appel H and Orenstein MA (2018) *From Triumph to Crisis: Neoliberal Economic Reform in Postcommunist Countries*. Cambridge: Cambridge University Press.

Batley R (2004) The politics of service delivery reform. *Development and Change* 35(1): 31–56.

Bazbauers AR (2018) *The World Bank and Transferring Development*. Cham: Springer.

Bebek S and Santini G (2013) Hrvatska kao članica Europske Unije: Put u (Ne)poznatu Budućnost [Croatia as European Union member: Road to (un)familiar future]. *Ekonomija* 20(1): 1–28.

Bičanić I and Franičević V (2003) Understanding reform: The case of Croatia (GDN/WIIW Working Paper). Available at: https://wiiw.ac.at/understanding-reform-the-case-of-croatia-dlp-3287.pdf (accessed 15 November 2020).

Cerami A (2006) *Social Policy in Central and Eastern Europe: The Emergence of a New European Welfare Regime*. Berlin: LIT Verlag.

Chen M and Mastilica M (1998) Health care reform in Croatia: For better or for worse? *American Journal of Public Health* 88(8): 1156–1160.

Croatian Government (2000) *Program Rada Vlade Republike Hrvatske Za Razdoblje 2000 – 2004 Godine* [Programme of the Government of the Republic of Croatia for the Period 2000 – 2004]. Zagreb: Croatian Government.

Croatian Government (2001) *Zajedničko pismo prema MMF-u* [Joint letter to the IMF]. Zagreb: Croatian Government

Croatian Government (2002) *Government letter of intent to Mr. Horst Kohler, general director of the IMF*. Zagreb: Croatian Government

Croatian Ministry of Health (2003) *Report on The State of Health Reform (2000 - 2003)*. Zagreb: Croatian Ministry of Health.

Croatian Ministry of Health and World Bank (2000) The reform of health care in Croatia. *Revija za socijalnu politiku* 7(3): 311–325.

Croatian National Bank (2021) International monetary fund. Available at: https://www.hnb.hr/temeljne-funkcije/medunarodni-odnosi/medunarodni-monetarni-fond (accessed 25 June 2021).

Croatian Office for Development Strategy (2002) *Hrvatska u 21. stoljeću: Zdravstvo* [Croatia in the 21st Century: Healthcare]. Zagreb: Tonimir d.o.o.

Croatian Parliament (2002) Odluka o vrsti i cijeni police dopunskog zdravstvenog osiguranja [Decision on the type and price of the complementary health insurance policy]. *Narodne Novine* 47: 1–3.

Croatian Parliament (2006) Nacionalna strategija razvitka zdravstva 2006. – 2011 [National strategy of healthcare development]. *Narodne Novine* 72: 1–43.

Dahl RA (1957) The concept of power. *Behavioral Science* 2(3): 201–215.

Deacon B (2007) *Global Social Policy and Governance*. London: Sage.

Deacon B and Stubbs P (2007) *Social Policy and International Interventions in South East Europe*. Cheltenham: Edward Elgar.

Deacon B, Hulse M and Stubbs P (1997) *Global Social Policy: International Organizations and the Future of Welfare*. London: Sage.

Deacon B, Lendvai N and Stubbs P (2007) Conclusions. In: Deacon B and Stubbs P (eds) *Social Policy and International Interventions in South East Europe*. Cheltenham: Edward Elgar, pp. 221–243.

De Beyer JA, Preker AS and Feachem RGA (2000) The role of the World Bank in international health: Renewed commitment and partnership. *Social Science & Medicine* 50(2): 169–176.

Druga E (2022) World Bank intervention and introduction of Social Health Insurance in Albania. In: Nullmeier F, González de Reufels D and Obinger H (eds) *International Impacts on Social Policy. Short Histories in a Global Perspective*. Cham: Palgrave Macmillan, pp. 225–235.

Đuretek D, Kovač B and Šarić M (2001) Zdravstvena usluga bit će skuplja, ali ne i bolja [Healthcare service will be more expensive, but not better]. *Večernji list*, 19 October, pp. 6.

Džakula A, Šogorić S and Vončina L (2012) Decentralization in Croatia's health system. In: Bartlett W, Bozikov J, Rechel B, et al (eds) *Health Reforms in South East Europe*. London: Palgrave Macmillan, pp. 64–75.

European Observatory on Health Care Systems, Regional Office for Europe, World Health Organization (1999) *Health Care Systems in Transition: Croatia*. Copenhagen: Regional Office for Europe, World Health Organization.

Grabbe H (2006) *The EU'S Transformative Power: Europeanization through Conditionality in Central and Eastern Europe*. New York: Palgrave Macmillan.

Grielen SJ, Boerma WG and Groenewegen PP (2000) Science in practice: Can health care reform projects in central and eastern Europe be evaluated systematically? *Health Policy* 53(2): 73–89.

Haas P (1992) Introduction: Epistemic communities and international policy coordination. *International Organization* 46(1): 1–35.

Heneghan M and Orenstein MA (2019) Organizing for impact: International organizations and global pension policy. *Global Social Policy* 19(1–2): 65–86.

Independent Evaluation Group (2006) Health system project (Report number: ICRR12473). Available at: http://documents1.worldbank.org/curated/en/630581474850232592/pdf/000020051-20140615103308.pdf (accessed 14 May 2021).

International Monetary Fund (IMF) (2000) *Republic of Croatia: Selected Issues and Statistical Appendix* (IMF Staff Country Report No. 00/22). Washington, DC: IMF.

International Monetary Fund (IMF) (2001) *Prvo preispitivanje stand-by aranžmana* [First Review of the Stand-By Arrangement]. Washington, DC: IMF.

International Monetary Fund (IMF) (2002a) *Republic of Croatia: 2002 Article IV Consultation-Staff Report; Staff Statement; Public Information Notice on the Executive Board Discussion; and Statement by the Executive Director for the Republic of Croatia* (IMF Country Report No. 02(178)). Washington, DC: IMF.

International Monetary Fund (IMF) (2002b) *Republika Hrvatska – Drugo preispitivanje u okviru stand-by aranžmana I zahtjev za odgodu ispunjenja kriterija za ocjenu uspješnosti izvršenja programa I izmjenu jednog kriterija za ocjenu uspješnosti – Izvješće misije; Izjava misije; Priopćenje za javnost o raspravi Izvršnog odbora; te izjava Izvršnog direktora za Republiku Hrvatsku* [Republic of Croatia – Second Review Under the Stand-by Arrangement and Request for Postponement of Fulfillment of the Criteria for Evaluating the Success of Program Implementation and Change of One Criterion for Evaluation of Success – Mission Report; Mission Statement; Press Release on the Executive Board Discussion; and the Statement of the Executive Director for the Republic of Croatia] (IMF Country report no. 02/76, 29 November). Washington, DC: IMF.

Kaasch A (2015) *Shaping Global Health Policy: Global Social Policy Actors and Ideas about Health Care Systems*. London: Palgrave Macmillan.

Kaminska ME, Druga E, Stupele L, et al. (2021) Changing the healthcare financing paradigm: Domestic actors and international organizations in the agenda setting for diffusion of social health insurance in post-communist Central and Eastern Europe. *Social Policy & Administration* 2021: 1–16.

Kasapović M (2005) Koalicijske vlade u Hrvatskoj: prva iskustva u komparativnoj perspektivi [Coalition governments in Croatia: First experiences in a comparative perspective]. In: Čular G (ed.) *Izbori i konsolidacija demokracije u Hrvatskoj* [Elections and Consolidation of Democracy in Croatia]. Zagreb: Fakultet političkih znanosti, pp. 181–209.

Killick T (1998) *Aid and the Political Economy of Policy Change*. London: Routledge.

Larmour P (2002) Conditionality, coercion and other forms of 'power': International financial institutions in the Pacific. *Public Administration and Development* 22(3): 249–260.

Laurell AC and Arellano OL (1996) Market commodities and poor relief: The World Bank proposal for health. *International Journal of Health Services* 26(1): 1–18.

Lukes S (2005) *Power. A Radical View*. New York: Palgrave Macmillan.

Mosley P, Harrigan J and Toye J (1995) *Aid and Power: The World Bank and Policy-Based Lending*. New York: Routledge.

Noy S (2017) *Banking on Health: The World Bank and Health Sector Reform in Latin America*. Cham: Palgrave Macmillan.

Noy S (2018) Healthy targets? World Bank projects and targeted health programmes and policies in Costa Rica, Argentina, and Peru, 1980–2005. *Oxford Development Studies* 46(2): 164–183.

Odling-Smee J (2006) The IMF and Russia in the 1990s. *IMF Staff Papers* 53(1): 151–194.

Orenstein MA (2008) *Privatizing Pensions: The Transnational Campaign for Social Security Reform*. Princeton, NJ: Princeton University Press.

Paloni A and Zanardi M (2006) Introduction and overview. In: Paloni A and Zanardi M (eds) *The IMF, World Bank and Policy Reform*. New York: Routledge, pp. 1–23.

Plehwe D (2007) A global knowledge bank? The World Bank and bottom-up efforts to reinforce neoliberal development perspectives in the post-Washington consensus era. *Globalizations* 4(4): 514–528.

Praljak S (2006) *Procjena ratnih šteta u Hrvatskoj* [War damage assessment in Croatia]. Zagreb: s.n.

Puljiz V, Bežovan G, Matković T, et al. (2008) *Socijalna politika Hrvatske* [Croatian Social Policy]. Zagreb: Pravni fakultet Sveučilišta u Zagrebu.

Radin D (2008) World Bank funding and health care sector performance in Central and Eastern Europe. *International Political Science Review* 29(3): 325–347.

Ramet SP (2010) *Central and Southeast European Politics since 1989*. Cambridge: Camebridge University Press.

Rebić G (2002) Mnogi nemaju 50 kuna mjesečno za zdravlje [Many do not have 50 kuna a month for health]. *Večernji list*, 21 May. Available at: https://www.vecernji.hr/zagreb/mnogi-nemaju-50-kuna-mjesecno-za-zdravlje-716705 (accessed 21 May 2021).

Rodwin VG and Šarić M (1993) The once and future health system in the former Yugoslavia: Myths and realities. *Journal of Public Health Policy* 14(2): 220–237.

Rothgang H, Cacace M, Frisina L, et al. (2010) *The State and Healthcare: Comparing OECD Countries*. New York: Palgrave Macmillan.

St. Clair AL (2006) The World Bank as a transnational expertised institution. *Global Governance* 12(1): 77–95.

Stone D and Wright C (2007) Introduction – The currency of change: World Bank lending and learning in the Wolfensohn era. In: Stone D and Wright C (eds) *The World Bank and Governance: A Decade of Reform and Reaction*. New York: Routledge, pp. 1–27.

Stubbs P (2008) Reflections on international actors and the making of social policy in Croatia. *Revija za socijalnu politiku* 15(3): 365–378.

Stubbs P and Zrinščak S (2007) Croatia. In: Deacon B and Stubbs P (eds) *Social Policy and International Interventions in South East Europe*. Cheltenham: Edward Elgar, pp. 85–103.

Stuckler D and Basu S (2009) The International Monetary Fund's effects on global health: Before and after the 2008 financial crisis. *International Journal of Health Services* 39(4): 771–781.

Večernji list (2001) Reforma zdravstvenog osiguranja – o čemu se ne govori [Reform of Health Insurance – What is not talked about]. *Večernji list*, 18 October. Available at: https://www.vecernji.hr/vijesti/reforma-zdravstvenoga-osiguranja-o-cemu-se-ne-govori-701248

Večernji list (2003) Gospodo, nismo krave muzare [Gentlemen, we are not milking cows]. *Večernji list*, 17 September. Available at: https://www.vecernji.hr/vijesti/gospodo-nismo-krave-muzare-741970 (accessed 21 May 2021).

Vončina L, Džakula A and Mastilica M (2007) Health care funding reforms in Croatia: A case of mistaken priorities. *Health Policy* 80(1): 144–157.

Vončina L, Kehler J, Evetovits T, et al. (2010) Health insurance in Croatia: Dynamics and politics of balancing revenues and expenditures. *The European Journal of Health Economics* 11(2): 227–233.

Weyland KG (2006) *Bounded Rationality and Policy Diffusion: Social Sector Reform in Latin America*. Princeton, NJ: Princeton University Press.

Wireko I and Béland D (2017) Transnational actors and health care reform: Why international organizations initially opposed, and later supported, social health insurance in Ghana. *International Journal of Social Welfare* 26(4): 405–415.

Woods N (2006) *The Globalisers: The IMF, the World Bank, and Their Borrowers*. Ithaca, NY: Cornell University Press.

World Bank (WB) (1997a) *Croatia beyond stabilization*. Report No. 17261, 19 December. Washington, DC: WB.

World Bank (WB) (1997b) Financiranje javnog sektora, reforma zdravstva i mirovinska reforma u Hrvatskoj [Public sector financing, health care reform and pension reform in Croatia]. *Revija za socijalnu politiku* 4(3): 265–285.

World Bank (WB) (1997c) *Health, Nutrition and Population Sector Strategy*. Washington, DC: WB.

World Bank (WB) (1998) *Assessing Aid: What Works, What Doesn't, and Why*. New York: Oxford University Press.

World Bank (WB) (1999) *Memorandum of the President of the International Bank for Reconstruction and Development and the International Finance Corporation to the Executive Directors on a Country Assistance Strategy of the World Bank Group for the Republic of Croatia*. Report No. 19820 HR, 11 May. Washington, DC: WB.

World Bank (WB) (2000) *Croatia: A Policy Agenda for Reform and Growth*. Washington, DC: WB.

World Bank (WB) (2001a) *Croatia economic vulnerability and welfare study*. Report No. 22079-HR, 18 April. Washington, DC: WB.

World Bank (WB) (2001b) Croatia regaining fiscal sustainability and enhancing effectiveness: A public expenditure and institutional review. Available at: https://openknowledge.worldbank.org/handle/10986/13993 (accessed 14 May 2021).

World Bank (WB) (2001c) *Loan Agreement (Structural Adjustment Loan) Between Republic of Croatia and International Bank for Reconstruction and Development* (Loan Number 4641 HR). Washington, DC: WB.

World Bank (WB) (2001d) *Report and recommendation of the President of the International Bank for Reconstruction and Development to the Executive Directors on a proposed structural*

adjustment loan in the amount of US$202 million to the Republic of Croatia. Report No. P7490-HR, 26 October. Washington, DC: WB.

World Bank (WB) (2004) *Croatia: Health Finance Study*. Washington, DC: WB.

World Bank (WB) (2005) *Conditionality Revisited: Concepts, Experiences, and Lessons Learned*. Washington, DC: WB.

World Bank (WB) (2021) World Bank Publications on Croatia between 1993 and 2000. Available at: https://documents.worldbank.org/en/publication/documents-reports/documentlist?keyword_select=allwords&srt=docdt&order=asc&qterm=Croatia&llan_exact=&strdate=01-01-1993&enddate=12-31-2000&count_exact=Croatia (accessed 10 June 2021).

Yılmaz V (2017) The impact of the World Bank on healthcare reform in Turkey. In: Yılmaz V (ed.) *The Politics of Healthcare Reform in Turkey*. Cham: Palgrave Macmillan, pp. 117–149.

Zrinščak S (2007) Zdravstvena politika Hrvatske. U vrtlogu reformi i suvremenih društvenih izazova [Croatian health policy. In the whirlwind of reforms and contemporary social challenges]. *Revija za socijalnu politiku* 14(2): 193–220.

Author biography

Ante Malinar is a doctoral researcher within the CRC 1342 Project 'Global Dynamics of Social Policy' at the Department of Political Economy of the Welfare State, Socium, University of Bremen.

3. Paper C: Healthcare financing reforms in post-communist Croatia and the role of International Organisations

Healthcare financing reforms in post-communist Croatia and the role of International Organisations

1. Introduction

Healthcare financing is a crucial aspect of healthcare systems as it provides the necessary funding for their overall functioning. According to Kutzin et al. (2010), healthcare financing includes revenue collection, pooling of funds, purchasing of services, and benefit entitlements. The healthcare system of Communist Yugoslavia, which consisted of six federal republics (Montenegro, Serbia, Bosnia and Herzegovina, Slovenia, Macedonia, and Croatia) and two autonomous regions (Kosovo and Vojvodina), shared many characteristics with other Central and Eastern European (CEE) countries. These commonalities included universal coverage, reliance on informal payments, overreliance on hospitals, and underfunding (Džakula, Šogorić & Vončina, 2012; Nemec & Lawson, 2008; Parmelee, 1985; Šarić & Rodwin, 1993). However, the Yugoslav healthcare system differed from healthcare systems in most other CEE countries in that it was financed through contributions, nominally decentralised, and based on Bismarckian and self-management principles (Džakula, Šogorić & Vončina, 2012; Parmelee, 1985; Šarić & Rodwin, 1993). Despite the implementation of social health insurance (SHI), healthcare expenditure in Yugoslavia was similar to that of other CEE countries, accounting for 4% of GDP in 1987 (Davis, 2010; Šarić & Rodwin, 1993).

In the early 1990s, Croatia began its economic, social, and political transition from the communist regime, which included democratisation, liberalisation and marketisation. This post-communist transition was followed by a severe economic and political crisis (Ramet, 2010; Žižmond, 1992). At the time, Yugoslavia began to disintegrate amidst growing discontent among the federal republics, which posed additional challenges for Croatia. These challenges included the Croatian War of Independence (1991-1995) and nation-building (see Ágh, 1998) that followed Croatia's secession from the Yugoslav federation (Ramet, 2010). By the end of 1991, Croatia had lost control of 30% of its territory, 40% of its industry had been destroyed, income from tourism had dropped by about 80%, and inflation and unemployment had significantly increased (Ramet, 2013: 38). Between 1991 and 1993, Croatia's GDP declined by approximately 31% (WB, 1995). These processes put Croatia in an extremely vulnerable position and made it heavily reliant on

international aid and support. Moreover, healthcare and its financing were severely affected and in dire need of reform (Hebrang, 2015; Malinar, 2022).

The role of international organisations (IOs), such as the World Bank (WB), in policy making in CEE has been extensively studied in relation to pension policy, specifically the introduction of three pillar systems (e.g. Müller, 1999; Orenstein, 2008). However, research on the influence of IOs on healthcare financing in post-communist countries remains inconclusive. Some authors suggest that domestic policy makers were the driving force behind the reforms, while IOs played a minor role (Radin, 2003; Rechel & McKee, 2009; Roberts, 2009; Sitek, 2008). The emphasis is on the role of domestic political institutions, party politics, and professional organisations such as medical chambers (Sitek, 2008) or horizontal policy transfer, whereby CEE countries emulated policies of Western countries such as Germany (Jacoby, 2004, p. 48; Rechel & McKee, 2009, p. 1187). Conversely, some argue that the post-communist transition in CEE countries created a policy vacuum, allowing IOs such as the WB, the World Health Organization (WHO), the International Monetary Fund (IMF), or the European Union (EU) to exert their influence on a range of policies, including healthcare financing (Cerami, 2005; Deacon, Hulse & Stubbs, 1997; Kaasch, 2015; Nemec & Kolisnichenko, 2006; Nemec & Lawson, 2008; Orenstein, 2008).

In terms of the content of WB and IMF healthcare policy advice in CEE the literature also presents a mixed picture. The IMF and the WB have indeed promoted policies characteristic of the Washington Consensus and neoliberalism (e.g. increasing individual responsibility, user fees for health services, opening the market to private providers, reducing health spending and benefits, and the like) (Cerami, 2005; Collins et al., 1999, p. 70; Deacon, 2000, 2007; Lehrer & Korhonen, 2004; Laurell & Arellano, 1996; Stuckler & Basu, 2009, p. 77). Such ideas were outlined in the *World Development Report: Investing in Health*, published by the World Bank in 1993. The report set out the WB's neoliberal healthcare agenda for low- and middle-income countries and former socialist countries (Laurell & Arellano, 1996). However, since 1997 and the publication of the *Health, Nutrition and Population Sector Strategy*, the WB began to promote a greater role for the state in healthcare, risk protection, increased access and social sensitivity to the poor (Deacon, 2007; Kaasch, 2015; Noy, 2017; WB, 1997c, 2007b). Despite the change in focus, Noy (2017) argues that the WB has continued to promote neoliberal instruments to achieve the above goals. The further significance of the *Health, Nutrition and Population Sector Strategy* is reflected in its

advocacy for greater flexibility on the part of the WB, abandoning rigid policy prescriptions in the healthcare sector and adapting aid to the specific context of the countries (WB, 1997c). Other WB activities in CEE countries have included rationalisation and downsizing of the hospital sector, strengthening of primary care, provision of equipment and training, and health promotion (Staines, 1999). As for WHO, over the past decades, it has promoted a reduction of health inequalities, the achievement of universal coverage, solidarity and risk pooling, and sustainable health financing based on solidarity and collective financing (Kaasch, 2015). In order to achieve the aforementioned goals, the WHO has advocated for prepayment systems, such as SHI or general taxation models, which would establish a fair distribution of funds and access to healthcare (Kaasch, 2015, p. 32). In addition, the WHO focuses on improving public health, "essential medicine activities and its specific disease programs…and emergencies" (Ruger & Yach, 2009, p. 3).

The aim of this chapter is to analyse the role of IOs and to what extent the interaction between IOs and domestic policy makers shaped healthcare financing policy making in Croatia. This analysis focuses on a country susceptible to external pressures, where IOs are believed to be more effective in promoting their agenda (e.g., Laurell & Arellano, 1996; Paloni & Zanardi, 2006; Woods, 2006). Moreover, the focus is on investigating the role of the WB, the IMF and the WHO because previous studies (e.g. Džakula, Sagan, Pavić, et al., 2014; Stubbs & Zrinščak, 2007; Zrinščak, 2007), as well as the empirical research on which this chapter is based, show that these have been the primary IOs involved in shaping Croatian healthcare financing policy.

The chapter will answer the following research questions: 1. How and to what extent did IOs shape policy changes in Croatian healthcare financing? 2. What was the rationale for IOs involvement in Croatian healthcare financing reforms? 3. What was the rationale for Croatia to seek aid from IOs? 4. What was the content of IOs policy advice in Croatian healthcare financing reforms and did it change over time? 5. Was the interaction between IOs and domestic policy makers cooperative or contentious and did it change over time? 6. Which policy changes occurred in Croatian healthcare financing in the period of analysis?

To answer these questions the chapter employs a case study of healthcare financing reforms in Croatia in the period from 1990 to 2019, i.e., from the start of the post-communist transition until the COVID crisis outbreak. The chapter relies on qualitative research methods, including an analysis of documents and in-depth semi structured interviews. The collection of documents

include 103 media publications (e.g. *Vjesnik*, *Večernji list*, *Slobodna Dalmacija, Jutarnji list, Liječničke novine)*, 83 legal acts, 108 parliamentary minutes, 9 government strategies and 124 documents produced by IOs such as project and loan reports, evaluation reports, publications, loan agreements and studies related to Croatia and its healthcare policy. The data were collected from online archives of the WHO, the WB and the IMF, and both physical and online archives of the Croatian government and parliament, Croatian national library, Croatian national bank and media outlets. The data cover the period from 1990 until 2020. In addition, 17 interviews were conducted with experts who are knowledgeable about the subject, including ministers and their assistants, healthcare administration staff from relevant institutions such as the Ministry of Health, Croatian Institute for Health Insurance (CIHI), and Croatian Institute of Public Health, politicians involved in the healthcare system, as well as academics, journalists and IO experts. The data were analysed using qualitative content analysis, supported by the MAXQDA software.

The following section presents a literature review on the role of the WB, the IMF and the WHO in healthcare policy and the various means of their influence. Subsequently, in section three, empirical findings on policy changes in Croatian healthcare financing and the influence of IOs are provided. Specifically, section three begins with a brief overview of Croatian healthcare financing in the communist Yugoslavia. Afterwards, it analyses the healthcare financing reforms since its independence, the role the WHO, the WB and the IMF had in these reforms and their interaction with domestic policy makers. It is divided into six periods: 1990-1993, 1994-1999, 2000-2004, 2005-2007, 2008-2011 and 2012-2019. Finally, in section four, discussions and conclusions of the study are provided.

2. WB, the IMF and the WHO in healthcare policy: instruments of influence

Contemporary social policy research is increasingly focused on explaining social policy changes in relation to policy transfer and influence of IOs (see Dolowitz & Marsh 2000; Obinger et al., 2013). In this view, IOs act as agents of policy transfer (Stone et al., 2020), disseminating policy ideas vertically from the international to the national domain. IOs use different instruments to influence national policy-making processes. These instruments can be coercive and non-coercive. The WB and the IMF rely on both types of instruments while the influence of the WHO is limited to non-coercive instruments.

Non-coercive influence is exerted by leveraging policy expertise and disseminating policy ideas to national policy makers (Bazbauers, 2018; Béland & Orenstein, 2013; Deacon, Lendvai & Stubbs, 1997; Heneghan & Orenstein, 2019; Kaasch, 2015; Kelley, 2004; Orenstein, 2008). Policy expertise is a significant source of legitimacy for IOs (Barnett & Finnemore, 2004). This expertise is disseminated through various means, including publications, studies, data collection and analysis, international conferences, and global norm setting (Bazbauers, 2018; Kaasch, 2015; Ruger & Yach, 2009). IOs can be considered an international epistemic community, consisting of a network of experts who disseminate policy-relevant knowledge (Haas, 1992). IOs offer advice, consult with governments and try to persuade them to implement policies. These policies are usually evidence-based or informed by experience from other countries. (Paloni & Zanardi, 2006). In this way, IOs can mould and bias the policy choices of domestic policy makers (Deacon, Lendvai & Stubbs, 1997, p. 226; Robertson, 1991, p. 55). They can frame "what is important and should be talked about, and what is unimportant and should not be talked about" (Larmour, 2002, p. 251). Orenstein (2000) notes that "international organisations often have a powerful agenda-setting capacity" through non-coercive influence (p. 11). This kind of influence can be positioned within the second and third dimension of power (see Lukes, 2005).

Conversely, coercion can be understood as the first dimension of power (see Dahl, 1957; Lukes, 2005), i.e. forcing countries to take actions they would not otherwise take. It is usually associated with the financial assistance provided by the WB and the IMF, which use their power and financial leverage to impose a set of policy-related conditionalities that the recipient country must fulfil in order to gain access to funds (Bazbauers, 2018; Cerami, 2005; Deacon, Lendvai & Stubbs, 1997; Kaasch, 2015; Kelley, 2004; Killick, 1998; Orenstein, 2008; Paloni & Zanardi, 2006). Although

the IMF prescribes conditionalities that are mainly related to macroeconomic policies (Easterly, 2003, p. 364; Deacon, 2007; Paloni & Zanardi, 2005), such conditionalities can indirectly influence health policies or "at least have an impact on health policy choices and decisions" (Kaasch, 2015, p. 56).

Compared to the IMF, the WB has had a much greater influence on health policy-making in many regions of the world, including CEE (Deacon, 2007; Odling-Smee, 2006; Orenstein, 2008; Tichenor & Sridhar, 2017). It has often imposed health sector conditionalities in its structural adjustment loans and health projects (Deacon, 2007; Paloni & Zanardi, 2006). However, the limitations of conditionalities have also been identified. Orenstein (2008) notes that while IOs can shape the preferences of veto actors in national constituencies, they lack formal veto power over domestic policymaking (p. 55). Woods (2006) supports this argument by noting that conditionalities are often not fulfilled and that their fulfilment is contingent on a number of factors (pp. 4, 6, 71, 72).

In a study analysing the effectiveness of conditionality, Killick (1998) distinguishes between two types of conditionality: pro forma and hard core. Pro forma conditionality is negotiable and mutually agreed between the donor and the recipient. In contrast, hard core conditionality is non-negotiable and imposed without considering the preferences of aid recipients. Thus, Killick (1998) argues that conditionalities can be voluntary in nature and are not necessarily imposed directly by IOs on countries receiving financial aid (pp. 9-11). Moreover, conditionalities, whether pro forma or hard core, are sometimes not fully enforced. For example, Mosley et al. (1995) argue that the WB may be lax in enforcing conditionalities because WB staff are incentivised to meet certain country lending targets (p. 47). In other words, IOs have an interest in lending money and seeking long-term relationships in the countries where they provide aid (Larmour 2002, p. 259).

Despite the ambiguity of conditionalities, it has been argued that the influence of IOs, whether coercive or non-coercive is greater in vulnerable countries which are experiencing developmental issues and rely on external financial aid (Batley, 2004; Laurell & Arellano, 1996; Woods, 2006). For instance, in a study analysing the role of IOs in South East Europe, Deacon, Lendvai and Stubbs (2007) argue that the influence of IOs on social policies has been much stronger in countries where state and economy is weaker, or find themselves in a crisis (p. 226). According to Woods (2006), countries dependent on foreign aid have less capacity to negotiate or resist policy

prescriptions from IOs (p. 70). In such conditions, the bargaining power and leverage of IOs is assumed to be greater (Aina et al., 2004; Batley, 2004; Laurell & Arellano, 1996; Weyland, 2006; Woods, 2006). Accordingly, Paloni and Zanardi, (2006) argue that developing countries often have no choice but to accept policies conditioned by IOs loans (p. 3). Similarly, Killick (1998) notes that the dependence on financial aid "gives the donors the economic power to impose their own wills" and exemplifies the upsurge of conditionalities in Latin America during the 1980s and sub-Saharan Africa (p. 12). Furthermore, a lack of policy experts and policy knowledge may make vulnerable countries dependent on the policy expertise and knowledge dissemination offered by IOs such as the WB and IMF (Paloni & Zanardi, 2006, p. 20; Weyland, 2006). Therefore, it can be assumed that both coercive and non-coercive influence of IOs is more likely to take hold in vulnerable countries. However, empirical research on the WB's influence in some low- and middle-income countries suggests that this is not always the case, and that the WB has been found to be flexible and accommodating to domestic governments (Kaminska et al., 2021; Noy, 2017; Weyland, 2006; Wireko & Béland, 2017).

3. Croatian Healthcare financing reforms and the role of IOs

3.1 Historical background: Croatian healthcare financing in Yugoslavia

Similar to other CEE countries, the Croatian healthcare system in the Yugoslav federation was organised according to the socialist principles of expanding healthcare services and free healthcare based on solidarity (Džakula, Šogorić & Vončina, 2012; Šarić & Rodwin, 1993). The main difference was that healthcare financing was highly decentralised and organised as a contribution-based model according to Bismarckian and self-management principles. Multiple healthcare funds called self-managing interest communities (Samoupravne interesne zajednice; SIZs) were organised on the municipal level. SIZs were formally managed by users and providers of healthcare services and were responsible for collecting and pooling payroll taxes and purchasing healthcare services (Parmelee, 1985; Šarić & Rodwin, 1993). However, the Communist Party had a strong influence on the decisions of the SIZs. In most cases, SIZs simply rubber-stamped the decisions of higher administrative units controlled by the Communist Party (Šarić & Rodwin 1993: 226). Although contributions were a dominant source of healthcare financing, a part of financing came from the republican and federal state government budget (cross subsidies paid to reduce inequalities between different republics, pooled in a special fund) and municipal budget (mostly for agricultural workers) (Parmelee, 1985; Šarić & Rodwin, 1993). Out-of-pocket payments (OOPPs), were widespread but only 3% of OOPPs were formal co-payments introduced in the late 1980s (e.g., for drugs, cosmetic surgery, abortions, while a large majority were informal payments (Šarić & Rodwin, 1993, p. 231).

By early 1970s, healthcare benefits and coverage had become practically universal (Parmelee, 1985; Šarić & Rodwin, 1993). Healthcare provision was public with only a few exceptions (e.g., dentists). Primary care centres and hospitals were allocated a budget based on their facilities and staff, while all healthcare professionals were paid on a salary basis **(**Himmelstein et al., 1984, p. 427; WHO, 1999). The system faced many problems due to heavy decentralisation, lack of financial expenditure control, duplication of procedures, inequality of access and quality of services between different regions and shortages of medical equipment and drugs (Chen & Mastilica, 1998; Šarić & Rodwin, 1993). These problems were exacerbated by the economic crisis of the 1980s, which reduced the resources available for healthcare (Davis, 2010).

3.2 1990-1993 healthcare financing reforms: domestically driven reforms and limited presence of IOs

In the early 1990s, the Croatian healthcare system was put under additional strain due to the post-communist transition and economic and political crises (disintegration of Yugoslavia, war) and was in dire need of reform. At the same time, the Communist Party lost its legitimacy, and the first multiparty elections were won by the Croatian Democratic Union (CDU). Many doctors turned politicians, joined the CDU and assumed positions in the most relevant healthcare institutions and set out to alleviate the deficiencies of the communist system (Malinar, 2022). The Ministry of Health drew both "negative" and "positive" policy lessons from abroad (Malinar, 2022), which served – respectively - to either avoid the mistakes of others or to add potential policy tools to the repertoire (Klein 1997, p. 1270). The Minister of Health at the time referred to positive outcomes of healthcare reforms in Western European countries (Interview 1, 2019[1]). For instance, Croatia was inspired by a "good example of market-oriented, efficient, professional, high-quality, and social solidarity-based health system present in Germany" (Deppe & Orešković, 1996, p. 785). At the same time, marketisation and privatisation in healthcare were approached with caution by Croatian policy makers as examples of failed reforms, due to negative experiences of the private insurance market in the USA or the establishment of multiple semi-competitive SHI funds in the Czech Republic (Malinar, 2022). Accordingly, the aim was to reform the Croatian healthcare system following Western European models (Malinar, 2022).

At the same time, Croatia initiated contacts with IOs to gain much needed political and economic support. Croatia was a newly independent, politically unrecognised and economically vulnerable country and the government wanted to improve its prospects for international recognition, gain access to funding and policy expertise by inviting IOs and requesting them to set up offices in the country. The WB expert present in Croatia at the time noted the following:

> "In Croatian case it was also external validation of the new Croatian state, they [The Croatian government] really wanted us [the World Bank] to open an office in Zagreb, to bless the policies in the international scene" (Interview 2, 2020[2]).

[1] Former Croatian Minister of Health.
[2] WB expert.

In turn, IOs were considering the post-communist transition as an opportunity to get involved, help the development of a newly independent state and offer their money and ideas on the table. However, the extremely difficult political situation eventually inhibited the involvement of most IOs in Croatia in that period[3]. The lack of international recognition and war which broke out following Croatia's secession from Yugoslavia produced uncertainties and security concerns. The EU suspended Croatian membership in the PHARE programme "in immediate response to the August 1995 military actions" (Stubbs & Zrinščak, 2007, p. 91). Similarly, although Croatia formally joined the IMF in 1992 and the WB in 1993, both organisations were highly wary of getting involved by initiating loans and projects with Croatia while the war was ongoing[4]. The WB stated that:

> "The difficult situation in the region has meant that the Bank's approach in assisting Croatia has necessarily been cautious… our dialogue was interrupted for about one year due to security concerns" (WB, 1995, p. 1).

The only IO that got involved in healthcare policy reforms in Croatia at the time was the WHO. Due to the personal connections of the Minister of Health and the WHO European Regional Office representative Jo Asvall, the WHO had set up an informal office in the Ministry of Health. As recalled by the then Minister of Health:

> I proposed to Jo Asvall that it would be best to communicate and cooperate by establishing a WHO office in my ministry. I said to him: no one can blame you for that... He accepted and I gave him a room at the Ministry of Health. The WHO set up its office as early as 1991... Other institutions were not so flexible because they were more involved with money (Interview 1, 2019).

As a result of that situation, the first major reforms and policy ideas regarding healthcare financing in Croatia were domestically driven, while the WHO supported the already established government reform agenda and provided policy advice during the formulation of the 1993 Healthcare Act (Malinar, 2022). The first step of reform was the establishment of the Republican Fund for Health

---

[3] However, it is important to note that a lot of international organisations and NGOs provided humanitarian aid (material and financial assistance) during the 1991-1995 war, such as the UN, Red Cross and alike (Stubbs & Zrinščak, 2007).

[4] The first IMF and WB loans to Croatia were negotiated in 1994 (HNB, 2015; WB, 2024).

Insurance in 1990. SIZs now acted as regional branches of the Republican Fund and collected payroll tax on its behalf. In 1993, a new Health Insurance Act completely abolished SIZs and CIHI replaced the former Republican Fund. Payroll tax was now collected and pooled by CIHI which acted as semi-autonomous health fund and was strictly controlled by the government (Malinar, 2022; Vončina, Džakula & Mastilica, 2007, p. 147). Besides SHI which remained the main mode of healthcare financing (Vončina, Džakula & Mastilica, 2007; WHO, 1999), private insurance companies could offer two forms of private insurance. Following the German model, people above an income threshold set by the Minister of Health could opt for private insurance instead of SHI. The second form was supplementary insurance, which offered better access to and quality of healthcare.

In addition, healthcare was partly financed by the government and county budgets. The government financed healthcare contributions to certain groups of people, such as the unemployed, and paid off accumulated debts, while the rest of the government and county budgets financed public health programmes. The entitlements and coverage were defined by contributions. Breadth and scope were practically universal as the state paid contributions for those unable to pay (e.g. the unemployed) and the basket of services was not strictly defined (there was only a negative list with only a few excluded services, such as cosmetic surgery). However, the depth of coverage was reduced with the introduction of co-payments for selected health services which amounted to 10% of the full cost of the service (Kovačić & Šošić 1998, p. 4).

Moreover, a new Healthcare Act was enacted in 1993 to regulate purchasing and provision. The government invited WHO experts to participate in the process of law formulation. They provided advice and feedback on drafts prepared by the government. According to the then Minister of Health, cooperation with WHO was entirely voluntary and the organisation helped to clarify many uncertainties in the government's policy proposals (Interview 1, 2019). The cooperation resulted in a policy in which the CIHI was the single payer for healthcare services and the main agency responsible for contracting healthcare providers and purchasing their services. The WHO supported the idea of privatisation of provision and a new purchasing model in primary care (Interview 1, 2019). It was decided that public primary care physicians were to be paid by salary while private ones were to be paid by capitation. In hospital care, Croatia adopted a mixed purchasing method. Hospital hotel services were paid at a flat rate per diem. Physician services

were paid per procedure using the WHO point system, while drugs and other materials were paid separately according to the cost of each item.

The healthcare financing reforms in the 1990-1993 period set the foundation for the Croatian healthcare financing policy to this day. The only IO involved in healthcare reforms was the WHO, which supported the government's agenda and provided policy advice and feedback on healthcare legislation drafted by the government. International financial institutions such as the WB were reluctant to get involved and provide financial assistance because of the security risks posed by the war. Therefore, during this period, healthcare financing reforms were driven by domestic actors, especially doctors who turned politicians and occupied the relevant decision-making venues (Malinar, 2022).

3.3 1994-1999: the WB taking a seat at the negotiating table

In March 1994, Croatia signed cease fire agreements with Serbia and Bosnia. The WB considered this the right time to continue the dialogue with Croatia and to start offering financial aid (WB, 1994; 1995). In turn, the Minister of Health seized the opportunity to request financial and material support from the WB (Interview 1, 2019). The WB affirmed that healthcare policy changes implemented during the 1990-1993 period provided "a sound basis for new investments and should be supported by the international community" and that "to sustain the reform, investment resources are badly needed" (WB, 1995, p. 4). Both the WB and the Minister of Health declared that their cooperation was very good, with the WB agreeing to provide the loan on good terms, while Croatia could choose which components to include in the project (Interview 1, 2019; Interview 2, 2020). With the help of WHO experts, the Croatian government prepared project components and negotiated the *Health Project* with the WB in 1995 (Interview 1, 2019; WB, 1995, p. 11). Within the project, the WB provided funding, expertise and material support to train primary care physicians and healthcare administration; establish procedures to control spending and efficiently collect and pool funds; replace outdated medical equipment; and install new computer hardware and software (WB, 1995).

The *Health Project* lasted until 1999 and was successful, thanks to the good cooperation between the government and the WB (Interview 1, 2019; WB, 1995, 2000b). Crucially, the project enabled the WB to occupy a seat at the table where reforms were discussed, and promote further ideas for

healthcare policy development. From the moment the project was negotiated, the WB became the most important IO involved in healthcare financing reforms while the WHO focused its work on public health and healthcare statistics (Interview 3, 2019[5]; Interview 4, 2019[6]).

In the period from 1995-1997, expenditure on health started rising due to lagging primary care reforms, overreliance on hospital care, and increased expenditure on healthcare sector wages, sick pays and drugs (WB, 1997b). In response to the rising expenditure in health, the WB led a continuous dialogue with the Croatian government and discussed possible reform directions in healthcare financing. The WB's policy advice on healthcare financing was based on its analytical work. The WB published studies with policy recommendations on healthcare financing, based on an evaluation of the Croatian healthcare system and the its experience in other countries (Interview 2, 2020; Interview 5, 2020[7]; Interview 6, 2020[8]). The WB began to push its reform agenda and acted as an epistemic community, providing evidence-based policy knowledge and advising Croatian government on how to change healthcare financing policy.

In particular, in 1997, the WB published two documents, *Public sector financing, health care reform and pension reform in Croatia*" and *Croatia – Beyond Stabilization*, which recommended to reduce public healthcare expenditure, sick and maternity pay leaves, and reliance on payroll taxes; further develop private insurance market and its regulation, and to introduce policies which would contain expenditure and reduce the demand for healthcare services e.g., increasing the role of co-payments and reducing co-payment exemptions, which would be justified only by income status (WB, 1997a, 1997b). To motivate GPs to provide more services and improve their quality, the WB recommended to increase capitation remuneration levels in private primary care practices. Regarding the hospital sector, the WB stated: "as seen in the Czech Republic, the point system can… lead to escalation of costs" and "give rise to incentives to offer more specialized and lucrative procedures than necessary" (WB, 1997b, p. 276). To avoid the same adverse effects, the WB recommended implementing global budgets whereby hospitals could get penalised for exceeding the budget limit (WB, 1997a, 1997b).

[5] WB consultant, Croatian healthcare expert and former assistant to the Minister of Health.
[6] Croatian healthcare expert.
[7] WB expert.
[8] External consultant of Croatian Ministry of Finance managing World Bank social sector loan.

In response to WB recommendations, the government implemented global budgets in 1997 and changed the capitation model to weighted capitation (adjusted by age of the patients) in 1998. However, the government decided against redefining the sick and maternity leaves, private insurance, co-payment schedule and exemptions. This policy course can be characterized as "captured social policy" (Stubbs & Zrinščak, 2007, p. 91) whereby social policies, including healthcare, were framed within the context of post-war social claims making (Puljiz, 2005, p. 83). In order to rectify the perceived unfairness related to the privatisation process, disempowered groups such as war veterans and pensioners "were able to press their demands on a populist regime" (Puljiz et al., 2008, p. 39). For this reason, reductions in benefits were hard to introduce in the years to come. Clearly, the WB's policy advice alone was not enough to incentivise the government to introduce unpopular policies so soon after the war.

To summarise, between 1994 and 2000, the WB began to directly influence health financing policy. The *Health Project* negotiated in 1995 enabled the WB to establish a continuous exchange with the Croatian government regarding healthcare financing policies. The WB started to act as an epistemic community by publishing studies, providing policy expertise and advice in healthcare financing policy. In this way, the WB was influencing the government's agenda and tried to frame the problems and potential policy solutions in healthcare financing (Interview 2, 2020; Interview 3, 2019; Interview 7, 2020[9]; Interview 8, 2019[10]). Although the WB was unable to persuade the government to reduce healthcare benefits, it did not give up and continued to push its agenda in the years that followed. The WHO, however, reoriented its work towards public health issues.

3.4 2000-2004: involvement of the IMF and the advancement of the WB agenda

In the late 1990s, Croatia was experiencing excessive trade and fiscal deficits, rising unemployment and inflation, insolvencies of banks and state-owned enterprises, excessive public sector employment and growing informal economy (Bičanić & Franičević, 2003, p. 18; IMF, 2001, p. 4; Vončina, Džakula & Mastilica, 2007; WB, 2000a, 2001a). Such a situation reflected poorly on the healthcare system. Despite reforms, the role of primary healthcare as a gatekeeper was inadequate. Both private and public primary care practices were paid by a model (weighted

[9] Croatian healthcare expert.
[10] Croatian healthcare expert.

capitation and fixed salary respectively) that incentivised patient referrals to higher levels of care. Consequently, the healthcare system was still over-reliant on hospital care. Together with overly generous benefits (about 80% of population was exempted from co-payments) the healthcare system was in financial crisis[11] (Vončina, Džakula & Mastilica, 2007; WB, 2004). In 2000, a new coalition led by the Social Democratic Party (SDP) and the Croatian Social Liberal Party came to power and requested support from the IMF and the WB to alleviate the above-mentioned issues (Stubbs & Zrinščak, 2007).

Soon after, the WB published *The Reform of Health Care in Croatia* (Croatian Ministry of Health & World Bank, 2000), *Croatia: A Policy Agenda for Reform and Growth* (WB, 2000a) and *Regaining Fiscal Sustainability* (WB, 2001b). Similar to previous WB studies, recommendations included increasing the scope and rate of co-payments and reducing the number of people exempted, introducing a basic basket of services, reducing sick pays, maternity leaves and payroll tax (Croatian Ministry of Health & World Bank, 2000; WB, 2000a, 2001b). Regarding purchasing policy, the WB suggested introducing Diagnosis Related Groups (DRGs) in hospital care and group practices with a fund holding model in primary care, similar to the UK system (Croatian Ministry of Health & World Bank, 2000).

WB's policy advice proved to be influential in the government's healthcare agenda (Interview 2, 2020; Interview 3, 2019; Interview 5, 2020). Indeed, healthcare strategies adopted in 2000 and 2002 incorporated WB ideas and emphasised a greater role for co-payments, the introduction of a standard basket of services, and the introduction of new purchasing mechanisms in primary and hospital care, e.g., DRGs and group practice funds (Croatian Government, 2000, p. 30; Croatian Ministry of Health, 2000, 2003, p. 36; Croatian Ministry of Health & World Bank, 2000; Croatian Office for Development Strategy, 2002).

With the reform agenda set, the WB and the government negotiated *Health System Project* in 2000. Conditionalities for the project were vague and did not include ex-ante healthcare financing policy changes e.g., respecting the WB's procurement procedures and sticking to the agreed framework of the project (WB, 1999). Thus, the WB did not try to impose any healthcare financing policy at

[11] Total healthcare expenditure amounted to 10.2% of GDP (Croatian Parliament, 2006) and the CIHI accumulated debts were HRK 4.2 billion (about 0.55 billion EUR) (Zrinščak, 2007).

the time. Pilot projects were set up in Koprivnica-Križevci county. The projects funded British consultants to work on the development of group practice and fund holding purchasing models in primary care. At the same time, broad case groupings similar to DRGs (PPTP in Croatian)[12] were being developed for hospitals (WB, 2006).

During the *Health System Project*, in 2001, the government negotiated a *Stand-by Arrangement* (SBA) with the IMF which focused on improving macroeconomic policies (Croatian Government 2001; Croatian Government 2002; IMF, 2002b, pp. 21-22). The IMF pressured the government to reduce healthcare benefits and expenditure (IMF, 2000, 2002a) but it did not recommend any specific policies nor did it institute conditionalities related to healthcare financing. The IMF lacked expertise in healthcare and the WB was leading a healthcare policy dialogue with the government (IMF, 2002a, p. 38; Interview 2, 2020; Interview 5, 2020 [13]).

In 2001, the WB and the government agreed on a *Structural Adjustment Loan* which focused on improving economic and social policies, including healthcare (WB, 2001d). For the first time, the loan included explicit conditionalities related to healthcare financing policy. However, conditionalities were a matter of negotiation and mutual agreement between the government and the WB. The interviewed WB experts stated the WB was willing to adjust its demands by considering the government's position and the political and economic circumstances of the country (Interview 2, 2020; Interview 5, 2020; Interview 6, 2020).

The WB insisted on increasing the scope and rate of co-payments, reducing the exemptions from co-payments based on income status and levying contributions from non-wage labour (Interview 5, 2020; WB, 2001c). Although the government was initially in favour of such policies, it was facing a strong opposition by the trade unions, the media and the public, and the political opposition in the parliament (Đuretek et al., 2001; Interview 2, 2020; Rebić, 2002; Večernji list, 2001; Večernji list, 2003). In response to this backlash, the government eventually contested some of the WB demands. In order to appease both the WB and the actors opposing the reforms, the government implemented most of the WB's policy recommendations (increasing the scope and rate of co-payments, reducing payroll taxes, sickness and maternity benefits, extending

[12] The major difference between DRGs and PPTPs was that PPPTs were broader and did not include more specific diagnosis groups which are found in the DRG model.
[13] WB expert.

contributions to non-wage labour, incorporating CIHI into the government budget) but insisted on less radical changes to the co-payment exemption policy.

The government wanted to limit the adverse effects of co-payments by exempting vulnerable groups (war veterans, unemployed, disabled etc.) and adopting voluntary complementary health insurance (CHI) which would be offered exclusively by CIHI for the span of 2 years (Interview 9, 2019[14], Interview 10, 2019[15]; Interview 17[16]). CHI premiums would be set as a fixed lump sum, with a discount for pensioners (about 10 euros and 5 euros respectively) (Croatian Parliament 2002; Vončina, Džakula & Mastilica, 2007). The WB opposed these policies, arguing that broader co-payment exemptions would not solve the problem of moral hazard, while CHI would introduce the problem of adverse selection (Interview 5, 2020; Interview 10, 2019; WB, 2004, p. xi). However, the WB acknowledged the difficult economic and social situation Croatia was facing (WB, 2001d, p. 34) as well as the already achieved reform progress, and approved the *Structural Adjustment Loan*. This shows that the WB is a rather flexible organisation, willing to adapt its position to political and economic developments in the country. Interviews conducted with Croatian healthcare experts and policy makers, as well as WB experts suggest that the WB's adjustment and flexibility can be explained by its development mandate, the desire to build domestic support for the reforms, but also by perverse incentives to sell loans (Interview 2, 2020; Interview 6, 2020; Interview 9, 2019; Interview 11, 2019[17]; Interview 12, 2019[18]; Interview 13, 2019[19]; Interview 14, 2019[20]).

In 2003, a new coalition government formed, led by CDU. It continued the co-operation with the IMF and the WB. A new SBA was agreed with the IMF because fiscal deficits and public debt continued to rise (IMF, 2003). The IMF stated that reforms in healthcare supported by the WB were underway and that progress was being made (IMF, 2002a, 2002b). However, the government turnover hindered the progress on the *Health System Project*. The new government lacked understanding and ownership of the project, and was not entirely committed to its implementation.

[14] Former Croatian Minister of Health.
[15] Former Croatian Minister of Health.
[16] Croatian healthcare expert involved in Coalition of Health Associations in Croatia.
[17] Croatian healthcare expert and reporter.
[18] CIHI 2000–2002 board member.
[19] Croatian healthcare expert.
[20] WB expert.

The WB was aware that the continuity of reforms was particularly vulnerable to government turnovers (Interview 5, 2020; Interview 10, 2019) and initiated negotiations to continue the project. The WB explained the rationale behind the project and was able to persuade the government to follow it through, however complete understanding and ownership was never regained (WB, 2006, p. 7). As a result, the project was only partially implemented and it was finally completed in 2005 with an 18-month delay (WB, 2006). A total of 33 PPTP service groupings were adopted. However, hospitals could choose between PPTPs and fee for service payments, which incentivised them to opt for a method generating higher returns. In primary care, six group practices were established. However, the healthcare laws were not changed to allow fund holding purchasing models. The WB acknowledged shortcomings of the pilot projects which had "not led to the desired learning outcomes and have been difficult to replicate and scale up" (WB, 2006, p. 5).

Despite policy slippages in the *Structural Adjustment Loan* and *Health System Project*, the WB concluded that overall policy changes represented an "important step in rationalizing the health financing system" (WB, 2004, p. 16). Although public healthcare expenditure decreased from 8% of GDP in 1999 to 6.4% in 2004, the WB argued that it was still too high and could likely rise in the future if previous policy setbacks were not corrected (WB, 2004, 2006, p. 6). To this end, the WB led an ongoing health sector dialogue with the government and was prepared to extend the cooperation (Interview 5, 2020; WB, 2006). Similarly, the second IMF SBA did not produce desired outcomes, either. External debt and budget deficits increased (the latter to 6.3% of GDP) (IMF, 2004). Consequently, the IMF and the government agreed on another SBA in 2004. This time the government obliged itself - should the budget deficits remain so high - to introduce measures to control health spending, e.g., by further increasing co-payments, reducing the number of people exempted and introducing changes to CHI (Croatian Government, 2004).

To sum up, the 2000-2004 period was marked by increased involvement of the WB in the making of healthcare financing policies in Croatia. It was the first period where the WB and the government negotiated loans which included healthcare financing policy components. Thus, the WB complemented its policy advice with financial assistance and tried to exert pressure on Croatia by setting conditionalities. However, conditionalities were mutually agreed with the government. The WB was flexible and considered the domestic context and standpoints of the government, thereby allowing for the introduction of policies it did not initially advocate for. During this time,

the government initiated arrangements with the IMF as well. Although the IMF pressured the government to cut healthcare expenditures, it left the healthcare financing policy dialogue to the discretion of the WB.

3.5 2005-2007: the WB's continuous attempts to correct previous policy setbacks

To correct the policy setbacks of the previous period and to continue to influence the government's agenda, the WB formulated further recommendations and published *Croatia: Health Finance Study* in 2004. The study recommended alternatives to CHI, such as ceilings on co-payments for chronic patients or developing the private voluntary health insurance market, and further reducing co-payment exemptions, payroll taxes, and sick and maternity leave (WB, 2004). With regards to service purchasing, recommendations included introducing fee for service remuneration in primary care and replacing PPTP grouping system with the Australian DRG system, which had shown positive results in other countries such as Slovenia (WB, 2004, pp. 41, 42, 44). The study provided input for healthcare policy components in the *Programmatic Adjustment Loan* (PAL) which was negotiated between the WB and the government in 2005[21] (WB, 2005a, p. 11). The loan was disbursed in tranches, and each year the WB and the government held discussions in order to evaluate the progress of the reforms and to decide whether or not to extend the loan (WB, 2009a, p. 13-15). Clearly, the WB had an interest into keeping the reforms on track by monitoring the reform progress and affirming its presence within the government.

The government and the WB agreed that the main goal of the loan in the healthcare sector was to reduce public spending on health to 6.0 percent of GDP in 2008 and to clear arrears (WB, 2005a, p. 25, 2007a). Similar to the *Structural Adjustment Loan*, the conditionalities were negotiated and it was agreed that the government would define a fiscally sustainable basic benefit package, reduce co-payment exemptions and restructure the CHI by shifting it to the private insurance market, thus resolving the issues of moral hazard and adverse selection (WB, 2005a, p. 30, 2007a). To fulfil the above-mentioned conditionalities, the Ministry of Health prepared a law proposal which was in line with the WB policy ideas (Interview 1, 2019). The proposal included a basic benefit package in which SHI would cover 90% of the price of all health services. For the remaining 10% of the price, people could insure themselves by purchasing complementary insurance in the private market (Interview 1, 2019). Although the WB and the IMF approved the proposal, it was opposed and vetoed by one of the government's coalition partners and never went through the parliamentary

[21] Other components included education, trade and transport, capacity building for EU integration, privatisation, private sector development etc. (WB, 2005a).

procedure (Interview 1, 2019; Međugorac, 2020). Consequently, the WB argued that the government would fall short of meeting the agreed conditionalities for the release of the second tranche, in particular defining fiscally sustainable basic benefit package and shifting CHI to the private sector (WB, 2007a, p. 14). However, the WB acknowledged the political obstacles that had led to the failure of the reform and aligned itself with the government's position. To secure the government's commitment to reform and to approve the second tranche of the loan, the WB and the government held another round of negotiations and agreed that alternative policy conditionalities should be met instead (WB, 2007a, p. 13, 2009a).

The alternative policies agreed between the WB and the government were adopted in 2005 and 2006. The rate of co-payments was increased and established between 15% (for most healthcare services) and 50% of the full cost of the service. In addition, an administrative fee of HRK 10 with a monthly ceiling of HRK 30 was introduced for primary care visits, referrals, prescriptions and visits to specialists without a referral. Soon after, a new *Healthcare Strategy* and a new *Healthcare Act* which were influenced by WB's policy proposals were adopted. The law introduced income testing to determine co-payment exemptions but categorical exemptions remained in place**.** Pharmaceutical coverage was reduced by introducing lists of essential (fully covered by SHI) and non-essential (subject to co-payment) pharmaceuticals. Moreover, the CHI did not cover administrative fees for pharmaceuticals on non-essential list. In the purchasing dimension, the development of performance-based payments continued. DRGs were piloted in four hospitals and private primary care practitioners started being paid on the basis of capitation (80%) and fee for service (20%) (WB, 2007a).

The WB stated that these reforms[22] confirmed the government's commitment to reform and achieved fiscal savings of almost HRK 1 billion (WB, 2007a, p. 27, 2007c). The loan continued and the WB provided technical assistance to implement DRGs and means-testing targeting for co-payment exemptions (WB, 2007a, 2009a). However, the 2007 elections were approaching and the opposition to the already unpopular administrative fees gained traction in the parliamentary discussions and the media (Letica, 2006, Mišlov, 2007; Tadin & Lovrić, 2005; Vjesnik 2005). The elections were won by a coalition led by the CDU which, once it formed the government, abolished

[22] Including policies introduced in provision and regulation dimension.

the administrative fee as part of the agreement between coalition partners. As the fee was a part of the previous conditionalities, the WB was not satisfied but it did not cancel the loan. Instead, the WB held further discussion with the new governing coalition which eventually promised to introduce alternative policies. The WB, in turn, stated that it would review progress on the design of these policies and condition the continuation of the loan if necessary (WB, 2009a, pp. 13 - 14). Ultimately, the loan was cancelled due to delays in other sectors (WB, 2009a).

To summarize, despite several policy slippages and reversals that occurred during the 2005-2007 period, the WB was generally satisfied with the healthcare financing reforms and noted that public health expenditure was reduced to 6.1 percent of GDP in 2008, close to the original target of 6% of GDP **(**WB, 2009c). Throughout the period, the WB's flexibility and adaptability can be observed. Even though the original WB's policy proposals suffered setbacks, this did not disrupt the cooperation between the WB and the government. On the contrary, the WB was in constant discussion with the government and was willing to agree on alternative policies as long as they were considered adequate to achieve the main objective of the loan.

3.6 2008-2011: addressing the impact of the economic crisis

When PAL ended, the WB continued its dialogue with the government and provided further recommendations for healthcare financing policy which were outlined in the 2008 study *Croatia: Restructuring Public Finance to Sustain Growth and Improve Public Services*. The WB recommended broadening the contribution base, diversifying revenue collection, introducing means-tested exemptions from co-payments, further reducing sickness and maternity benefits, and expanding performance-based payment mechanisms in primary and hospital care (WB, 2008).

During this period, Croatia was hit hard by an economic crisis. Between 2008 and 2012, Croatia's GDP shrank by an average of 2.8% per year, 270,000 people lost their jobs, industrial production fell by 17.3% and the debt-to-GDP ratio rose to 104.7% (Bebek & Santini, 2013). In response to the economic crisis, the WB and the government began negotiating a series of loans focused on economic recovery and short-term measures to improve macroeconomic and social stability (WB, 2009b, 2015). Two loans, the *Fiscal, Social and Financial Sector Development Policy Loan* (WB, 2009b) and the *Economic Recovery Development Policy Loan* (WB, 2011a) contained healthcare

financing policy components and conditionalities[23] that were – again - jointly agreed with the government and based on the evaluation of the previous loan and the 2008 WB study. It was agreed that the government would increase co-payment rates and CHI premiums, reduce co-payment exemptions, sick leave and drug costs, and extend healthcare contributions to pensioners (Lovrić, 2008; WB, 2010, 2011b).

The government followed the agreement with the WB and introduced changes in the period of 2008 and 2011. Co-payment rates and CHI premiums were increased. Co-payment exemptions were reduced and an income test was introduced for government-subsidised CHI premiums (Vončina, Kehler, Evetovits, et al., 2010; WB, 2009b, 2011a). However, categorical exemptions from co-payments remained in place and the price cap for co-payments was set at HRK 3000 per episode of illness (Vončina, Kehler, Evetovits, et al., 2010; WB, 2008). Fees for primary care visits and prescriptions were reintroduced, but could be covered by CHI. Payroll tax was reduced to 15% (Croatian Parliament, 2008) while pensioners were required to contribute 3% of their pensions to the SHI (Vončina, Kehler, Evetovits, et al., 2010). Taxes on tobacco and car insurance were earmarked for healthcare. Finally, Australian DRGs were implemented as hospital remuneration method (global budget caps remained) and fee for service payments for GPs working in private primary care practices were increased (20% fee for service, 80% capitation).

In the 2008-2011 period, the WB and the government continued the dialogue and cooperation in healthcare financing policy. At that time Croatia was facing an economic crisis and the policies agreed between the WB and the government were focused on financial stabilisation of the healthcare system. The economic crisis was a catalyst for diversifying the revenue collection, increasing the private share of healthcare financing and incentivising the purchase of CHI premiums. Although proper means testing for targeting co-payment exemptions was not introduced, the WB commended the government for implementing difficult decisions during this period (WB, 2015).

[23] Other components were related to pensions, budget law, public administration etc. (WB, 2010; 2010b).

3.7 2012-2019 reforms: the WB's shift of focus from demand to supply side healthcare policies

Despite reforms in the previous period, healthcare arrears did not decrease and public health expenditure increased to 7.2% of GDP. The WB acknowledged that the increase in expenditure was due to the fall in real GDP and a more precise definition of arrears (WB, 2015). To reduce arrears in the health sector, the WB continued its dialogue with the SDP-led coalition government which formed in 2011. The WB pointed out that further reforms should focus on healthcare provision and purchasing instead of revenue collection policies (WB, 2012). At the same time, the SDP-led government started preparing a new healthcare strategy for the 2012-2020 period. To influence the government's agenda, the WB produced another study, *Croatia Policy Notes: A Strategy for Smart, Sustainable and Inclusive Growth* in 2012 (WB, 2012).

The government's new healthcare strategy, published in 2012, was clearly inspired by the WB ideas outlined in the 2012 study and included objectives such as reducing inefficiencies in service provision**,** adjusting DRGs in the hospital sector and outlining additional policies such as expanding performance-based payments in primary care, increasing private healthcare expenditure and the role of voluntary private insurance (Croatian Government, 2012; WB, 2012). The healthcare strategy provided input for a new loan negotiation between the government and the WB. The negotiations resulted in a new project: *Improving Quality and Efficiency of Health Services* (Interview 15, 2019[24]; WB, 2014a). The project started in 2014 and did not have any prior policy conditionality required for the disbursement of the loan funds. However, it was the first loan to disburse funds according to outcomes specified in disbursement link indicators. Similar to the second *Health System Project*, it supported the introduction of group practices and additional financial incentives for GPs, but also a hospital master plan which included rationalisation of care provision and improvement of DRGs (WB, 2014a).

In the meantime, the government had introduced revenue collection reforms to reduce the financial burden on citizens in times of crisis and, more importantly, to preserve the revenues of the state-owned CHI. In 2013, co-payments for primary care visits and prescriptions were reduced to HRK 10, and the price cap on co-payments was reduced to HRK 2000 (Džakula, Sagan, Pavić, et al.,

[24] WB and Croatian healthcare expert.

2014). The income test for determining CHI premiums was abolished and the premium was offered to everyone at the price of HRK 70 (about 10 euro). The idea was to retain existing policyholders and attract new ones, especially younger ones, who were able to buy cheaper CHI with Croatia's entry into the European Union and the arrival of competition (Hina, 2013).

Shortly thereafter, the WB produced another study, the *Public Finance Review*, which reaffirmed the established government agenda in provision and purchasing, supported by the recently approved project (WB, 2014b). However, in response to the recent changes, the WB argued that to reduce the burden on the public sector, the CHI premium should be brought in line with actuarial standards, the role of the private insurance market should be increased, and means-testing should be introduced for groups exempted from co-payments. In addition, to secure additional revenue, the WB recommended increasing 'sin taxes' earmarked for health care, such as tobacco (WB, 2014b). Despite these recommendations, the focus of the SDP led government and subsequent governments remained on provision and purchasing policies supported by the 2014 project. The same was true for the WB which argued that hospital arrears had put substantial financial pressure on the system and that the implementation of the project would be more beneficial in improving the efficiency and control of public health expenditure (WB, 2014a, 2020). This position of the WB was confirmed in a new study *Croatia Policy Notes: restoring macroeconomic stability, competitiveness and inclusion* which recommended rationalising provision and reducing pharmaceutical expenditure, improvement of purchasing policies and expansion of public health services (WB, 2016).

The WB was also concerned with keeping the 2014 project on track. Regarding healthcare financing components, the project had a promising start. Group practices and a new purchasing model for primary care were developed (WB, 2020). Fee for service payments increased to 30% and bonus payments based on based on quality and performance indicators were introduced (e.g., number or referrals, sick leave or prescribed drugs, online patient scheduling, patient's counselling) (Vončina, Arur, Dorčić, et al., 2018, p. 24). This led to an increase in primary care visits, GP home visits and preventive check-ups, and a decrease in referral rates (Vončina, Arur, Dorčić, et al., 2018, p. 24).

However, the reforms in hospital purchasing policy were partially reversed in 2016 when a new CDU/Most coalition came to power. Although fine tuning of DRGs continued, the new Minister

of Health reduced the share of costs that were paid to hospitals according to DRGs and increased the share that was paid in advance (based on global budgets) (Interview 10, 2019; Interview 16, 2019[25]; WB, 2020). The rationale of the new Minister of Health was that global budgets were better for controlling costs in hospitals (Laušić, 2019; Klepo, 2019). Since then, hospitals have been paid mostly in advance "with only 10% payments based on diagnosis related groups, and 3% performance payments" (WB, 2020, p. 14). The WB put a lot of effort in revitalising the project implementation and held monthly meetings with the Ministry of Health to discuss reform progress, problems encountered and possible solutions (WB, 2020, p. 27). However, frequent changes in the hospital managerial positions[26] and the government (twice between 2016 and 2018) reduced the level of government commitment. The project was delayed and ended in 2019, with some of the components being cancelled or modified, e.g., clearing hospital arrears, hospital accreditation, joint centralised procurement (WB, 2020). Despite these shortcomings, the WB concluded that improvements had been made as the number of in-patient beds was reduced, more services were provided on out-patient basis, 50% of hospitals completed accreditation, the share of centralised procurement increased and a number of hospitals completed functional integration (WB, 2020). During the project, minor changes in revenue collection were made to increase revenue for the health system, e.g. payroll tax was increased to 16.5% in 2019 (Džakula, Vočanec, Banadinović, et al., 2021).

To sum up, the cooperation between the WB and Croatia in the 2012-2019 period shifted towards purchasing and provision, while revenue collection policy remained in the background. As in other periods, project implementation depended on the political will of domestic actors. In addition, frequent changes in government and hospital management reduced the understanding and the commitment of domestic actors to implement WB-supported reforms. Despite policy setbacks, the WB took a pragmatic and flexible approach and tried to adapt to changes in the domestic context. The WB had an understanding towards leadership changes and engaged in frequent discussions with domestic policy makers, trying to negotiate solutions to continue with the 2014 project by

[25] WB expert.
[26] Majority of hospitals in Croatia are owned by counties. The 2013 Law on Rehabilitation of Public Institutions transferred the ownership of hospitals to the central government which could then appoint the managers of hospitals (Vehovec et al., 2014). The law was repealed in 2016 and the hospital ownership returned to counties.

modifying its components. A summary of the activities of IOs and of healthcare financing reforms in Croatia is presented in Tables 1 and 2.

Table 1. Summary of IOs activities

1990-2000 period			
IOs	**Non-coercion**	**Financial aid**	**Conditionalities related to healthcare financing**
WHO	Policy advice in formulating 1993 Healthcare acts.	-	-
WB	**Policy studies** *Public sector financing, health care reform and pension reform in Croatia (1997)* *Croatia – Beyond Stabilization (1997)* **Policy advice** **Revenue collection and coverage:** Reduce public healthcare expenditures, sick and maternity pay leaves, reliance on payroll taxes, and exemptions from co-payments. Develop private insurance market and its regulation. Increase the scope and rate of co-payments. **Purchasing:** Increase the level of capitation payments to GPs. Introduce global budgets in hospital financing.	*1995- 1999 Health Project* Unrelated to healthcare financing. Provided financial and material assistance to support the implementation of the reforms initiated during 1990-1993 period e.g., education, training, equipment.	-

<table>
<tr><th colspan="4">2000-2004 period</th></tr>
<tr><th>IOs</th><th>Non-coercion</th><th>Financial aid</th><th>Conditionalities related to healthcare financing</th></tr>
<tr><td rowspan="2">WB</td><td>Policy studies
The Reform of Health Care in Croatia (2000)

Croatia: A Policy Agenda for Reform and Growth (2000)

Regaining fiscal sustainability (2001)</td><td>2000-2005 Health System Project

Pilot projects in primary care: group practices and fund holding model (English consulting firm).

Pilot projects in hospitals: introduction of prospective or case mixed adjusted payments similar to DRGs.</td><td rowspan="2">2001-2003 Structural Adjustment Loan

Increase the scope and rate of co-payments.

Reduce the exemptions from co-payments.

Levy additional contributions from non-wage labour.</td></tr>
<tr><td>Policy advice

Revenue collection and coverage:
Reduce public healthcare expenditures, sick and maternity pay leaves, payroll tax, and exemptions from co-payments.
Increase the scope and rate of co-payments.
Introduce a basic basket of services.

Purchasing:
Introduce GP fund holding model in primary care.
Introduce DRGs in hospital financing.</td><td>2001-2003 Structural Adjustment loan

Technical assistance for healthcare financing reforms.</td></tr>
<tr><td>IMF</td><td>Policy advice

Reduce healthcare benefits and healthcare expenditures.</td><td>2001-2002 Stand-by Arrangement

2003-2004 Stand-by Arrangement</td><td></td></tr>
</table>

2005-2011 period			
IOs	**Non-coercion**	**Financial aid**	**Conditionalities related to healthcare financing**
WB	**Policy studies** *Croatia: Health Finance Study (2004)* *Croatia: Restructuring Public Finance to Sustain Growth and Improve Public Services (2008)*	*2005-2008 Programmatic Adjustment loan* Reduce public spending on health to 6.0 percent of GDP in 2008 and to clear arrears in health sector.	*2005-2008 Programmatic Adjustment Loan* Define a fiscally sustainable basic benefit package. Reduce co-payment exemptions. Restructure the CHI.
	Policy advice **Revenue collection and coverage:** Introduce ceilings on co-payments for chronic patients. Further reduce co-payment exemptions, payroll tax, and sick and maternity leaves. Broaden the contribution base by including pensioners above certain income level. Reduce sick and maternity leave benefits. Develop the private voluntary health insurance market. **Purchasing:** Introduce performance-based mechanisms in primary care e.g., fee for service. Replace PPTP grouping system with Australian DRGs.	*2009-2010 Fiscal, Social and Financial Sector Development Policy Loan* Reduce healthcare sector arrears to 1% of GDP by the end of 2009 and further by the end of 2010.	*2009-2010 Fiscal, Social and Financial Sector Development Policy Loan* Increase co-payments, and CHI premiums. Extend healthcare contributions to pensioners. Reduce sick leaves.
		2010-2011 Economic Recovery Development Policy Loan Reduce public health spending from 6.9 percent of GDP in 2010 to 6.2 percent of GDP in 2012.	*2010-2011 Economic Recovery Development Policy Loan* Reduce co-payment exemptions.

IMF	**Policy advice** Reduce healthcare benefits and healthcare expenditures.	*2004-2006 Stand-by Arrangement*	Government obliged itself to introduce measures to control health spending should the budget deficits continue e.g., further increasing co-payments, reducing the number of people exempted and introducing changes to CHI.
2012-2019 period			
IOs	**Non-coercion**	**Financial aid**	**Conditionalities related to healthcare financing**
WB	**Policy studies** *Croatia Policy Notes: A Strategy for Smart, Sustainable and Inclusive Growth* *Public Finance Review* *Croatia Policy Notes 2016*	*2014-2019 Improving Quality and Efficiency of Health Services* Technical support for reforms in primary care and hospitals, e.g. new purchasing model for primary care, further development of DRGs in hospitals. Mostly focused on hospital reform, e.g. functional integration, hospital accreditation, joint centralised procurement.	-
	Policy advice **Purchasing:** Extended the fee for service model in primary care based on quality and performance indicators. Further develop DRGs in hospitals. Focus shifted to provision reforms.		

Table 2: Summary of healthcare financing reforms

1990-2000 period			
Revenue collection	CIHI: semi-autonomous SHI fund. Collects contributions through payroll tax. SHI is compulsory except for people that opt-out and purchase substitutive private insurance. Supplementary private insurance for better standard of care. Contributions for certain groups such as the unemployed, public health programmes paid by the state.		
Purchasing	**Primary care**: **1.** Physicians in medical centres are paid by salary. **2.** Physicians who lease offices in medical centres and are in private practice are paid on a capitation basis. **3.** Private GPs in their own practice, paid by capitation.	**Hospitals**: **1.** Hotel services, flat per diem payment. **2.** Physician services, paid per procedure using WHO points system. **3.** Pharmaceuticals and other material paid for separately depending on the cost of single item. **4.** Global budgets instituted in 1997.	**Private secondary care specialists**: Fee for service.
Coverage	All Croatian citizens, residents and temporary residents are required to register for SHI. **Breadth:** Almost universal. Entitlements are based on contributions. The state covers and pays for contributions to the unemployed, pensioners, the disabled, people under the age of 18, war veterans... Dependent family members are covered by contributions paid by working family members. **Scope:** Practically universal. Comprehensive, negative list with only few services excluded such as cosmetic surgery. **Depth**: 10% co-payment on selected healthcare services such as specialist visits, diagnostic tests and drugs (exemptions for pensioners, war veterans, disabled...).		

2000-2004 period		
Revenue collection	Payroll tax decreased to 15.5% Substitutive private insurance abolished. CIHI incorporated into the State Budget Treasury. Voluntary complementary health insurance (CHI) offered by CIHI and private providers (since 2004) introduced. CIHI offered CHI at community rated premiums (HRK 50 for pensioners and HRK 80 for the rest of the population).	
Purchasing	**Primary care:** Additional reimbursement for GPs for preventive examinations. Total funding in addition to capitation cannot exceed 7% of annual capitation or 12% for GPs working in nursing homes.	**Hospitals**: Beginning of the introduction of "DRGs". Broad groupings called Plaćanje po terapijskom postupku (PPTP).
Coverage	Reduced **depth**, mostly for secondary specialist care, hospital care and pharmaceuticals. Co-payments divided into 6 groups based on the percentage of cost sharing (10%,15%, 25%, 30%, 50%,75%). The right to free healthcare at the point of use can be restored through the purchase of CHI. Exemptions from co-payments for certain groups (children, disabled, poor, war veterans, etc.).	
2005-2011 period		
Revenue collection	Payroll tax decreased to 15% CHI premiums increased. HRK 50-80 for retired and HRK 80-130 for employed. 32% of cigarette taxation and mandatory car insurance earmarked for healthcare. Retired required to contribute 1% (paid by the state) or 3% of their pensions to the SHI, depending on the amount of their pensions.	
Purchasing	**Primary care**: Capitation 80%, fee for service 20%.	**Hospitals:** Paid fully by DRGs (Australian DRG model). Global budget caps remained.

Coverage	Increase in co-payment rate: 2005 (15-50%); 2008 (20%) of full-service cost. Price cap for all co-payments per episode of illness HRK 3000. User fees: HRK 10 fee for primary care visits, referrals, prescriptions, visits to specialists without referral. 5 HRK for medical transportation costs regardless of whether someone is exempt from co-payments or has acquired CHI, with the only exceptions being children and people with 80% or more disability. Monthly ceiling of HRK 30 (abolished in 2008). User fees for primary care visits and prescriptions set at HRK 15 (introduced in late 2008). Income test for government-subsidised CHI premiums. Reduced co-payment exemptions. Categories such as children, students, people with disabilities, war veterans etc. remained exempted or the government subsidised their CHI premium. Two lists of drugs have been drawn up: 1) a essential list for which no co-payments are required; 2) a list of non-essential drugs for which people have to pay co-payments even if they have CHI.	
2012-2019 period		
Revenue collection	CIHI moved out of the State Budget Treasury (2015). Payroll tax decreased from 15% to 13%. Reversed in 2014 to 15%. In 2019 increased to 16.5%. CHI premium fixed at HRK 70 for everyone.	
Purchasing	**Primary care**: Fee for service increased to 30%. GPs can also receive bonus payments of up to 30% of their fee for service reimbursements depending on their performance and quality indicators, e.g. telephone consultations, e-appointments...	**Hospitals**: Mostly paid in advance. 10% of payments are based on DRGs and 3% on performance payments.
Coverage	Co-payments for primary care visits and prescriptions reduced to HRK 10. Price ceiling for all co-payments per episode of illness reduced to HRK 2000.	

4. Discussions and conclusions

Over the past 30 years, Croatian healthcare financing policy has undergone major changes. In the early 1990s, healthcare financing moved away from communist towards Western models. The SHI system was retained but centralised into a national health fund, while co-payments and private insurance became more prominent. Since then, healthcare financing reforms have aimed to increase financial sustainability, generate additional revenues, moderate the demand for healthcare services, promote primary care gatekeeping, and reduce hospital expenditure. Accordingly, the focus has been on reducing the scope and depth of coverage by increasing the role of co-payments, voluntary CHI, and performance-based payments in primary and hospital care, such as fee-for-service and DRGs. Since 2010, healthcare reforms in Croatia have focused on rationalising provision, particularly in hospital care. Overall, the Croatian healthcare financing policy has been characterised by incremental changes, sporadic implementation and policy reversals.

Ideas for changes in healthcare financing were largely shaped by IOs. As early as the 1990-1993 period, domestic actors initiated contacts with IOs to obtain much-needed support, funding and policy expertise for a newly independent and vulnerable country. However, the involvement of IOs, particularly international financial institutions, was limited by security concerns raised by the 1991-1995 war. Only WHO was able to open an informal office in the Ministry of Health. Unable to provide financial assistance, WHO relied on non-coercive influence and provided policy expertise in the formulation of the 1993 Health Act and the definition of purchasing models for primary and hospital care.

The WB only became involved in Croatian health after political and security concerns had been addressed. At the time, it worked with WHO and the government to define a project to support the 1993 reforms through financial and technical assistance. Once the project was in place, WHO shifted its focus to public health, while the WB took the lead in influencing health financing policies. Since then, ideas for changes in healthcare financing policy have largely come from the WB and, to a limited extent, the IMF. Between 2001 and 2006, the IMF supported the Croatian government with three Stand-By Arrangements that focused on improving macroeconomic policies. These arrangements had an indirect impact on health care financing by pressuring the government to adopt policies that would reduce healthcare expenditure. As in some other countries

(e.g. Russia), the IMF delegated healthcare issues to the WB because of its own lack of expertise (Odling-Smee, 2006, p. 182).

The WB exercised its power through both non-coercive and coercive influence. It had direct access to the government and relied heavily on non-coercive influence. The WB acted as an epistemic community (Haas, 1992) by providing policy expertise and technical assistance, holding continuous consultations with domestic policy makers, and publishing numerous analytical studies. As in other CEE countries, the WB did not rely on a "one size fits all" approach to healthcare reform (Radin, 2008, p. 328). The WB's policy advice was based on the evaluation of the Croatian healthcare system as well as on the policy experience of other countries such as the Czech Republic, Slovenia or the UK. In addition, the WB relied on external consultants with expertise in specific areas. For example, British consultants were hired to develop a group practice model for primary care in Croatia. By hiring foreign consultants and applying policy lessons from other countries, both positive and negative, to the Croatian context, the WB acted as an intermediary for horizontal policy transfer. As Kuhlmann et al. (2020) note, policy ideas can travel in both directions, from countries to IOs and from IOs to countries (p. 85).

Because of its extensive expertise in healthcare policy and its ability to provide country-specific advice, the WB was seen as a legitimate source of policy knowledge. As a result, the WB's non-coercive influence had a significant impact on the healthcare financing policy ideas that the government considered implementing. For example, since the 2000s, every government strategy related to health financing has been influenced by the ideas proposed by the WB. In this way, the WB introduced policy ideas that, as Weyland (2006) characterises it, "would otherwise not enter decision-makers' radar screen," a concept he refers to as availability enhancement (p. 52). Interestingly, Deacon, Lendvai and Stubbs (2007) find "similar practices of enframing used through a series of 'data', 'report' and 'knowledge' production throughout South Eastern Europe, whereby important studies, reports and databases are developed to be acted upon" (p. 230). Similar findings have been found in other studies which argue that IOs such as the WB are able to influence government's agenda and frame the discourse on policy goals, problems and solutions (Killick, 1998; Larmour, 2002; Noy, 2017; Orenstein, 2000; Robertson, 1991).

As far as the content of the advice itself is concerned, it has remained consistent over time. Since the late 1990s, the WB has promoted the reduction of public healthcare expenditure through

measures aimed at reducing demand and increasing the share of private healthcare expenditure, e.g. by reducing the scope and depth of coverage, increasing the level and rate of co-payments, increasing the role of private insurance, etc. Similar to some Latin American countries, the WB promoted neoliberal policy instruments such as means tested targeting to increase financial sustainability, but also equity and access, especially for the poor (Noy, 2017, 2018). In addition, the WB advocated for a stronger role for primary care and better management of hospital spending, such as incentivising GPs through fee-for-service models, introducing DRGs, etc. Since 2012, the focus of WB policy advice has shifted to the supply side of the health system. Instead of revenue collection and coverage reforms, the WB favoured changes in the service provision and further development of performance-based payments in primary and hospital care. It can be observed that the policy advice provided by the WB remained within the boundaries of policy instruments and settings, rather than promoting a paradigm shift (see Hall, 1993)[27]. To clarify, the paradigm was defined domestically by the government in the early 1990s and included SHI policy. The WB, however, exerted its influence solely on the instruments and settings within that established paradigm. Other studies investigating the role of the WB in CEE healthcare financing policy came to similar conclusions (e.g. Kaminska, 2022).

The WB's policy ideas formed the foundation for negotiating healthcare financing components that were incorporated into the WB's projects and loans. However, although the WB attached conditions to the disbursement of loans, its coercive influence was limited. Healthcare financing conditionalities were not unilaterally prescribed by the WB nor were they strictly imposed. On the contrary, conditionalities were consensual and mutually agreed, resulting from negotiations between the WB and the government, or what Killick (1998) defines as pro forma conditionality. The purpose of the latter was to create government identification with and ownership of the lending programme, to induce the government to adhere to mutually agreed priorities, and to increase the success of lending programmes (Bazbauers, 2018; Killick, 1998; WB, 1997c, 1998).

The negotiation process was not always smooth, as the interests of the government and the WB on certain policies sometimes diverged. Whenever a dispute arose, the WB took a lenient stance,

[27] The chapter is grounded in the framework of the book, which incorporates Hall's (1993) categorisation of policy into three levels.

either in negotiating conditionalities or in enforcing them, and often adjusted its position according to the changing political and economic context of the country. Even when agreed project components and conditionalities were not implemented, the WB was willing to bargain by renegotiating conditionalities and accepting alternative policies as long as they were consistent with project objectives.

Therefore, this case study does not support the view of the WB acting as a hegemon that is trying to coerce a weak country and impose unilaterally defined policies. Instead, it provides evidence that the aim of the WB was to cooperate with the government and support the development of Croatia and its healthcare system. To achieve the latter, WB's policy advice was tailored to the country's specific context and conditionalities were a matter of negotiation. The interaction of the WB with the Croatian government clearly reflected the changing approach within the WB itself, as defined in the publications: *Health, Nutrition and Population Sector Strategy* (WB, 1997c; 2007b), *Assessing Aid* (WB, 1998) and *Conditionality Revisited* (WB, 2005b). A common theme in these publications is that the WB should avoid rigid policy prescriptions and base its approach on international best practice, country-specific sector analysis, promoting government ownership, and adapting lending policies and procedures to client needs (WB, 1997c, 1998, 2005b, 2007b). The WB has argued that this leaves a larger space for country-grown policies while following the minimum standards of the donor (WB, 2005b).

In addition, the often-lenient approach of the WB can be explained by perverse incentives to continue lending money which include country lending targets, staff promotions based on negotiating new loans, guaranteed loan repayments by aid recipient countries, offering new loans to help countries pay off old ones, and incentives to secure future relationships with aid recipient countries (Killick, 1998; Larmour, 2002; Mosley et al., 1995). The WB itself recognised these limitations (WB, 1997c, 1998, 2005b), which explains why it has focused more on non-coercive influence. This study shows that the influence of the WB on Croatian healthcare financing policies has not been exercised through the use of strict conditionalities, but largely through non-coercive means. The WB relied heavily on policy advice, dialogue and persuasion to build consensus with different Croatian governments, which for the most part followed and implemented WB's recommendations in healthcare financing. When consensus between the WB and the government was not possible, the WB was willing to accept policies which fell short of its preference, either

because it believed that the government's proposals were sound or because it believed that it would be able to persuade governments in the future. In this way, the WB was able to stay continuously involved in the reform game, offer new loans and ensure long-term influence on healthcare policy in Croatia.

To conclude, the healthcare policy making process and healthcare financing changes in Croatia cannot be explained without considering the influence of IOs. In healthcare financing policy, WB was by far the most important IO, taking the leading role in shaping healthcare financing policy, while the WHO and IMF played a secondary role. To shape healthcare financing policy, the WB relied on coercive and, above all, non-coercive means. By using non-coercive means of influence, the WB was able to introduce new policy ideas for the government to consider, thereby influencing its agenda. Coercion, was limited because the WB did not impose strict conditionalities. In order to stay in the reform game and establish a long-term influence on Croatian healthcare, the WB often adjusted its position according to the developments in the country. In other words, the WB did not act as a hegemon trying to unilaterally shape the healthcare financing policy. This left room for Croatia to introduce policies that were not in line with the WB's prescriptions. Thus, the chapter shows that even a vulnerable country like Croatia was able to resist policy preferences of a powerful IO such as the WB, at least in the case of healthcare financing policy.

5. References

Literature

Ágh, A. (1998). *The politics of Central Europe*. London: SAGE Publications Ltd.

Aina, T., Chachage, C., & Annan-Yao, E. (2004). *Globalisation and social policy in Africa*. CODESRIA.

Barnett, M., & Finnemore, M. (2004). *Rules for the World: International Organizations in Global Politics*. Cornell University Press.

Batley, R. (2004). The politics of service delivery reform. *Development and Change, 35*(1), 31– 56.

Bazbauers, A. R. (2018). *The World Bank and Transferring Development*. Springer.

Bebek, S., & Santini, G. (2013) Hrvatska kao članica Europske Unije: Put u (Ne)poznatu Budućnost [Croatia as European Union member: Road to (Un)familiar future]. *Ekonomija* 20(1): 1-28.

Béland, D., & Orenstein, M. A. (2013). International organizations as policy actors: An ideational approach. *Global Social Policy, 13*(2), 125-143. https://doi.org/10.1177/1468018113484608

Bičanić, I., & Franičević, V. (2003). *Understanding reform: The case of Croatia* (GDN/WIIW Working Paper). https://wiiw.ac.at/understanding-reform-the-case-of-croatia-dlp-3287.pdf

Cerami, A. (2005). *Social policy in Central and Eastern Europe: The emergence of a new European welfare regime*. [Doctoral dissertation, Universität Erfurt]. Electronic Text Center der Universitäts- und Forschungsbibliothek Erfurt/Gotha.

Chen, M., & Mastilica, M. (1998). Health care reform in Croatia: For better or for worse? *American Journal of Public Health, 88*(8), 1156–1160.

Collins, C., Green, A., & Hunter, D. (1999). Health sector reform and the interpretation of policy context. *Health Policy, 47*(1), 69–83.

Dahl, R. A. (1957). The concept of power. *Behavioral Science, 2*(3), 201–215.

Davis, C. (2010). Understanding the legacy: Health financing systems in the USSR and central and eastern Europe prior to transition. In J. Kutzin, C. Cashin, & M. Jakab (Eds.), *Implementing health financing reform* (pp. 25–63). World Health Organization, on behalf of the European Observatory on Health Systems and Policies.

Deacon, B. (2000). Globalization and social policy: The threat to equitable welfare (Geneva 2000 Occasional Paper No. 5). United Nations Research Institute for Social Development (UNRISD), Geneva. (Working Paper).

Deacon, B. (2007). *Global Social Policy and Governance*. Sage.

Deacon, B., Hulse, M., & Stubbs, P. (1997). *Global Social Policy: International Organizations and the Future of Welfare*. Sage.

Deacon, B., Lendvai, N., & Stubbs, P. (2007). Conclusions. In B. Deacon & P. Stubbs (Eds.), *Social Policy and International Interventions in South East Europe* (pp. 221–243). Edward Elgar.

Deppe, H.-U., & Oreskovic, S. (1996). Back to Europe: Back to Bismarck? *International Journal of Health Services*, *26*(4), 777–802. https://doi.org/10.2190/G36U-BC5G-J71G-PY00

Dolowitz, D. P., & Marsh, D. (2000). Learning from abroad: The role of policy transfer in contemporary policy-making. *Governance, 13*(1), 5–23. https://doi.org/10.1111/0952-1895.00121

Džakula, A., Sagan, A., Pavić, N., Lončarek, K., & Sekelj-Kauzlarić, K. (2014). *Croatia: Health System Review*. World Health Organization. Regional Office for Europe.

Džakula, A., Šogorić, S., & Vončina, L. (2012). Decentralization in Croatia's health system. In Bartlett, W., Bozikov, J., Rechel, B., et al. (Eds.), *Health Reforms in South East Europe* (pp. 64–75). Palgrave Macmillan.

Džakula, A., Vočanec, D., Banadinović, M., Vajagić, M., Lončarek, K., Lukačević Lovrenčić, I., Radin, D., & Rechel, B. (2021). Croatia: health system review 2021. *Health Systems in Transition, 23*(2).

Easterly, W. (2003). IMF and World Bank Structural Adjustment Programs and Poverty. In *Managing Currency Crises in Emerging Markets* (pp. 361–391). National Bureau of Economic Research, Inc.

Haas, P. (1992). Introduction: Epistemic communities and international policy coordination. *International Organization, 46*(1), 1–35.

Hall, P. A. (1993). Policy Paradigms, Social Learning, and the State: The Case of Economic Policymaking in Britain. *Comparative Politics*, *25*(3), 275–296. https://doi.org/10.2307/422246

Hebrang, A. (1994). Reorganization of the Croatian health system. *Croatian Medical Journal, 35*(3), 130-136.

Hebrang, A. (2015). *Hrvatski sanitet tijekom srpsko-crnogorske agresije na Republiku Hrvatsku 1990–1995* [Croatian Medical Corps During the Serbian-Montenegrin Aggression on the Republic of Croatia 1990–1995]. Medicinska naklada: Udruga hrvatskih liječnika dragovoljaca 1990–1991.

Heneghan, M., & Orenstein, M. A. (2019). Organizing for impact: International organizations and global pension policy. *Global Social Policy, 19*(1-2), 65-86. https://doi.org/10.1177/1468018119834730

Himmelstein, D. U., Lang, S., & Woolhandler, S. (1984). The Yugoslav Health System: Public Ownership and Local Control. *Journal of Public Health Policy*, *5*(3), 423–431. https://doi.org/10.2307/3342166

Hrvatska Narodna Banka. (2015). *Međunarodni monetarni fond*. https://www.hnb.hr/temeljne-funkcije/medunarodni-odnosi/medunarodni-monetarni-fond

Jacoby, W. (2004). *The enlargement of the European Union and NATO: Ordering from the menu in Central Europe*. Cambridge University Press.

Kaasch, A. (2015). *Shaping global health policy: Global social policy actors and ideas about healthcare systems*. Palgrave Macmillan.

Kaminska, M. E. (2022). Variations on Bismarck: Translations of Social Health Insurance in Post-Communist Healthcare Reforms in Central and Eastern Europe—The Role of Vertical and Horizontal Interdependencies. In F. Nullmeier, D. González de Reufels, & H. Obinger (Eds.), *International Impacts on Social Policy: Short Histories in Global Perspective* (pp. 449–462). Palgrave Macmillan. https://doi.org/10.1007/978-3-030-86645-7_35

Kaminska, M. E., Druga, E., Stupele, L., & Malinar, A. (2021). Changing the healthcare financing paradigm: Domestic actors and international organizations in the agenda setting for diffusion of social health insurance in post-communist Central and Eastern Europe. *Social Policy & Administration*, *55*(6), 1066–1081. https://doi.org/10.1111/spol.12724

Kelley, J. (2004). International Actors on the Domestic Scene: Membership Conditionality and Socialization by International Institutions. *International Organization, 58*(3), 425–457. doi:10.1017/S0020818304583017

Killick, T. (1998). *Aid and the Political Economy of Policy Change*. Routledge.

Klein, R. (1997). Learning from Others: Shall the Last be the First? *Journal of Health Politics, Policy and Law, 22*(5), 1267–1278.

Kovačić, L., & Šošić, Z. (1998). Organization of Health Care in Croatia: Needs and Priorities. *Croatian Medical Journal, 39*(3), 249–255.

Kuhlmann, J., González de Reufels, D., Schlichte, K., & Nullmeier, F. (2020). How social policy travels: A refined model of diffusion. *Global Social Policy, 20*(1), 80-96. https://doi.org/10.1177/1468018119888443

Kutzin, J., Cashin, C., & Jakab, M. (2010). *Implementing Health Financing Reform: Lessons from Countries in Transition*. World Health Organization Regional Office for Europe, on behalf of the European Observatory on Health Systems and Policies.

Larmour, P. (2002). Conditionality, coercion and other forms of 'power': International financial institutions in the Pacific. *Public Administration and Development, 22*(3), 249–260.

Laurell, A. C., & Arellano, O. L. (1996). Market commodities and poor relief: The World Bank proposal for health. *International Journal of Health Services, 26*(1), 1–18.

Lehrer, D., & Korhonen, A. (2004). Postcommunist aid negotiation: a review of recent research. *Cambridge Review of International Affairs, 17*(3), 593-616. DOI: 10.1080/0955757042000298192

Letica, S. (2006). Teorijski osvrt na Prijedlog nacionalne strategije razvoja zdravstva i "paket" predloženih zakona o zdravstvenom osiguranju [Theoretical overview of the proposed National Health Development Strategy and the "package" of bills on health insurance]. *Hrvatski Časopis za javno zdravstvo, 2* (7). Available at: https://hrcak.srce.hr/file/431564

Lukes, S. (2005). *Power: A Radical View*. Palgrave Macmillan.

Malinar, A. (2022). Anti-communist Backlash in the Croatian Healthcare System. In J. Kuhlmann & F. Nullmeier (Eds.), *Causal Mechanisms in the Global Development of Social Policies* (pp. 239-270). Palgrave Macmillan. https://doi.org/10.1007/978-3-030-91088-4₈

Mosley, P., Harrigan, J., & Toye, J. (1995). *Aid and Power: The World Bank and Policy-Based Lending*. Routledge.

Müller, K. (1999). *The political economy of pension reform in Central-Eastern Europe*. Edward Elgar.

Nemec, J., & Kolisnichenko, N. (2006). Market-based Health Care Reforms in Central and Eastern Europe: Lessons after Ten Years of Change. *International Review of Administrative Sciences, 72*(1), 11–26.

Nemec, J., & Lawson, C. (2008). Health Care Reforms in CEE: Processes, Outcomes and Selected Explanations. *NISPAcee Yearbook, 1*, 27–50.

Noy, S. (2017). *Banking on Health: The World Bank and Health Sector Reform in Latin America.* Palgrave Macmillan.

Noy, S. (2018). Healthy targets? World Bank projects and targeted health programmes and policies in Costa Rica, Argentina, and Peru, 1980–2005. *Oxford Development Studies, 46*(2), 164-183. https://doi.org/10.1080/13600818.2017.1346068

Obinger, H., Schmitt, C., & Starke, P. (2013). Policy diffusion and policy transfer in comparative welfare state research. *Social Policy & Administration, 47*(1), 111-129. https://doi.org/10.1111/j.1467-9515.2011.00843.x

Odling-Smee, J. (2006). The IMF and Russia in the 1990s. *IMF Staff Papers, 53*(1), 151–194.

Orenstein, M. A. (2000). How Politics and Institutions Affect Pension Reform in Three Postcommunist Countries (SSRN Scholarly Paper 630682). https://papers.ssrn.com/abstract=630682

Orenstein, M. A. (2008). *Privatizing Pensions: The Transnational Campaign for Social Security Reform*. Princeton University Press.

Paloni, A., & Zanardi, M. (2006). Introduction and overview. In: Paloni, A., & Zanardi, M. (Eds.), *The IMF, World Bank and Policy Reform* (pp. 1–23). Routledge.

Parmelee, Donna E. (1985). Whither the State in Yugoslav Health Care? *Social Science & Medicine, 21*(7), 719–728.

Puljiz V., Bežovan G., Matković T., et al. (2008) *Socijalna politika Hrvatske* [Croatian Social Policy]. Pravni fakultet Sveučilišta u Zagrebu.

Puljiz, V. (2005). Croatia: searching for a new social model. In S. Kuhnle (Ed.), *Social Policy Development in South Eastern Europe: Outside Influences and Domestic Forces* (pp. 79-92). Stein Rokkan Centre for Social Studies.

Radin, D. (2003). The impact of the World Bank on health care reform in transitional economies. *Politička misao, 40*, 30–51.

Radin, D. (2008). World Bank funding and health care sector performance in Central and Eastern Europe. *International Political Science Review, 29*(3), 325–347.

Ramet, S. P. (2010). *Central and Southeast European Politics since 1989*. Cambridge University Press.

Ramet, S. P. (2013). Croatian Politics since 1990. In R. Lukić, S. P. Ramet, & K. Clewing (Eds.), *Hrvatska od osamostaljenja: Rat, politika, društvo, vanjski odnosi* (pp. 33-59). Golden marketing-Tehnička knjiga.

Rechel, B., & McKee, M. (2009). Health reform in central and eastern Europe and the former Soviet Union. *The Lancet, 374*, 1186–1195.

Roberts, A. (2009). The politics of healthcare reform in Postcommunist Europe: The importance of access. *Journal of Public Policy, 29*, 305–325. https://doi.org/10.1017/S0143814X09990110

Robertson, D. B. (1991). Political Conflict and Lesson-Drawing. *Journal of Public Policy, 11*(1), 55–78. doi:10.1017/S0143814X00004931

Šarić, M., & Rodwin, V.G. (1993). The once and future health system in the former Yugoslavia: Myths and realities. *Journal of Public Health Policy, 14*(2), 220–237.

Ruger, J. P., & Yach, D. (2009). The Global Role of the World Health Organization. *Global health governance: The scholarly journal for the new health security paradigm, 2*(2), 1–11.

Sitek, M. (2008). Politics and Institutions in the Reforms of Health Care in the Czech Republic, Hungary and Poland. *Polish Sociological Review, 1*(161), 39–53.

Staines, V. S. (1999). *A health sector strategy for the Europe and Central Asia region.* Health, nutrition, and population series. World Bank Group. http://documents.worldbank.org/curated/en/476421468771112126/A-health-sector-strategy-for-the-Europe-and-Central-Asia-region

Stone, D., De Oliveira, O. P., & Pal, L. A. (2020). Transnational policy transfer: The circulation of ideas, power, and development models. *Policy and Society, 39*(1), 1–18. https://doi.org/10.1080/14494035.2019.1619325

Stubbs, P., & Zrinščak, S. (2007). Croatia. In Deacon, B., & Stubbs, P. (Eds.), *Social Policy and International Interventions in South East Europe* (pp. 85–103). Edward Elgar.

Stuckler, D., & Basu, S. (2009). The International Monetary Fund's effects on global health: before and after the 2008 financial crisis. *International Journal of Health Services, 39*(4), 771–781.

Tichenor, M., & Sridhar, D. (2017). Universal health coverage, health systems strengthening, and the World Bank. *BMJ, 358*, j3347.

Vehovec, M., Rašić Bakarić, I., & Slijepčević, S. (2016). Bolnice pred poslovnim izazovima restrukturiranja [Hospitals facing the business challenges of restructuring]. In Vehovec, M. (Ed.), *O zdravstvu iz ekonomske perspective* (pp. 167 – 201). Ekonomski institut.

Vončina, L., Kehler, J., Evetovits, T., & Bagat, M. (2010). Health Insurance in Croatia: Dynamics and Politics of Balancing Revenues and Expenditures. *The European Journal of Health Economics* 11(2): 227–233.

Vončina, L., Arur, A., Dorčić, F., & Pezelj-Duliba, D. (2018). Universal Health Coverage in Croatia: Reforms to Revitalize Primary Health Care (Universal Health Coverage Studies Series; No. 29). World Bank. http://hdl.handle.net/10986/29181

Vončina, L., Džakula, A., & Mastilica, M. (2007). Health care funding reforms in Croatia: A case of mistaken priorities. *Health Policy, 80*(1), 144–157.

Weyland, K. G. (2006). *Bounded Rationality and Policy Diffusion: Social Sector Reform in Latin America*. Princeton University Press.

Wireko, I., & Béland, D. (2017). Transnational actors and health care reform: Why international organizations initially opposed, and later supported, social health insurance in Ghana. *International Journal of Social Welfare, 26*(4), 405–415.

Woods, N. (2006). *The Globalisers: The IMF, the World Bank, and Their Borrowers*. Cornell University Press.

World Bank. (1997c). *Health, Nutrition and Population Sector Strategy*. World Bank.

World Bank. (1998). *Assessing Aid: What Works, What Doesn't, and Why*. World Bank.

World Bank. (2005b). *Conditionality Revisited: Concepts, Experiences, and Lessons Learned*. World Bank.

World Bank. (2007b). *Healthy Development: The World Bank Strategy for Health, Nutrition, and Population Results*. World Bank.

World Bank. (2024). World Bank Publications on Croatia between 1990 and 1995. https://documents.worldbank.org/en/publication/documents-reports/documentlist?keyword_select=allwords&srt=docdt&order=asc&qterm=Croatia&lla n_exact=&strdate=01-01-1990&enddate=12-31-1995&count_exact=Croatia

World Health Organization. (1999). *Health Care Systems in Transition: Croatia.* World Health Organization Regional Office for Europe.

Žižmond, E. (1992). The Collapse of the Yugoslav Economy. *Soviet Studies, 44*(1), 101–112.

Zrinščak, S. (2007). *Zdravstvena politika Hrvatske. U vrtlogu reformi i suvremenih društvenih izazova* [Croatian health policy. In the whirlwind of reforms and contemporary social challenges]. *Revija za socijalnu politiku, 14*(2), 193–220.

Government documents

Croatian Government. (2000). *Program Rada Vlade Republike Hrvatske Za Razdoblje 2000 – 2004 Godine* [Programme of the Government of the Republic of Croatia for the Period 2000 – 2004]. Zagreb: Croatian Government.

Croatian Government. (2001). *Zajedničko pismo prema MMF-u* [Joint letter to the IMF]. Croatian Government.

Croatian Government. (2002). *Government letter of intent to Mr. Horst Kohler, general director of the IMF*. Croatian Government.

Croatian Government. (2004). *Letter of Intent, Memorandum of Economic and Financial Policies, and Technical Memorandum of Understanding*. Croatian Government.

Croatian Government. (2012). Nacionalna Strategija Razvoja Zdravstva 2012.-2020. [National Strategy for Healthcare System Development]. Croatian Government.

Croatian Ministry of Health. (2000). Reforma zdravstva: Strategija i plan reforme sustava zdravstva i zdravstvenog osiguranja Republike Hrvatske [Health care reform: Strategy and plan for the reform of the health care and health insurance system of the Republic of Croatia]. Croatian Ministry of Health.

Croatian Ministry of Health. (2003). *Report on The State of Health Reform (2000 - 2003)*. Croatian Ministry of Health.

Croatian Ministry of Health and World Bank. (2000). The reform of health care in Croatia. *Revija za socijalnu politiku* 7(3): 311–325.

Croatian Office for Development Strategy. (2002). *Hrvatska u 21. stoljeću: Zdravstvo* [Croatia in the 21st Century: Healthcare]. Tonimir d.o.o.

Legal acts

Croatian Parliament. (2002). Odluka o vrsti i cijeni police dopunskog zdravstvenog osiguranja [Decision on the type and price of the complementary health insurance policy]. *Narodne Novine* 47, 1–3.

Croatian Parliament. (2006). Nacionalna strategija razvitka zdravstva 2006. – 2011 [National strategy of healthcare development]. *Narodne Novine* 72, 1–43.

Croatian Parliament. (2008). Odluka o proglašenju zakona o doprinosima [Decision on promulgation of the law on contributions]. *Narodne Novine* 84, 1–43.

Newspaper articles

Đuretek, D., Kovač, B., & Šarić, M. (2001, October 19). Zdravstvena usluga bit će skuplja, ali ne i bolja [Healthcare service will be more expensive, but not better]. *Večernji list*, 6.

Hina. (2013, August 23). Cijena police HZZO-ova dopunskog osiguranja vjerojatno 70 kuna mjesečno [The price of the HZZO complementary insurance policy will probably be HRK 70 per month]. *Hina*.

Klepo, M. (2019, May 9). Bivši ministar Varga: Najuspješniji je bio model plaćanja bolnicama po izvršenju poslova [Former Minister Varga: The most successful was the model of payment to hospitals upon completion of work]. *Jutarnji list*. Available at: https://novac.jutarnji.hr/novac/novcanik/bivsi-ministar-varga-najuspjesniji-je-bio-model-placanja-bolnicama-po-izvrsenju-poslova-8843264

Laušić, F. (2019, April 20). Država dosad utrošila 17,7 milijardi kuna, a dug ne pada ispod 8 milijardi [The state has spent HRK 17.7 billion so far, but the debt does not fall below HRK 8 billion]. *Jutarnji list*. Available at: https://novac.jutarnji.hr/novac/aktualno/drzava-dosad-utrosila-177-milijardi-kuna-a-dug-ne-pada-ispod-8-milijardi-8801954

Lovrić, B. (2008, November 6). Predstavljen prijedlog reforme zdravstvenog sustava [A proposal for the reform of the health care system was presented]. *Vjesnik*. Available at: https://www.dugirat.com/novosti/121-zdravlje/7849-Predstavljen-prijedlog-reforme-zdravstvenog-sustava-v15-7849

Međugorac, I. (2020, November 17). Hebrang potpuno iskreno: Evo zašto sam privatno obavio dijagnostiku! Rješenje za zdravstvo je jedno, sve ostalo su iluzije! [Hebrang completely honest: This is why I did the diagnosis privately! There is only one solution for healthcare system, all the rest are illusions!]. *Dnevno.hr*. Available at: https://www.dnevno.hr/vijesti/hebrang-potpuno-iskreno-evo-zasto-sam-privatno-obavio-dijagnostiku-rjesenje-za-zdravstvo-je-jedno-sve-ostalo-su-iluzije-1607421/

Mišlov, Z. (2007, January 24). Liječnici kao TV inkasatori [Doctors as TV subscription controllers]. *Slobodna Dalmacija*. Available at: http://haw.nsk.hr/arhiva/vol1/7/13021/www.slobodnadalmacija.hr/20070124/tribina01.asp.html

Rebić, G. (2002, May 21). Mnogi nemaju 50 kuna mjesečno za zdravlje [Many do not have 50 kuna a month for health]. *Večernji list*. Available at: *https://www.vecernji.hr/zagreb/mnogi-nemaju-50-kuna-mjesecno-za-zdravlje-716705*

Tadin, A., & Lovrić, B. (2005, October 4). Zbog 30 kuna negoduju i pacijenti i liječnici [Due to HRK 30, both patients and doctors are outraged]. *Vjesnik.*

Večernji list (2001, October 18). Reforma zdravstvenog osiguranja – o čemu se ne govori [Reform of Health Insurance – What is not talked about]. *Večernji list*. Available at: *https://www.vecernji.hr/vijesti/reforma-zdravstvenoga-osiguranja-o-cemu-se-ne-govori-701248*

Večernji list (2003, September 17). Gospodo, nismo krave muzare [Gentlemen, we are not milking cows]. *Večernji list*. Available at: *https://www.vecernji.hr/vijesti/gospodo-nismo-krave-muzare-741970*

Vjesnik (2005, October 13). Najsiromašnijima povrat novca od pristojbe [The poorest who pay administrative fee will get their money back]. *Vjesnik*.

IO documents

International Monetary Fund. (2000). *Republic of Croatia: Selected Issues and Statistical Appendix* (IMF Staff Country Report No. 00/22). International Monetary Fund.

International Monetary Fund. (2001). *Prvo preispitivanje stand-by aranžmana* [First Review of the Stand-By Arrangement]. International Monetary Fund.

International Monetary Fund. (2002a). *Republic of Croatia: 2002 Article IV Consultation-Staff Report; Staff Statement; Public Information Notice on the Executive Board Discussion; and Statement by the Executive Director for the Republic of Croatia* (IMF Country Report No. 02(178)). International Monetary Fund.

International Monetary Fund. (2002b). *Republika Hrvatska – Drugo preispitivanje u okviru stand-by aranžmana I zahtjev za odgodu ispunjenja kriterija za ocjenu uspješnosti izvršenja programa I izmjenu jednog kriterija za ocjenu uspješnosti – Izvješće misije; Izjava misije; Priopćenje za javnost o raspravi Izvršnog odbora; te izjava Izvršnog direktora za Republiku Hrvatsku* [Republic of Croatia – Second Review Under the Stand-by Arrangement and Request for Postponement of Fulfillment of the Criteria for Evaluating the Success of Program Implementation and Change of One Criterion for Evaluation of Success – Mission Report; Mission Statement; Press Release on the Executive Board Discussion; and the Statement of the Executive Director for the Republic of Croatia] (IMF Country report no. 02/76, 29 November). International Monetary Fund.

International Monetary Fund. (2003). MMF je odobrio Hrvatskoj 146 milijuna dolara vrijedan stand-by kredit na razdoblje od 14 mjeseci [The IMF granted Croatia a stand-by loan worth 146 million dollars for a period of 14 months]. International Monetary Fund.

International Monetary Fund. (2004). Republic of Croatia: 2004 Article IV Consultation and Request for Stand-By Arrangement—Staff Report; Public Information Notice and Press Release on the Executive Board Discussion; and Statement by the Executive Director for the Republic of Croatia. IMF Country Report No. 04/253. International Monetary Fund.

World Bank. (1994). *Croatia - Emergency Reconstruction Project*. Report No. P-6360-HR, 27 May. World Bank.

World Bank. (1995). *Memorandum and Recommendation of the President of the International Bank for Reconstruction and Development to the Executive Directors on a Proposed Loan in an Amount Equivalent To US$40.0 Million to Republic of Croatia for a Health Project*. Report No. P-6480-HR. World Bank.

World Bank. (1997a). *Croatia beyond stabilization*. Report No. 17261. World Bank.

World Bank. (1997b). Financiranje javnog sektora, reforma zdravstva i mirovinska reforma u Hrvatskoj [Public sector financing, health care reform and pension reform in Croatia]. *Revija za socijalnu politiku* 4(3): 265–285.

World Bank. (1999). Conformed Copy - L4513 - Health System Project - Loan Agreement. Report No. 4513 HR World Bank. http://documents.worldbank.org/curated/en/965011468247827375/Conformed-Copy-L4513-Health-System-Project-Loan-Agreement

World Bank. (2000a). *Croatia: A Policy Agenda for Reform and Growth*. World Bank.

World Bank. (2000b). *Croatia - Health Project. Implementation Completion and Results Report. Report No. 20336.* World Bank.

World Bank. (2001a). *Croatia economic vulnerability and welfare study*. Report No. 22079-HR, 18 April. World Bank.

World Bank. (2001b). *Croatia regaining fiscal sustainability and enhancing effectiveness: A public expenditure and institutional review*. World Bank. https://openknowledge.worldbank.org/handle/10986/13993

World Bank. (2001c). *Loan Agreement (Structural Adjustment Loan) Between Republic of Croatia and International Bank for Reconstruction and Development*. Loan Number 4641 HR. World Bank.

World Bank. (2001d). *Report and recommendation of the President of the International Bank for Reconstruction and Development to the Executive Directors on a proposed structural adjustment loan in the amount of US$202 million to the Republic of Croatia*. Report No. P7490-HR, 26 October. World Bank.

World Bank. (2004). *Croatia: Health Finance Study*. World Bank.

World Bank. (2005a). *Croatia - Programmatic Adjustment Loan: Croatia - Programmatic Adjustment Loan Project (English).* Report No. 30293-HR. World Bank. http://documents.worldbank.org/curated/en/692461468025814288/Croatia-Programmatic-Adjustment-Loan-Project

World Bank. (2006). *Croatia - Health System Project (English). Implementation Completion and Results Report.* Report No. 36436. World Bank. http://documents.worldbank.org/curated/en/352341468026398038/Croatia-Health-System-Project

World Bank. (2007a). Croatia - Second Programmatic Adjustment Loan (English). Report No. 39392-HR. World Bank. http://documents.worldbank.org/curated/en/450581468248374738/Croatia-Second-Programmatic-Adjustment-Loan

World Bank. (2007c). *Loan Agreement L7450-HR Conformed (English).* World Bank. http://documents.worldbank.org/curated/en/953651468247284951/Loan-Agreement-L7450-HR-Conformed

World Bank. (2008). *Croatia - Restructuring public finance to sustain growth and improve public services: a public finance review (English).* Public expenditure review (PER). Report No. 37321-HR. World Bank. http://documents.worldbank.org/curated/en/156871468026677139/Croatia-Restructuring-public-finance-to-sustain-growth-and-improve-public-services-a-public-finance-review

World Bank. (2009a). *Croatia - First and Second Programmatic Adjustment Loan Project (English). Implementation Completion and Results Report.* Report No. ICR00001052. World Bank.

http://documents.worldbank.org/curated/en/243821468025814045/Croatia-First-and-Second-Programmatic-Adjustment-Loan-Project

World Bank. (2009b). *Croatia - Fiscal, Social, and Financial Sector Development Policy Loan Program (English).* Report No. 51174-HR. World Bank. http://documents.worldbank.org/curated/en/755301468026656987/Croatia-Fiscal-Social-and-Financial-Sector-Development-Policy-Loan-Program

World Bank. (2009c). *Croatia - Croatia Programmatic Adjustment Loan (English).* Report No. ICRR13247. World Bank. http://documents.worldbank.org/curated/en/461851474397983045/Croatia-Croatia-Programmatic-Adjustment-Loan

World Bank. (2010). *Croatia - Fiscal, Social, and Financial Sector Development Policy Loan Project (English). Implementation Completion and Results Report.* Report No: ICR00001496. World Bank. http://documents.worldbank.org/curated/en/504701468028843964/Croatia-Fiscal-Social-and-Financial-Sector-Development-Policy-Loan-Project

World Bank. (2011a). *Croatia - Economic Recovery Development Policy Loan Program (English).* Report No. 58226-HR World Bank. http://documents.worldbank.org/curated/en/289611468261567700/Croatia-Economic- Recovery-Development-Policy-Loan-Program

World Bank. (2011b). *Loan Agreement for Loan 8063-HR Conformed (English).* World Bank. http://documents.worldbank.org/curated/en/499151468260092113/Loan-Agreement-for-Loan-8063-HR-Conformed

World Bank. (2012). *Croatia - Policy notes: a strategy for smart, sustainable and inclusive growth (English).* Report No. 66673-HR. World Bank. http://documents.worldbank.org/curated/en/996751468246610844/Croatia-Policy-notes-a-strategy-for-smart-sustainable-and-inclusive-growth

World Bank. (2014a). *Croatia - Improving Quality and Efficiency of Health Services Project (English).* Report No. 83881-HR. World Bank. http://documents.worldbank.org/curated/en/469211468026657207/Croatia-Improving-Quality-and-Efficiency-of-Health-Services-Project

World Bank. (2014b). *Croatia - Public finance review: restructuring spending for stability and growth (English).* Public Expenditure Review (PER). Report No. 78320-HR. World Bank. http://documents.worldbank.org/curated/en/532211468245997938/Croatia-Public-finance-review-restructuring-spending-for-stability-and-growth

World Bank. (2015). *Croatia - Economic Recovery Development Policy Loan (ERDPL) Project (English). Implementation Completion and Results Report.* Report No. ICR00003565. World Bank.

http://documents.worldbank.org/curated/en/398671467987855299/Croatia-Economic-Recovery-Development-Policy-Loan-ERDPL-Project

World Bank. (2016). *Croatia policy notes 2016: restoring macroeconomic stability, competitiveness and inclusion (English).* World Bank. http://documents.worldbank.org/curated/en/876601468000628285/Croatia-policy-notes-2016-restoring-macroeconomic-stability-competitiveness-and-inclusion

World Bank. (2020). *Croatia - Improving Quality and Efficiency of Health Services Project (English). Implementation Completion and Results Report.* Report No. ICR00004883. World Bank.

http://documents.worldbank.org/curated/en/548561605538619135/Croatia-Improving-Quality-and-Efficiency-of-Health-Services-Project

4. Paper D: International organisations as policy bricoleurs: An analysis of the World Bank's healthcare financing recommendations for Argentina and Croatia

Contemporary Politics

ISSN: (Print) (Online) Journal homepage: www.tandfonline.com/journals/ccpo20

International organisations as policy bricoleurs: An analysis of the World Bank's healthcare financing recommendations for Argentina and Croatia

Ante Malinar & Gabriela de Carvalho

To cite this article: Ante Malinar & Gabriela de Carvalho (18 Feb 2024): International organisations as policy bricoleurs: An analysis of the World Bank's healthcare financing recommendations for Argentina and Croatia, Contemporary Politics, DOI: 10.1080/13569775.2024.2314217

To link to this article: https://doi.org/10.1080/13569775.2024.2314217

Published online: 18 Feb 2024.

CONTEMPORARY POLITICS
https://doi.org/10.1080/13569775.2024.2314217

International organisations as policy bricoleurs: An analysis of the World Bank's healthcare financing recommendations for Argentina and Croatia

Ante Malinar [a] and Gabriela de Carvalho [b]

[a]Bremen International Graduate School of Social Sciences (BIGSSS), University of Bremen, Bremen, Germany; [b]SOCIUM Research Center on Inequality and Social Policy, University of Bremen, Bremen, Germany

ABSTRACT

This article analyses how the World Bank formulates healthcare financing recommendations by examining the cases of Argentina and Croatia, two representative cases of socio-political transformations in Latin America and Central and Eastern Europe during the Washington (1987–1997) and post-Washington Consensus (1997–2007) periods. It argues that when formulating recommendations, the World Bank is involved in the process of *policy bricolage*, defined as a process in which policy actors draw on multiple sources of knowledge and information to piece together contextualised policy solutions instead of relying on textbook blueprints or predefined solutions. By conducting a document analysis of World Bank publications, our findings suggest that, in formulating healthcare financing recommendations, the organisation does not dogmatically follow a particular policy paradigm. Instead, it contextualises and recombines existing ideas to tailor recommendations to country-specific conditions, namely economic and political circumstances, as well as healthcare system performance.

ARTICLE HISTORY
Received 3 June 2023
Accepted 30 January 2024

KEYWORDS
Healthcare financing; International organisations; World Bank; Policy bricolage; Argentina; Croatia

1. Introduction

Healthcare financing policy, although it is adopted and implemented within state boundaries, is a matter of global concern: Healthcare financing is a core functional dimension of healthcare systems, and it greatly influences the extent of coverage and financial protection (Frisina Doetter et al., 2021; World Health Organization [WHO], n.d.). Healthcare (financing), therefore, is considered a global matter, increasingly impacted by international organisations (IOs). Notably, the World Bank (WB) has become the greatest lender in healthcare policy and one of the most influential actors over the last five decades (Deacon, 2007; Kaasch, 2015). In line with global social policy research, IOs are regarded as key and legitimate sources of advice for national health policymaking

CONTACT Ante Malinar malinar@uni-bremen.de Bremen International Graduate School of Social Sciences (BIGSSS), University of Bremen, Mary-Somerville-Straße 9, 28359 Bremen, Germany

(Niemann et al., 2021). One of the main instruments IOs use to shape domestic policies is recommendations, which entail ideas, normative standards, and practical models of desirable forms of social policies (Deacon, 2007; Schmitt, 2020).

Unlike pension policy, where the WB had a defined reform blueprint (Orenstein, 2008), there is limited understanding of the WB's preferences for healthcare financing reform. Moreover, the process of how the WB formulates the content of healthcare financing recommendations is not entirely clear. Does the WB provide healthcare financing policy advice based on top-down, one-size-fits-all solutions? Or does the WB adjust general, established blueprints in view of concrete national conditions? Several studies touch on this topic, but none specifically address it. Although some scholars have argued that the WB favoured a Social Health Insurance (SHI) model in Central and Eastern Europe (CEE) (Cerami, 2006; Nemec & Lawson, 2008), recent literature suggests otherwise (Kaminska et al., 2021). Similarly, studies on Latin America have revealed that the WB did not offer a clearly defined healthcare reform plan for different countries (Noy, 2017; Weyland, 2006). Furthermore, some argue that the WB often disregarded specific national conditions (Nemec & Kolisnichenko, 2006), while others indicate that it does take them into account (Noy, 2017; Weyland, 2006; Wireko & Béland, 2017).

Following the latter line of thought, this paper argues that the WB formulates healthcare financing recommendations by reinterpreting prevailing policy paradigms in the light of national conditions in a process labelled *policy bricolage*. To investigate this process, the paper analyses the WB's healthcare financing recommendations in Argentina and Croatia and focuses on the period between 1987 and 2007. During this time, the WB was influenced by two prominent paradigms, the Washington Consensus (WC) (1987–1997) and the post-Washington Consensus (post-WC) (1997–2007). These two paradigms represented significant shifts in the WB's healthcare priorities and were influential worldwide.

Argentina and Croatia are representative cases for the socio-political transformations experienced in Latin America and Central and Eastern Europe during the observation period (Misztal, 1992; Vidučić, 2000). Both countries shared a preceding statist regime (rightist military dictatorship in Argentina and communism in Croatia) and their transition to democracy and a market economy was marked by wide-ranging reforms as well as the involvement of the WB in social reforms, including healthcare financing (Misztal, 1992; Noy, 2017; Radin, 2008; Weyland, 2006). Clearly, both countires underwent numerous significant changes throughout the observed period, thus making them good cases for investigating how the WB responds to continually evolving national conditions.

By means of a dual twofold comparison (Argentina vs. Croatia, WC vs. post-WC periods), this article aims to provide a better understanding of IOs' healthcare policy recommendation making in middle-income countries that experienced significant changes during the period of observation in terms of social, political and economic contexts. Moreover, the article introduces a novel analytical framework for assessing policy bricolage in IOs' policy recommendation making. Consequently, it makes valuable contributions to the literature on global social policy and policy bricolage.

The following section provides theoretical background and presents an analytical framework to examine policy bricolage in healthcare policy recommendation making. The third section describes the data used in this research and the data collection and analysis processes. The subsequent empirical sections present national conditions, map WB healthcare financing recommendations in Argentina and Croatia and analyse

whether and how the WB acted as a policy bricoleur. Finally, discussions and conclusions of the study are presented.

2. The WB as a policy bricoleur

The analytical framework of this paper derives from the concept of bricolage, an 'innovative recombination of elements that constitutes a new way of configuring organisations, social movements, institutions, and other forms of social activity' (Campbell, 2005, p. 56). Policy bricolage embodies an evolutionary process where certain policy elements undergo change while others remain unchanged. In this process, policy bricoleur plays a crucial role (Carstensen, 2011). It is a policy actor who takes stock of an 'existing set of ideas, policies, and instruments and reinterprets them in the light of concrete circumstances' (Carstensen, 2011, pp. 155–156). Bricoleurs are, above all else, flexible and pragmatic. They use and combine ideas to make them work within a specific context. In this process, bricoleurs do not strictly adhere to the dominant policy paradigm and can choose 'ideas that may answer multiple logics simultaneously' (Carstensen, 2011, p. 160). Therefore, their policy ideas are not rigid but are like a toolkit in which multiple ideational perspectives co-exist and in which old and new ideas can be combined and adjusted to create something new (Carstensen, 2011). In this perspective, paradigms are viewed as flexible and adaptable frameworks, susceptible to continuous reinterpretation and modification over time (Carstensen & Matthijs, 2018).

Existing research on bricolage usually deals with policy change topics in which disparate existing policies were repurposed and recombined to offer (new) policy solutions (e.g. Allain & Madariaga, 2020; Carstensen, 2017; Hannah, 2020). For instance, Allain and Madariaga (2020) argue that in Chile, environmental organisations successfully garnered wider political support and integrated their ideas into a new energy policy by creatively combining existing policy ideas. These ideas included multiple perspectives such as environmental protection, economic efficiency, local development and democratisation, and supply security.

This paper conceptualises policy bricolage primarily as a process in which policy actors draw on multiple sources of knowledge and information to piece together contextualised policy solutions instead of relying on textbook blueprints or predefined solutions. This paper argues that the WB uses bricolage to formulate policy recommendations by reinterpreting and/or combining current and/or past policy paradigms in view of current national conditions. Accordingly, the WB, as a bricoleur, follows a four-step approach: It (1) takes stock of past and current policy paradigms (existing set of ideas), (2) evaluates current national conditions (concrete circumstances), (3) reinterprets the existing ideas in light of domestic conditions, and (4) formulates recommendations. These four necessary steps, then, constitute the process of policy bricolage.

Even though policy bricolage considers any extant, past or present, ideas to develop policy solutions, we operationalise the stock of ideas by considering the dominant and distinct policy paradigms existing during our observation period. The literature argues that during this period, the WB was focused on healthcare system reform and that its recommendations followed two different paradigms, WC (1987–1997) and post-WC (1997–2007) (Tichenor & Sridhar, 2017).

The WC refers to homogeneous neoliberal solutions for (social) policies promoted by International Financial Institutions (IFIs), such as the International Monetary Fund (IMF)

and the WB (Almeida, 2015). These solutions were mainly designed for Latin American countries to assist them in recovering from the economic and financial crises they experienced during the 1980s; however, the WC ideas rapidly spread to other regions, such as CEE (Lütz & Kranke, 2014; Williamson, 1993). The approach revolved around the principles of liberalisation, privatisation and macro-stability to expand private markets and, consequently, minimise (and replace) the role of the state (de Carvalho & Frisina Doetter, 2022). Improving health conditions was understood as a way to leverage economic development, with a 'selective increase of social spending focused on the poorest' (Almeida, 2015, p. 211, own translation). With regards healthcare financing, these neoliberal solutions were mostly laid out in the WB's publications such as *Financing health services in developing countries* (1987) and *Investing in Health* (1993). The main instruments promoted by the WB during the WC period were related to the establishment and/or expansion of private financing sources (such as voluntary private health insurance and out-of-pocket payments), encouragement of non-government provision of health services, decentralisation to lower levels of government, and the introduction or expansion of risk-coverage programmes (i.e. schemes in which individuals participate in some form of risk-sharing agreement). Further, the WB insisted that public healthcare spending should be focused on 'a basic basket of services based on a cost-effectiveness evaluation of each medical procedure' (Tobar, 2010, p. 119, own translation) that prioritises primary care, and vulnerable groups (Almeida, 2015; Deacon, 2007; Noy, 2017; Tichenor & Sridhar, 2017; World Bank [WB], 1987, 1993).

As the limitations of the WC became more apparent, a new approach emerged known as the post-WC. The main difference to the WC was the view that the state and the market should complement each other (Krogstad, 2007; Öniş & Şenses, 2005). Moreover, the primary goals were not only economic growth and efficiency but also social protection, e.g. alleviation of unemployment, poverty, and inequality (Öniş & Şenses, 2005). The concept of health was also redefined as an end in itself rather than an investment in human capital and economic growth (Noy, 2017). While the WB remained concerned about efficiency, it also started emphasising universal healthcare coverage, equity, risk protection, increased access, quality of services, and health outcomes (Deacon, 2007; Kaasch, 2015; Noy, 2017). To achieve these goals, the WB advocated for an increased role of the state, mobilisation of additional resources, less reliance on user-fees, expansion of risk pooling and taxation instruments (Deacon, 2007; Fair, 2008; Kaasch, 2015; Noy, 2017). Noy (2017) argues that the WB shifted its emphasis from neoliberal ends to neoliberal instruments. For instance, performance-based management or targeting were sometimes used to achieve equity and universalism. Finally, the post-WC emphasised government ownership and adapting lending policies to the country's needs (WB, 1997).

This study refers to existing national conditions which have a significant impact on social and health policymaking: namely, economic, political, and healthcare system performance factors. Economic conditions impact the resources available for healthcare, dictating the level and quality of service provision (Polte et al., 2022; Wilensky, 1975). Political factors are also said to explain changes in welfare. There is a strong causal relationship between the alignment of parties in government with social groups and social policy change (e.g. Myles & Quadagno, 2002). Further, pressing health issues and the performance of the healthcare system stimulate the development of healthcare policy to adjust and/or advance health policy outputs and outcomes (Cacace et al., 2008; Schmid et al., 2010).

In this paper, evidence of bricolage relies on the necessary condition that the WB considers the existing stock of ideas and national conditions to formulate recommendations. This may be presented in two different ways. First, the WB may adjust policies associated with the dominant paradigm of the time (WC or post-WC) to different national conditions. In other words, although the recommendations follow the paradigm, they differ depending on the country. Second, recommendations may deviate from and/or contradict the dominant paradigm. For example, the observation of non-neoliberal principles in the WC period and neoliberal, pro-market principles in the post-WC years. It should be noted that this paper only analyses the WC and post-WC paradigms.

3. Data collection and analysis

The data used in this article comes from two main sources: Secondary scholarship and documents published by the WB. The former was used to outline internal national conditions in each country, namely, political and economic conditions and healthcare system performance. These factors were selected in accordance to scholarship, as stated in the previous section. To map WB healthcare financing recommendations, all reports and strategy papers published by the WB regarding the cases of Argentina (1987–2007) and Croatia (1993–2007)[1] were collected. These were identified via structured searches in the WB's public database using the filters 'Argentina' OR 'Croatia' AND 'Health Systems Development and Reform' in English and Spanish/Croatian equivalents. In addition, an unstructured search was conducted to account for non-indexed documents. Searches were conducted between June and August of 2022.

The documents selected for analysis meet five criteria: They (a) were produced between 1987 and 2007; (b) addressed the topics of healthcare and/or healthcare financing; (c) contained recommendations related to healthcare financing; (d) do not contain a disclaimer that the document does not represent the opinion of the WB; and (e) addressed the whole country, as opposed to specific regions/provinces. After excluding documents that did not meet the pre-established criteria, 14 publications related to Argentina and 11 to Croatia were identified for analysis.[2]

The methods employed were a literature review of the secondary scholarship and a qualitative content analysis of WB documents. The analysis is divided into two periods corresponding to the WC and post-WC paradigms. For both countries, national conditions are first described, accounting for, among others, shifts in the party in power, political (in)stability during the period, economic recession and growth/recovery, and healthcare system performance. Then, healthcare financing recommendations published by the WB in each period are mapped. Finally, an analysis considering the aforementioned analytical framework is used to determine whether and how the WB acted as a policy bricoleur. Figure 1 details the data collection and analysis steps employed in this research.

4. 1987–1997: Washington Consensus paradigm

4.1. Argentina[3]

Between 1987 and 1997, Argentina transitioned back to democracy after seven years of military dictatorship characterised by a weak economy and hyperinflation (Blake, 1998;

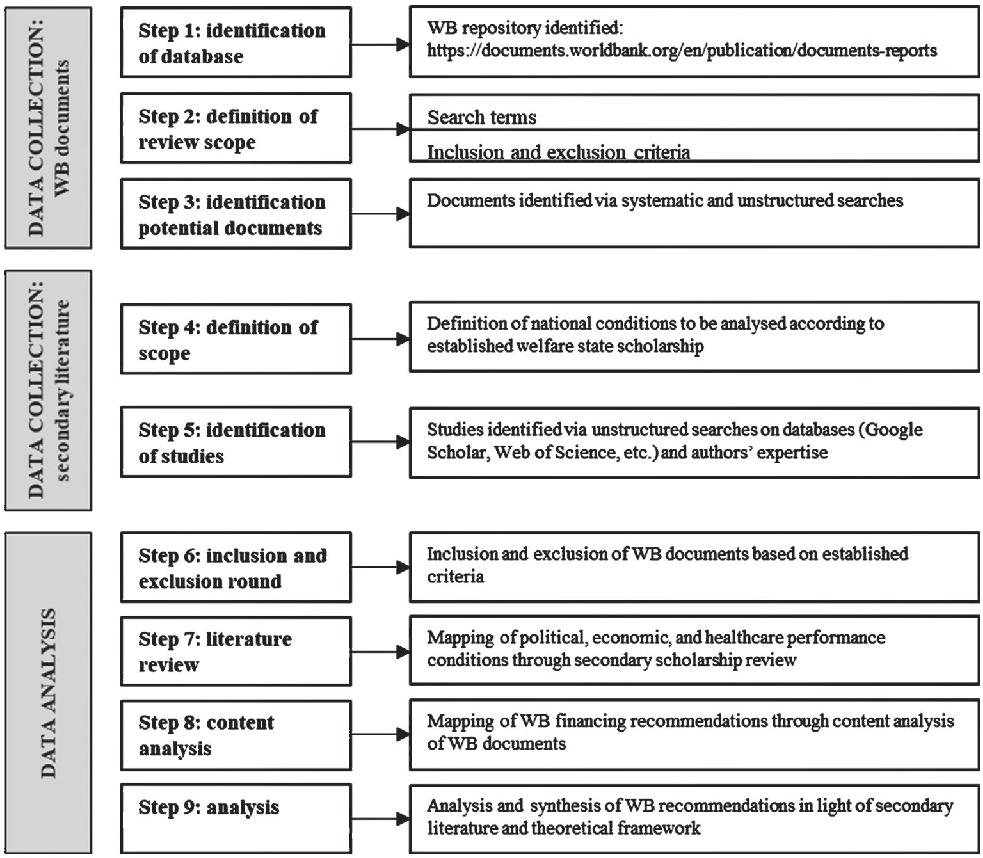

Figure 1. Flow chart of data collection and analysis.
Source: Own presentation.

Colonna, 2019; O'Donnell, 2008). The previous statist model was restructured and pro-market, neoliberal reforms were advanced by Menem from the leftist *Partido Justicialista* (Justicialist Party, PJ) (Blake, 1998; Nochteff, 2002) in order to control the early 80s economic crisis (Cerruti & Ciancaglini, 1992). These reforms resulted in lower inflation, lower unemployment, higher foreign investment and an annual GDP increase of about 6.5% (García-Lema, 1994). The initial success of neoliberal policies in the economy opened the door to further market-oriented reforms in social areas, such as pension and healthcare (Etchemendy & Palermo, 1998).

In this period, the expenditure on health was around 8% of GDP and Argentina's healthcare system was characterised by segmentation with different financing schemes targeting distinct societal groups (Alonso, 2003; Guerrero Espinel et al., 1999; Stillwaggon, 1998; WB, 2023). A SHI scheme covered more than 50% of the population, comprising more than 300 different funds which only pooled risks for their members (Rubinstein et al., 2018; Tobar, 2012). To compensate for the differences between poorer and richer funds, the *Fondo Solidario de Redistribucion* (Solidarity Redistribution Fund, FSR) was created in 1989. Although not fully implemented at the time, the FSR reimbursed money to different health insurance funds for complex and expensive treatments and

provided subsidies to the poorest funds. A private insurance scheme was financed by monthly premiums and targeted the upper classes. Finally, a tax-funded scheme targeted the most vulnerable segments of society not covered by SHI or private insurance, particularly informal workers and the poor (Cavagnero, 2008). The SHI and tax-funded schemes were not able to cover the costs of all available health treatments (D7). In terms of health conditions, it is important to note that the poor, in particular children and mothers, suffered from inadequate healthcare (D2).

During this period, the WB supported PJ's neoliberal agenda and pushed for (public) cost control, liberalisation, increasing private sector involvement, and reducing the role of the state. The WB argued that public healthcare expenditure was too high due to a large number of doctors and hospital beds and a growing demand for healthcare services (D7). In order to reduce costs, moderate demand, and guarantee basic services to the whole population, the WB recommended that every healthcare financing scheme should (1) create and standardise a basic benefits package (D4) and (2) implement cost-recovery from individuals and third-party payers by billing for services provided by public facilities. At the same time, the WB recognised the high mortality and morbidity levels of poor children and mothers and recommended that the tax-funded scheme (3) expand health services (such as prenatal, child delivery, and postnatal care) to these groups (D2) and (4) define priority services to be financed by government subsidies (D3).

Most recommendations concerned the SHI scheme, which covered the largest portion of the population due to low unemployment. The WB aimed to liberalise the sector and introduce market mechanisms to reduce the number of funds. Accordingly, the WB recommended to (5) 'introduce consumer choice of insurer' (D7, p. 24); (6) allow 'competition among private and public insurance institutions' (D6, p.19) and among union-run health insurers (D6); (7) 'leave employees to purchase additional coverage if they wish' (D7), and (8) 'reduce payroll taxes from 7 to 5.5% for health insurance to a level that would just cover the cost of the standard package for everyone' (D5b, p.25). Moreover, the WB tried to tackle the issues associated with risk pooling and recommended that FSR (9) automatically allocate funds on the basis of members' income, starting with the poorest, and (10) compensate for household differences in income and health risk.

4.2. Croatia

Croatia began transitioning away from the communist regime in the early 1990s. This transition was led by the Croatian Democratic Union (CDU), a right-wing party determined to achieve democratisation, liberalisation, marketisation, and independence from the Yugoslav Federation. This period was characterised by economic and political crises and the Croatian War of Independence (1991–1995), which followed Croatia's secession from the Yugoslav Federation (Ramet, 2013). Inflation and unemployment surged while GDP declined dramatically compared to pre-war levels (D15; Ramet, 2013; Stubbs & Zrinščak, 2007). After the war, the political and economic situation started to improve. Although GDP grew by 6% in 1996 and 1997, 9.7% of the population remained unemployed (WB, 2023). The CDU became increasingly dependent on voter support which was acquired by increasing public spending (Schönfelder, 2013). Consequently, disempowered groups, such as war veterans, their families, and, to a certain extent, pensioners, could claim generous social benefits (Puljiz et al., 2008; Stubbs & Zrinščak, 2007).

Regarding healthcare financing, Croatia inherited a heavily decentralised SHI system in which multiple SHI funds were organised at the municipal level according to Bismarckian and self-management principles (Malinar, 2022). Healthcare benefits and coverage were practically universal. However, the system faced numerous issues due to heavy decentralisation, lack of financial expenditure controls, duplication of procedures, inequality of access, lack of medical equipment and drugs, as well as economic and political crises (Chen & Mastilica, 1998; Šarić & Rodwin, 1993). The reforms initiated in the early 1990s aimed to contain costs, introduce liberal and market policies, and, at the same time, maintain solidarity (Malinar, 2022). In 1993, SHI was centralised into one national health fund, the Croatian Institute for Health Insurance (CIHI), which collected and pooled payroll tax contributions.[4] Co-payments for selected services were established, while groups such as war veterans, the unemployed, and children were exempted (Kovačić & Šošić, 1998; Vončina et al., 2007). Finally, substitutive and supplementary private insurance were introduced (Zrinščak, 2007). Despite the reforms, healthcare expenditure rose from 6.4 to 8.6% of GDP during the 1993–1996 period (D16). The expenditure was driven by inappropriate management and resource allocation, outdated technology, and high demand for services, especially pharmaceuticals (Langenbrunner, 2002; Vončina et al., 2007; WHO, 1999).

The WB only became involved in Croatian healthcare in 1995 because the war interrupted and delayed its dialogue with Croatia (D15). At this time, the WB praised the 1993 reforms, highlighting the importance of redefined healthcare benefits, centralising SHI, and enabling private insurance involvement. Moreover, to support their implementation, the WB financed the *Health Project,* which was primarily prepared by the government itself (D15). However, as public healthcare expenditure began to rise, the WB noted that the previous reforms should be extended to preserve the sustainability of the healthcare system and fiscal sustainability (D16; D17).

In particular, the WB wanted to address post-war social entitlements by reducing the benefits and shifting the burden of financing on to those who could pay. Moreover, the WB argued that increased unemployment and the growing informalisation of the economy hindered the collection of payroll taxes. Efforts to raise revenue from other sources (e.g. co-payments) were necessary to reduce reliance on payroll contributions. In addition, the WB noted that the tax burden was too high, which created incentives to misreport wage income and discouraged formal employment (D16; D17). To address these issues, the WB recommended: (1) reducing payroll tax; (2) moderating the demand for healthcare services by removing co-payment exemptions (except for the poor) and increasing the scope and rate of co-payments; and (3) further developing a private insurance market and its regulation (D16; D17).

4.3. Analysing policy bricolage in the WC period

During the 1987–1997 period, the WB recommendations for Argentina and Croatia were heavily aligned with WC and neoliberal ideas, such as curbing public spending on health and encouraging private sources of revenue, be it through private insurance or out-of-pocket payments. However, the WB also considered the different national conditions in both countries when it formulated its recommendations. In Argentina, the WB supported

the government's pro-market neoliberal programmes and took into account SHI fragmentation, healthcare system segmentation, issues associated with risk pooling, and high mortality and morbidity levels of poor children and mothers. The WB was mainly focused on reducing the role of the state, increasing competition between SHI funds, instituting complementary private insurance and a basic benefits package, and targeting health services to poor mothers and children. These recommendations are strongly associated with cost-saving and efficiency, which were extensively promoted during the WC.

In Croatia, the WB offered a loan to support the government's pro-market initiatives and implementation of the 1993 healthcare financing reforms. Later, the WB noted the rise in public healthcare expenditure, high unemployment, a growing informal economy, and issues concerning post-war social claims-making. Compared to Argentina, where the WB favoured competition between SHI funds, in Croatia, the WB favoured a centralised model of SHI insurance, which increased the role of the state. Moreover, the focus in Croatia was on diversifying the sources of revenue collection, private insurance development (substitutive and supplementary), and moderating the demand for healthcare services by increasing the role of co-payments while exempting the poor.

The evidence shows that the WB formulated its recommendations by considering and combining different sources of knowledge, i.e. the WC and an evaluation of different national conditions found in Argentina and Croatia, in particular healthcare system performance and healthcare policies which were already in place. It can be observed that most of the recommendations reflect the ideas of the WC, but at the same time, they are contextualised for different national conditions. However, the WB did not strictly adhere to the established paradigm because some recommendations diverged from what is usually associated with neoliberalism. For instance, the WB showed a preference for a centralised SHI model in Croatia and FSR's redistribution of funds from wealthier to poorer SHI funds in Argentina. The WB did not have a uniform approach for both countries and deviated from the WC to adjust its recommendations to national conditions. Therefore, it can be argued that during this period, the WB indeed acted as a policy bricoleur. However, for the most part, this role was limited to contextualising the WC to different national conditions.

5. 1997–2007: post-Washington consensus paradigm

5.1. Argentina

After ten years in power, the PJ lost the election to the *Unión Cívica Radical* (UCR, Radical Civic Union) led by Fernando de la Rúa (1999–2001) (Corrales, 2002; Ollier, 2001). Between 1998 and 2002, the economy shrank by 28%, GDP decreased by 11%, private consumption fell by 14.4% while unemployment and poverty increased dramatically, with 56% of the population living below the national poverty line (Bernhardt, 2008; Cibils et al., 2002; WB, 2023). The economic turmoil was accompanied by social unrest and political instability. Although de la Rúa favoured increased social spending to address the crises, his attempts failed, and he was eventually forced to resign (Auyero, 2007; Corrales, 2002; Hochstetler, 2006). Soon after, Argentina had five provisional and congress-

elected presidents and announced a default on the government's debt to foreign investors (Bernhardt, 2008).

The political and economic situation stabilised only when Nestor Kirchner (PJ) (2003–2007) came to power. Kirchner was highly critical of the US and the constraints imposed by IFIs (Becerra, 2015). He distanced himself from the pro-market agenda and promoted greater state intervention, poverty and unemployment reduction, and income redistribution (Busso, 2016; Levitsky & Murillo, 2008). His election was followed by high GDP growth rates of around 8% annually and low inflation levels (Mercado, 2007). Unemployment fell from 13.5 to 8.5% in the period, while poverty decreased from 60% in 2002 to 19% in 2007 (D12; WB, 2023).

During the WC period, several healthcare financing changes were introduced (Barrientos & Lloyd-Sherlock, 2000; Cavagnero, 2008; Tobar, 2012). First, co-payments and complementary insurance were introduced in both the tax-funded and SHI sector (Machado, 2018). Second, public hospitals were allowed to charge user-fees, although this did not translate into more resources (Cavagnero, 2008; Lloyd-Sherlock & Novick, 2001). Third, the FSR established criteria to redistribute revenue between richer and poorer healthcare funds (Cavagnero, 2008). Fourth, the private sector was growing because public healthcare funds could transfer provision and regulation responsibilities to private providers and companies (Arnaudo et al., 2017). According to Tobar (2012), an expansion of private services and insurance offerings was driven by state incentives, which 'reaffirms the notion of health as a commodity' (Tobar, 2012, p. 14, own translation). Fifth, employers' contributions were reduced from 7% to 5% to cut labour costs. Ultimately, in an attempt to reduce the high number of healthcare funds, the SHI sector was liberalised, and workers were free to select their funds (Cavagnero, 2008; Machado, 2018). However, the number of funds remained high, e.g. 268 in 2003 (D7; D10).

Between 1998 and 2002, healthcare expenditure decreased by 2% of GDP (WB, 2023). Low contribution rates, the growing informal economy, and high unemployment caused a decrease in revenue and coverage in the SHI sector (Lloyd-Sherlock & Novick, 2001). Moreover, 9% of the population lost SHI coverage, and most transferred to the tax-funded sector. This put additional pressure on the already underfinanced system (Lloyd-Sherlock & Novick, 2001). Moreover, the crises exacerbated further health inequalities, especially the rise of infant mortality and the incidence of infectious diseases in mothers and children in poorer areas (Johannes, 2007).

During the tenure of the UCR/de la Rúa and the provisional presidents, the WB was particularly concerned with deteriorating healthcare coverage caused by increased poverty and high unemployment. The WB was willing to support de la Rúa's and the provisional presidents' intent to increase social spending to cushion the effects of ongoing political and economic crises. In general, the WB encouraged the expansion of coverage to vulnerable groups; however, it recommended that public spending should target social groups that could not be integrated into the SHI.

The WB made several recommendations regarding the SHI scheme. It recommended that the scheme should (1) not only cover formal employees but also be expanded to those in the informal sector. The WB also suggested that (2) eligible beneficiaries to SHI should be clearly defined. These two measures were proposed to strengthen social protection for beneficiaries. It also suggested (3) the creation of parallel and alternative health plans for uninsured non-poor households (D8; D9; D10).

To extend coverage to those ineligible for or unable to be covered by the existing SHI scheme, the WB suggested the creation of tax-funded alternative health plans for the uninsured population. The first scheme involved the (4) establishment of health insurance for the poor, which offered (5) a fiscally affordable basic benefit package. Additionally, the WB proposed (6) creating the Maternal-Child Health Insurance Programme. This policy targeted pregnant women and children up to age six who were not covered by the SHI scheme. The programme would also (7) define a basket of services tailored to the specific needs of mothers and children (D13; D14).

These recommendations were an active response from the WB to the economic crisis. They aimed to compensate for the loss of insurance, the significant growth in demand in the tax-funded sector, and to mitigate health challenges among vulnerable populations.

Moreover, the WB recommended measures for both SHI and tax schemes. It encouraged the (8) decentralisation of the systems by separating financing from the service delivery functions in the public sector at the provincial level. This can be seen as an attempt to transfer authority to provincial governments in response to central government turmoil, with continued emphasis on targeting and tailoring schemes (and services) for disadvantaged segments of society (D10; D11; D12).

When Kirchner came to power, health spending constituted around 7% of GDP, and a three-tier system continued to exist (D12; WB, 2023). The economic and political crises of 1999–2002 had long-lasting effects on the delivery of public programmes, impacting public responses, especially in relation to the control of diseases (D13; D14). Kirchner's government restored contributions to 6% of payroll and increased the percentage of contributions channelled through the FSR to mitigate the consequences of health spending cuts promoted by the government and the WB in the WC period (Cavagnero, 2008). Moreover, a system for uninsured mothers and children was implemented, which secured funding for priority services and achieved 65% coverage of the eligible population (D13; D14). Nevertheless, great inequalities between society's vulnerable and wealthier segments in terms of mortality (especially for mothers and children) and morbidity remained and were aggravated by the 1998–2002 economic crisis (Bossio et al., 2020; Finkelstein et al., 2016; Tobar, 2002; D12).

During Kirchner's administration, the WB produced the lowest number of recommendations on healthcare financing. Kirchner's open opposition to IFIs may have discouraged the WB from pushing for new and bolder reforms. Instead, it can be observed that the WB aligned with Kirchner's agenda and continued promoting already established measure that targeted vulnerable populations. Even though the WB had already tried to tackle health problems caused by the 1998–2002 crisis prior to Kirchner's election, the effects of the turmoil, including declining health outcomes and increasing health disparities, continued to be a prominent issue in the WB's agenda. The IO focused on these pressing issues rather than healthcare financing itself (D12, p. 9).

Consequently, the recommendations the WB put forth remained somewhat unchanged between de la Rua's and Kirchner's administrations, with continued emphasis on targeting and tailoring schemes (and services) for disadvantaged segments of society. There was still a clear focus on mothers and children; however, other vulnerable groups, such as indigenous and rural peoples, were also targeted. Moreover, concerns about the benefits package continued with the WB pushing for a revision of the basket of benefits for uninsured mothers and children to increase cost-effectiveness.

5.2. Croatia

In the late 1990s, the CDU weakened considerably and in 2000 a coalition headed by the left-wing Social Democratic Party (SDP) and the centrist Croatian Social Liberal Party (HSLS) came to power (Bičanić & Franičević, 2003, p. 24; Stubbs & Zrinščak, 2007). The new government continued pro-market reforms, initiated social policy reforms, consolidated Croatian democracy, and began to westernise (Bičanić & Franičević, 2003; Stubbs & Zrinščak, 2007). However, the government suffered from internal struggles and negative public opinion and had to fulfil high expectations for economic growth and social justice (Bičanić & Franičević, 2003; Kasapović, 2005). In 2003, a new centre-right government led by the CDU came to power, lasting until 2007. It continued social and economic policy reforms but also faced internal disagreements and was reliant on support from its coalition partners, mainly the Pensioner's Party and the Serbian Democratic Party (Stubbs & Zrinščak, 2007).

GDP growth slowed from 6.1% in 1997 to −0.9% and 2.9% in 1999 and 2000, respectively. However, from 2002–2007, GDP recovered significantly, averaging around 5% growth annually. Inflation surged to 8.2% in 1998 but quickly decreased in the following year. Until 2007 it remained relatively stable, between 3% and 4%. Unemployment peaked at 16.1% in 2001 and gradually decreased to 9.9% in 2007 (WB, 2023). Moreover, Croatia was still recovering from the war, and had to tackle excessive trade and fiscal deficits, rising public debt, and insolvencies of banks and state-owned enterprises (Bičanić & Franičević, 2003, p. 18; D20 Bebek & Santini, 2013; Schönfelder, 2013; WB, 2008).

In healthcare, public expenditure continued to rise as issues from the previous period persisted. The adverse economic situation created an additional mismatch between revenue and expenditure (Langenbrunner, 2002). In 2000, total healthcare expenditure amounted to 10.2% of GDP (Croatian Parliament, 2006), and CIHI's debts were about EUR 500 million (Zrinščak, 2007). Private insurance played a marginal role, amounting to 6% of total healthcare expenditure in 2002 (Langenbrunner, 2002; Vončina et al., 2007).

The WB tried to use the reform-motivated and market-oriented SDP-led government to break the status quo and push for healthcare financing reforms. The WB was particularly concerned about the CIHI's deficit and debts, high public healthcare expenditure, generous healthcare benefits, and lack of revenue diversification (D18; D19; D20). Moreover, the WB argued that dwindling CIHI revenues were caused by the growth in unemployment and the informal economy and warned that high labour costs discouraged formal employment (D21). To address these issues, the WB recommended (1) reducing payroll tax; (2) moderating the demand for healthcare services by removing co-payment exemptions and increasing the scope and rate of co-payments. However, compared to the WC period, the WB recommended that besides the poor, other groups, such as chronic patients, should remain exempted from co-payments. The WB further recommended to (3) introduce a basic basket of healthcare services; (4) levy additional SHI contributions from non-wage labour, i.e. honoraria, and (5) centralise SHI by merging CIHI with the government budget (D20; D21; D22).[5]

Eventually, the SDP-led government introduced several changes: (1) payroll tax was reduced twice, eventually down to 15% in 2003; (2) the scope and rate of co-payments were increased while exemptions from co-payments were decreased. However, groups such as war veterans, the unemployed, and the disabled remained exempted; (3)

complementary health insurance (CHI), which covered co-payments, was introduced. Monthly premiums were fixed at EUR 10.50 and EUR 6.50 for pensioners. CIHI was given the exclusive right to initially offer CHI while private insurers could not enter the market for two years (Vončina et al., 2007; Zrinščak, 2007); (4) substitutive private insurance was abolished to pull more insurers into the SHI (Vončina et al., 2007); (5) CIHI was incorporated into the government budget (Vončina et al., 2007; Zrinščak, 2007).

Despite these reforms, healthcare expenditure rose (Vončina et al., 2010). Financing remained reliant on payroll tax, and CIHI still experienced sizeable deficits between 2003 and 2006. Moreover, CHI introduced the problem of adverse selection and contributed to moral hazard, which co-payments were meant to mitigate (Langenbrunner, 2002; Vončina et al., 2007, 2010). After the change of government in 2003, the WB worked with the CDU-led government, insisting on healthcare financing reforms.

The WB was unsatisfied because public healthcare expenditure and CIHI's deficit remained high. Although the payroll tax rate was reduced and the economy was recovering, the WB still argued that it 'place[d] a heavy burden on the productive labour force and the economy' and that additional revenue from co-payments and CHI was necessary (D23, p. 40). In response to the abolished substitutive private insurance, the WB stated that sustainability of the SHI was increased as it enabled it to pool more insurers. However, the WB also stated that it was a setback in private insurance development and that a private voluntary health insurance market should be promoted instead (D23). Finally, the WB argued that broad co-payment exemptions and the existence of CHI exacerbated the moral hazard issue and that CHI suffered from adverse selection and increased administrative costs (D23).

This time the WB recommended (1) reducing payroll tax; (2) moderating demand for healthcare services by introducing means-testing criteria for co-payment exemptions and further increasing the scope and rates of co-payments; (3) introducing a basic basket of healthcare services, and (4) abolishing CHI and instituting ceilings on co-payments for chronic patients or allowing only private insurance companies to offer CHI (D23; D24; D25). The WB argued that the premiums of private CHI would appropriately reflect the cost of services and ensure that excessive demand for services would be controlled (D25).

However, during the appraisal of reform progress, the WB recognised that the CDU-led government was unwilling to shift the CHI to the private insurance market or introduce a basic basket of services. Consequently, the WB recommended alternative policies acceptable to the CDU government (D25). These included: (1) the introduction of user-fees for primary care visits, referrals, recommendations, and visits to specialists without referrals, (2) reducing the scope of pharmaceutical coverage by introducing essential (fully covered by SHI) and non-essential (subject to co-payments) lists of pharmaceuticals and (3) reducing the scope of CHI coverage which should not include user-fees nor pharmaceuticals on the non-essential list.

5.3. Analysing policy bricolage in the post-WC period

The empirical evidence presented here shows that during the post-WC period, the WB formulated its recommendations in both countries by considering principles consistent with the post-WC, as well as the WC. Moreover, as in the WC period, the WB also considered national conditions when formulating its recommendations. In Argentina, the WB

considered the effects of political and economic crises and was particularly concerned about increased poverty and high unemployment, which shrank healthcare coverage, deteriorated health outcomes, and fuelled health inequalities. The WB also considered the positions of different governments. For instance, it backed UCR's proposal to increase social spending and acknowledged Kirchner's reluctance to collaborate with IFIs and introduce further healthcare financing reforms. The WB still advocated for neoliberal ideas such as defining basic health services to increase cost-effectiveness, decentralising the tax-funded and SHI healthcare financing schemes, and targeting. It is important to note that even though targeting is usually associated with neoliberalism, in this period it served as an instrument to restore and/or expand coverage to vulnerable population groups, such as the poor, mothers and children, indigenous people, and those not covered by SHI. Therefore, it can be observed that the WB recommendations began to move away from the fundamental principles of neoliberalism, such as prioritising cost-effectiveness, promoting efficiency through privatisation, and minimising the role of the state. Instead, the WB was focused on restoring and expanding coverage in both SHI and tax-funded schemes by increasing the role of the state and mobilising additional resources for vulnerable groups.

In Croatia, the WB recognised the growth in the unemployment rate and the informal economy as well as issues facing the healthcare system more directly, such as CIHI's deficits and debts, lack of revenue diversification, moral hazard, and adverse selection in CHI. Similar to the case of Argentina, the WB was also adjusting to the government agenda, e.g. changing its recommendations to better suit the preferences within the CDU-led government coalition. In contrast to the recommendations made for Argentina, the WB was still focused on reducing public healthcare expenditure and social protection. Consequently, neoliberalism was more prominent. Most of the recommendations revolved around reducing healthcare benefits, expanding private sources of revenue (e.g. out-of-pocket payments and private voluntary health insurance) and promoting individual responsibility for health. However, the WB also recommended policies which were consistent with the post-WC. For instance, some neoliberal recommendations were more nuanced (e.g. co-payment exemptions, not only for the poor, but also for other groups such as chronic patients), while some recommendations completely diverged from neoliberalism (e.g. expansion of payroll taxes, endorsing the abolishment of private substitutive insurance, and further centralisation of SHI). It can be observed that post-WC principles were less emphasised in the WB's recommendations for Croatia. They mostly involved the increased role of the state in the mandatory SHI, mobilisation of additional resources, and expansion of taxation instruments. Interestingly, in both countries, during times of economic crisis, the WB recommended policies which increased the role of the state, aligning with post-WC ideas. For instance, in Croatia, the WB advocated for stricter control of the SHI fund, while in Argentina, the WB supported the expansion of the tax-funded scheme.

Considering the points mentioned above, it is clear that the WB began to embrace post-WC principles. This was more evident in Argentina than in Croatia, where the WB still prioritised WC and neoliberal tenets. Much like during the WC period, the WB's approach in formulating healthcare financing recommendations was neither uniform nor monolithic. The WB considered specific national conditions, leading to divergent suggestions for each country. Moreover, the WB did not strictly follow the post-WC paradigm.

Compared to the previous period, where the WC principles were primarily contextualised to different national conditions, the WB formulated its recommendations by taking inspiration from two different paradigms simultaneously, WC and post-WC. In other words, the WB did not just contextualise the post-WC to national conditions but also deviated from it by recommending ideas aligned with the WC. This was particularly notable in Croatia, thus further supporting the argument that the WB did not rely on paradigms as dogmas. Instead, the WC and post-WC were regarded as toolkits providing different tools which were used to respond and adjust to the concrete circumstances in Argentina and Croatia. Therefore, the WB was involved in the process of bricolage when it formulated its recommendations. During this process, the WB considered the principles found in the WC and post-WC, as well as different national conditions. Table 1 summarises the empirical findings of the study.

Table 1. The WB approach to Argentina and Croatia during the WC and post-WC period.

	Argentina		Croatia	
	National conditions	WB recommendations	National conditions	WB recommendations
WC	- Transition to democracy - Neoliberal, promarket reforms - Lower inflation, GDP grow, high foreign investment - Low unemployment - Co-existence of different health schemes - High number of sickness funds - Health inequalities: poor vs. rich	- Introduction of standardised basic benefit package - Cost-recovery - Targeted public services for specific population groups - Prioritisation of public spending - Increase competition and consumer choice - User-fees	- Transition to democracy - Economic crisis and recovery - High unemployment - High public health spending - Inequality in access and lack of resources - Centralisation of health system - Co-payment for selected health services (except for specific groups) - Substitutive and supplementary insurance	- Centralisation - Redefinition and reduction of benefit package - Involvement of private insurance - User-fees, including reduction in co-payment exemptions - Reduction of payroll tax
Post-WC	- Economic crisis and recovery - High unemployment and poverty - Social unrest and political instability - Political criticism of IFIs - Greater state intervention - Healthcare user-fees - Growing participation of private sector in healthcare - SHI: decrease in revenue and coverage - Tax-financed system: increased coverage and underfinancing - Health inequalities	- Increase social spending - Expansion of coverage to vulnerable groups (e.g. informal workers) - Prioritisation of public spending - Creation of parallel plans for uncovered groups - Decentralisation	- Pro-market reforms - Consolidation of democracy - Political turmoil - Economic stabilisation followed by growth - High levels of unemployment - Rising public debt - High public health spending - Moral hazard	- Reduction of payroll tax - Increase in co-payments and removal of exemptions - Introduction of a basic benefit package - Centralisation of SHI - Levy of additional SHI contributions - Promotion of the private insurance market - Introduction of user-fees for specific services - Reduction in pharmaceutical coverage

Source: Own compilation.

6. The WB as policy bricoleur: final remarks and future research

This study investigated WB healthcare financing recommendations in Argentina and Croatia from 1987 to 2007. Literature suggests that during this period, WB recommendations were framed within WC (1987–1997) and post-WC (1997–2007) paradigms (Tichenor & Sridhar, 2017). However, the cases of Argentina and Croatia demonstrate that by considering national conditions when formulating recommendations, the WB did not strictly adhere to mentioned paradigms.

In the first period, the WB primarily promoted neoliberal ideas associated with the WC which were contextualised to unique domestic circumstances. Moreover, in its attempt to adjust to national conditions, the WB went as far as diverging from the WC and neoliberalism. The second period saw the WB considering national conditions as well as neoliberal and post-WC principles, with the latter more evident in Argentina than Croatia. Neoliberal rhetoric began to evolve in both countries, with some recommendations being abandoned or becoming less pervasive (e.g. reducing the role of the state in Argentina) while others were more nuanced (e.g. co-payment policy in Croatia). Moreover, in Argentina, neoliberal instruments such as targeting were utilised to advance post-WC goals (e.g. coverage expansion) rather than promoting cost saving.

It can be observed that in both periods the WB acted as a policy bricoleur. It took stock of existing ideas (WC and post-WC) and reinterpreted or deviated from them to adjust recommendations to Argentinian and Croatian national conditions. As a result, the WB did not consider the WC and post-WC as paradigms to be followed rigorously or dogmatically but rather as tools to be used and (re)combined to address country specific issues. Furthermore, it is evident that the WB does not ignore ideas from past paradigms. This is most clearly seen during the post-WC period, when the WB still formulated recommendations which can be associated with the WC, especially in Croatia. This nuanced approach shows that the WB considers multiple sources of knowledge when formulating healthcare financing policy recommendations. In these particular cases, past and contemporary policy paradigms, national political and economic conditions, and healthcare system performance.

It can be argued that, as a policy bricoleur, the WB is more capable to adapt, innovate its approach and provide country tailored recommendations in the face of diverse and changing national conditions. This is particularly crucial for an organisation dealing with a wide range of countries with distinct political, economic, and social conditions. By providing country tailored recommendations in such diverse environments, the WB can preserve and extend its authority and expert legitimacy (Barnett & Finnemore, 2004). Moreover, bricolage can also be used to garner wider political support for reform (Allain & Madariaga, 2020), thus improving the prospects for implementing WB's policies.

Furthermore, the concept of the WB as a policy bricoleur has implications for understanding WC and post-WC periods. It suggests that WB policy recommendations cannot be strictly categorised within distinct paradigms and policy eras. Instead, the WB selectively incorporates and combines elements from different policy paradigms, thus blurring the boundaries between them. Consequently, WC and post-WC should be viewed with more nuance, aligning with the argument that paradigms are flexible frameworks open to continuous reinterpretation (Carstensen & Matthijs, 2018).

To conclude, the paper has shown that the WB did not rely on pre-cooked ideas which should be blindly implemented despite the particularities of each country. Instead of proposing one-size-fits-all recommendations, the WB appeared as a policy bricoleur, a pragmatic and reflexive actor which formulates its recommendations by reinterpreting current and/or past paradigms in light of concrete circumstances.

These findings are consistent with the scholarship which argues that the WB does not offer a single blueprint for healthcare financing reforms and that it accounts for specific national conditions (Noy, 2017; Weyland, 2006). Consequently, the paper provides further evidence that the WB does not act as a neoliberal hegemon in healthcare financing and is willing to use the 'logic of accommodation' (Noy, 2017; Wireko & Béland, 2017). Conversely, the paper diverges from studies contending that the WB provides a well-defined reform blueprint and disregards national conditions (e.g. Cerami, 2006; Nemec & Kolisnichenko, 2006). The findings also show that the WB operates differently across policy sectors. For instance, in the pension sector, the WB pushed for a standardised three-pillar pension system (Orenstein, 2008).

The paper contributes to the growing literature on global social policy and provides a novel concept on how the WB formulates recommendations in healthcare financing policy. It advances the theory of policy bricolage, putting forth a novel definition and an analytical framework to measure policy bricolage in IOs' policy recommendation making. In addition, the paper shows that there should be a more nuanced understanding of WC and post-WC and how they are used to define WB's impact.

Finally, it is worth noting some study limitations and possible avenues for future research. The paper was primarily based on document analysis. Further research, including additional methods such as interviews with national and IO stakeholders, and data, such as national documents, is needed to support the findings of the paper. Furthermore, future research should offer insights on this topic by focusing on different timeframes, countries/regions, and policy sectors. On a final note, the findings of the paper show adaptation and deviation from the WB's global reports on healthcare financing (e.g. *Financing health services in developing countries* and *Investing in Health*). This suggests a potential divergence in recommendations between WB's headquarters and its country offices. As a result, a promising avenue for future research would be to investigate and compare the extent of such divergence.

Notes

1. The differences in the timeframe are due to WB membership: Argentina joined the WB in 1956, Croatia in 1993.
2. For a list of all analysed documents, see Appendix 1.
3. The analysed documents are cited according to the numbering system (Document Code) in Appendix 1, Tables A1 and A2.
4. In addition to SHI, healthcare was partly financed by the government and county budgets (WHO, 1999).
5. The rationale behind this idea was to achieve better control over expenditure, debt collection, and management (Vončina et al., 2007).

Disclosure statement

No potential conflict of interest was reported by the author(s).

Funding

This work was supported by the Deutsche Forschungsgemeinschaft (DFG, German Research Foundation) under grant number 374666841-SFB 1342 (Collaborative Research Centre 1342 'Global Dynamics of Social Policy' at the University of Bremen).

Notes on contributor

Ante Malinar is a doctoral researcher within the Collaborative Research Centre 1342, project B08 'Transformation of Health Care Systems in Central and Eastern Europe', University of Bremen. He holds a master degree in political science from University of Zagreb. His research focuses on healthcare system reforms in Central and Eastern Europe and the role international organisations have in shaping healthcare policy.

Gabriela de Carvalho is a postdoctoral researcher within the Collaborative Research Centre 1342, project A04 'Global developments in health care systems', University of Bremen. She holds a doctoral degree in Economics and Social Sciences from the University of Bremen. Her current research focuses on comparative health care systems of the Global South and the role of global actors in shaping social policies.

ORCID

Ante Malinar http://orcid.org/0000-0002-9793-3098
Gabriela de Carvalho http://orcid.org/0000-0001-5156-674X

References

Allain, M., & Madariaga, A. (2020). Understanding policy change through bricolage: The case of Chile's renewable energy policy. *Governance*, *33*(3), 675–692. https://doi.org/10.1111/gove.12453

Almeida, C. (2015). O Banco Mundial e as reformas contemporâneas do setor saúde. In J. M. Pereira, & M. Pronko (Eds.), *A Demolição de direitos: Um exame das políticas do Banco Mundial para a educação e saúde* (pp. 183–122). Escola Politécnica de Saúde Joaquim Venâncio.

Alonso, V. (2003). Consumo de medicamentos y equidad en materia de salud en el Área Metropolitana de Buenos Aires, Argentina. *Revista Panamericana de Salud Pública*, *13*(6), 400–406. https://doi.org/10.1590/S1020-49892003000500009

Arnaudo, F., Lago, F., & Viego, V. (2017). Assessing equity in the provision of primary healthcare centers in Buenos Aires Province (Argentina): A stochastic frontier analysis. *Applied Health Economics and Health Policy*, *15*(3), 425–433. https://doi.org/10.1007/s40258-016-0303-9

Auyero, J. (2007). *Routine politics and violence in Argentina: The gray zone of state power*. Cambridge University Press.

Barnett, M., & Finnemore, M. (2004). *Rules for the world: International organizations in global politics*. Cornell University Press.

Barrientos, A., & Lloyd-Sherlock, P. (2000). Reforming health insurance in Argentina and Chile. *Health Policy and Planning*, *15*(4), 417–423. https://doi.org/10.1093/heapol/15.4.417

Bebek, S., & Santini, G. (2013). Hrvatska kao članica Europske Unije: Put u (Ne)poznatu Budućnost [Croatia as European Union member: Road to (Un)familiar future]. *Ekonomija*, *20*(1), 1–28.

Becerra, M. (2015). *De la concentración a la convergencia. Políticas de medios en Argentina y América Latina*. Paidós.

Bernhardt, T. (2008). Dimensions of the Argentine crisis 2001/02. A critical survey of politico-economical explanations. *Intervention: European Journal of Economics and Economic Policies*, *5*(2), 254–266.

Bičanić, I., & Franičević, V. (2003, November). *Understanding reform: The case of Croatia*. GDN/WIIW Working Paper. The Wiiw Balkan Observatory. https://wiiw.ac.at/understanding-reform-the-case-of-croatia-dlp-3287.pdf

Blake, C. H. (1998). Economic reform and democratization in Argentina and Uruguay: The tortoise and the hare revisited? *Journal of Inter-American Studies and World Affairs*, *40*(3), 1–26. https://doi.org/10.2307/166198

Bossio, J. C., Sanchis, I., Herrero, M. B., Armando, G. A., & Arias, S. J. (2020). Mortalidad infantil y desigualdades sociales en Argentina, 1980-2017 [Infant mortality and social inequalities in Argentina, 1980–2017]. *Revista panamericana de salud publica=Pan American journal of public health*, *44*, e127.

Busso, A. (2016). Neoliberal crisis, social demands, and foreign policy in Kirchnerist Argentina*. *Contexto Internacional*, *38*(1), 95–131. https://doi.org/10.1590/S0102-8529.2016380100003

Cacace, M., Götze, R., Schmid, A., & Rothgang, H. (2008). Explaining convergence and common trends in the role of the state in OECD healthcare systems. *Harvard Health Policy Review*, *9*(1), 5–16.

Campbell, J. L. (2005). Where do we stand? Common mechanisms in organizations and social movements research. In G. F. Davis, D. McAdam, W. R. Scott, & M. N. Zald (Eds.), *Social movements and organization theory* (pp. 41–68). Cambridge University Press.

Carstensen, M. (2011). Paradigm man vs. the bricoleur: Bricolage as an alternative vision of agency in ideational change. *European Political Science Review*, *3*(1), 147–167. https://doi.org/10.1017/S1755773910000342

Carstensen, M. (2017). Institutional bricolage in times of crisis. *European Political Science Review*, *9*(1), 139–160. https://doi.org/10.1017/S1755773915000338

Carstensen, M., & Matthijs, M. (2018). Of paradigms and power: British economic policy making since Thatcher. *Governance*, *31*(3), 431–447. https://doi.org/10.1111/gove.12301

Cavagnero, E. (2008). Health sector reforms in Argentina and the performance of the health financing system. *Health Policy*, *88*(1), 88–99. https://doi.org/10.1016/j.healthpol.2008.02.009

Cerami, A. (2006). *Social policy in Central and Eastern Europe : The emergence of a new European welfare regime*. Lit Verlag.

Cerruti, G., & Ciancaglini, S. (1992). *El óctavo círculo: Crónica y entretelones del poder menemista* (3a ed). Editorial Planeta.

Chen, M. S., & Mastilica, M. (1998). Health care reform in Croatia: For better or for worse? *American Journal of Public Health*, *88*(8), 1156–1160. https://doi.org/10.2105/AJPH.88.8.1156

Cibils, A., Weisbrot, M., & Kar, D. (2002, September 3). *Argentina Since Default: The IMF and the Depression*. CEPR Center for Economic and Policy Research. https://www.cepr.net/report/argentina-since-default-the-imf-and-the-depression/

Colonna, M. de la P. (2019). Los años 90 en la Argentina: Transformación y complejización del sindicalismo argentino. *Revista de Investigación Del Departamento de Humanidades y Ciencias Sociales*, *1*(15), 57–78.

Corrales, J. (2002). The politics of Argentina's meltdown. *World Policy Journal*, *19*(3), 29–42. https://doi.org/10.1215/07402775-2002-4002

Croatian Ministry of Health & World Bank. (2000). The reform of health care in Croatia. *Revija za socijalnu politiku*, *7*(3), 311–325.

Croatian Parliament. (2006). Nacionalna strategija razvitka zdravstva 2006. – 2011 [National strategy of healthcare development]. *Narodne Novine*, *72*, 1–43.

Deacon, B. (2007). *Global social policy and governance*. SAGE.

de Carvalho, G., & Frisina Doetter, L. (2022). The Washington consensus and the push for neoliberal social policies in Latin America: The impact of international organisations on Colombian healthcare reform. In F. Nullmeier, D. González de Reufels, & H. Obinger (Eds.), *International impacts on social policy: Short histories in global perspective* (pp. 211–224). Springer International Publishing.

Etchemendy, S., & Palermo, V. (1998). Conflicto y concertación. Gobierno, Congreso y organizaciones de interés en la reforma laboral del primer gobierno de Menem (1989–1995). *Desarrollo Económico*, *37*(148), 559. https://doi.org/10.2307/3467412

Fair, M. (2008). *From population lending to HNP results : The evolution of the World Bank's strategies in health, nutrition and population*. World Bank.

Finkelstein, J. Z., Duhau, M., & Speranza, A. (2016). Trend in infant mortality rate in Argentina within the framework of the Millennium Development Goals. *Archivos argentinos de pediatria*, *114*(3), 216–222.

Frisina Doetter, L., Schmid, A., de Carvalho, G., & Rothgang, H. (2021). Comparing apples to oranges? Minimizing typological biases to better classify healthcare systems globally. *Health Policy OPEN*, *2*, 100035–8. https://doi.org/10.1016/j.hpopen.2021.100035

García-Lema, A. (1994). *La reforma por dentro: La dificil construcción del consenso constitucional*. Editorial Planeta.

Guerrero Espinel, E., Levcovich, M., Lima Quintana, L., Santich, I., & Jasín, M. (1999). Transformaciones del sector salud en la Argentina: Estructura, proceso y tendencias de la reforma del sector entre 1990 y 1997. *Representación OPS/OMS Argentina*, *48*, 1–152.

Hannah, A. (2020). Evaluating the role of bricolage in US Health Care policy reform. *Policy & Politics*, *48*(3), 485–502. https://doi.org/10.1332/030557319X15734252004022

Hochstetler, K. (2006). Rethinking presidentialism: Challenges and presidential falls in South America. *Comparative Politics*, *38*(4), 401–418. https://doi.org/10.2307/20434009

Johannes, L. (2007). *Output-based aid in health: The Argentine maternal-child health insurance program. 11033*. The World Bank Group.

Kaasch, A. (2015). *Shaping global health policy. Global social policy actors and ideas about health care systems*. Palgrave Macmillan.

Kaminska, M. E., Druga, E., Stupele, L., & Malinar, A. (2021). Changing the healthcare financing paradigm: Domestic actors and international organizations in the agenda setting for diffusion of social health insurance in post-communist Central and Eastern Europe. *Social Policy & Administration*, *55*(6), 1066–1081. https://doi.org/10.1111/spol.12724

Kasapović, M. (2005). Koalicijske vlade u Hrvatskoj: prva iskustva u komparativnoj perspektivi [Coalition Governments in Croatia: First experiences in a comparative perspective]. In G. Čular (Ed.), *Izbori i konsolidacija demokracije u Hrvatskoj* [Elections and consolidation of democracy in Croatia] (pp. 181–209). Biblioteka Politička misao. Hrvatska politologija, 11. Fakultet političkih znanosti.

Kovačić, L., & Šošić, Z. (1998). Organization of health care in Croatia: Needs and priorities. *Croatian Medical Journal*, *39*(3), 249–255.

Krogstad, E. (2007). The post-Washington consensus: Brand new agenda or old wine in a new bottle? *Challenge*, *50*(2), 67–85. https://doi.org/10.2753/0577-5132500205

Langenbrunner, J. C. (2002). Supplemental health insurance: Did Croatia miss an opportunity? *Croatian medical journal*, *43*(4), 403–407.

Levitsky, S., & Murillo, M. (2008). Argentina: From Kirchner to Kirchner. *Journal of Democracy*, *19*(2), 16–30. https://doi.org/10.1353/jod.2008.0030

Lloyd-Sherlock, P., & Novick, D. (2001). "Voluntary" user fees in Buenos Aires hospitals: Innovation or imposition? *International Journal of Health Services*, *31*(4), 709–728. https://doi.org/10.2190/0AKN-3N3E-3C9K-V3G5

Lütz, S., & Kranke, M. (2014). The European rescue of the Washington Consensus? EU and IMF lending to Central and Eastern European countries. *Review of International Political Economy*, *21*(2), 310–338. https://doi.org/10.1080/09692290.2012.747104

Machado, C. V. (2018). Health policies in Argentina, Brazil and Mexico: Different paths, many challenges [Políticas de Saúde na Argentina, Brasil e México: Diferentes caminhos, muitos desafios]. *Ciência & Saúde Coletiva*, *23*(7), 2197–2212. https://doi.org/10.1590/1413-81232018237.08362018

Malinar, A. (2022). Anti-communist backlash in the Croatian Healthcare System. In J. J. Kuhlmannm, & F. Nullmeier (Eds.), *Causal Mechanisms in the Global Development of Social Policies* (pp. 239–270). Springer International Publishing.

Mercado, R. (2007). *The Argentine recovery: Some features and challenges*. VRP Working Paper. https://explore.openaire.eu/search/publication?articleId=od_645::a6e406fa86d8b8674279ca0bb04c3141

Misztal, B. (1992). Must Eastern Europe follow the Latin American way? *European Journal of Sociology*, *33*(1), 151–179. https://doi.org/10.1017/S0003975600006391

Myles, J., & Quadagno, J. (2002). Political theories of the welfare state. *Social Service Review*, *76*(1), 34–57. https://doi.org/10.1086/324607

Nemec, J., & Kolisnichenko, N. (2006). Market-based health care reforms in Central and Eastern Europe: Lessons after ten years of change. *International Review of Administrative Sciences*, *72*(1), 11–26. https://doi.org/10.1177/0020852306061611

Nemec, J., & Lawson, C. (2008). Health care reforms in CEE: Processes. *Outcomes and Selected Explanations, NISPAcee Yearbook*, *1*, 27–50.

Niemann, D., Martens, K., & Kaasch, A. (2021). The architecture of arguments in global social governance: Examining populations and discourses of international organizations in social policies. In K. Martens, D. Niemann, & A. Kaasch (Eds.), *International Organizations in Global Social Governance* (pp. 3–28). Springer International Publishing.

Nochteff, H. (2002). La experiencia argentina de los años 90 desde el enfoque de la competitividad sistémica. In T. Altemburg, & D. Messner (Eds.), *America Latina Competitiva: Desafíos para la economía, sociedad y el estado* (pp. 205–221). Deutsches Institut für Entwicklungspolitik (DIE); Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ); Nueva Sociedad.

Noy, S. (2017). *Banking on health: The World Bank and health sector reform in Latin America*. Springer International Publishing.

O'Donnell, G. A. (2008). *Catacumbas* (1 ed). Prometeo Libros.

Ollier, M. M. (2001). *Las coaliciones políticas en la Argentina: El caso de la Alianza* (1a ed). Fondo de Cultura Económica.

Öniş, Z., & Şenses, F. (2005). Rethinking the emerging post-Washington consensus. *Development and Change*, *36*(2), 263–290. https://doi.org/10.1111/j.0012-155X.2005.00411.x

Orenstein, M. A. (2008). *Privatizing pensions: The transnational campaign for social security reform*. Princeton University Press.

Polte, A., Haunss, S., Schmid, A., de Carvalho, G., & Rothgang, H. (2022). The Emergence of Healthcare Systems. In M. Windzio, et al. (Ed.), *Networks and geographies of global social policy diffusion: Culture, economy, and colonial legacies* (pp. 111–138). Springer International Publishing.

Puljiz, V., Bežovan, G., Matković, T., Šućur, Z., & Zrinščak, S. (2008). *Socijalna politika Hrvatske* [Croatian Social Policy]. Pravni fakultet Sveučilišta u Zagrebu.

Radin, D. (2008). World Bank funding and health care sector performance in Central and Eastern Europe. *International Political Science Review*, *29*(3), 325–347. https://doi.org/10.1177/0192512107088392

Ramet, S. P. (2013). Politika u Hrvatskoj od 1990. [Croatian politics since 1990]. In K. Klewing, R. Lukic, B. Marjanovic, & S. P. Ramet (Eds.), *Hrvatska od osamostaljenja: rat, politika, drustvo, vanjski odnosi* [Croatia since independence: War, politics, society, external relations] (pp. 33–59). Golden Marketing-Tehnicka Knjiga.

Rubinstein, A., Zerbino, M. C., Cejas, C., & López, A. (2018). Making universal health care effective in Argentina: A blueprint for reform. *Health Systems & Reform*, *4*(3), 203–213. https://doi.org/10.1080/23288604.2018.1477537

Šarić, M., & Rodwin, V. G. (1993). The once and future health system in the former Yugoslavia: Myths and realities. *Journal of Public Health Policy*, *14*(2), 220–237. https://doi.org/10.2307/3342966

Schmid, A., Cacace, M., Götze, R., & Rothgang, H. (2010). Explaining health care system change: Problem pressure and the emergence of "hybrid" health care systems. *Journal of Health Politics, Policy and Law*, *35*(4), 455–486. https://doi.org/10.1215/03616878-2010-013

Schmitt, C. (2020). External actors and social protection in the Global South: An overview. In C. Schmitt (Ed.), *From colonialism to international aid. External actors and social protection in the global south* (pp. 3–18). Springer International Publishing.

Schönfelder, B. (2013). Utjecaj rata na gospodarstvo [The influence of war on economy]. In R. Lukić, S. Ramet, & K. Clewing (Eds.), *Hrvatska od osamostaljenja: rat, politika, društvo, vanjski odnosi* [Craotia since independence: War, politics, society and external relations] (pp. 201–223). Golden Marketing-Tehnicka Knjiga.

Stillwaggon, E. (1998). *Stunted lives, stagnant economies: Poverty, disease, and underdevelopment*. Rutgers University Press.
Stubbs, P., & Zrinščak, S. (2007). Croatia. In B. Deacon, & P. Stubbs (Eds.), *Social policy and international interventions in South East Europe* (pp. 85–103). Edward Elgar.
Tichenor, M., & Sridhar, D. (2017). Universal health coverage, health systems strengthening, and the World Bank. *BMJ*, *358*, j3347. https://doi.org/10.1136/bmj.j3347
Tobar, F. (2002). Una reforma estructural del sistema de salud. *Tram[p]as de La Comunicación y La Cultura*, *7*(1), 46–48.
Tobar, F. (2010). *¿Qué aprendimos de las Reformas de Salud? Evidencias de la experiencia internacional y propuestas para Argentina*. Fundación Sanatorio Güemes.
Tobar, F. (2012). Breve historia del sistema argentino de salud. In O. E. Garay (Ed.), *Responsabilidad Profesional de los Médicos. Ética, Bioética y Jurídica. Civil y Penal* (pp. 1–19). La Ley.
Vidučić, L. (2000). Progress in the Croatian transition and prospects for Croatia-EU relations. *SEER: Journal for Labour and Social Affairs in Eastern Europe*, *3*(1), 47–64.
Vončina, L., Džakula, A., & Mastilica, M. (2007). Health care funding reforms in Croatia: A case of mistaken priorities. *Health Policy*, *80*(1), 144–157. https://doi.org/10.1016/j.healthpol.2006.02.016
Vončina, L., Kehler, J., Evetovits, T., & Bagat, M. (2010). Health insurance in Croatia: Dynamics and politics of balancing revenues and expenditures. *The European Journal of Health Economics*, *11* (2), 227–233. https://doi.org/10.1007/s10198-009-0163-4
Weyland, K. (2006). *Bounded rationality and policy diffusion: Social sector reform in Latin America*. Princeton University Press.
Wilensky, H. (1975). *The welfare state and equality: Structural and ideological roots of public expenditures*. University of California Press.
Williamson, J. (1993). Democracy and the "Washington consensus". *World Development*, *21*(8), 1329–1336. https://doi.org/10.1016/0305-750X(93)90046-C
Wireko, I., & Béland, D. (2017). Transnational actors and health care reform: Why international organizations initially opposed, and later supported, social health insurance in Ghana. *International Journal of Social Welfare*, *26*(4), 405–415. https://doi.org/10.1111/ijsw.12257
World Bank. (1987). *Financing health services in developing countries: An agenda for reform*. World Bank Publications.
World Bank. (1993). *World development report 1993: Investing in health, Volume 1*. The World Bank.
World Bank. (1997). *Health, nutrition and population sector strategy*. The World Bank.
World Bank. (2008). *Country partnership strategy for The Republic of Croatia for the period FY09-FY12*. Report No. 44879-HR. The World Bank.
World Bank. (2023). *World Bank open data.* https://data.worldbank.org/
World Health Organization. (n.d.). *Health financing*. Retrieved April 26, 2023 from https://www.who.int/health-topics/health-financing#tab=tab_1
World Health Organization. Regional office for Europe & European Observatory on Health Systems and Policies. (1999) *Health care systems in transition: Croatia*. WHO Regional Office for Europe.
Zrinščak, S. (2007). Zdravstvena politika Hrvatske. U vrtlogu reformi i suvremenih društvenih izazova [Croatian health policy. In the whirlwind of reforms and contemporary social challenges]. *Revija Za Socijalnu Politiku*, *14*(2), 193–220.

Appendix 1. Analysed documents

Table A1. Argentina.

No.	Name of Document	Year	Link	Document Code
1	Population, Health and Nutrition Sector Review	1987	https://documents.worldbank.org/en/publication/documents-reports/documentdetail/524711467999097146/argentina-population-health-and-nutrition-sector-review	D1
2	Maternal and Child Health and Nutrition Project	1993	https://documents.worldbank.org/en/publication/documents-reports/documentdetail/724541499097500930/argentina-maternal-and-child-health-and-nutrition-project	D2
3	Social Sector Management Technical Assistance Project	1994	https://documents.worldbank.org/en/publication/documents-reports/documentdetail/218091468204555811/argentina-social-sector-management-technical-assistance-project	D3
4	Provincial Health Sector Development Project	1995	https://documents.worldbank.org/en/publication/documents-reports/documentdetail/471401468009326471/argentina-provincial-health-sector-development-project	D4
5	Health Insurance Reform Loans Project	1995	https://documents.worldbank.org/en/publication/documents-reports/documentdetail/181611468210574279/argentina-health-insurance-reform-loans-project	D5
6	Health Insurance Technical Assistance Project	1996	https://documents.worldbank.org/en/publication/documents-reports/documentdetail/362151485897560905/argentina-health-insurance-technical-assistance-project	D6
7	Facing The Challenge of Health Insurance Reform	1997	https://documents.worldbank.org/en/publication/documents-reports/documentdetail/373441468741669679/argentina-facing-the-challenge-of-health-insurance-reform	D7
8	Poor People in a Rich Country: Poverty Report for Argentina	2000	https://documents.worldbank.org/en/publication/documents-reports/documentdetail/768561468000279728/poverty-report-for-argentina	D8
9	Provincial Health Sector Development Project	2002	https://documents.worldbank.org/en/publication/documents-reports/documentdetail/496961468217777755/argentina-provincial-health-sector-development-project	D9
10	Health Insurance for The Uninsured	2003	https://documents.worldbank.org/en/publication/documents-reports/documentdetail/228731474566915988/argentina-health-insurance-for-the-uninsured	D10
11	Health Sector Adjustment Project	2003	https://documents.worldbank.org/en/publication/documents-reports/documentdetail/757321468768590717/argentina-health-sector-adjustment-project	D11
12	Essential Public Health Functions Project	2006	https://documents.worldbank.org/en/publication/documents-reports/documentdetail/326991468004205213/argentina-essential-public-health-functions-project	D12
13	Provincial Maternal-Child Health Sector Adjustment Loan	2007	https://documents.worldbank.org/en/publication/documents-reports/documentdetail/686531468202183937/argentina-provincial-maternal-child-health-sector-adjustment-loan	D13
14	Provincial Maternal-Child Health Sector Adjustment Ln. (PMCHSAL)	2007	https://documents.worldbank.org/en/publication/documents-reports/documentdetail/280241474591032513/argentina-provincial-maternal-child-health-sector-adjustment-ln-pmchsal	D14

Source: Authors' compilation.

Table A2. Croatia.

No.	Name of Document	Year	Link	
1	Memorandum and Recommendation of the President of the International Bank for Reconstruction and Development to the Executive Directors on a Proposed Loan in an Amount Equivalent to US$40.0 Million to Republic of Croatia for a Health Project. Report No. *P*-6580-HR.	1995	http://documents1.worldbank.org/curated/en/559441468244221414/pdf/multi0page.pdf.	D15
2	Croatia Beyond Stabilisation. Report No. 17261	1997b	https://documents1.worldbank.org/curated/en/537421468746754080/pdf/Croatia-Beyond-stabilization.pdf	D16
3	Financiranje javnog sektora, reforma zdravstva i mirovinska reforma u Hrvatskoj [Public Sector Financing, Health Care Reform and Pension Reform in Croatia].	1997c	Revija za socijalnu politiku 4(3): 265–285	D17
4	Croatia: A Policy Agenda for Reform and Growth	2000	https://web.worldbank.org/archive_old/website00978/WEB/PDF/A_POLICY.PDFhttps://web.worldbank.org/archive_old/website00978/WEB/PDF/A_POLI-2.PDF	D18
5	The Reform of Health Care in Croatia	2000	Croatian Ministry of Health & World Bank. (2000). Revija za socijalnu politiku, 7(3), 311–325.	D19
6	Croatia Regaining Fiscal Sustainability and Enhancing Effectiveness: A Public Expenditure and Institutional Review	2001	https://openknowledge.worldbank. org/handle/10986/13993	D20
7	Report and recommendation of the President of the International Bank for Reconstruction and Development to the Executive Directors on a proposed structural adjustment loan in the amount of US $202 million to the Republic of Croatia. Report No. P7490-HR, 26 October	2001d	https://documents1.worldbank.org/curated/en/995481468244223640/pdf/multi0page.pdf	D21
8	Loan Agreement (Structural Adjustment Loan) Between Republic of Croatia and International Bank for Reconstruction and Development (Loan Number 4641 HR)	2001c	https://documents1.worldbank.org/curated/en/396551468248953182/pdf/396E4FE7150A8EA485256F030015F4EE.pdf	D22
9	Croatia: Health Finance Study	2004	https://openknowledge.worldbank.org/server/api/core/bitstreams/3c4c38bb-b9e8–5d99-8424-3cf7beb7d2b0/content	D23
10	International Bank for Reconstruction and Development Program Document for a Proposed Programmatic Adjustment Loan in The Amount of Eur150 Million (US $184.9 Million Equivalent) to the Republic of Croatia. Report No. 30293-HR	2005	https://documents1.worldbank.org/curated/en/692461468025814288/pdf/302931init0rev0pdf.pdf	D24
11	International Bank for Reconstruction and Development Program Document for a Proposed Programmatic Adjustment Loan in The Amount of Eur150 Million (US $197.4 Million Equivalent) to the Republic of Croatia. Report No. 39392-HR	2007	https://documents1.worldbank.org/curated/en/450581468248374738/pdf/39392main.pdf	D25

Source: Authors' compilation.

General declaration

I declare that I have autonomously completed my dissertation without seeking any unauthorised aid. All sources and aids employed in the dissertation are properly referenced, with clear acknowledgment and citation. Any ideas, excerpts, or citations not originating from my own work are explicitly identified. I will also allow the dissertation to be checked with qualified software in the event of allegations of plagiarism.

Date and Place Ante Malinar