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Improving access to healthcare for minority groups: qualitative study with social workers in Croatia

Abstract
Social workers are employed in hospitals and healthcare institutions to contribute to integrative healthcare that considers social aspects of health. Practitioners should be aware of influence that cultural background, values and structural, socio-political factors have on patients' access to healthcare system and provision of healthcare. The aim of this paper was to describe and analyze experience hospital social workers have working with patients from diverse cultural backgrounds, what are the challenges they face and what contributes to good practice. Qualitative approach was used, and two focus groups were held with 12 social workers participating in discussions. Transcripts were analyzed using thematic analysis. Six themes and twelve subthemes were identified. Social workers perceive foreigners and Roma minority as patients from diverse cultural backgrounds. Factors that contribute to good practice and positive outcome for patients are: effort that social workers invested in administrative tasks and procedures, advocacy for patients and their rights on all levels, frequent communication and counseling with patients and communication with patient's family members.

1. Introduction

Bio-psycho-social model of understanding health and disease has led to the involvement of non-medical professionals in the prevention, diagnosis and treatment of disease and preservation of health. One of the included professionals that contribute to integrative healthcare are social workers. Their work in healthcare should complement the

traditional way of conducting clinical/medical work oriented towards the elimination of symptoms and treatment of disease. Social workers should assess the needs of patients, risk and protective factors and plan interventions taking into account patients existing preserved psychosocial potentials and use effort to strengthen them. Advocate for the patient in situations when he/she cannot do it for himself/herself, especially for members of minority groups who due to their social position have poorer access to social resources including healthcare. Social work in healthcare includes direct work with patients, their family members, building a bridge between, for example, hospital and community–based services.[1] In Croatia, social workers are included in healthcare system from the beginning of professionalization of social work, when the first social worker was employed at the Vrapče Psychiatric Hospital in 1955 in Zagreb. Since then, social workers are continuously employed in hospitals and clinical hospitals. In 2019, 93 social workers were employed in healthcare, mostly in the field of psychiatry and addiction, e.g. at the psychiatry departments in general hospitals, university clinics and special psychiatry hospitals, less in other parts of the healthcare system such as in public health institutes and at special hospitals, e.g. rehabilitation hospitals, long term care hospital.[2] The work of social workers in healthcare is based upon concepts like system theory, person in environment perspective, empowerment, and inclusion.

In the Constitution of the Republic of Croatia[3] the right to healthcare is proscribed to all citizens according to law. So, the system is based on the principles of inclusiveness, solidarity, reciprocity and accessibility to all citizens. According to the Central Bureau of Statistics (2020), with health insurance is covered a total of 4,188,658 people in 2019, which indicates good coverage of citizens with healthcare. The Croatian Health Insurance Institute is in charge of implementing basic health insurance. Healthcare is provided at the primary (preventive and general, family medicine), secondary (specialized and

[1] Cèsar M. Garcès Carranza: Social work in the hospital setting: interventions. Bloomington 2012.

[2] Croatian Institute of Public Health: National Register of Health Care Provider. https://www.hzjz.hr/en/division-for-public-health/ (accessed on 7.2.2023).

[3] Republic of Croatia: Constitution of Republic of Croatia, Article 59. In: Official Gazette of the Republic of Croatia 85 (2010). https://www.usud.hr/sites/default/files/dokumenti/The_consolidated_text_of_the_Constitution_of_the_Republic_of_Croatia_as_of_15_January_2014.pdf (accessed on 7.2.2023).

hospital level) and tertiary level (the most complex forms of healthcare) and at the level of healthcare institutes.[4] Last 30 years, since the independence of Croatia, have been marked with several reforms in healthcare system. All these reforms had similar goal to rationalize and make financing of the health system more efficient. As in other countries in the world, the increased costs in healthcare are influenced by the aging population and the further development of technology in medicine and pharmacology, which allows a greater number of diagnostic and curative treatments that are becoming more expensive.[5] In Croatian public discourse, there are critics of the healthcare system regarding long waiting lists for diagnostics and specialist examination, provision and accessibility of healthcare in rural regions and on islands. According to research conducted by Economic Institute, Zagreb in 2010, patients stated that they are satisfied (40 %) or very satisfied (40 %) with quality of services physicians provide.[6]

But the differences in satisfaction and perception of accessibility of healthcare services exist and are related to socio-economic factors and minority status that contribute to existence of health inequalities.[7] Ombudswomen in Croatia emphasizes the need to systematic collect data about public services – health, social, educational – provided to national and ethnic minority to gain data and indicators that can be used for planning and delivering policies that recognize needs of

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[4] Republic of Croatia: Health Care Act. In: Official Gazete of the Republic of Croatia 100 (2018).

[5] Dubravko Mihaljek: Kako financirati zdravstvo u doba financijske krize? [How to finance healthcare in times of financial crisis?]. In: Maja Vehovec (Ed.): O zdravstvu iz ekonomske perspektive [About healthcare from an economic perspective]. Zagreb 2014, pp. 29–50.

[6] Jelena Budak: Ocjena pacijenata o kvaliteti rada zdravstvenog osoblja [Patients' assessment of the quality of work of the healthcare staff]. In: Maja Vehovec (Ed.): O zdravstvu iz ekonomske perspektive [About healthcare from an economic perspective]. Zagreb 2014, pp. 271–282.

[7] Luka Vončina, Ivan Pristaš, Miroslav Mastilica, Ozren Polašek, Zvonko Šošić, Ranko Stevanović: Use of Preventive Health Care Services among Unemployed in Croatia. In: Croatian Medical Journal 48 (2007), pp. 667–674; Zoran Šućur: Zdravlje i kvalitete zdravstvenih usluga [Health and the quality of health services]. In: Lidija Japec, Zoran Šućur (Eds.): Kvaliteta života u Hrvatskoj. Regionalne nejednakosti [Quality of life in Croatia. Regional inequalities]. Zagreb 2007, pp. 79–88; Zoran Šućur, Siniša Zrinščak: Differences that Hurt: Self-Perceived Health Inequalities in Croatia and European Union. In: Croatian Medical Journal 48 (2007), pp. 653–666.

particular group and in that way deal with structural discrimination.[8] On policy level, in new National Health Development Plan 2021 to 2027 that is in process of delivering, upbringing of healthcare for vulnerable groups is clearly stated as a priority of public policy but without any other operationalization.[9] On the system level as well as in practice there is possibility that obstacles and problems of minority group also remain »invisible« or approached by »equal treatment to everyone«[10], which has elements of culturally blind practice[11]. Especially in the light of strong predominance in number of white Croatian catholic heterosexual population in all social systems.

According to latest national Census (2011) 90.42 % declared themselves as Croats, 86.3 % as Catholic.[12] Other largest declared ethnic groups are Serbs (4.36 %), Bosnians (0.73 %), Albanians (0.41 %) and Roma (0.40 %). Since 2011. Croatia has continuing increase of immigrants coming to Croatia (from 8,534 in 2011 to 33,414 in 2020).[13] In addition, tourism is important economic branch with continually increase in number of tourist coming to Croatia (84,147,631 foreign tourists in 2019).[14] In 2020 there were 1,932 asylum seekers in Croatia.[15] All these groups bring to cultural diver-

[8] Ombudsman Office of the Republic of Croatia: Discrimination based on race, ethnicity or color, and national origin (2020). https://www.ombudsman.hr/hr/diskriminacija-temeljem-rase-etnicke-pripadnosti-ili-boje-koze-te-nacionalnog-podrijetla-2/ (accessed on 7.2.2023).

[9] Ministry of Health of the Republic of Croatia: Nacrt prijedloga nacionalnog plana razvoja zdravstva za razdoblje od 2021 do 2027 godine [Draft proposal of the national health development plan for the period from 2021 to 2027]. https://esavjetovanja.gov.hr/Econ/MainScreen?EntityId=19191 (accessed on 7.2.2023).

[10] Derald Wing Sue, David Sue: Counseling the culturally different: Theory and practice. Hoboken 1990.

[11] Clara S. Simmons, Leticia Diaz, Vivian Jackson, Rita Takahashi. NASW cultural competence indicators: A new tool for the social work profession. In: Journal of Ethnic and Cultural Diversity in Social Work 17 (2008), pp. 4–20.

[12] National Bureau of Statistics: Croatia Census of Population, Households and Dwellings. https://www.dzs.hr/Hrv_Eng/publication/2012/SI-1469.pdf (accessed on 7.2.2023).

[13] National Bureau of Statistics: Migration of the population of the Republic of Croatia in 2020. https://www.dzs.hr/Hrv_Eng/publication/2021/07-01-02_01_2021.htm (accessed on 7.2.2023).

[14] National Bureau of Statistics: Tourist arrivals and nights in 2019. https://www.dzs.hr/Hrv_Eng/publication/2019/04-03-02_01_2019.htm (accessed on 7.2.2023).

[15] National Bureau of Statistics: Statistical indicators of persons granted international protection in the Republic of Croatia until 31.12.2020. https://mup.gov.hr/UserDoc

sity in Croatian society and their members can be users of healthcare services. In that respect, it is important for healthcare professionals to be aware of influence that cultural background, values and structural, socio-political factors have on patients' access to healthcare system and provision of healthcare. Culturally competent practice in healthcare is well known and debated in different European countries and in USA where majority of literature is produced. Cultural competence is changeable and dynamic concept, depending of individual, time, population and system.[16] In Croatian context not much about cultural competence in social work profession is problematized and researched, so we have turned to social workers in the hospitals to get insight into their experience working with patients from diverse cultural backgrounds, what are the challenges they face and what contributes to good practice.

2. Methods and Materials

Results presented in this article are part of study »Specifics of social work in healthcare during pandemic« funded by University of Zagreb in 2020. Research about social work in healthcare and about cultural diversity are rear in Croatian context, so we wanted to focus on social workers' experiences in hospital setting with patients form different cultural background. Therefore, qualitative research method was used to gain insight in social workers' personal experiences and practice related to the goal of this research. To gain insight into commonalities and differences in viewpoints of social workers the focus group as a technique of group conversation was conducted.[17]

Target population for this study consisted of healthcare social workers in Croatia. We recruited purposive sample of social workers based on inclusion criteria: a) social workers that are employed in university hospitals, clinical centers and municipality hospitals; b) have direct experience working with minority population and patients from diverse cultural background; c) social workers that agreed to participate and gave informed consent and d) come from

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sImages/statistika/2021/Medjunarodna_zastita/Medjunarodna_zastita_4kvartal2020.pdf (accessed on 7.2.2023).

16 Simmons, Diaz, Jackson, Takahashi: NASW cultural competence (Note 11).

17 Goran Milas: Istraživačke metode u psihologiji i drugim društvenim znanostima [Research methods in psychology and other social sciences]. Zagreb 2005.

different Croatian regions, from coastal part, heartland, rural and urban. Recruited social workers were invited to participate in focus group discussion via e-mail explaining the study goal, purpose and the aim of the focus group discussion.

Focus groups were conducted in 2021 and lasted 90 minutes. Two groups were carried out online using Zoom platform. Online way was used because of pandemic time and difficult access to hospitals and clinics. Besides that, online platform enables social workers from different part of Croatia to participate easily in focus group discussion – without traveling and other expenses. Online meetings were recorded; all the participant gave written consent to record the Zoom meeting. Later the audio was transcribed verbatim. Authors of this article led focus groups using previously agreed semi structured question guide. Both researchers are social workers, one working in hospital setting, and other teaching healthcare social work, both with experience in qualitative research. The focus group open ended question addressed experiences that social workers have working with patients with different cultural backgrounds, description of current practice, difficulties they face and how they deal with them, and examples of good practice.

Framework analysis was used »to classify and organize data according to key themes, concepts and emergent categories«.[18] Two researches, and authors of this paper, separately analyzed the transcripts, derived themes and subthemes following phases for thematic analysis:[19] (1) familiarizing with data, (2) generating initial codes, (3) searching for themes, (4) reviewing themes, (5) defining and naming themes and (6) producing the report. After that, process of comparing and discussing of findings was undertaken. Six themes and twelve subthemes emerged from thematic analysis of transcripts. A code for each participates was assigned to make data anonymized.

Social workers participated voluntary in the study. Separate approval of an ethics committee was not required because in this research participant were not members of vulnerable group or patients. Participants in research were social work professionals that

[18] Jane Ritchie, Liz Spencer, William O'Connor: Carrying out Qualitative Analysis. In: Jane Ritchie, Jane Lewis (Eds.): Qualitative research practice: a guide for social science students and researchers. London, Thousand Oaks, New Delhi 2003, pp. 219–262.

[19] Virginia Braun, Victoria Clarke: Using Thematic Analysis in Psychology. In: Qualitative Research in Psychology 3 (2006), pp. 77–101.

gave informed consent to participate in the focus group discussion and to record the meeting. The participants were not anonym to researchers and to each other but were inform at the beginning of the focus group about confidentiality and way that anonymization of data will be delivered to safeguard their anonymity and confidentiality. In addition, they were informed about their right to opt out during the discussion at any time.

Two focus groups were conducted with 12 participants. All of them were women, social workers, average 40 years of age, with average 15 years working experience, and average 9 years working in healthcare system. They were working in university clinical hospital, general hospitals and special clinics from Zagreb, Rijeka, Split, Pula, Dubrovnik, Varaždin i Čakovec. Half of them are employed as hospital social worker and another half as a social worker within psychiatric hospital unit but have experiences going to other hospital units when needed, i.e., conciliatory work.

3. Results

3.1. Patients from diverse cultural background

At the beginning, before talking about the role of social workers working with patients with different cultural background, it was important to comprehend how social workers understand concept of patients from diverse cultural background.

3.1.1. Foreigners

All the participants had common understanding that when the talk is about cultural differences and patients from diverse cultural background it is about »foreigners«. Social workers define foreigners by the criteria of »formal citizenship and nationality«. By foreigners, they mean all the »patients that do not have Croatian citizenship. Therefore, during the focus group discussion examples of working with »migrants and asylum seekers, tourists, foreign workers of different national background« were described. Mainly Bosnia and Hercegovina, Serbia, Slovenia, Macedonia – people from the states that were together with Croatia part of Yugoslavia until 1990, and

then from other EU countries e.g. Germany, Swiss Austria, Italy, Denmark, Hungary.

> »We are city on the coast, transit city, so we have lot of tourist, foreign workers, lot of foreigners, all countries of Europe are presented, we have Roma minority, people that do not have citizenship, just temporary stay, without health insurance.« (SW3)

3.1.2. Roma minority

Roma national minority was mentioned when »lack of health insurance and unregulated stay in Croatia« was addressed.

> »We are close to the border so working with foreigners is constant, we have lot of Slovenians, Austrians, Roma people, ethnic minority that most usual have no health insurance or unregulated stay in Croatia that we deal with.« (SW4)

3.2. Perception of working with patients from diverse cultural background

All participants agreed that work with foreigners is a »creative work« that engages all the knowledge and skills. Social workers need to be »resourceful«, with »lot of contacts and good professional network« in local community and with officers in different institutions. Also, the reactions and work need to be done »fast and prompt«.

> »Working with foreigners is exhausting because it last for weeks, but for me it is a career achievement. That is a specific field of practice that requires from social worker to use all knowledge and skills, from administrative, organizational, legal and all other knowledge that we gain through education and experience.« (SW5)

Participants stated that they did not pay much attention on how their own cultural background influenced their social work practice. They attached more importance to the »professional values« and practice, to have »individualized approach« to every patient and due to that, and they »respect every patient« with his/her »unique needs«.

> »I don't have any problems with cultural diversity, it is easier with someone and more difficult with others. Every patient is individual and unique, but it is a patient and you have to communicate, you have

to find a way, you have to do your work, you have to be adroit, and manage.« (SW1)

3.3. Access to hospital healthcare

3.3.1. Good access to healthcare

Participants perceive that foreigners, migrants and other national minorities have »good access to emergency healthcare« services, they think »healthcare is available to anyone« who is in need for it. »Hospitals provide medical care« to help the patient, especially acute emergency care, often »without any information about patients' health insurance«. Because of that, social workers perceive that the system is open to everyone.

»Emergency healthcare is provided without any questions.« (SW4)

Secondly, social workers try to solve healthcare insurance and coverage of medical expenses – or write-off due to social reasons – and in majority of cases, they are successful in that, so the patients get the care they need.

»Foreigners have good access to healthcare. If they are longer here they have registered stay here, if not we always come up with something. « (SW6)

3.3.2. Social works access to patients and patients' access to social workers

Social workers talked about the way they are informed about the patient and when their intervention start. All participants stated that they are »contacted by the physicians« to provide services to patients. Medical staff ask for social work intervention »when combination and accumulation of problems are in place«. Usually they are: communication problems arising from language barrier with the patients, lack of medical insurance, not clear legal status, no documents, no family members or disturbed family relationships, obvious socioeconomic problems. One social worker stated:

»I think they would call us in this situation and for Croatian citizens as well. They do not call us for every foreigner.« (SW5)

3.4. Role of social workers

Next theme was about the services social workers provide to patients with different cultural background.

3.4.1. Getting to know the patient

All participants agreed that first thing they do is »get in contact with patient« when possible – if patient is able to communicate – then »check patients' personal identification data and documentation« and »get in touch with all contacts« that patient provides to see are there family, relatives or friends that can take care for the patient. If the communication with the patient is not possible then they try to »get all the information possible« using patient personal belongings, getting in touch with police, center for social welfare, municipality, neighbors to see »what is the life story of patient«, is there someone who can take care of patient.

> »It is like a detective work.« (SW1)
>
> »We are researchers.« (SW6)
>
> »Policeman said to one of my colleagues, you are faster than police, you can come to work with us.« (SW7)

3.4.2. Developing the helping relationship with patient and family members

Some social workers emphasized importance of »building relationship and trust« with the patient, using »counseling skills and techniques«. That contributes to patient ability to »accept help and have trust that interventions and suggestions from social worker are in good manner«.

> »It is a process of alignment, at the begging we are more like detectives, and then we become allies, and the patients see us that way. Patients face with difficult and complex life situations that they cannot handle with own capacities, they need support and help.« (SW8)

Others emphasized importance of building relationship through »communication with the family« members to get insight into family situation and to: a) »motivate family members« to come

and take care of the patient and b) »provide support to family members« so they can take care or carry on with care for patient.

> »I provided hour and hours of phone counseling to patients son, daughter and wife who were very exhausted [caring for father who was psychiatric patient]« (SW4)

3.4.3. Administrative and formal tasks and procedures

All participants agreed that first thing they do is »checking patients' documentation and, identity«. Second step is according to patients' situation »resolving legal status, health insurance, post hospital care or continuing of care and transportation« in patients' homeland country or in Croatia. If the patient dies in hospital then the social worker is involved in »funeral organization – if the patient has no family, who will pay for the funeral, where it will take place«.

3.4.4. Bridge between hospital, patient and professionals in other institution

For the provision of all these administrative and formal tasks »cooperation with other institutions and systems is necessary«. Contacts with the »police, centers for social welfare, embassies, ministries – most usual healthcare and social care, health insurance institute, local and municipality government, general physicians, long term care hospitals or specialized hospitals, social care institutions« in country and abroad.

Cooperation with other institutions is good when they receive »quick response« to their notes, questions, e-mails with »concrete answers and directions«. Also, when the officers in other institutions are cooperative

> »It is important who is on the other side, who is official in insurance agency, in the police, to somebody nothing is problematic, and to others everything is problematic.« (SW6)

3.5. Impeding factors in provision of social work services

3.5.1. Lack of procedure and protocols

All participants stated that there is »no clear protocol« or written procedure what needs to be done, and who is in charge for what »on the level of their organization«, on the »level between institutions« and »multisector coordination«. Social worker »need to know about the laws« that determine patience rights, and they think »laws are good«, but their »provision in everyday life have obstacles«. Majority of participants described that they »wrote protocols of conduct for themselves« based on experience. Participants stated that the participation in this group discussion was empowering for them because they get confirmation for »their protocol«.

> »Now I realized that the others are doing the same things, in the same order and have similar problems.« (SW4)

3.5.2. Time

Participants problematized time it takes to do their job in two ways. One is connected with »administrative tasks and formal procedures that are time consuming«, lot of phone calls, waiting for other institutions to replay to some notes, e-mails. As there is »no clear protocol of conduct«, or clearly articulated »multisector cooperation« than lot of time is invested in writing notes and phone calls from one institution to other with the goal to »advocate the patients' rights and needs«. Secondly, time is connected with the social workers' access to patients. Physicians call social workers, sometimes at the beginning of medical treatment and sometimes at the end, then the quick solutions from social workers are expected, but not realistic due to time it takes to make all necessary work.

3.5.3. Language barriers

When patients are able to communicate then language that patents and care providers speak became impeding factor. Usually patients – migrants, tourists, foreign workers not coming from ex-Yugoslav countries – »do not speak Croatian«, and social workers »usually speak only English« and little Germany, Italian or Slovenian depend-

ing on the Croatian region they are form. Then social workers use »google translate, help from patients' friends or family« and if there are any, they hire »professional translators«.

3.6. Examples of good practice

Through focus group discussion, each social worker described a case that consider being example of good practice. Analyze of examples showed that factors that make good practice and bring to positive outcomes for the patients are:

a) »the effort that social workers invested in administrative tasks and procedures« to find the best solution for the patient, the solution that is according to law, suitable to patient's wishes and interests and feasible. This effort is manifested through »invested time« – from one month to one year, lot of phone calls and lot of written communication with social care services, police, and embassies;
b) »advocacy of the patient and their rights on all levels – from hospital to multisector cooperation«, communication with the hospital medical staff, institute for health insurance, social care services, general physicians, and other institutions;
c) »frequent communication and counseling with patients«, taking care of their needs, e.g., get clothes for patient, staff for personal hygiene, »communication with patients' family members«.

4. Discussion

In this paper, we analyzed how social workers describe their work with patients from diverse cultural backgrounds, challenges they face and what contributes to good practice. Social workers clearly related patients of diverse cultural background with the foreigners based on citizenship and by ethnicity, i.e. Roma minority. That is in accordance with the view that concept of culture refers to national origin, race, ethnicity and religious practice.[20] Influence that personal cultural

[20] Paula Allen-Meares: Cultural Competence: An Ethical Requirement. In: Journal of Ethnic and Cultural Diversity in Social Work 16 (2007), pp. 83–92.

background has on social work practice, social workers connected with professional values and norms. Value to respect each person with his/her individual characteristic, to be respectful and focused on patients' needs were highlighted as most important. These basic ethical principles of the profession are developed through social workers' codes of ethic on local and global level.

The Code of Ethics of Croatian Association of Social Workers speak of professional activity based on the principles of social justice regardless of cultural and other differences. The concepts of social justice, respect for cultural diversity in society »taking account of individual, family, group, and community differences«[21] are included into all documents defining the profession and its activities, e.g. in the Global Standards for Social Work Education and Training[22] and the Global Social Work Statement of Ethical Principles by International Federation of Social Workers[23]. Concept of culturally sensitive practice leans on these principals, and is well known and elaborated in literature coming from more diverse societies than Croatian. Also, Croatian society is not that diverse, but it is becoming more various, it is important to talk, write and research about cultural diversity and review common work practice and methodologies. Therefore, we plead that raising awareness and open discussion about cultural diversity and professionals' cultural background can bring to social workers that »(…) become sensitized to the role culture plays in our lives, and practice the skills necessary to address issues that may arise in a cultural context.«[24]

Concept of culturally sensitive practice can be useful because it can incorporate three levels important for delivering of health and social services: micro, i.e., professionals providing help, mezzo, i.e., institutions roles and regulations, and macro, i.e., public policies and regulations. Cross, Bazron, Denis and Isaacs conceptualize cultural competence as »a set of congruent behaviors, attitudes and policies that come together in a system or agency or among professionals

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21 International Federation of Social Workers: Global social work statement of ethical principles (2018). https://www.ifsw.org/global-social-work-statement-of-ethical-principles/ (accessed on 7.2.2023).

22 International Federation of Social Workers: Global Standards for Social Work Education and Training. https://www.ifsw.org/global-standards-for-social-work-education-and-training/ (accessed on 7.2.2023).

23 International Federation of Social Workers: Global social (Note 21).

24 Allen-Meares: Cultural Competence (Note 20).

that enable effective interactions in a cross-cultural framework.«[25] Influenced by critical paradigm, theory and practice in social work become more interested in structural sources of inequality, reduction of discrimination, culture, language in which we shape reality and practice, which has led to anti-racist, anti-discrimination and culturally sensitive practices.[26] Such development leads to changes in education and practice of social work, as well as in healthcare social work, in which experts should have adequate knowledge, skills, values and are sensible to notice the needs and obstacles arising from client cultural characteristics and act in that respect.

Practitioners in this study were more focused on their direct work with patients and family member, their effort, dedication and creativity they use to advocate for patients' rights through administrative task and procedures and psychosocial support they provide. On that micro level they have direct access and possible impact. Social workers have »ability to work effectively across differences and negotiate cultural impasses in the helping relationship is at the root of our potential to achieve positive outcomes.«[27] Role of social workers can be described trough two main parts. One is development of helping relationship with patient and family members and building trust with patient in order to empower individual. Other are all administrative procedures that need to be done to realize patients' rights and complement medical care. This process of psychological and social empowerment, mobilization of all available resources is in accordance with psychosocial approach that is widely used and accepted in Croatian social work practice.

What is also important, and participants in our study talked about it, is development of cooperation and collaboration on the micro and mezzo level, within and between institutions and systems. Collaboration with other professions in multidisciplinary teams is inevitable and social workers should strive to be as visible in this

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[25] Terry L. Cross, Barbara J. Bazron, Karl W. Dennis, Mareasa R. Isaacs: Towards a culturally competent system of care (1989). https://spu.edu/~/media/academics/school-of-education/Cultural%20Diversity/Towards%20a%20Culturally%20Competent%20System%20of%20Care%20Abridged.ashx (accessed 7.2.2023).

[26] David Howe: A Brief Introduction to Social Work Theory. London 2009.

[27] Corry Azzopardi, Ted McNeill: From Cultural Competence to Cultural Consciousness: Transitioning to a Critical Approach to Working Across, Differences in Social Work. In: Journal of Ethnic and Cultural Diversity in Social Work 25 (2016), pp. 282–299.

multidisciplinary environment as in the public eye.[28] Participant stated that physicians are calling them when they evaluate that social worker intervention is needed for some patient. In that context, it is important that medical team is informed about social workers and their role and services. Better cooperation could lead to improvement in impeding factors that social workers addressed as lack of procedures and protocols and time of interventions. For social workers it would be important to start interventions as soon as the patient come to hospital and when first risk factor can be detected, e.g., lack of medical insurance. For that reason, it is important to consider development of network collaboration that implies, as Ajduković[29] stated: a) closer relationship among professionals, b) equality, c) engagement with time and resources.

On the mezzo level multisector cooperation come to place. Lack of clear procedures within hospitals as well as lack of procedures for cooperation between the systems – health and social welfare most usual – is contributing to different practice and questions equal delivery of rights and services. Talk about multisector cooperation in the social care issues such as child welfare and childcare, as well as in healthcare provision is contemporary topic in Croatian professional communities, as well on the policy level. In the new National Health Development Plan 2021 to 2027[30] that is in process of delivering, multisector cooperation between healthcare and social welfare systems is emphasized and for that purpose establishment of a separate working body with representatives of both systems is envisaged. Their role is to establish harmonized protocols and guidelines that will bring to complementary practice within social and healthcare.

We think that what Ajduković[31] wrote in Guidelines for multisector cooperation in child welfare can also be appropriate to have in mind talking about development of cooperation within healthcare and between healthcare and other systems which is complex process. Based on that Guidelines we can say that cooperation within hospitals,

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[28] Rosalie B. Pockett, Liz Beddoe: Social work in health care: An international perspective. In: International Social Work 60 (2015), pp. 126–139.

[29] Marina Ajduković: Smjernice za unaprjeđenje međuresorne suradnje u zaštiti dobrobiti djece: Kako postići »novi pogled« na »staru temu suradnje« [Guidelines for improving interdepartmental cooperation in the protection of children's well-being: How to achieve a »new perspective« on the »old topic of cooperation«]. Zagreb 2021.

[30] Ministry of Health of the Republic of Croatia: Nacrt prijedloga (Note 9).

[31] Ajduković: Smjernice za unaprjeđenje (Note 29).

between medical team and social work department should be based on a) harmonized policies, i.e., strategies, laws; b) clear standards and procedures within each department; c) identified common ground between different departments; d) knowledge about the psycho-social risks, patients' rights, cultural diversity, minorities, functioning of social welfare and health system, e) creating preconditions for development of mutual support between departments; f) competent human resources that share values and some knowledge and g) time that will be invested in cooperation.[32]

5. Limitations

Aldo's qualitative methodology and focus groups are suitable for gaining insight into people experiences and attitudes and social workers participated provided valuable and interesting information and insights. It is possible that interviews would provide alternative perspective regarding influence of personal culture to social work practice.

6. Conclusion

In modern and contemporary social work practice, professionals should have adequate knowledge, skills and values to identify needs and act respecting the differences arising from client characteristics and culture such as gender, age, nationality, ethnicity, or socio-economic differences. Professionals should be aware of their own cultural background and experiences as well as experiences of others and work for the benefit of service users and patients in healthcare.[33] Therefore, concept of cultural competence should be part of educational programs for social workers and medical professionals and part of lifelong learning programs.

The social worker should be well acquainted with the functioning of the healthcare system and social care system at the regional and local level and with available community health and social services in order to provide relevant information to patients and families,

[32] Ajduković: Smjernice za unaprjeđenje (Note 29), here p. 17.
[33] Derald Wing Sue: Multicultural social work practice. Hoboken 2006.

to be able to take steps to advocate patients' rights. Results show that social workers describe their role trough development of helping relationship with patient and family members and through different administrative procedures and tasks that need to be done to realize patients' rights and complement medical care. They are aware of impact that social work interventions have on patients, especially when they have time, behave in flexible, creative way using appropriate language in proposing interventions needed to patients. All this makes up good practice and contributes to good results for patients.

To be more efficient it is important to develop clearly articulated protocols within hospitals based on shared understanding of social risks, cultural diversity and tasks that need to be performed. The clear protocols for multisector cooperation between hospital social workers, social care system, police, other state agencies are also needed to up bring professional relationship and provision of better services to patients. Till then social workers will do the best they know in helping and advocating patients in need.