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POLITICS AND HEALTH REFORM IN THE UNITED STATES

ABSTRACT

The US Health care system is a victim of delayed national policies where the interest groups always have the upper hand. Honest attempts had repeatedly failed in confronting the powerful lobby that governs health policy formulation. This article demonstrates the recent attempts of health reform in the US by the President Clinton, and the ongoing attempts to kill the basic reform achieved by President Obama. And the storey is not yet finished.

Key words: Health Reform. US health System. Obama Health Care Act

In 1994, after the Republicans paralyzed the Clinton health reform proposal, I published an article in the Florida Journal of Public Health titled "Reforming health care in the US and Europe: Why we fail and they succeed." It addressed: "The administration, inherited a basket full of bad news from its predecessor - the budget deficit, the recession, a weak economy and unemployment, to name a few. Among the problems, the health care crisis is the worst by far. This Issue has been evolving since the 1950s. A number of incremental actions have been aimed at solving the problem, but none has worked. Our inability to face the issue with a defined national health care policy has made it even more complex and perhaps even unsolvable. Except for the United States, all develop countries have adopted national health insurance that ensures coverage to every citizen with an affordable cost to individuals, communities and governments. Most of these countries are currently facing - and acting on cost problems caused by the development and use of costly technology, the aging of the population and a rate of medical inflation that exceeds tekst the general consumer price index. Most European countries adopted a commitment-to national health coverage in the 30's and 40's and have practiced the systems' controls despite the opposition of interest groups. Grappling with an "intractable" health care problem is not unique to America. Abdicating the responsibility of doing something about it, unfortunately, is. The United States suffers from all the inflationary problems. In addition, more than 16 percent of our population is uninsured, and we have the highest cost of health care in the world double that of most European countries. We also have extensive, unnecessary expenses caused by the cost of administrating a fragmented system, paying for malpractice insur-

ance and litigation, and covering a great deal of high-tech surgeries and procedures largely for the financial gain of physicians or as defense mechanisms against malpractice suits. More important, we have allowed special interest groups to grow, govern the political process, block any significant reform and manipulate “reform” actions to serve their interests. Controlling costs is a desirable, yet wishful act. As long as the, inflating factors exist - indeed, persists. Practically, there is no hope to lower the cost and the practical approach is to control its escalation. Dramatic actions would have to be taken to reshape the health care system”

The rest of the story is that President Clinton assigned the task to Msr Clinton who chaired a committee that met for months behind closed doors that were easy to be penetrated by the powerful lobbyists, produced a plan that was killed in the Congress by introducing five more competing plans, then the whole problem was dropped and ignored during the second Clinton term, and naturally during the two terms of the Republicans two terms of President Bush President Barak Obama took the early advantage of his presidency of the new president push and the majority in the two chambers of the Parliament and was able to pass the Affordable Health Care Act in March 2010

It explained why health reforms succeed in other Western countries with policies of universal access and user-friendly systems. In our case, the Republicans sacrificed health security of all citizens to play the political game of “Repeal the Obama Affordable Health Care Act,” responding to lobbyists and funding from interest groups. Members of Congress who **voted to repeal the law** come from the same category of irresponsible politicians who represent special interests that opposed Social Security, Medicare and Medicaid for short political gains.

To review where we are, the American health care non-system:

- is the only system that does not provide *health security* to its citizens. The uninsured population **reached 46.3 million in 2008** (compared to 36 million in 1993) and is steadily increasing. If the status quo continues by repealing Obamacare, it is expected to reach 75 million in 2019.
- is the most expensive system in the world. American healthcare expenditures **made up 16.2% of our gross national income in 2008**, compared to an average of 9–10 % in Europe. Without the recently passed reforms, it will soon reach 25%, which is almost double the cost in any country of comparable national income. The cost per individual reached \$7,681 in 2008.
- has one of the lowest provider-to-population ratios and the highest administrator-to-provider ratios (8 administrators per 10 health providers) among Western nations. The administrative portion of private health insurance agency expenditures is 30%, compared to 2–4% in Medicare and governmental agencies.

- has one of the lowest proportions of hospital beds for the population, the lowest hospital admission rate and the shortest length of hospital stay among Western nations. While European citizens use an average of 7-8 outpatient doctor visits per year, Americans use 3.8 visits per year.

These are just few features of our system that some falsely call “the best system in the world.” By technical and scientific standards, this system is ranked 37th among the 190 countries in the world. Life expectancy at birth, 78 years in the US, is among the lowest of industrial countries. Seven out of 1,000 American children die before their first birthday, a figure similar to that of Thailand and Lithuania. While many are proud of our rate of high-tech surgical procedures, research has demonstrated that about 20% of these procedures are unnecessary and are financially driven or performed to avoid litigation. The scientific measures of quality of care indicate that the American system is, at best, comparable to most Western countries.

Many opponents of the reforms cite concerns such as mandating insurance coverage or government involvement. However, health insurance is compulsory in most developed nations to avoid the costs incurred by individuals who do not pay for coverage and go to emergency rooms for care, shifting the cost to the insured. Also, the notion that the public option will increase government’s involvement in health care is false: about **45% of Americans’ health care costs are covered by governmental programs**, including Medicare, Medicaid, Veterans health services, and state and local government services. Another allegation is the cost and the deficit, but this does not take into account the savings for individuals and families from reducing out-of pocket costs, as well as the cost to employers, who will either pay more or will lower health benefits or shift the cost to the employees. Others intentionally confuse the debate by bringing in political ideology or simply targeting the President and the Democratic party. This irresponsible act will hurt all Americans in the future.

It is essential at this time to focus the debate on the health system. To those fighting for repeal, please come with the alternatives first. What will happen to the escalating number of citizens who are uninsured, and those who have preexisting conditions, and the skyrocketing health care cost?

Let us play politics away from the nation’s health security.

LINKS

WHO World Health Statistic 2009 Report (PDF)
OECD Health Data 2009

THE IMPACT ON THE HEALTH CARE SYSTEM IN SPAIN IN VIEW OF REGULATORY REFORMS

ABSTRACT

This article is addressing the manner in which recent regulatory changes have impacted upon Spain's National Health Care System and how this, in turn, has brought about changes to pre-existing structures in this sector, in addition to giving rise to those that are new. Following on from a brief outline of the health care system, the key regulatory reforms and their objectives will constitute the main thrust of analysis in this paper. Finally, a description detailing the impact that these changes have affected in the areas of health care management, the adoption of market processes, immigration, and the implementation of information systems technology by the NHS in Spain, shall also be covered.

Keywords: health system regulation, health care management, public health, Spain, market solution

INTRODUCTION

Prior to looking at the most notable changes under legislative and regulatory policy affecting the NHS in Spain, it is worth mentioning the political system and organisation of the Spanish NHS itself, thus providing a descriptive backdrop to the topic in hand.

The democratic form in Spain comprises a parliamentary government that is headed up by a constitutional monarchy. After many years of dictatorship, the Spanish Constitution was created in 1978, thus paving the way for fundamental changes to the basic tenets that underpinned the nation-state and its political framework. As a country, Spain is made up of a central state and 17 autonomous region, all of which have their own respective governments (or autonomous communities, ACs). With a population of 47,150,832 people (1st January, 2011), the expanse of Spain covers approximately 505,955 km² and makes up Western Europe's third largest surface area. There are strong indications of an ageing population in years to come, as Spain has one of the lowest fertility rates in the EU (1.47 children per woman in 2010). Spain does, however, enjoy one of the highest rates of life expectancy in Europe with the average life span of women running to 84.64 years whilst men live to an average of 79.96 years.

1943 saw the creation of the health care system at which point Compulsory Health Insurance was implemented too. This was later reorganised under a law passed in 1963, leading to the birth of the Social Security Public

Health Care System. The National Institute of Health (INSALUD) was established in 1978, in the form of a semi-independent public agency that would be placed in charge of the centralised management of the Social Security System. As such, the foundations had been laid for what constitutes today's NHS in Spain, with the national government retaining control over areas relating to its effective coordination and collaboration during the democratic transitional phase. Come 1986, reforms were underway to divert the main source of funding away from social insurance and channel it towards general taxation; this ultimately led to practically universal health care cover for all. By 2001, changes to the health care system in respect of the system in place regarding its funding had concluded with the adoption of LOFCA (Law for the Financing of the Autonomous Communities, which was passed in September, 1980). LOFCA is currently facing new reforms that are in the process of being negotiated. It is unlikely, however, that this will affect the manner in which the Spanish NHS is funded as in 2002, the decentralisation process granting control to regional governments was ended.

The objective of the financial model adopted in 2001 was to guarantee a financial sustainability. Regional taxes and allocations are the two main sources of funding for the ACs from the national government. Private health care is financed by three complementary sources: out-of-pocket payments to the public system, out-of-pocket payments to the private sector and voluntary health insurance (VHI). The current system for funding health care in Spain has been in effect since 2002. (Figure 1).

In 2008, in accordance with the Organisation for Economic Co-operation and Development (OECD), the per capita health expenditure in Spain was US\$2,902 (adjusted according to purchasing power parity), while in OECD countries the average was US\$2,975, with public health expenditure running to 72.5%. For the same year, the total health expenditure in Spain ran to 9.0% of its GDP, whilst the average for OECD countries worked out at 8.8%. Predictions made by the OECD indicate that health care spending will sharply rise in Spain in light of its ageing population [1].

ACs financial reckoning reveals that there are difficulties associated with the national government being able to guarantee a minimal level of health care expenditure on the part of every AC. This health cost can be worked out at a per capita average expenditure of approximately 1,3202€, with the ACs with the highest budget being País Vasco (1,675€) whilst the lowest was Valencia (1.140€). This points the finger at the fact that neither social cohesion or equity has been achieved, as the national government is unable to guarantee either. The allocation of funds no longer caters for an assessment of demand or deficiencies in health services, in addition to which, as the allocation of resources largely depends on political deals in areas where resources are no longer limited but scarce, this directly impacts on the fact that equity limitations regarding the personal distribution of health are completely ignored.

Deficiencies in health care are now coming to light. Lack of AC funding in this matter is systematic and, as such, a two-fold explanation exists for the increase in regional health expenditures. First of all, exogenous factors have to be taken into consideration: demographics, state of health, and the costs of new drugs and technologies. Secondly, endogenous factors come into play which is down to the individual responsibility of each region. Combined, the factors lead to staff and salary increases, and to the introduction of new technologies, as well as organisation structures.

While unforeseen risks have surfaced over the course of time, in general terms, the coordination process would appear to have been relatively smooth and successful. Areas that continue to remain problematic for the Spanish NHS include: increased demand for services, funding shortages in funding, inequitable access, in addition to a host of other common problems experienced amongst NHS systems across Europe. Following decades accompanied by conflict and tension, the health care system that has been constructed is still faced with the same crisis factors (equitable access), the same dilemmas (inequality) and the same debates (financial sustainability) as those that ran prior to it. That said, reform measures have been implemented to invoke necessary change in the Spanish NHS. In what follows, a description of how the NHS is organised will be given, in addition to a third party perspective on key reform measures that have been implemented and what impact these have had on the health services provided, especially in respect of public-private partnerships.

ORGANISATIONAL STRUCTURE OF THE NHS IN SPAIN

The right of all citizens to enjoy health protection and care is laid down in article 43 of the Spanish Constitution of 1978. These rights are held by:

All Spanish citizens and foreign citizens in Spanish according to the terms of article 1.2 of Organic Law 4/2000.

Citizens of other European Union Member States as provided by EC law and any applicable treaties and conventions signed by the Spain.

Citizens of non-European Union Member States whose rights are recognised under applicable laws, treaties and conventions.

Spanish civil servants and their dependants may be entitled to special insurance coverage through civil, military or judiciary mutual funds (MUFACE, ISFAS and MUGEJU respectively).

Health care in Spain is a **non-contributory benefit**. It is paid for through taxation and is included in the general budget for each autonomous community. Two additional funds are the Cohesion Fund managed by the Ministry of Health and Consumer Affairs and the Savings Programme for Temporary Incapacity. Health care is one of the main policy instruments for redistribut-

ing wealth amongst Spanish citizens: all citizens pay taxes based on their financial capacity and receive health services as needed.

The main principles governing the exercise of this right are regulated by the General Health Act 14/1986, as follows [2]:

Public funding of free universal health services provided upon demand

Specific rights and duties of citizens and public authorities

Competence for health affairs transferred to the ACs

Comprehensive health care designed to provide quality services subject to proper evaluations and control

Inclusion of the different public health structures and services in the National Health System

The National Health System is made up of both the State and Autonomous Community Health Departments and provides all the health care functions and services for which the public authorities are legally responsible. On a national level, the Spanish Ministry of Health and Consumer Affairs assumes responsibility for certain strategic areas, including general coordination and basic health legislation, definition of a benefits package guaranteed by the NHS, international health care coverage, pharmaceutical policy, and undergraduate and postgraduate education. The 17 autonomous communities in Spain have the power to plan health care policies and to organise their own regional health services. The -Council of the NHS (CISNS), composed of national and AC representatives, promotes the cohesion of the system. Health policy-making power in Spain lies at the regional level, with health authorities and regional health governments playing a central role. (Figure 2).

The Spanish National Health System is organised according to fundamental principles. Since it aims to provide universal coverage, it has to ensure equitable access to services for all citizens and, since it is financed with public funds, expenditure must be based on efficiency criteria. [3]

The System is therefore organised at two care levels in which accessibility and technological complexity are juxtaposed. The first level – **Primary Health Care** – is characterised by wide accessibility and sufficient technical resources to resolve the most frequent health problems. The second level – **Specialised Care** – has more complex and costly diagnostic and therapeutic tools and resources which have to be gathered together in order to maximise efficiency. Patients must obtain a referral from a Primary Health Care professional before access to a specialist is granted.

Primary Health Care aims to provide basic services within a 15-minute radius from the patient's place of residence. The main facilities are the *Primary Care Centres*, which are staffed by multi-disciplinary teams of general practitioners, paediatricians, nursing staff and administrative personnel and, in some cases, social workers, midwives and physiotherapists. Since this level of

care is community-based, the centres also carry out measures that focus on promoting good health and preventing illness. Accessibility and equity are maximised by making house calls, where necessary.

Specialised Care is provided in *Specialist Centres and Hospitals*, for both in-patients and out-patients. Once care is complete, the patient is referred back to the Primary Health Care professional who consults the complete medical file in order to determine further treatment and overall care. Continued care is given for similar conditions, irrespective of the patient's place of residence or financial situation. Specialised care is also provided at a patient's home, where necessary.

Each Autonomous Community establishes its own **Health Area**, according to demographic and geographic criteria, and their main priority is to guarantee the proximity of health care services to patients. Each health area is responsible for managing health facilities, and benefits and health service programmes within its geographical limits for a population between 200,000 and 250,000 inhabitants. The Health Areas are then sub-divided into Basic Health Zones, which are the territorial framework for Primary Health Care and the Primary Care Centres. Each Area has a general hospital for Specialised Care. In some Health Departments there is an additional intermediate level of health services between the Health Area and the Basic Health Zone. [4]

FUNDAMENTAL CHANGES IN THE NHS AS A RESULT OF RECENT REFORM MEASURES

The following analysis discusses the NHS reform measures introduced over the last few years and their effect on management structures, health care for immigrants, and information systems.

NEW "MEZZO" LEVEL MANAGEMENT: DIFFERENT LEGAL ENTITIES ENTER THE ARENA

The contracting out of management services by government pursuant to partnership agreements did not become available to the public health services system in Spain until recently, although use of this management formula has spread significantly throughout other European countries. A case worthy of special mention is the Private Financing Initiative of the United Kingdom, which began during Margaret Thatcher's conservative revolution, and has been widely used in the health sector since 1997 by the Labour-party government as a means of addressing the important renovations required by British hospitals. As a direct result of the neglect suffered by the National Health Service under the Conservative party for almost two full decades, a number of hospitals were quite old, scarcely equipped with technological resources, and had fallen obsolete.

Government partnership agreements for public health care services were first employed in Spain in the AC of Valencia, where one such agreement was a key factor in the construction and management of the Alcira Hospital and its health area. This model was subsequently adopted by hospitals in Torrevieja, Denia, Manises and their respective health areas. Similar agreements have been reached in other ACs, such as Madrid, where the Infanta Elena Hospital in Valdemoro is managed under a public-private partnership agreement. These types of concessions are awarded to private entities under a system of public bidding, and awardees are responsible for the cost of building infrastructures for the hospitals and primary care centres for an entire health area, as well as full operations for an established period of time. Upon expiry of the agreement, all assets, buildings, installations, instruments and other items required for providing services are transferred to the regional AC health authorities, which can choose to manage services directly or open the bidding process for awarding management services to private entities.

Recently, other ACs have followed Valencia's lead and have built a significant number of hospitals using the public-private partnership (PPP) formula, subject to treatment under the SEC-95 Manual concerning public deficit and public debt as a non-financial national government expense for accounting effects, and held to the full range of technical specifications, although with some regional variations. Specifically, hospitals have been built in the ACs of Madrid (in Aranjuez, Majadahonda, Arganda del Rey, Coslada, Parla, San Sebastián de los Reyes and Vallecas), the Balearic Islands (in Son Dureta), and Castilla y León (in Burgos).

Another specially adapted model of management led to the creation of public hospital foundations, which operate hospitals extensively throughout ACs such as Galicia (Verín, Salnés, Valedoras and Monforte Hospitals), Madrid (Hospital de Alcorcón); the Balearic Islands (Manacor and Son Llàtzer Hospitals), Murcia (Hospital de Cieza), La Rioja (Hospital de Calahorra) and in the Principado de Asturias (Hospital de Poniente).

Hospital foundations are created with start-up capital provided by the regional government, which also usually builds the centre and supplies the necessary equipment. They are run by an administrative board responsible for appointing management professionals to the entity and hiring medical personnel who may also be employed, at least partially, by the corresponding regional health service.

Other ACs have chosen to create companies to operate hospitals that are 100% owned by the regional governments. An example of such an arrangement is the public company Hospital Costa del Sol (owned by the regional government of Andalusia), which was launched as a pilot project for testing alternative organisational models in that AC. Managers by applied business management tools to the public health sector in order to improve efficiency

and the quality of services. The Fuenlabrada Hospital in the AC of Madrid operates under a similar arrangement.

The advantages that public-private partnerships hold for government entities are as plentiful as their disadvantages. On one hand, public funds are not required to finance the construction of hospitals or the procurement of supplies. Leasing a health facility for a limited time can lead to more flexibility in allocation formulas using capitation and specially designed managerial structures for operating hospital food services and support services, and in units that provide health services. The health care units are entitled to amortise the investments made by the business owners holding the concession. This type of partnership agreement may represent an attractive investment for businesses if the period of operations and the economic margins from capitation and service operations are sufficient and profitable.

The disadvantages of PPP are always linked to a hypothetical drop in the quality of public health services provided on a for-profit basis, as well as the objective issue of inherent difficulties in a system where public health services are rendered by businesses according to standards that differ from those of the traditional public health authorities. Moreover, the risk of placing health zones into private, monopolistic hands is readily apparent and quite difficult to address in the medium term. The final guarantor of health centres designed according to this formula is political authority, even in cases where the structure is more private, at least where there are no legal mechanisms or business assets that would allow the company to assume responsibility for the deficit. In fact, concessions require greater financial discipline and wider and more rigorous economic control only if the public guarantor performs thorough evaluations and follow-up.

These models have been applied to the management of public hospitals in Spain only recently. This fact, in addition to a lack of transparency with respect to data (characteristic of the health care system) and the difficulties posed by statistical analysis of data obtained from diverse sources using different criteria, makes it difficult to carry out a rigorous assessment of the advantages and disadvantages each model raises.

This issue has received some attention in studies on the relationship between the model of management (public or private) and normal health care procedures in cases such as heart attack, breast cancer and chronic obstructive pulmonary disease [5]. Evidence suggests that the quality of care is similar in all models, however waiting lists for surgeries are most efficiently managed in centres with an independent legal status, which may explain why they perform such a high percentage of out-patient surgeries. At hospitals with the widest range of services, the highest number of specialised services units, and procedures for the procurement and utilisation of resources that most closely follow protocols and clinical practice guidelines, care appears to be the most satisfactory. These factors seem to benefit hospitals operated as PPPs, and

they their greater efficiency is attributable to their wider array of technological resources, incentive measures and work schedules.

The decision of an AC health service to utilise these alternative models turns on two factors. First of all, the creation of a PPP is usually based on circumstantial factors of a financial and budgetary nature, often times driven by a need to attempt to offset the health deficit. In other cases, the partnership is designed as a means to gain maximum flexibility and freedom in managing health care facilities by resorting to what is known as “fleeing the confines of administrative law”, and thereby facilitating access to private hiring practices and managing normal hospital activities in accordance with a budgeting process that is less demanding, in legal terms, than the public one has been traditionally. If patients were given a choice, this formula could lead to increased efficiency due to greater competitiveness.

NEW MICRO-MANAGEMENT LEVEL: INSTITUTES AND CLINICAL UNITS

Over the past decade, some hospitals have implemented new formulas of micro management that have made it easier to carry out investigations that are far superior, in both quantity and quality, to those performed at most hospitals in Spain. Clinical Practice Management Areas, as they are known, provide top-rate institute-based instruction at all levels and offer cutting-edge health care.

In the study *A Qualitative Analysis of Organisational Innovations in Public Hospitals in Spain*, chief executive officers (CEOs) and clinical physicians at public hospitals were interviewed about organisational changes that had recently been introduced in Spanish hospitals. [6]. Overall, those interviewed viewed the cultural changes at hospital clinics included in the study in a positive light. Furthermore, physicians had become more active in management and there was a substantial improvement in the level of communication between management and institute directors. Institutes have successfully adopted a management model based on objectives. Thus, they have redesigned the most common care procedures. Indicators have shown an increase in health services rendered marked by an increase in production, improvement in the quality of care, and shorter delays in performing additional tests.

On the other hand, shortcomings were also mentioned. Participants in the study stated that INSALUD offered no clear guidelines on how to set-up and develop an institute. Paradoxically, INSALUD was reticent when faced with a project in the process of failing and unwilling to address a lack of strong strategic guidelines, a high level of insecurity, and a compromised situation unable to withstand risks.

The study offered evidence that the creation of an institute brings with it “islands of competency” within the hospital itself, as the transfer and assumption of risks did not actually take place, the budgets they managed were not

separate for the institutes and the information systems were fragile and functioned poorly.

These clinical practice management areas are borne of a philosophy of focusing on disease processes causing patients to become ill (Departments such as Coronary Care, Accident and Emergency, Renal Medicine) and not the typical hierarchical structure of traditional health services established according to separate medical specialities.

The results this study provides regarding the relationship between organisational structure and improvements in quality of care and greater economic efficiency are widespread and, in fact, inconclusive. Actually, the economic results of the Catalanian health service, which manages its public hospitals using every possible organisational structures known at this time, are not markedly better, or even much different from, those of the regional health services run in accordance with traditional guidelines. [7].

It is not unusual for management reforms to be written off as “privatisation measures”, without regard for the objective benefits they produce, and the immediate media and political backlash to any changes in the status quo of the employment situation of civil servants in a public service sector such as health makes it extremely difficult to implement them.

In fact, a recent study analysing the decentralised public health care sector in Spain, in which 141 directors and former directors of the NHS were interviewed, revealed surprisingly high levels of pessimism among NHS management teams (mostly managing directors of hospitals) when they were questioned about the possibility of making changes in the system. This outcome reflects the extent to which “the desire for change is not enough”. Institutional resistance to change where labour conditions are concerned is firmly entrenched in the health care system and often fails to give way, even when questionable provisions are contained in the Workers’ Statute, however problematic they might be. [8]. This situation makes it nearly impossible for the interests of patients to become the focal point of the health care system in Spain, which is theoretically its goal. Instead, they are disregarded whilst other priorities, such as labour conditions and the salaries of management and staff, take precedence.

IMMIGRATION

The importance of tourism for the Spanish economy explains the tolerant reaction that the use of the NHS by visitors to Spain evokes among a significant portion of government agencies and the public. Safety and the administrative ease with which tourists are able to receive medical attention when they experience a health problem during their stay are unquestionably factors that contribute to Spain’s popularity as a tourist destination.

A disproportionate amount of the NHS expenditure is spent on medical care for tourists. The 18 million Euros that Spain received for health care provided to tourists falls way short of the 30 billion Euros paid out by the National Institute of Social Security for health services rendered to Spanish tourists on their visits in different countries with which Spain has reciprocity agreements with respect to medical care. This sizable difference reflects the fact that the number of Spaniards who travel who outside of Spain are far outnumbered by the foreign tourists who come to Spain.

In addition to the occasional tourists, there is also a steady the influx of immigrants who stay in Spain permanently and receive public services of all kinds. The majority of people in Spain who have legal resident status, but have not secured an employment contract, are immigrants. The low wages of those who are employed have had a positive, yet transitory, effect on the competitiveness of the Spanish market. However, if steps are not taken to improve human capital and technological resources soon they may in fact turn out to be a burden in the mid and long terms.

The absence of a connection between employment contracts and access to basic services financed by tax contributions supporting the Social Security Administration as established under to Royal Decree 1030/2006 is, objectively speaking, a situation that favours the existence of the black market economy. This holds especially true in situations where the immigrants who work in the black market economy are included in the municipal census, and are therefore taken into account when health services are organised and budgeted. [9].

The immigrant population is generally believed to be younger and healthier than the average Spanish worker, and consequently immigrants require fewer health services. However, bias in the selection process may be responsible for the results showing immigrants to be healthier than their non-migrant counterparts. Furthermore, there are a number of factors that may increase their vulnerability to illness, thereby causing their health to deteriorate. Known factors include an impoverished environment, marginalisation, and overcrowded living conditions. [10].

A recent study on this situation compares the utilisation of health services by immigrant and non-immigrant populations in Spain revealed that immigrants use fewer services. [11]. However, the study is questionable for two reasons. First of all, it is based on surveys. Secondly, the report states that immigrants use fewer health services, in reference to therapies and preventative medicine alike. For example, in the case of women performing few mammograms or Pap smears that can lead to early detection of cancer, which will result more costly to cure in the long run. The savings to the NHS are theoretical. The study includes data demonstrating that in ACs such as Catalonia, Madrid and Valencia, immigrants use emergency services more than Spaniards.

PUBLIC MANAGEMENT: A CRITICAL LOOK

A serious problem in the public service sector is the low level of motivation that affects both those who are responsible for managing services and workers who provide them. The general approach to providing public services has not dealt with issues of motivation.

The work productivity of public servants in Spain has little bearing on their salaries. Positions are assigned according to a ranking system and seniority based on time, and has little to do with merit or ability. The selection process based on standardised criteria intended to prevent arbitrariness, the extremely high level of job security (a civil servant has “a job for life”), and the restrictions on reassigning tasks or geographical location, are little help in improving the efficiency of government agencies. In addition, the lack of commitment and strong leadership on the part of political leaders only add to the difficulties experienced when attempting to implement incentive measures based on job performance. Furthermore, the public sector is not burdened by additional incentives created by possible bankruptcy or closings. When we consider the additional factor that patients in the public health care system do not pay for services directly, the introduction of individual or collective incentives based on performance becomes just that much more complicated. The total effect of all of these factors is seen most clearly in service sectors where social factors are so important, such as in health care.

CONCLUSIONS

Since 1986, the NHS in Spain has been subject to constant reform. Universal coverage, primary health care, financing and management, public health and research have made up the primary focus of areas in which measures have been taken and put in place. It is fair to state that, since the 1970s, demonstrable progress has been made in respect of the nation's health indicators and this may not only be attributed to improvements in the health care system but in general terms, to change in the Spanish society at large.

There is work that still needs to be done, however, with a series of important challenges that must be faced in the near future. Glaring issues such as cost-containment, the state of Primary Health Care, and long-term care and social services comprise, *inter alia*, a few of those that need to be addressed. Reforming the regional financing system, fully implementing a national information system, reducing regional inequalities, and improving the mechanisms for coordinating services on national and regional levels are some of the special challenges posed by the implementation of a decentralised health care system.

The status quo requires an entirely fresh approach, based on model that is centred around patients' requirements, leading many ACs to advocate an NHS with multi-centred operations. Combined energies could once again be

taken advantage of through a centrally coordinated unit, thus cutting back on operational expenses and political costs, whilst reaping the benefits of economies of scale and scope. Scattered data could also be avoided if coordination were organised on an inter-territorial scale, whilst positively impacting at the same time on multi-level decision-making.

Integration presents one of the key challenges for regional health information systems, with ACs systems being not nearly as compatible as they should be and this is undoubtedly a daunting task for any hardware or software developer. Adopting criteria for establishing connectivity and communication protocols to handle the systems for storing, processing and distributing data and images also presents a major uphill struggle, as without these, health service cards can only be used in the region in which they are issued. Bearing in mind that the rest of the world has been using an infinitely more efficient system for over 20 years, this limitation in a country such as Spain comes as an even greater surprise.

Finally, the division that exists on public health policies should be mentioned and, at present, that there are now forward-thinking plans to address major health issues in Spain. In addition, there is a total absence of economies of scale to encourage the pooling of resources among neighbouring regions. This will ultimately have the direct consequence of worsening the current situation with insufficient funds and the lack of equitable access to health care for patients deteriorating as time goes on, highlighted by the fact that there is a complete lack of detailed analyses or evaluation of the situation in hand.

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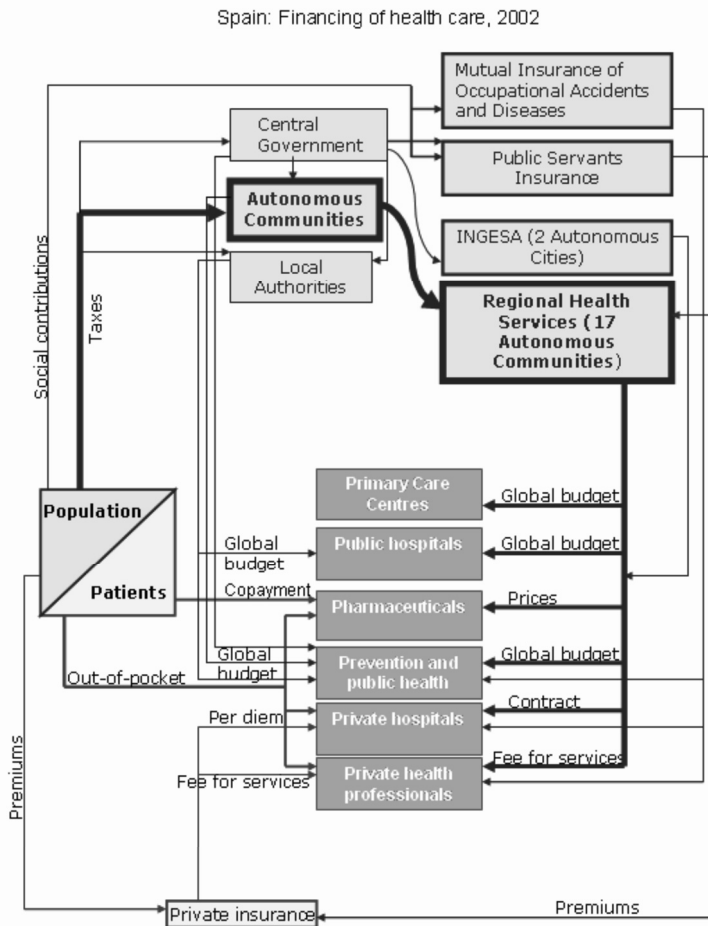
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FIGURE 1. – Financing of Health Care, 2002



Source: Ministry of Health and Consumer Affairs. D.G. of NHS Cohesion and Senior Inspectorate. Elaborated by S.G. Economic Analysis and Cohesion Fund (2006)

FIGURE 2. – Powers of the Public Administration on health matters

NHS INTER-TERRITORIAL BOARD	
CENTRAL GOVERNMENT	<ul style="list-style-type: none"> • HEALTH BASIC PRINCIPLES AND COORDINATION • FOREIGN HEALTH AFFAIRS • PHARMACEUTICAL POLICY • MANAGEMENT OF INGESA
AUTONOMOUS REGIONS	<ul style="list-style-type: none"> • HEALTH PLANNING • PUBLIC HEALTH • HEALTHCARE SERVICES MANAGEMENT
LOCAL COUNCILS	<ul style="list-style-type: none"> • HEALTH AND HYGIENE • COOPERATION IN THE MANAGEMENT OF PUBLIC SERVICES

Source: Distribution of responsibilities according to the Spanish Constitution of 1978, Act 14/1986, April 25th 1986, the General Health Act, and Act 16/2003, May 28th 2003, on the Cohesion and Quality of the National Health System.

TABLE 1. – Per capita expenditure on patients with NHS coverage 2003-2009

	2003	2004	2005	2006	2007	2008	2009
Andalucía	863,87	921,93	978,7	1.122,01	1,145.6	1,231.3	1,245.9
Aragón	997,94	1.046,17	1.121,26	1.266,82	1,334.8	1,390.7	1,474.4
Asturias	987,19	1.070,71	1.174,85	1.259,47	1,284.1	1,305.9	1,487.8
Baleares	749,95	759,24	1.033,48	1.073,75	1,090.7	1,152.6	1,181.8
Canarias	866,11	957,13	1.075,79	1.220,36	1,298.8	1,406.6	1,444.7
Cantabria	1.079,65	1.126,37	1.185,38	1.266,74	1,308.0	1,344.2	1,399.4
Castilla y León	962,61	1.043,83	1.116,39	1.205,60	1,284.9	1,387.5	1,412.5
Castilla – La Mancha	950,54	1.007,31	1.084,99	1.187,17	1,272.8	1,346.0	1,423.1
Cataluña	857,61	997,5	1.060,55	1.141,27	1,232.1	1,272.6	1,295.6
Comunidad Valenciana	761,02	852,67	924	995,5	1,080.7	1,123.1	1,140.5
Extremadura	1.000,06	1.086,75	1.209,97	1.309,11	1,425.9	1,548.8	1,658.0
Galicia	916,46	997,77	1.097,81	1.207,59	1,284.6	1,372.5	1,419.6
Madrid	862,6	941,79	994,44	1.077,15	1,135.5	1,173.2	1,182.1
Murcia	879,19	933,49	1.024,88	1.096,81	1,186.9	1,305.8	1,338.5
Navarra	1.067,91	1.123,88	1.165,33	1.244,59	1,362.6	1,438.4	1,473.2
País Vasco	972,66	1.060,70	1.123,57	1.221,60	1,392.9	1,543.5	1,675.5
Rioja (La)	1.050,49	1.164,73	1.240,44	1.439,37	1,576.6	1,617.3	1,462.3
TOTAL	885,36	968,66	1.043,76	1.140,27	1,215.4	1,284.5	1,320.0

Source: Ministry of Health and Social Policy, General Directorate for Professional Regulation, National Health System Cohesion and High-Level Inspection.

TABLE 2. – Major health care reforms and policy measures in Spain

Year	Major health care reforms and policy measures
1978–1986	Decentralisation of responsibility for the pre-social security health care networks to Autonomous Communities (ACs)
1981	Decentralisation of responsibility for health care to the AC of Catalonia.
1984	Start of Primary Health Care (PHC) reforms
1986	Adoption of the General Health Care Act
1987	Decentralisation of responsibility for health care to the ACs of the Basque Country and Valencia.
1989	Switch of the main source of funding of the health care system from social insurance to general taxation. Coverage extended to patients lacking financial resources
1990	Transfer of health care powers to ACs of Galicia and Navarra. Rights to all public benefits and services extended to non-Spanish children
1991	Presentation of a review of the NHS by the parliamentary commission containing several proposals for organisational and cost-containment measures (Informe Abril)
1992	Launch of public-private partnerships (PPP) as pilot programmes
1993	List of non-subsidised pharmaceuticals published Introduction of Free Choice policy permitting patients to choose General Practitioners and paediatricians (under pilot programmes since 1984).
1994	Agreement between national government and the seven “special” ACs on the regional resource allocation system. Transfer of responsibility for health care to the AC of the Canary Islands. Creation of the National Agency for the Assessment of Health Technologies
1995	A single common benefits package to be provided by the NHS was established. Approval of the National Health Plan
1996	Introduction of Free Choice policy permitting patients to choose specialists (of 12 specialties) for the INSALUD territory (comprised of 10 “ordinary” regions – see subsection on decentralisation). Approval of law regarding the self-governing status of health care centres Introduction of the Decree on the liberalisation of pharmaceutical services
1997	Adoption of the Decree on the liberalisation of pharmaceutical services
1998	Approval of an updated list of non-subsidised pharmaceuticals Signature of an agreement with the main employers’ association in the field of pharmaceuticals (Farmindustria) on a set of cost-containment measures was signed. Agreement on a new regional resource allocation system
1999	Legislation designating all public hospitals as independent agencies
2001	Adoption of the Food Safety Agency
2002	Decentralisation of responsibilities for health care to the 10 ACs remaining (effective 1 January) Introduction of a new general financing scheme Development of additional statutory regulations for the Spanish Food Safety Agency
2003	Adoption of the Law on the Regulation of Health Care Professionals Adoption of the Labour Regulation Framework for Health Services Employees Approval of Royal Decree 1555/2004 on the new structure of the Ministry of Health and Consumer Affairs and Royal Decree 605/2003 on Information about Waiting Lists of the NHS Approval in parliament of The Law on Cohesion and Quality of the NHS

Year	Major health care reforms and policy measures
2004	Adoption of the Law on Comprehensive Measures to Protect against Domestic Violence
2005	Adoption of the Law on Health Measures to End Smoking and Regulate the Sale, Distribution, Consumption, and Advertising of tobacco products.
2006	Adoption of the Law on Assisted Human Reproduction Techniques Adoption of the Law on Guarantees and the Rational Use of Drugs and Medical Supplies.
2007	Adoption of the Law on Biomedical Investigation

Source: Contains additions and adaptations to Durán A, Lara JL, van Waveren M [5].

HOSPITAL SECTOR REFORM POLICIES: THE CASE OF THE REPUBLIC OF SRPSKA, BOSNIA AND HERZEGOVINA

ABSTRACT

This paper contributes to the understanding of hospital reforms in the Balkans by providing an overview of how contemporary health policies have framed the reform of the hospital sector in the Republic of Srpska. The analysis was based on 'the five control knobs for health-sector reform' framework. It showed that fragmentation of the health policy on hospital sector reform complicates its implementation, monitoring and analysis. The actual use of the control knobs (financing, payment, organization, regulation and behaviour) has diverted from the intended use in implementation of the hospital sector reform related policies in the Republic of Srpska. This has also lead to a divergence from intended adjustments of intermediate health system performance measures (quality, efficiency and access).

Keywords: health policy, hospital reform, control knobs, Republika Srpska, Bosnia and Herzegovina JEL classification codes: I18

1. INTRODUCTION

The health sector reform involves a significant, purposeful effort to improve the performance of the healthcare system (Roberts, et al., 2004). Successful reform often involves introducing a set of interdependent and mutually supporting interventions. As an important component of the healthcare system, hospitals are central to the reform process (McKee and Healy, 2002). The hospitals have to adapt constantly to changing circumstances within the hospital, in their interaction with the rest of the health care system, and in the wider social and economic environment.

Many countries are in search of effective hospital reform policies and the research evidence on the best strategies for improving health care system performance through better hospital performance. A recent literature review demonstrated a significant knowledge gap in research and analysis of hospital delivery models and its reforms in Central and Eastern Europe (Tsolova, et al., 2007). Some of the most relevant literature was found to be published in non-peer reviewed journals, in electronic format, or was not published at all, and was therefore difficult to access. The body of published work on health policy processes in low and middle income countries is, at the same time, dominated by authors based in Northern organizations (Gilson and Raphaely, 2008).

This paper seeks to contribute to the understanding of hospital reforms in the Balkans by providing an overview of how contemporary health policies framed the reform of the hospital sector in the Republic of Srpska.

2. CONTEXT

Republika Srpska, or the Republic of Srpska (RS), is one of two entities in Bosnia and Herzegovina (the other being the Federation of Bosnia and Herzegovina), which has its own legislative and executive functions and responsibility, including those related to health policy making and implementation. The RS, with an estimated population of 1.4 million, has a centralized health care system, with an entity level Ministry of Health and Social Welfare (MoHSW), Public Health Institute and Health Insurance Fund. The declining birth rate in the RS, coupled with the increase in life expectancy and increased proportion of the population aged sixty-five and older indicates a need, common to that seen in many other parts of Europe, for the healthcare system to shift towards better prevention and management of chronic disease, as well as increased provision of geriatric and long term care (Marković-Peković, et al., 2009).

The provision of health care services in the RS is organized at three levels: primary, secondary and tertiary. Primary health care is provided in 54 health centres (called *Dom zdravlja*). Hospital services are provided in three types of hospitals: clinical centres (there are 2 existing in the RS), general acute hospitals (9 of them) and specialized hospitals (3 of them). The MoHSW regulates and manages public secondary and tertiary health care facilities, while municipalities own and operate public primary health care facilities.

Social insurance contributions are the main source of financing for the healthcare, including the hospital care, in the RS. The Health Insurance Fund of RS receives transfers from the entity government, most of which cover health insurance contributions for exempt individuals (World Bank, 2006). About 44 per cent of the total Fund's revenue was allocated to the hospital sector at the time of the preparation of the key sector reform policies (Health Insurance Fund of Republic of Srpska, 2008).

Health policy making is one of the main roles of the MoHSW. A significant number of health policy documents existed in late 2010 in the RS, providing a framework for the healthcare reform.

The fundamental hospital sector reform related document is the Secondary and Tertiary Health Care Strategy in the RS (Republic of Srpska Government, 2007c). According to the strategy, the goal of the reform is to implement different groups of activities which lead to the building and development of an efficient, effective and sustainable hospital sector, oriented towards provision of accessible, quality and safe health services to all the citizens of the RS, responsive to their health needs. There are twelve strategic objectives,

TABLE 1. – Key health policy documents in the RS in 2010

Policy document	Period covered
Program of Health Policies and Strategies for Health in the RS until 2010 (National assembly of the Republic of Srpska, 2002)	2002–2010
Strategies for Reduction of Differences in Health Status and Access to Healthcare, Reorientation and Reorganization of Health Service, and Improvement of Efficiency and Quality of Work in Healthcare Institutions (Republic of Srpska Government, 2003)	2003–2010
National Medicines Policy (Republic of Srpska Government, 2006b)	2006–2012
Mental Health Policy (Republic of Srpska Government, 2006a)	2006–2015
The Primary Health Care Strategy (Republic of Srpska Government, 2006c)	2006–2010
Strategy for Iodine Deficiency Control (Ministry of Health and Social Welfare of the Republic of Srpska, 2007)	2007–2010
Secondary and Tertiary Health Care Strategy in the RS (Republic of Srpska Government, 2007c)	2007–2012
Blood Safety Strategy in the RS until 2015 (Republic of Srpska Government, 2007a)	2007–2015
Policy for Improvement of Quality and Safety of Health Care in the RS until 2010 (Republic of Srpska Government, 2007b)	2007–2010
Strategy for Monitoring of Opiate Drugs and Containment of Opiate Drugs Abuse in the RS for the period 2008 to 2012 (Republic of Srpska Government, 2008a)	2008–2012
Youth Health Policy of the RS for the period from 2008 to 2012 (Republic of Srpska Government, 2008b)	2008–2012
Medicines Strategy until 2012 (Republic of Srpska Government, 2009b)	2008–2012
eHealth Development Strategy in the RS (Republic of Srpska Government, 2009a)	2009–2014
The RS Mental Health Development Strategy (Republic of Srpska Government, 2009c)	2009–2015

which need to be achieved in order to accomplish the vision. Other health policies complement the strategy, providing more details on specific aspects of the hospital sector reform (improvement of quality and safety of hospital care, provision of mental health related services, blood safety, referrals from the primary to secondary health care, hospital information system, hospital medicines and hospital pharmacies).

There were five main groups of reasons for initiation of the hospital sector reform in the RS (Republic of Srpska Government, 2007c):

Inadequate management of hospital capacities: In secondary and tertiary health care institutions, the managerial personnel did not possess the necessary skills and knowledge of strategic, tactful and operational management. Health management skills were very modest and limited to obsolete management techniques and methods. Managers of health institutions seldom had a clear picture of the mission, vision and basic values of their institutions. Very few hospitals had a strategic plan, and almost none of them dealt with annu-

al business planning. One of the prime indicators that managerial capacities were lacking in the Republic of Srpska hospitals was a predominant focus of the managerial personnel on the staff of the hospital, mainly on doctors, instead of putting focus on planning, organization and work processes, that is, on patients and quality of health services. In such a situation, one could not expect the users of health services to have any influence on the soundness of decisions that were of importance for the course and outcome of hospital treatment.

Inefficient provision of health services could be manifested in: low admission rates, long length of hospital stay, low occupancy rates, inexistence of clinical standards, inexistence of standardized patient pathways, unbalanced ratio of the numbers of nurses and doctors, unbalanced ratio of the numbers of nonmedical staff and doctors and nurses, inexistence of day surgery services, provision of unnecessary services and examinations, repetition of examinations, admission to elective surgery a few days before the operation, prolonged stay in hospital due waiting for a specific examination or procedure to be done, long birthstay in hospital, duplication of laboratory capacities, excessive staff in night shifts and unsatisfactory procurement of equipment and drugs. On top of that, almost all hospitals in the RS had a problem with the productivity of their staff. The most conspicuous example was the low number of surgical admissions and surgical interventions per the number of staff employed in surgical departments and clinics. Such a system of service provision seriously thwarted the application of economy of scale.

Disregard of evidence based medicine: Patients were usually treated without the observation of contemporary doctrine principles in the secondary and tertiary health care institutions; in other words, their treatment was mainly based on experience. As there were no evidence based guidelines for good clinical practice, there was a great diversity in selection and application of patient treatment methodologies. This led to conclusion that unsafe medicine was practiced in the hospitals. This issue was augmented by the fact that there was no trustworthy system of continuous medical education and professional development. In general, the application of evidence based medicine took place sporadically and unsystematically.

The main shortcomings of the hospital payment system in the RS were: financial planning was not based on health needs, the existing hospital payment mechanism (payment for inputs – number of beds and hospitalization days) was obsolete and outdated, there was no system to monitor and validate services provided, performance based payment and bonus payment systems were not developed, the contracting model was obsolete, there were no incentives to develop a partnership between the Health Insurance Fund and hospitals, financial analysis techniques and methods were not used and they could not help compare the outputs against the expenditures, financial reporting system was redundant, and there was a high level of informal payments.

Inadequate human resource planning and management: The RS health system did not have a strategy for human resources. As a consequence, no hospital had a short, mid or long term plan for human resource development. Human resource management was limited to the administrative function, performed by hospitals' personnel departments. The best example of inexistence of adequate human resource management was the lack of monitoring of staff performance and utilisation. No hospital had regulated an internal system of continuous medical education and professional development, which would utilize modern Internet based education methods, audio and video conferences or telemedicine. Consequently, many hospital doctors were not trained to provide a sufficiently wide spectrum of services. There was also a problem with the work motivation of the staff, which was usually, erroneously though, linked to the lack of financial stimulation.

Other reasons for reforming the hospital sector included: high level of users' dissatisfaction with the service quality and provision system; high level of health professionals' dissatisfaction with level of salaries; existence of dual practice, which created unfair competition; redundant employees (especially nonmedical staff and mid-level medical staff); inadequate management of infrastructure (buildings and medical equipment); inadequate information management (system predominantly based on utilization of typed forms); inexistence of internal systems for promotion, monitoring and control of quality and safety; lack or poor utilization of internal control mechanisms in material and financial bookkeeping and poor application of public procurement procedures.

3. METHODOLOGY

Case studies are the preferred research strategy when 'how' or 'why' questions are being posed, when the investigator has little control over events, and when the focus is on a contemporary phenomenon within some real-life context (Yin, 2005). By the research design, most health policy analyses are regarded to be case studies (Walt, et al., 2008). The case study was, therefore, considered to be the most suitable research strategy to investigate how contemporary health policies have framed the reform of hospital sector in the RS.

The existing RS health policy documents and different local documents were used as main data sources in the study. The analysis of data was based on 'the five control knobs for health-sector reform' framework, developed by Roberts et al. (2004: 27). The use of a framework, which can organize inquiry by identifying elements and relationships among elements that need to be considered, was recommended for strengthening of health policy analysis (Walt, et al., 2008). The framework also provides the logic, linking the data to the propositions, and the criteria for interpreting the findings, which are two important components of a case study research design (Yin, 2005).

‘The five control knobs for health-sector reform’ framework covers the mechanisms and processes that reformers can adjust to improve system performance (Roberts, et al., 2004). The health system ‘control knob’ is conceived as something that can be adjusted by government action. The five control knobs (financing, payment, organization, regulation and behaviour) are discrete areas of health system structure and function that matter significantly for health system performance and are subject to change as part of health reform. The framework proposed focusing of health sector reformers on three performance goals (the health status of the population, the satisfaction citizens derive from the health system and the degree to which citizens are protected from the financial risks of ill health), when defining problems and evaluating solutions. Three intermediate performance measures (efficiency, quality and access) were recognised as critical links, connecting root causes (and the control knobs) to the ultimate performance goals.

Financing ‘control knob’ refers to all mechanisms for raising the money that pays for activities in the health sector. These mechanisms include taxes, insurance premiums and direct payment by patients. The design of the institutions that collect the money is also part of this control knob, as is the allocation of resources to different priorities. Payment ‘control knob’ refers to the methods for transferring money to healthcare providers. These methods in turn create incentives, which influence how providers behave. Money paid directly by patient is also included in this control knob. Organisation ‘control knob’ refers to the mechanisms reformers use to affect the mix of providers in healthcare markets, their roles, their functions and how the providers operate internally. These mechanisms include measures affecting competition, decentralisation, and direct control of providers making up government service delivery. It also includes managerial aspects of how providers work internally. Regulation ‘control knob’ refers to the use of coercion by the state to alter the behaviour of actors in the health system, including providers, insurance companies and patients. Behaviour ‘control knob’ includes efforts to influence how individuals (both patients and providers) act in relation to health and healthcare.

For the purpose of this case study, the content of the RS’s hospital sector reform related policies is first reviewed, in order to recognize the control knobs the policy makers intended to use. Secondly, the intended adjustments of the intermediate performance measures in the hospital sector in the RS are identified. Thirdly, the actual use of the control knobs in implementation of the policies is compared with their intended use. Finally, the intended adjustments of the intermediate performance measures are compared with the expected adjustments.

A decade (or more) is the minimum duration of most policy cycles, from emergence of the problem through sufficient experience with implementation to render a reasonably fair evaluation of impact (Walt, et al., 2008). No intended or actual impact of the hospital sector reform on the three health sector performance goals are, therefore, considered in the study.

4. RESULTS OF THE HEALTH POLICIES REVIEW

As the main reform policy, the Secondary and Tertiary Health Care Strategy in the RS (Republic of Srpska Government, 2007c) is reviewed separately from other hospital sector related policies. The intended use of control knobs in hospital sector reform and the intended adjustments of intermediate performance measures are identified on the basis of strategic objectives of the policy documents. Where more than one control knob or intermediate performance measure was related to a strategic objective, these were listed by the level of importance.

TABLE 2. – Review of the Secondary and Tertiary Health Care Strategy in the RS against the ‘five control knobs for health-sector reform’ framework

Intended use of control knobs	Strategic objectives of the Secondary and Tertiary Health Care Strategy in the RS	Intended adjustments of the intermediate performance measures
Regulation	Objective 1: Development, adoption and enforcement of new legislation in order to better define the position of the hospital sector	Efficiency, Quality, Access
Organization	Objective 2: Establishment of central function in hospital sector management	Efficiency
Regulation, Organization	Objective 3: Establishment of an efficient service provision system	Efficiency
Behaviour, Organization, Regulation	Objective 4: Introduction of a management system and strengthening of managerial capacities	Efficiency, Quality
Organization, Financing, Payment, Regulation	Objective 5: Construction and reconstruction of hospital premises	Access, Quality
Organization, Financing, Payment, Regulation	Objective 6: Procurement and delivery of new medical equipment	Access, Quality
Payment	Objective 7: Developing, testing and introduction of new payment mechanisms	Efficiency, Quality
Regulation, Organization	Objective 8: Establishment of a human resource planning and management system	Quality, Efficiency
Behaviour, Organization	Objective 9: Introduction and application of quality standards with an aim to improve, ensure and control healthcare quality	Quality
Organization	Objective 10: Introduction and application of international accountancy standards and international financial reporting standards	Efficiency
Organization, Behaviour	Objective 11: Development and implementation of the hospital information system	Efficiency, Quality
Regulation, Organization, Behaviour	Objective 12: Development and implementation of a monitoring and evaluation system	Quality, Efficiency

TABLE 3. – Review of other hospital sector reform related policies against the ‘five control knobs for health-sector reform’ framework

Source document	Objective/goal/priority/area	Intended use of control knobs	Intended adjustments of the intermediate performance measures
The Primary Health Care Strategy (Republic of Srpska Government, 2006c)	Goal 5: Establishment of an efficient system of service delivery	Organization, Behaviour	Efficiency, Access
Mental Health Policy (Republic of Srpska Government, 2006a)	Priority 2: Availability of medication	Financing	Quality
The RS Mental Health Development Strategy (Republic of Srpska Government, 2009c)	Action area: Mental health institutions and professionals at the primary, secondary and tertiary level	Organization, Behaviour	Quality, Access
Policy for Improvement of Quality and Safety of Health Care in the RS until 2010 (Republic of Srpska Government, 2007b)	Strategic objectives 3, 4, 5, 6, 7, 11, 12, 14, 15 and 16	Organization	Quality, Efficiency
	Strategic objective 2: Define and adopt appropriate legislation	Regulation	Quality
	Strategic objective 8: Involve the health service users in all activities related to quality		
	Strategic objective 9: Continue with development of care pathways	Behaviour	Quality
	Strategic objective 10: Establish sustainable and stimulating methods of financing	Payment	Quality, Efficiency
Blood Safety Strategy in the RS until 2015 (Republic of Srpska Government, 2007a)	Specific objective 2: Policies in the clinical transfusion field	Organization, Behaviour	Quality
	Specific objective 3: Establishment of a quality management system	Organization, Behaviour	Quality
	Specific objective 4: Establishment of the RS transfusion medicine service	Organization	Efficiency
	Specific objective 5: Financing of the RS transfusion medicine service	Financing, Payment	Efficiency
	Specific objective 6: Improvement of infrastructure necessary for advancement of blood/blood components safety	Organization	Quality

Source document	Objective/goal/priority/area	Intended use of control knobs	Intended adjustments of the intermediate performance measures
Medicines Strategy until 2012 (Republic of Srpska Government, 2009b)	Strategic area 1: Availability of medicines/ Component 1.1: Supply system	Organization	Quality
	Strategic area 1: Availability of medicines/Component 1.2: Medicines lists	Financing	Efficiency
	Strategic area 1: Availability of medicines/Component 1.3: Financing and affordability	Financing	Efficiency
	Strategic area 3: Rational use of medicines/Component 3.3: Human resources	Organization	Quality
	Strategic area 3: Rational use of medicines/Component 3.4: Drugs committees	Organization, Behaviour	Efficiency
eHealth Development Strategy in the RS (Republic of Srpska Government, 2009a)	Objective 9: Introduction of electronic health record	Organization, Behaviour	Efficiency

4.1 . SECONDARY AND TERTIARY HEALTH CARE STRATEGY IN THE RS

A majority of the hospital sector reform intentions can be associated with use of the organisation control knob. Just two strategic objectives, out of twelve, do not require use of this control knob for their achievement. While being the most used, organization has also been the most important control knob. Implementation of two strategic objectives depends exclusively on changes in the organization. The organization related mechanisms were to be primarily used for the implementation of majority of the strategic objectives.

Use of the regulation control knob is the next on the scale of importance for the strategy. More than half of the strategic objectives rely on its use. Development, adoption and enforcement of new legislation, in order to better define the position of the hospital sector, is a key strategic objective associated to the regulation control knob.

Two of the strategic objectives rely primarily on the use of the behaviour control knob. Its indirect use can also be recognised under hospital information system implementation intentions.

The RS Government's intention to develop, test and introduce new payment mechanisms clearly represents a use of the payment control knob. The control knob is, to some extent, to be used under two additional strategic objectives. The decision of whether the price of health services should entail the depreciation costs, or not, influences responsibilities and mechanisms for

covering maintenance costs of new buildings and newly procured medical equipment.

Intention to use the financing control knob can barely be recognised in the strategy. The control knob is, to a minimal extent, used under two strategic objectives. Its use is related to consideration of the public-private partnership models in planning of capital investments in premises and medical equipment.

The intended reform, presented in the strategy, has the primary potential to significantly adjust the efficiency of hospital sector. The link to the efficiency, as an intermediate performance measure, can be recognized throughout a majority of the strategic objectives. While three strategic objectives are solely related to the adjustment of efficiency, only one is solely related to the adjustment of quality. The overall focus of the strategy on efficiency and quality of hospital sector is in line with its goal. Access is not among major concerns of the hospital reform in the RS. The reform could primarily improve physical availability of hospital care, through (re)construction of hospital premises and procurement of medical equipment.

4.2 OTHER HEALTH POLICIES, AFFECTING THE HOSPITAL SECTOR

Besides the Secondary and Tertiary Health Care Strategy in the RS (Republic of Srpska Government, 2007c), there are seven other policy documents, which directly or indirectly support the hospital sector reform. A considerable synergistic effect can only be expected from improvements of quality and safety of hospital care (Republic of Srpska Government, 2007b) and introduction of hospital information system (Republic of Srpska Government, 2009a). Other policies, presented in the table 3, could only partially affect specific aspects of the hospital sector in the RS. An impediment for comparison of the health policies was a fact that different policy documents were structured differently. Strategic objectives are not clearly stated in many of the reviewed policies. Some policies provided only priorities, action areas or strategic areas.

The main adjustments of the hospital sector, stemming from other policies, can also be associated with use of the organisation control knob. Almost all reviewed policies rely on the control knob, mostly tending to influence division of activities among organizations in the RS health system or internal administrative structures of these organizations.

The behaviour control knob is next on the scale of importance in the reviewed health policies. Intended changes of individual behaviour are in relation to changes in the system for referral of patients to hospitals, hospital information system implementation and quality and safety improvements. The behaviour change intentions focus more on health professionals than on the users of hospital services.

The use of the payment control knob can be linked to the establishment of sustainable and stimulating methods for financing health institutions that introduce quality improvement systems, that intend to apply for accreditation and those that have been accredited (Republic of Srpska Government, 2007b), and to the contracting of transfusion medicine services by the Health Insurance Fund (Republic of Srpska Government, 2007a).

Intentions of using two aspects of financing control knob can be recognised in reviewed documents: change of the mechanisms by which money for transfusion medicine is mobilized (Republic of Srpska Government, 2007a) and change of mechanisms used for allocation of resources to medicines (Republic of Srpska Government, 2006a and 2009b).

The use of the regulation control knob is restricted to the definition and adoption of appropriate legislation, in order to strengthen the structures and processes in the establishment and improvement of safety and quality systems in health care (Republic of Srpska Government, 2007b).

The intentions, synergistically supporting the hospital reform, have the primary potential to adjust the quality in the hospital sector. It is the major focus of the Policy for Improvement of Quality and Safety of Health Care in the RS until 2010 (Republic of Srpska Government, 2007b), but the policy also intends to adjust the efficiency of the hospital sector. Access is not among major concerns of other reviewed health policies.

5. DISCUSSION

Any significant health reform requires the use of more than one control knob (Roberts et al., 2004). Changes in one control knob often produce or enable changes in other control knobs. For the synergistic effect to take place, parallel use of all the control knobs is necessary.

The case of the hospital reform in the RS shows that policy makers' intentions were to use all five control knobs and to exploit the possible synergy between them. Most attention in the health policies was put on the use of the organization control knob, followed by use of regulation, behaviour, payment and financing. The major intended adjustments of intermediate performance measures were those related to efficiency and quality of hospital sector.

Information on progress in implementation of the health policies can be used to indicate actual use of the control knobs in the hospital reform in the RS. The actual use of the control knobs could indicate what adjustments of intermediate performance measures can be expected in the hospital sector.

5.1 USE OF THE ORGANIZATION CONTROL KNOB IN HOSPITAL SECTOR REFORM

Organization, as the control knob, refers to both overall structure of the healthcare system and to the individual institutions that provide healthcare

services. The adjustments of the organization of hospital sector in the RS focus on all four major characteristics, described by Roberts, et al. (2004). There are intentions to change the mix of organizations that provide hospital care services, division of activities among these organizations, interactions among them and the internal administrative structures of the organizations. Such a broad scope of intended reform interventions makes this knob the most important among the control knobs.

Significant investments have been made in (re)construction of hospital premises and procurement of medical equipment for hospitals since 2006 (Ministry of Health and Social Welfare of the Republic of Srpska, 2010), changing scope of services provided by existing secondary and tertiary healthcare providers. Changes in division of services the health system provide were also supported by the Health Insurance Fund's initiative for separate contracting of outpatient consultative services provided by doctors, specialists in different fields. These services, previously typically provided by the hospitals, are in some areas now provided by primary healthcare centres or by private providers. The Project of Introducing Management and Quality Systems in the RS Hospital Sector has provided support to the introduction of management systems in hospitals, strengthening of managerial capacities and application of quality standards, changing internal administrative structures in hospitals.

Effective use of the organization control knob in the RS highly depends on the achievement of the Secondary and Tertiary Health Care Strategy in the RS (Republic of Srpska Government, 2007c) strategic objective 2 (establishment of central function in hospital sector management) and strategic objective 3 (establishment of an efficient service provision system). Unfortunately, a recent review of the progress in implementation of the health policies in the RS found that strategic objective 2 and strategic objective 10 (introduction and application of international accountancy standards and international financial reporting standards) of the strategy have remained unachieved. Implementation of both of strategic objectives relies exclusively on the use of the organization control knob. At the same time, there is a significant delay in the implementation of the strategic objective 3, due to delays in adoption of the legislative framework. A partial implementation of activities was also noted in relation to other objectives, using the organization control knob (development and implementation of the hospital information system and establishment of a human resource planning and management system).

Implementation of other policies, presented in the Table 3, was also reviewed recently. The results of the review showed only partial achievement of all objectives of the Blood Safety Strategy in the RS until 2015 (Republic of Srpska Government, 2007a) and the Medicines Strategy until 2012 (Republic of Srpska Government, 2009b), which are using the organization control knob. The review did not show achievement of the objective of introducing electronic health record (Republic of Srpska Government, 2009a).

The organization knob remains the most important among the control knobs, when the knobs are compared by the actual use in hospital sector reform in the RS. However, its actual scope of use has been significantly narrower than intended. The key objectives of health policies, relying on the use of the knob, have not been implemented so far. The ultimate effectiveness of the organization control knob will primarily depend on the establishment of central function in the hospital sector management and the establishment of an efficient service provision system.

5.2. USE OF THE BEHAVIOUR CONTROL KNOB IN HOSPITAL SECTOR REFORM

There are two categories of individual behaviour the reform intends to change – behaviour of health professionals and treatment-seeking behaviour of users of health services. Adherence of hospital health professionals to practice guidelines (such as care pathways), influence of hospital information system on clinicians' decisions, referral of patients from primary healthcare to the hospitals, and respect of patients' rights are intended to be addressed through this control knob. Two treatment seeking behaviours are addressed in the health policies - where to seek treatment (primary care versus other locations) and how to seek treatment (practising the guaranteed patients' rights). The use of behaviour-change was intended to be a moderately utilized mechanism in the RS hospital sector reform. However, as it directly influences patients' perspective and satisfaction with hospital care, it is of a critical importance for the reform.

Significant support to the development and introduction of care pathways and the establishment of structures and processes allowing realization of the guaranteed patients' rights has been provided to all hospitals through the Project of Introducing Management and Quality Systems in the RS Hospital Sector. Support to development of managerial capacities in hospitals, support to introduction of family medicine model in the primary healthcare and the strengthening of the referral system have been provided through the Health Sector Enhancement Project (World Bank, 2005). The Project for Development and Implementation of Hospital Information System (Republic of Srpska Government, 2007c) has not been launched, though it was intended. The partial use of the behaviour-change control knob has slightly reduced its significance in the hospital sector reform. The knob has been secondly ranked on the scale of the actual use in reform, mainly because of the underuse of the regulation control knob.

5.3 USE OF THE REGULATION CONTROL KNOB IN HOSPITAL SECTOR REFORM

The reviewed health policies intended to use a range of legal instruments (laws, bylaws, internal hospital acts, plans and certificates) to change behaviour of in-

dividuals and organizations in the hospital sector. By the extent of intended use, the regulation can be regarded to be the second of importance among the control knobs. By its significance, it might be might regarded as the first of importance, since a number of changes related to use of other knobs cannot be implemented without creation of a supportive legislative framework.

The recently adopted Law on Healthcare (National assembly of the Republic of Srpska, 2009) addressed majority of issues raised in the reviewed policy documents (such as categorisation of hospitals, improvement of quality and safety of healthcare, indicators for monitoring of quality and safety of healthcare, certification of need for procurement of the capital value equipment, human resource planning). The Law on Transfusion Medicine (National assembly of the Republic of Srpska, 2008) provided legal framework for implementation of the intended blood safety related activities. The laws did not enable professionalization of hospital management positions, envisaged by the health policies (Republic of Srpska Government, 2007c)

There are, however, a number of bylaws needed for effective implementation of the Law on Healthcare. Adoption of the key bylaws, necessary for the hospital sector reform, has been delayed due to the need to negotiate the complex issue they cover with the multiple stakeholders. The delay stalled revision of internal hospital acts. The bylaws are expected to regulate a number of issues in detail (categories of hospitals, clinical networks, specialization programs, benchmarking of hospitals on the basis of quality indicators and publishing of the benchmarking results). Development of the human resource plan for the RS health system has also been delayed, stalling human resources planning processes at hospital level. The delay in the development of appropriate legislation has a significant impact on the effectiveness of all other control knobs, as it reduces the time available for the implementation of other activities.

The Law on Healthcare and the Law on Transfusion Medicine have been the major legal instruments supporting hospital sector reform. Lack of use of other legal instruments has led to a severe underuse of the regulation control knob in the reform.

5.4 USE OF THE FINANCING CONTROL KNOB IN HOSPITAL SECTOR REFORM

Medium-term macroeconomic projections for the RS indicated no increase in public funds available to the health sector by 2013 (Republic of Srpska Government, 2010). It required identification of innovative hospital services financing methods, within the framework provided by existing health policies. Public-private partnership arrangements are an innovative option for financing capital investments. The RS MoHSW had previously successfully established several partnerships with private sector, particularly in the area of dialysis services (Kerschbaumer, 2007). The capital investments (premises

and equipment) for 6 new dialysis centres and the radiotherapy centre have been provided by private sector partners since 2006 (Health Insurance Fund of Republic of Srpska, 2010a). An additional arrangement for the establishment of cardio-surgery in the RS is under negotiation with a private partner.

5.5 USE OF THE PAYMENT CONTROL KNOB IN HOSPITAL SECTOR REFORM

The decisions on (1) which organization to pay, (2) what to pay them for and (3) how much to pay them, create powerful incentives that influence the actions of all the organization and individuals in the healthcare system (Roberts, et al., 2004). Financial incentives are among the most important influences over organizational and individual behaviour in the health sector. Though the intentions to adjust the payment control knob do not spread across a number of objectives in reviewed policy documents, they have a strong potential to further the goals of the RS hospital reform. The approach to the payment of hospital services by the Health Insurance Fund included elements of different payment mechanisms in 2010. Contracts with hospitals in the RS, concluded annually, were based on the annual work plan proposal submitted to the Health Insurance Fund. The payment system still used population-based standards and payments per unit of input, such as patient day, service or diagnostic test/procedure (Health Insurance Fund of Republic of Srpska, 2010b). The recent review of implementation progress showed that almost no activities related to the development, testing and introduction of new payment mechanisms were completed. There are still no direct links between quality improvement activities in the hospitals and payment rates.

The main support to the development of the payment system based on the AR-DRG classification is expected to be provided through the IPA financed program "Support for the Development of the Healthcare Systems in Bosnia and Herzegovina". Its implementation is expected to commence in 2011. In preparation for the considerable change of the hospital payment system, the introduction of a simple case based payment for acute hospital patients is planned in 2011 (Health Insurance Fund of RS, 2011). It is also planned to keep global budget as a payment method for transfusion medicine services in 2011.

Though the use of the payment control knob was a clear intention of the hospital reform related policies, the knob has remained quite underused. Its actual underuse has a significant potential to reduce reform's influences on the efficiency and quality of hospital care.

5.6. EXPECTED ADJUSTMENTS OF INTERMEDIATE PERFORMANCE MEASURES OF HOSPITAL SECTOR IN THE RS

The intended adjustments of intermediate performance measures are majorly related to efficiency and quality of hospital sector. Such a choice can be related to the main reasons for initiation of the hospital sector reform in the RS,

presented in the Section 2. Improvement of access was not among the major concerns of policy makers, when policies related to hospital reform were created.

Actual use of the control knobs in the hospital sector reform in the RS indicates that focus on improvement of the quality has been retained in the health policy implementation. Majority of quality related objectives, presented in Table 2 and Table 3 have been achieved to some extent. The focus of quality and safety improvement initiatives was put on structure (premises, equipment, human resources) and processes (care pathways, managerial processes).

The adjustment of access, through the hospital sector reform, remains at the intended level. It is primarily related to (re)construction of hospital premises and procurement of medical equipment.

6. CONCLUSIONS

The health policy on hospital sector reform in the RS is fragmented. The main reform related document is the Secondary and Tertiary Health Care Strategy in the RS, but a direct or indirect support to the hospital sector reform can be identified in seven other policy documents. The fragmentation complicates implementation, monitoring and analysis of the health policy in the RS.

There are considerable differences between intended and actual focus on areas of the RS health system structure and function that are subject to change as part of the hospital sector reform. The most attention in the health policies was put on the changes in the organization of hospital sector, followed by the changes in regulation, behaviour, payment and financing. Actual progress in implementation of the reform has shown that changes in performance of the hospital sector in the RS can be primarily expected from changes in organization and behaviour. Changes of regulation, financing and payment have remained underused mechanisms, thus reducing the possible synergy between implementation of different health policies. The difference between intended and actual use of the control knobs has also lead to divergence from intended adjustments of intermediate health system performance measures (quality, efficiency and access).

The case of the Republic of Srpska could be a useful one to study, as it (1) reveals possibility of influencing policy outcomes at the implementation stage, (2) demonstrates use of the 'five control knobs for health-sector reform' framework in monitoring of policy implementation, (3) demonstrates use of the same framework in identification of critical implementation gaps, related to stalling of the health reform and (4) demonstrates applicability of the framework to analysis of hospital sector reform, as a subset of the overall health reform.

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SOCIAL HEALTH INSURANCE REFORM IN THE FEDERATION OF BOSNIA AND HERZEGOVINA DURING TRANSITION

ABSTRACT

The aim of this study is to review major steps of health financing reform process in the Federation of Bosnia and Herzegovina during transition period from the socialist system within ex-Yugoslavia to free market economy after the war. Analysis of health financing reform process highlighted the following domains of the system: policy choices and constitutional background; organizational design of health insurance funds and administrative compliance; available resources and contribution rates; risk equalization scheme; contracting process and provider-purchaser split; provider payment methods; basic benefit package; cost-containment methods; market regulations of insurance funds and health care providers; privatization process; and lessons learned.

Key words: reform, social health insurance, Federation of Bosnia and Herzegovina

Introduction and Reform Objectives. The aim of this study is to review the major steps of health financing reform process in the Federation of Bosnia and Herzegovina during transition period from the socialist system within ex-Yugoslavia to free market economy after the war.

The main objectives of the health financing reform in the Federation of Bosnia and Herzegovina were as follows: (a) control expenditures on macro level; (b) improve institutional efficiency; (c) to promote principles of solidarity; (d) develop instruments for implementation of health policy objectives through contracting process; (e) develop sustainable health financing system through establishing two types of health insurance (compulsory and voluntary); and (f) establish a uniform health care system in the Federation which would correspond to the Cantonal administrative organization of the country, rather than merely ethnic organization as a result of war conflict (Hrabač, 1998; Ljubić, 1999).

Policy Choices and Constitutional Background. Policy choice in BiH is to establish “non-competitive regionally-based social health insurance system”. Social health insurance assumes non-profit and public insurance system established by law and functioning under the aegis of the Parliament and Government. This system is not financed through general taxation, but through health insurance contribution. Non-competitive system means lack of competition among various social health insurance funds. Regionally-based means that there will be more funds, namely one in each region. Citizens do

not have a possibility of free choice of health insurance fund, nor it is possible to leave insurance which is compulsory for all citizens (Hrabač, 2004).

In accordance with current trends in Europe, health care in the country is decentralized and it is based on two Constitutions: BiH Constitution (commonly called “the Dayton Constitution”) and the Federation Constitution. BiH Constitution defines health care as a full responsibility of Entity level authorities. In terms of share of responsibilities, according to the Federation Constitution, health belongs to a group of responsibilities shared between Federation and Cantonal authorities. To that end, the Article III/3 says: “Depending on needs, responsibilities referred to in the Article III/2 (which responsibilities include, inter alia, health) can be performed jointly or separately, or by Cantons with coordination from Federation level. Cantons and Federation authorities shall maintain dialogue on these responsibilities on continuous basis.” After extensive discussions, it has been agreed that health care will be organized in the Cantons, and coordinated by the Federation Government. This option responds best to the actual situation in the Federation and enables establishment of a decentralized health care system in line with the experiences of developed health care systems in the world. This option avoids risk of the system fragmentation, which would be present realistically if we decided to pursue performance of health responsibilities separately by Cantons. The spirit of this intermediary option referred to in the Constitution, has been translated into two overarching health laws: the Law on Health Care and the Law on Health Insurance adopted in 1997 (Ljubić, 1999).

Organizational Design of Health Insurance Funds and Administrative Compliance. The 1992–1995 war divided the country into two Entities: the Federation of Bosnia and Herzegovina (51.00 percent of the territory, mostly populated by Bosniacs and Croats) and Republika Srpska (49.00 percent of the territory, mostly populated by Serbs). The Federation of BiH was further divided into 10 Cantons (3 Croat-majority, 5 Bosniac-majority and 2 mixed Cantons). During the war and several years after the war, there were, de facto, two administrative parts of the Federation: (1) “Herzeg-Bosnia” territory under Croat control (2) territory under Bosniac control. Such administrative division of the Federation, created in health sector two parallel and separated health systems, namely, Croat one and Bosniac one (Ljubić, 1999).

„Inter-Cantonal Health Insurance Fund“ was established in Mostar during the war, in order to provide health insurance for the territories mostly populated by Croats (temporary administrative domain called „Herceg-Bosnia“). It covered three Cantons with Croat majority and Croat-populated parts of the two mixed Cantons. Health insurance contributions were earmarked and paid directly to the Inter-Cantonal Health Insurance Fund in Mostar, enabling solidarity scheme function within Croat-controlled territories.

In the other part of the Federation with Bosniac majority, majority of Health Insurance Funds were established during late 1990s. However, in the territory covered by these Funds, health resources were within Ministries of Finance and Health, neither guaranteeing transparent resources allocation, nor creating precondition to develop solidarity mechanisms at Federation level. At the same time, Federation Health Insurance and Reinsurance Fund was established, without clear responsibilities and manner of financing.

During the period 1998-2000, Federation Ministry of Health invested significant political efforts to establish regionally-based Cantonal Health Insurance Funds, respecting political and administrative boundaries of the Cantons. As result of these efforts, ten Cantonal Health Insurance Funds were established in the Federation. The other important achievement of the Ministry was arrangement to make direct payment of health insurance contribution to the Health Insurance Funds, rather than to the Ministry of Finance, as it was earlier practice in the Bosniac part of the Federation. That ensured transparency in health financing and created preconditions to develop solidarity scheme at Federation level.

Available Resources and Contribution Rates. Our choice of health care financing system based on health insurance is a continuity of the activities which have been implemented in BiH for decades before the war, as remnant of Bismarck system. Namely, health insurance contribution has never been a part of government budget, but has been directly paid to Health Insurance Funds. Compulsory Health Insurance Contribution is collected through payroll taxation, rather than through health insurance premium or general taxation.

Health insurance legislation provides “universal coverage of population by health insurance” in order to ensure equal access to health care. Contributors and their family members, who benefit the right to health care based on compulsory insurance of the contributor, are collectively called “insured persons”. Despite wide window of opportunity to access social health insurance system, around 15.00 percent of population is estimated to be uncovered by the insurance. Population coverage by health insurance varies significantly among Cantons and regions, and differences are even more dramatic among municipalities. Information on number of insured persons should be taken with reservations, as health insurance contributions are not being paid regularly for all the categories of insured persons (National Health Accounts, 2010).

Review of available resources in Cantonal Health Insurance Funds in FBiH, according to “FBiH Health Accounts”, indicted significant inequality among average amounts of collected contributions per capita in individual Cantons, differences are approximately 2:1, and at the times they used to be as much as 3.5:1. Such inequity is unallowable in health care financed through compulsory health insurance, which proclaims principles of equality and solidarity.

The following Table shows breakdown, by Cantons, of collected health contribution per capita for 2007, 2008, and 2009, as well as of expenditures on prescription drugs. (National Health Accounts, 2010).

TABLE 1. – Review of collected health insurance contribution per insured person and expenditures on prescription drugs by Cantons for 2007, 2008, and 2009.

Canton	2007		2008		2009	
	Contribution/ Insured Person	Average expenditures on prescription drugs	Contribution/ Insured Person	Average expenditures on prescription drugs	Contribution/ Insured Person	Average expenditures on prescription drugs
Una-Sana	337	41	377	50	408	57
Posavina	429	30	516	35	559	36
Tuzla	388	63	454	72	462	82
Zenica-Doboj	336	39	419	45	441	50
Bosnia – Podrinje	437	63	582	69	549	74
Central Bosnia	305	27	396	32	414	45
Herzegovina – Neretva	472	24	540	28	562	33
West Herzegovina	375	46	454	61	502	56
Sarajevo	675	122	793	131	802	159
Herzeg- Bosnia	376	40	441	46	469	48
TOTAL FBiH	431	59	513	67	531	78

*Source of data: National Health Account for the Federation of Bosnia and Herzegovina in 2009 (2010).

In FBiH in 2009, total revenues collected based on compulsory health insurance amounted KM 531 per insured person. However, health expenditures vary by Cantons, ranging in 2009 from KM 408 in Una-Sana Canton, to KM 82 in Sarajevo Canton. In 2009 in FBiH average expenditures on prescription drugs were KM 78, accounting for 15.00 percent of total health expenditures, which is in line with European practice. However, review of Cantonal distribution of expenditures on drugs reveals dramatic differences among the Cantons, with amounts ranging from KM 33 in Herzegovina-Neretva Canton to KM 159 in Sarajevo Canton. Socially responsible health system must not tolerate so large differences in health expenditures, particularly on drugs in Primary Health Care.

Risk Equalization Scheme. FBiH Law on Health Insurance provides possibility for two or more neighboring Cantonal Funds to merge into a single Fund, provided that it is done for the sake of increased risk pooling and reduced administrative costs. Merger of Cantonal Funds must be based on free political will of Cantonal Ministries of Health. During 1999 and 2000, Fed-

eration Ministry of Health urged the Cantons to take advantage of this legal provision enabling merger of two or more Funds on the grounds of the above mentioned technical justification. However, Cantonal authorities did not accept this initiative, primarily due to lack of political will in richer Cantons (Hrabač, 1998).

Over the period of three years (1999–2001), Federation Ministry of Health had extensive discussions, with key stakeholders in health sector, aimed to introduce solidarity among Cantons in the Federation. It was proposed to allocate 20.00 percent of health insurance contributions from each Canton, to finance Federation Solidarity Fund in Sarajevo. The idea was to use these resources into three strategic directions with the objective to promote solidarity, as follows: (1) primary health care in poorest Cantons; (2) vertical programs (such as haemodialysis); (3) all tertiary health care services for all insured persons in the Federation (Hrabač, 2000a). Public consultation process resulted with the amendment of Health Insurance Law in 2001. The adopted Federation-level solidarity scheme, financed by 8% of total health insurance contribution, was directed towards very narrow “risk pooling” (solidarity) in poor Cantons, covering haemodialysis costs for all patients in Federation, and some expensive secondary health care services (oncology in Cantonal hospitals), as well as tertiary health care delivered in the three University Hospitals (Clinical Centers). There is not any inter-cantonal solidarity for primary health care services. Discrepancies of expenditures on prescription drugs per capita among Cantons present the most obvious example of inequity in health care delivered at the territory of Cantons.

The contracting Process and Provider-Purchaser Split. In the Federation, contracting between Health Insurance Funds and health providers is considered to be an instrument of health policy objectives implementation. This is a coordination mechanism which provides an alternative to traditional central-level command and control models in health care management. Essential element of contracting is introduction of more market oriented form of institutional allocation of resources based on separation between financier and service provider. Contracting mechanisms oblige both sides to explicit obligations and create economic incentives to fulfill obligations (Mosialos, 2002). Main reasons to promote contracting mechanisms in health are the following (Ljubić and Hrabač, 1999): (1) encourage management decentralization; (2) improve quality of work of service providers; (3) improve health care development planning; (4) improve health management. Federation Health Insurance Fund has recently completed a document titled: “Unified Health Services Contracting Methodology in FBiH”. The objective of this approach is to promote single methodology framework in contracting process in all the Cantons, which would significantly enhance equity and equality principles (Huseinagić, 2010).

Provider Payment Methods. Family medicine physicians in primary health care will be paid through capitation scheme for each patient registered with

a health services provider and this payment will be a basic level of their income but only up to the maximum number of patients. The income paid this way may vary depending on the area where the physician works (urban or rural). Incentive payments are foreseen also for various achievements (i.e. immunization of children, or conspicuous results of health promotion). Fee-for service can be introduced in practice of outpatient departments, but only for minor portion of the total income. The proposed payment system tends to give physicians incentives to practice preventive medicine and control expenditures, but may also lead to a better geographical distribution. However, payment systems are only one among several determinants of professional behavior, such as professional standards, access to the education and professional expectations (Hrabač, 1997 and 2003; Huseinagić, 2010).

Reform of hospital payment mechanisms affects the control of expenditure, quality of services and access to services for the community. Hospitals are already paid prospectively through annual global budgets. The budget may be calculated according to actual costs, historical patterns of expenditure, provision of beds, population covered, or volume of services to be provided. Health professionals as individuals are still paid through monthly salary within health institutions (Hrabač, 1998).

New payment methods have been tested in family medicine only locally through a few pilot projects. However, introduction of these payment models in the whole territory of a Canton or throughout Federation was not possible, despite significant investments in equipment and civil works, family medicine teams training, and changed work organization and management. Reasons of failure of those changes are mainly attributed to lack of political will of the Ministries of Health and Health Insurance Funds, resistance shown by Health Centers' managers, as well as by specialist from various clinical disciplines. Ungrounded fear shown, by family medicine doctors, of capitation based budget management financial risks, and possible bankruptcy during the process of family medicine practices privatization, was particularly interesting. Significant changes of payment methods were implemented successfully only in hospitals through global prospective budget.

Basic Benefit Package. Inequality and inequity in health care in FBiH can be characterized as an important problem existing in our health system. All the data indicate undoubtedly high inequalities in health care financing among Cantons, allocation of resources for prescription drugs and structure of services subject to co-payment, as well as benefiting the right to orthopedic and other aids. Basic package of health benefits can be only one of possible interventions, to mitigate the said inequity (Hrabač, 2000b).

Confronted to scarce resources for health sector, governments often tend to influence health care demand by setting health care priorities, namely basic package of health benefits. Setting priorities in health care can be defined as a process of making decision to exclude certain number of health servic-

es from “Basic Package” financed by collective solidarity (risk pooling), and leaving them as responsibility of individual citizen. (Dunning, 1992). In FBiH health benefits package, financed by compulsory health insurance, is defined as “a range of benefits to accommodate citizens’ basic health needs, guaranteed under equal conditions to all insured persons within each Entity based on equality, equity and solidarity principles, irrespectively of where they live, and how much health insurance contribution they can pay” (Hrabač, 2004). Equality, equity and solidarity principles are main values on which our health care system is based.

In public health literature health benefits package design is also referred to as “health care priorities setting”, and defined as follows: “Health care priorities setting assumes process of making choice among alternative health care programs and services, as well as patients and groups of patients which need health care. Priorities setting is also a process within which alternatives are ranked according to norms and technical rules, resulting with defined minimum or basic health benefits package.” (WHO, 1998).

In FBiH during 2008, key stakeholders in health benefits package design were the following: Ministries of Health, Health Insurance Funds, health providers, public health experts, general public and patients. Priorities setting legitimacy corresponds directly to decision making process, provided that the process is open and provided that it demonstrated pluralism of interests of the society. However, priorities setting is ultimately responsibility of selected government officials (Working Group of the Federation Ministry of Health) who make decision taking into account balance between, health costs control, on one hand, and wider social values and principles, health policy objectives, legal framework, demand for services, political pressures, necessity to reduce disease burden, cost-effectiveness and efficiency of health services, as well as expectations of general public and patients, on the other hand. Working Group of the Federation Ministry of Health was expanded by experts in the area of public health and health insurance, as well as certain clinical disciplines. Chairman of the Working Group was professor dr. Boris Hrabač, public health specialist.

Working Group of Federation Ministry of Health produced comprehensive technical study titled “Basic Package of Health Benefits for the Federation of Bosnia and Herzegovina”. The Study elaborated from technical aspects Ministry’s choices, with particular emphasis on defining the issues, reform proposal, benefits package design methodology, formal documents of the benefit package, cost estimates, manner of implementation of the proposed scheme with health services contracting mechanisms, as well as instruction for patients. Within basic health benefits package design process, it was necessary to address explicitly the following issues: (1) who is covered by the scheme; (2) what benefits are offered by the scheme (3) who administers the scheme; (4) who provides the services included in the scheme; (5) what are payments manners for the service providers; (6) how is the scheme financed.

FBiH health benefits package consists, in administrative and technical sense, of four separate formal decisions made by the Parliament, as follows: (1) the decision on direct co-payment by citizens to finance a portion of health services; (2) the decision on drugs financed by Health Insurance Funds (Positive Drugs List); (3) the decision on rights to orthopedic aid; (4) the decision on health services and programs financed by Federation Solidarity Fund. Main principle for implementation of health benefits package in 10 Cantons with high level of decentralization are that all the Cantons must respect minimum benefits to which they are obliged by the said decisions made by FBiH Parliament, and that assumes implicitly that they can offer to their contributors larger scope of benefits than the one mentioned here, if they can afford it. Such legislative solution protects interest of patients throughout Federation territory, promoting equality and equity principles.

Leading reason to introduce co-payments ("cost sharing") is ability to have influence to unjustified requests for health care. Thus, co-payment must be high enough to keep away patients with unjustified requests, but again low enough for sick patients with genuine requests. Majority of Western Europe countries puts little emphasize on co-payment as a method, either to mobilize resources or to control costs of out-patient and hospital services. On the other hand, co-payment is widespread in the area of pharmaceuticals. Although objectives of such policies are rarely pointed out explicitly, their main purpose is to shift costs of drugs towards users, particularly drugs which are not on the essential list and which are not of vital importance. In many countries co-payment tends to be conditional and is often associated with comprehensive "system of exceptions". Within the Federation Parliament Decision on Health Care Cost Sharing, Government choices are classified in a systematic way into 4 groups of services/groups of patients, as follows (Hrabač and Huseinagić, 2008b):

1. Group 1 presents services not covered by Health Insurance Fund. This is so called "negative list of services". (Health Insurance Fund does not cover costs of these services, as they often provide low health benefits, compared to the costs of their provision. Also, such services can often be left to citizens' individual responsibility, as they do not present essential health care from the aspect of social approach to the concept of health. Such services include e.g. esthetic surgery, non-compulsory immunization, dental-prosthesis, spa treatment, issuing various health certificates and copies of health records, certificate on health condition, etc.).
2. Group 2 presents services which would be provided to all insured persons free of co-payment. Health Insurance Fund would cover full costs of a range of services linked to the said conditions and circumstances, as obliged by normative criteria for health benefits package design, referred to in the Law on Health Insurance (Article 32); (These are the following: emergency medical interventions; treatment of communicable diseases; treatment of acute and chronicle conditions in life-threatening circum-

stances and conditions; health care of children below 15; health care of students attending regular education; endemic nephropathy detection and treatment; treatment of malign conditions and insulin-dependent diabetes; health care during pregnancy and maternity; health care of patients with mental disorders who, due to the nature of their condition, can present a threat to their own life or lives of others; health care of progressive neuro-muscular diseases, paraplegic, quadriplegic, cerebral paralysis and multiple sclerosis; implementation of compulsory immunization against child communicable diseases; treatment of work-related injuries and professional diseases; health care of population above 65; treatment of drug-addicts; and blood donation service.)

3. Group 3 presents vulnerable groups of insured persons who are exempted of co-payments. (Health Insurance Fund covers fully health care costs of the following categories of insured persons which are considered to be vulnerable, as follows: children below 15 and students below 26 if they attend regular education; military invalids with 60.00 percent disability; family members of killed or deceased FBiH Army members; civilian war victims and invalids with over 60.00 percent disability; pensioners whose pension amounts below KM 170 per months; persons over 65, unless they have pension or other income above KM 170; insured beneficiaries of social institutions; insured beneficiaries of social assistance; insured members of Association of Blind Persons; expelled persons and refugees; insured persons who are voluntarily blood donors or organ donors; insured persons registered with Employment Bureau as unemployed persons.)
4. Group 4 presents services subject to co-payment at the amounts specified explicitly in tabular presentation. All the groups of insured persons referred to in the Group 3, as well as all the services, diagnoses, and conditions referred to in the Group 2 are exempted of such co-payment. (Health Insurance Fund does not cover fully costs of the said services, for the amount of co-payment which is to be borne by patient. These amounts of co-payment are maximum ones allowed to be charged at the territory of a Canton. Cantons are allowed to charge lower amounts than the specified one, as well as to limit co-payment to lower number of services than the ones specified here. Such an approach protects patients against high financial risks for the duration of the disease. This group lists amounts of co-payment for 162 services.)

Health benefits package was adopted by FBiH Parliament in 2008. A document titled "Cost Estimates of Basic Health Benefits Package and Manner of Financing" was presented to the Parliament. According to the said estimate, financial gap to finance the proposed scheme of health benefits package in the poorest Cantons was KM 50 million, thus it was decided that this amount would be paid from Federation Budget resources. Implementation of health benefits package is conditioned by covering the said financial gap by the Budget, thus implementation of the adopted legislation was put on hold.

Market Regulations of Insurance Funds and Health Care Providers. There is a significant dilemma in the countries which transform their health financing system related to balancing solidarity principle and competition among insurance companies. If there is only one health insurance company which covers health care services, then there is no competition. Likewise there is no competition if there are several insurance companies, but without right of choice among them. Contributors in Federation are not allowed to be insured with compulsory Health Insurance Fund of another Canton, but the Canton of their residence. To finance level of benefits exceeding basic package of health benefits, voluntarily/private health insurance funds would be established. Federation Ministry of Finance would define manner how to regulate operations of such funds in order to ensure solidarity and equity principle for all the citizens. These funds would not be direct competition to compulsory Health Insurance Funds, as they would mainly finance different health care benefits. Besides, compulsory health insurance does not provide free choice to leave it and shift to private insurance only. Thus, there would be competition only among private health insurance funds, rather than between private and compulsory insurance or among compulsory insurance funds.

Pursuant to Health Care Law and Health Insurance Law, contracting by compulsory Health Insurance Funds in Cantons is limited to the “network of health institutions”. Cantonal Parliaments and Federation Parliament shall verify network of institutions, both public and private ones. Other health providers, which are not a part of “the network of health institutions”, will be financed from direct payments by patients („out-of-pocket payment“) or private health insurance. In general, there is no strong competition among providers within the network of health institutions, i.e. in public sector. Contracting seems to be the only way of implementing health policy objectives. Systems of payment of health workers and institutions are considered to be competitive measures and market incentive, as well as privatization of certain parts of sector’s sub-systems (Hrabač et al., 1998).

Privatization Process. Health sector privatization process is being increasingly present in the discussion agenda among key stakeholders of health reform in FBiH. Now we have significant private sector in the area of pharmacies and pharmaceutical wholesalers, specialist practices, as well as dental health care. Expected privatization process is most likely to be limited to certain sub-sectors of health, as well as to surplus hospital capacities, which would not be included in the networks of health institutions. However, we are facing very important dilemma: whether privatization process in health assumes implicitly private ownership or it is possible to organize functioning of health practices irrespectively of ownership nature. The other major dilemma is the following: what mix of public and private ownership is to be allowed for the future in terms of participation of private owned facilities into the networks of health institutions and their access to compulsory health insurance resources (Hrabač, 2008a).

Federation Ministry of Health's documents dealing with health reform policy and strategy, point out privatization within decentralized health care system as one of key choices of health reform. They also point out necessity of careful and planned approach using the following wording: "Privatization process must not be unorganized, covering simultaneously parts of health sector". However, whole process of privatization in health must not be done for the sake of privatization itself, it must rather accommodate pluralism of interest of all the stakeholders in health systems by achieving certain objectives. Unless privatization process objectives are explicit and transparent, unless they promise significant benefits for the society as a whole, whole privatization process would not make sense. Health privatization objectives, could be, for example, defined as follows:

- Introduce market incentive mechanisms in certain sub-sectors of health (e.g. family medicine);
- Improve institutional efficiency;
- Rent excess premises;
- Sell or rent facilities which are not part of "the network of health institutions", thereby reducing total costs of the compulsory Health Insurance Funds.

CONCLUSIONS: LESSONS LEARNED

Health Care and Health Insurance Laws support socially responsible approach to health care issues in the Federation as opposed to purely market-oriented approach. Health of the population is of major sociological interest for the society as a whole and therefore cannot be entirely left to the simplified demand-and-supply market rules. Therefore the state, as a representative of the community, must possess the instruments to control health care system. These instruments must correspond to the substantive global economic and social changes in the countries in the process of transitions. Decisions to introduce more market-based incentives into one or more sub-sectors of the health system require somewhat altered activities of the government which, in any case, are not to be reduced. Federation government will have to show more competence in the area of monitoring contracting process between Health Insurance Funds and health care providers, as well as control of market arrangements then at the time when it managed directly the system. Incentive-based market mechanisms may be introduced into some of the segments of the health care system, but only under government-led control of the effects of such measures (Hrabač et al., 1998).

Health care reforms are more difficult to implement than expected. Moreover, they often have undesired consequences. Numerous countries faced difficulties related to inadequate reform implementation planning process, rather than reform content itself. Discussions on the reform still pay little attention to implementation issues and change management strategies.

Implementation should be viewed as an integral part of the reform process. The same level of efforts devoted to policy development, should be devoted to implementation strategy. However, implementation is not exact science. There is no agreed set of strategies which would, if followed consistently, ensure successful results. Furthermore, circumstances under which the reform is implemented, vary significantly from country to country. Nonetheless, better understanding of the factors facilitating or aggravating change and of the strategies proven to be effective in certain countries, can help policy makers in achieving desirable changes.

A framework which can help policy makers understand factors which facilitate or aggravate changes assumes presence of four components, these being: reform context, process, stakeholders and content. More attention should be paid to the *context* in which reform policy is introduced, *process* through which it is formulated, implemented and evaluated, as well as *stakeholders* which are affected and which can influence its *content*, context and process. Health reform development is subject to whole range of contextual factors, including macro-economic situation, socio-political circumstances and mix of social values. Implementation process is affected directly by government organization system, particularly division of responsibilities between central and local level. Although context and process are important, reform stakeholders and interest groups are often key determinants of change policy. Four groups have actual influence on implementation: citizens, health workers, political elite and interest groups. (WHO, 1996).

Choice of *adequate timing for reform*, such as a moment with specific circumstances suitable for changes, present key determinant of success. In the times of political and social transformation, opportunities for radical changes can lead towards quite dramatic reforms. *Financial sustainability* is also critical for reform implementation, as economic recessions were often main impediment. One of key factors for reform sustainability is *technical capacity*, such as availability of adequate information systems and managerial skills to introduce, often very complex, financial and organizational arrangements. Probably *political will and leadership* are the most important factors affecting policy implementation. Useful strategy for successful reform implementation is to develop potentials of "policy friends" though establishment of *strategic alliances* individuals, organizations and agencies which support the proposed changes. However, it is also necessary to reduce influence of "policy enemies", making them less efficient through trade offs and incentives. It is particularly important to seek *general public* support. (Roberts, 2001).

Implementation process management is of high importance for changes in the health system. Five key aspects of this process are the following ones: *one*, set explicit reform objectives to have clear direction and facilitate social consensus; *two*, establish adequate management arrangements with clear division of responsibilities and identify implementing authority with adequate mechanisms; *three*, adopt adequate legislation at the outset of the process;

four, use financial incentives to facilitate implementation process, and *five*, establish adequate steps for introduction of changes. Extensive discussions are being held on merit of radical “big-bang” reform, as opposed to step-by-step approaches. Generally speaking, the best approach in any country would depend on its specific circumstances. However, there are certain advantages of gradual and flexible approach, through which the desired change is first tested locally or by a pilot sample before rolling it out throughout the country.

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GLOBAL DIRECTIONS FOR REFORMING HEALTH SYSTEMS AND EXPANDING INSURANCE IN THE ARAB GULF STATES

ABSTRACT

Most countries are exploring and implementing reforms of their health care systems. The Arab countries in the Gulf are no exception after establishing modern governmental health care systems accessible to all and free of charge. Current problems of the Arab systems include financial, managerial and quality issues. The private sector in these countries has no defined national role and is growing abruptly and unplanned. The paper presents the major global health reform directions, analyzing the current activities in the Arab Gulf countries and proposing certain practical relevant approaches for health reform, and expansion of insurance in these activities.

Keywords: Health reform, health insurance, medical care.

WHY HEALTH REFORM?

Most countries of the world, developing and industrial, are struggling for are coping with the escalating cost of health care, and at the same time are seeking to preserve their commitment to universal coverage of their populations and maintaining a high quality level of services provided. This rising cost of care results from at least 3 factors

1. Advancement in health and medical technology, where costly procedures for diagnosis, treatment, and surgery that were not available in the past became a demand by the consumers and by the health care providers, and are being widely used.
2. The medical care inflation rate is always rising higher and is sometimes double the general inflation rate in most countries.
3. Aging of populations where the percentage and numbers of persons 65 years and over are increasing due to better health care and improved nutrition and environment.

Normally, the elderly require 2-3 times more health services than the non-elderly. For this reason, countries are looking for the best ways of raising the efficiency and effectiveness of their health systems through aggressive national reforms. Countries with governmental systems similar to many Arab countries, where the government owns, finances and manages its medical care facilities are changing to health insurance schemes, leaving medical care to public and private independent providers (hospital, physicians). In doing so, ministries of health in these countries are focusing on establish-

ing health policies, regulations, monitoring the quality of care, controlling cost, and providing public health services. Examples of these countries are the United Kingdom (UK), Ireland, Spain, and all the Eastern/ Central European countries. On the other hand, countries with predominantly private insurance schemes such as the United States of America (USA) are considering mandating insurance through public insurance schemes and managed care models.(1–4)

GENERAL DIRECTIONS

Health insurance or security appears to be the Global directions for reforming health systems and expanding insurance ultimate solution in the long range. It has been proven all over the world that a medical care system totally owned, financed and operated by governments is less efficient and less effective. Apart from Eastern and Central European countries, which are moving to health insurance and privatization, the UK, which is known by its public central national services is departing from its classic model to:

1. Contracting groups of general practitioners for the total care of individuals, and those practitioners contract hospitals to provide hospital care and acting as fund holders for their patients.
2. Allowing the district health authorities to contract public or private hospitals to provide care creating competition on cost and quality.
3. Converting large regional and teaching hospitals to become autonomous organizations that contract the district or the private insurance organizations to provide care.

These changes aim at more choices for the beneficiaries. At the same time, it is gradually introducing privatization and the buildup of a public-private mix that can compete for contracts, and the only way for competition is to save costs by becoming more efficient, and to provide better quality of care. It is apparent that such a scheme may be suitable for many Arab countries. In this respect it should be noted that

1. Although the study of the most prevailing systems in the world is very useful, it is clear that copying one system and transplanting it in another community is never successful. This was further proven by experiments and experiences of Eastern and Central European countries that rushed into copying some western systems between 1989 and 1992. Naturally the concepts and principles from other countries can be used only to design a system that is custom tailored to the country, and is relevant to its social cultural, political and economic patterns of both the healthcare users and providers.
2. The most prevailing systems are those using job related insurance with employer-employee contributions under an acceptable national policy.

3. Implementation of national health insurance or a health security scheme does not mean turning the governmental system to the profit-making insurance companies, nor does it suggest selling hospitals and health facilities to the private sector. On the contrary, the majority of hospitals in Western countries are still public, and most of the health insurance organizations are public or private not-for-profit organizations. The American model is the exception to that, and this is why the system is difficult to change. Although the needed changes are well known, the major problem in the absence of a national health policy is that the special interest groups have become politically powerful so that they almost run the system and abort any radical change. The USA model is useful to learn with regards to issues that should be avoided rather than a model to be imitated.“

4. There are many insurance models in the world. Policy makers in many countries may find it necessary to use different models in the same country in response to regional differences or certain types of beneficiaries.

5. Many Arab countries have strong ingredients and potential to introduce a national system for health security or insurance in the long range due to the following:

- a) The presence of a social security system that can be expanded to cover health security
- b) Many insurance companies are already selling health insurance policies. The coverage and benefits of such policies and the number of persons covered by comprehensive care by private insurance needs to be determined
- c) A general attitude of concern regarding the current health system where most people including the policy makers feel the need for its change and reform
- d) Many governments are adopting policies of economic reform and privatization. This can be clearly applied to health care by introducing health insurance
- e) The move towards health security or social health insurance that is prevailing in most industrial and developing countries is creating a wealth of information on the types, experiences, and lessons of success and failure, which, if studied carefully, can assist in designing a relevant system for the Arab world.

DIRECTIONS IN THE ARAB GULF REGION

The Arab Gulf States' governments have financed, and are financing their health care systems especially during the past 3 decades. This is natural, and was associated with the oil revenues that facilitated generous funding of all services including health care. With the expansion of its developmental proj-

ects and the decline in oil revenues, these countries are carefully planning for cost sharing of services by their users, and rationalizing health spending which used to be unlimited. These directions can be illustrated by the following:

1. As early as 1980, the „Kuwait Health Plan to the year 2000“ concluded clearly the need for converting the national governmental system to a health insurance scheme in the long term. This plan (directed by the writer) was based on extensive studies and analysis of demographic projections, cost and utilization of health services for the long range.
2. In 1985, the Gulf Ministers of Health conducted a conference on „Health Economics and alternatives of health care financing“. This conference, attended by approximately 35 senior participants from all the Arab gulf countries recommended health insurance as the only viable solution for the member countries in the future.
3. Most of the Arab Gulf states began to introduce in the early 80's a system of cost sharing and collecting fees for services at least from expatriate populations. At the same time, many countries are beginning to explore some type of health insurance/security suitable for its needs. During the 90's, the writer conducted the following studies or organized the following conferences, or both: A study on introducing National Health Security in United Arab Emirates (UAE) (1995), Conference for the Arab League (21 countries) on Alternatives of health care financing (1995) Proposal for applying national health insurance in Kuwait (1995 & 1997), Consultancy on resource mobilization and health financing in Oman (1996), Conference on health management and financing and social insurance, Najran, Kingdom of Saudi Arabia (1996). Therefore, there are clear indications that the Arab governments are moving with variable paces towards application of health reforms including health insurance schemes, privatization, decentralization, and the introduction of managed care models. Particularly, most of the Arab Gulf countries are moving towards expanding health insurance. This approach, although natural can be harmful to the national health systems if it is created without careful planning. To be successful, health insurance systems should: Introduce and enforce strict regulations and careful monitoring of quality in the private sector; prevent any restrictions on insurance policies such as presenting conditions, imposing caps on annual expenditure or utilization by the beneficiaries or other forms of indemnity insurance applications. Models of current applications are mainly covering the expatriate populations in these countries and not the citizens

Typically a community rated system should be introduced for citizens as a community rated system that allows choice, and where the government will contribute at least to cover the poor, the elderly, the disabled and the unemployed. Also, the government will have the responsibility of providing pub-

lic health services and of regulation of practices, licensing of providers and health facilities, and quality monitoring of all services provided.(5-8)

PROPOSED REFORM PLANNING

Before entering into insurance planning, applications and regulations, a scientific feasibility study should be made in each country. The general goal of such study is to analyze the current health care system in terms of service utilization, cost and funding of services for the different population groups, and to present recommendations on the best alternatives of health care organization and financing under a national health security scheme. It should be noted that most of the data available does not include private utilization and expenditures. The specific objectives of the study should include analysis of the feasibility and application of expanding the national security scheme that should enable the use of the most efficient model or models of providing health care as part of the social security benefits for citizens and their dependents. The system(s) should eliminate duplication of service utilization, allow for competition among providers, and improve the consumers' satisfaction giving them more choices and a positive role in cost-sharing, planning, and management of health services. The expected outcome of such a feasibility study is to present the main options of the schemes to be considered in the country in terms of its organization, provider funding sources and projected costs, at least for the next 10 years and the methods of payment. It should specifically describe beneficiaries, benefits, and expected sources of funding for the following categories 1. Government employees and their dependents (citizens and non-citizens). 2. Public sector employees and their dependents (citizens and non-citizens) 3. Private sector employees (citizens and non-citizens) 4. Citizens not in the workforce (unemployed, retired, housewives, disabled, and in long-term care) 5. Non-citizens who are self employed and their dependents 6. Non-citizens who are working in households (servants, maids, cooks, drivers, guards, gardeners.) 7. Treatment of work-related accidents and diseases and compensations. 8. Treatment of visitors from the GCC. and other foreign visitors. The study should also address the organizational changes and the new role of the Ministry of Health.

THE ROLE OF THE PRIVATE SECTOR

Given the policy directions in health care, the private sector should prepare itself for a new role and different strategic planning from the current ad hoc short-term approaches, namely:

1. The concept of fee-for-service is disappearing, and can no longer survive in the long-term. The private sector should be prepared to utilize capitation and managed care models.

2. More regulation and monitoring of quality of care is to be expected since the governments in turning a large market share to the private sector, will be more obligated to monitor the quality of care provided by this sector.

3. Managed care requires large systems that can cover comprehensive care. Therefore, small medical organizations should have plans to expand, integrate with other small organizations, or at least collaborate with other private and public organizations through contracting and partnership if merging is not feasible. The goal should be the formation of large, financially viable health systems.

4. The success of a private corporation will depend on price and quality. Therefore effective scientific management of health agencies is the only solution for the efficient use of resources and control of expenditure without compromising quality of care provided. Therefore, the choice of specialized trained health management consultants and administrators is never a waste, but an essential ingredient for success. Likewise, training of administrators and heads of technical services should be central to the success of private organizations.

5. New systems can not be imported but can be designed and adjusted to each situation. This applies specifically to:

- a) Hospital and comprehensive health insurance management,
- b) Quality assurance/improvement/management
- c) Management Information systems.

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HEALTH SECTOR MANAGEMENT: EMPHASIS ON THE GREEK EXPERIENCE

In writing this short paper I state only one claim to uniqueness; I have experienced gestation and birth of radical reform in three different health sectors and followed their postnatal developments namely, in the British National Health Service [NHS], Medicare and Medicaid in America and the Greek National Health System. They are functionally troubled organizations; more or less physician centered and operate within societies where socio-economic polarization is growing. They were born after serious national trials and under strong governments; post WWII Britain, the assassination of President Kennedy with social unrest over Vietnam and after the Colonel's dictatorship and subsequent participation of Greece on the European stage. Historical accident also made a contribution: The man who won the war lost the elections to Attlee who launched the NHS, which was implemented in 1948 by a tough Minister who it is said brought the senior doctors around by "stuffing their throats with gold"; President Johnson in the 1960's pushed for a system of care for the elderly. The American Medical Association argued that it would do nothing for the truly needy and scorned it as "socialized medicine". Johnson's response was to add a second system targeting the poor. Andreas Papandreou established the Greek NHS in 1983 just a few years after a similar plan by the then Minister of Health Spiros Doxiadis had been dismissed by his own conservative party as being socialistic and even communistic. All three systems were based on conscious political decision-making. Their related interventions were rolled out nationally with little thought to evaluation. Since their inception, correction of perceived or real shortcomings has been periodically attempted. Since WWII structural reform has occurred in most industrialized Western democracies driven by various social, economic and political pressures, for example France 1945, Denmark 1970, and Portugal 1979. To these international personal experiences I have seen first hand the changes during the socioeconomic transition of Balkan health systems from Soviet style to free market.

Once implemented, health systems differ from the originally intended model. The differentiation is brought about through a process of reductionism based on legal and financial considerations, ideological conflict and changes in thinking about provision and delivery of services. It reflects the complexity of politics in health and the difficult challenges presented to government by health issues. Between intention-conception and design-implementation,

things happen, the results of which are publicly announced. The direction taken has a stamp of approval even though undesirable to opposition politics. A system's purpose can also be side tracked to accommodate 'unannounced goals,' which represents subliminal accommodation by an interest group to serve its own or another purpose. It can occur at different levels and in all parts of the hierarchy. As complexity increases so does the potential for self serving accommodations and for overall system losses, which can be held in check only by transparency and good governance. Some accommodations may be silently tolerated. Corrective measures but not radical reform reflect specific goals, perspectives, or policy initiatives of weaker governments e.g. cost-containment, choice, purchaser-provider split, private-public mix or an emphasis on patient waiting time restriction.

Health systems are exceedingly complex, relatively unfair and can be classified based on their overall funding mix. Related issues are important to the election process or they can produce political crisis. They produce useful outputs much of the time with varying degrees of efficiency, effectiveness and cost-benefit. They are quite wasteful, contribute about 20% more or less, to the health of the population and they have been ranked in various ways [tax based, social security, mixed] according to specific goal criteria [economic fairness, performance] or value system [solidarity or not]. Distinctive differences have been noted, including variations in operational transparency, quality and levels of integration. One noteworthy similarity is the general absence of preventive services. To achieve system optimality a dynamic balance is necessary between several objectives together with the support of a good menu of policy tools. There is however no single best system.

In Greece the story is a "tale of fragmentation and inertia" and a paradoxical case of "measuring nothing". The radical reform of 1983 gave rise to a model different from the one envisioned by Minister Avgerinos. The one enacted by Parliamentary law was never fully implemented. At its inception, limitations included a weak public administration, the absence of a sociological review of the health seeking behavior of the Greek population and limited health management skills. In principle, it was based on universal, free and equal access. In all phases, it has adopted high cost technological innovation and undergone subsystem "redesign" influenced by party politics, trade unionism, private sector interests, pharmaceutical companies and physicians. The voice of nursing, the patient's voice, and advocacy for primary health care have remained weak voices. As it evolved the structural elements of financing, provision and delivery of services and regulatory mechanisms have eroded. Results include: illness costs have been personalized-privatized, the principle of egalitarian health care has been abandoned and there is a growing population of "outsiders" with limited access to health services.

The Greek health care model is mixed, it demonstrates paradoxical behavior, and operates with limited transparency. Its overall performance has been given a relatively high score while its goal attainment and economic fairness

have been given low scores by the WHO. Within Greek society there are “insiders” and “outsiders”; those belonging or not to the governing network or specific groups; those capable of paying out of pocket expenses including the doctor’s “little envelope” and those who can’t. Out of pocket spending in a lower income family is proportionally higher, which carries the stamp of societal unfairness. Patient dissatisfaction is high and can be interpreted as relating to social costs in a paradoxical system. Although service utilisation is income related, even so, it may be a fuzzy function as a result of tax evasion.

Some interesting contrasts are worth noting for their own sake but also as a reflection on complexity: Greece spends less and gets more compared with American, which spends more and gets less as expressed by various indicators, better attributed to living standards, climate and healthy nutrition; Greeks eat more vegetables and fruits than most other peoples. Patient satisfaction within Europe is lower in Greece than in Denmark, Finland or the Netherlands, which appears roughly linearly related to expenditure. Other snapshots include: when there is a need to support a loved one in need of clinical care, strong family ties surface to pool support; poorly paid doctors going more than the extra mile for patients on the basis of “filotimi” or honour; ambulatory patients visiting several doctors in search of a diagnosis and treatment with no continuity of care; old installations are being renewed, new centers are being opened with utilisation of new and expensive technology as well as new hospitals in the making. Human resources include too many doctors, mostly underpaid and underutilised, too few nurses, few primary health care physicians, work place doctors or biomedical engineers. Educational programmes are being reviewed and modernised in an attempt to steer them closer to Greek reality requirements; research and innovation reflects much misdirected and frugal spending in a weak idiosyncratic culture. The most disappointing snapshot is that of medicine moving away from the Hippocratic ideal, especially since “the tap roots of western civilisation sink deep in Greek soil, the astounding fertility of which is one of the outstanding facts of history”. Today, Hippocrates the “father of medicine” venerated the world over is sliding fast into a “step father” role.

The Greek NHS is centralized with service disaggregation and resource allocation is disconnected from performance. It functions with significant deficits both of information and of management. A phrase typically heard is “management without data”, Greek management “without numbers”. On the positive side, rural areas are now less isolated and access to service has improved, which has contributed two years to life expectancy. On the down side, the door opened wide to corrupting practices with payments for fictitious work and the system *lingua franca* became the “fakelaki”. The little envelope is now the full blown “fakelara”. This is one of the reasons why Transparency International and the Euro barometer have placed Greece in the second group of nations for corruption just below the group of “Super Leaguers”. In a recent parliamentary “blame-game” mini debate on health, the opposition

leader criticized the government for mismanagement. The Prime Minister's response stressed ongoing improvements to a bad situation inherited from the past.

Greece has neither formal public health policy nor an annual health status of the population report. Given the large number of doctor in parliament absence of such policy instruments is at least strange. Doctors should know that health equals wealth in a productive society; that there are health considerations in all other policies. Is the deep pocket of medicine more important than health policy? How should we view the "perks" to senior doctors from the pharmaceutical industry, while poorly paid and less senior doctors can not afford to stay in expensive conference hotels with their foreign colleagues when abroad? How should we view the development of private public health? How should we respond to a system's practice of medicine moving away from the maxim of "first do no harm" towards one with an operating principle of "ends justifying means"? These are important issues for Greek society.

Expert opinion says that the 'black market' flourishes as a means of ensuring earlier hospital admission, access to specialists and/or better treatment, which all depends on the decision of individual doctors whose performance is never recorded. Indeed health professional performance is something of a state secret only argued about by lawyers in TV windows. There are daily anecdotal references to abuse such as the arbitrary use of beds by hospital management and the selective harvesting of patients by emergency medical services. The going tariff for a quick surgical fix says the man on the street is 2000-3000 euro while an ambulance ride can depend on family connections says the citizens advocate.

In the absence of primary health care hospital emergency services are utilised to treat minor health issues. As a result of poor allocation efficiency specialised Centers are inundated with routine examinations. In the absence of effective referral systems continuity of care across service boundaries is a mute question. Service fragmentation together with variations in clinical and professional practice and the absence of monitoring and evaluation systems, diminish the effectiveness of delivered care. Given the information deficit scientific evaluation is highly problematic.

Lack of modern information systems poses key questions: how accurate are laboratory measurements, how comparable are they; how good are the diagnostic and therapeutic systems; what is the level of acquired hospital infections and related use of antibiotics; how many medical mistakes occur? The answer is we don't know. Even though the private sector dominates in the use of medical technology and Greece comes about first in per capita imaging technology, we have no accurate data on health technology utilisation. We are told that senior doctors are sponsored by industry and hospitals have rising pharmaceutical expenditures yet we don't know the actual drug con-

sumption rate or the level of patient drug compliance. It is difficult to know if, and how, survival rates differ within diagnosed cancer groupings [pulmonary, colorectal, pancreatic etc] and there is no way to contrast the effectiveness and performance of public and private sectors. Indeed a “parasitic” relationship between the two makes it impossible. To this background a patient finds his way to a public or private service, or seeks cure abroad after considerable loss of time to access and slower than necessary diagnosis. In the process patient pathways remain uncoordinated, personnel foot dragging and system slack time exists and patients suffer psychologically and loose dignity.

The first American Nobelist in physics mastered Greek mythology before he mastered mathematics. Michelson, the man who captured light and measured its speed, knew that before there was a world, confusion reigned and the Greeks called it chaos, which of course was extremely fertile. It produced Gaea, plants and animal life. The life-giving rains made the earth sustainable. It was the first golden age. At the end of long healthy life men fell into deep sleep and returned to the earth. The age achieved the squaring of the mortality curve, no childhood diseases, chronic disease, accidents, only longevity, which is the vision today of genome public health. There was no need of physicians, health services, vaccinations, imaging technology, spinal cord units, or evidence based medicine.

But all was not light; the sky sent torrential rains; the seas raged; the earth flooded. Men and cities were destroyed, the earth was depopulated. Forewarned by the early warning system of Prometheus, Deucalion built an ark and survived the flood. Survival reflected the use of proactive management and the use of preventive measures. He and his wife repopulated the land by obeying the command of the supreme strategist, Zeus. Stones thrown over his shoulder became men; those thrown by Pyrrha his wife became women.

In the coming decades disasters will increase in frequency while infectious disease experts say it is not impossible for a devastating pandemic to strike; the prospect of environmental catastrophe, resultant health problems and creeping population vulnerability is being taken too lightly. Certainly, disaster management and public health must be moved up the political and scientific agenda. Better use must be made of the practice of prevention and preparedness ahead of crisis; rapid deployment of efficient readiness and emergency response plans must be rolled out once one occurs; while in the aftermath there is a need for socially fair and effective disaster mitigation and recovery mechanisms. Questions arising are: How can we better address environmental matters, politically, scientifically, socially?; How can we rise above the quite frequent mountains of garbage with improved waste management and a lower public health risk?; How can we provide better theoretical underpinnings for public health and build a new operational theory? In this The Year of Sanitation we are faced with water shortage, unsustainable systems.

Several summers ago wild fires got the better of the organizational and response capacity of the state. It is not unreasonable to assume that they have precipitated future complications for population health. One solitary icon, the President of Greece, constantly draws our attention to these issues.

Much more must be done through scientific management by a better trained human resource with the freedom to act fairly and effectively. Inspirational leadership means that managers must be trained to embrace the ancient Greek axiom “know thyself”. Scientific management entails doing things through and by people in a professional manner as a forward looking process [team work, professionalism, programming]. When one or all elements of management are missing, numbers are hard to find, functions and processes are difficult to assess and neither evidence-based-practice nor outcome evaluation find fertile footholds. Hospitals function with limited use of patient guidelines, safety mechanisms and without medical records. When the scientific auditing capacity of a hospital is nullified it ceases to be a professional bureaucracy and becomes vulnerable to manipulation in the service of unannounced goals. Without informational transparency, hospital materials procurement will remain a large black hole and system losses will increase.

One way forward is to eliminate known inefficiencies, which may equate to one quarter of the overall health sector budget. The savings could be used to improve system dynamic balance or the three arms of the iron triangle namely; universal free and equal access, service quality and cost benefit. There would be great advantage to having a single organisation providing life time health care to the population, instead of perpetuating of the existing fragmented and inefficient systems. At the beginning of the NHS this idea was abandoned as a result of opposition from trade unions and privileged groups. One apt phrase describing the health sector is a “syndicated democracy”.

Another way forward is to implement primary health care would certainly be opposed by over-specialised Greek medicine and a large number of physicians. The proposals to impact public health and to curtail tobacco smoking for which Greece is a world champion require informed policy and policy support tools. Progress will depend on a collective approach, management acumen and intelligent interventions, which must include a refocusing of medical thinking, evidence based transparency and management of values and cost-effectiveness. Reform could be driven by the combined weight of medical practice and academic medicine. A radical breakthrough can only result from a break with the past, a breakdown of various influences and the introduction of systems thinking into health politics and policy.

Major obstacles to radical reform stem from a polarised political system, which champions political evaluation to the exclusion of outcome evaluation and reinforcing legalistic principles at the expense of scientific legitimacy. The science and research cultures are politically dominated, institutions have a tendency to reproduce mediocracy, and the research budget is essentially

non-existent. The concept of truth beyond a reasonable doubt in any scientific sense is socially embryonic, which boils down to no evaluation and bad policy. Interventions which should be based on measured numbers of reality are driven more by perceptions of reality and can receive a boost or blow from media fuel.

After Zeus the supreme strategist unleashed disaster on the world, in the form of a woman, a butterfly of hope fluttered out of Pandora's Box, a box she was never meant to open. Today, it is mandatory to open the black box of health politics and work out the political determinants of health. However, rough times and tough decisions lie ahead for the work of many governments with respect to curing the ills of the health sector whether or not the black box is opened or remains hermetically sealed.

In Greece the situation is especially acute. Political structures steer clear of change promotion on the basis of political cost and seem incapable of accepting and implementing evidence based criteria. Consequently, a political shift is insufficient to drive towards scientific health management and public health development no path has been revealed to press for a strong interest in an autonomous and scientifically independent research body to inform health policy. Beyond promises neither one has demonstrated direct support for public health. Indeed the pending national public health strategy takes no real stand on the repositioning of the historical Athens School of Public Health, while the School itself back-peddles on such issues as intramural smoking control, disaster management training or the appropriate recognition of its academic staff while biased to technology rather than public health management.

Until a new culture emerges the health sector will chug along wastefully while producing socially useful outputs most of the time but with less than effective outcomes for money spent. The NHS will remain input oriented, doctor centered and without access to scientific evaluation and management. Medical practice will continue to have a local clinical focus, remain reform resistant and lack accountability. Greek patients will remain at the periphery and will have to rely much more on their own pockets and family solidarity. In seeking health care, patients will suffer delays, organizational snarls and therapeutic fumbling in a dysfunctional and inflexible system. The current Minister of Health is making almost heroic efforts to improve the NHS but in my opinion it would be better while moving in this direction to formulate policy and strategy to modify the organizational, professional and patient behaviour cultures, enact a national strategy for health promotion and ensure that primary health care is finally implemented together with an appropriate set of parallel developments.

However, there is a scarcity of public icons and social role models, which requires experiential wisdom, an ability to laugh at the self and an understanding that "life is short, the art is long, experience deceptive and judgment dif-

ficult”. Nobel Laureate Richard Feynman was such an icon. Above all else, he was a truth teller. In his report on the Challenger Space Shuttle he wrote “**we have laid out the facts and done it well. The large number of negative observations is the result of the appalling condition the shuttle program has gotten into. It is unfortunate, but true, and we would do a disservice if we tried to be less than frank about it.**” My comments on health sector management Greek Style, are intended to lay out a few important issues within the context of Europe and the Balkans.

DONCHO M. DONEV

HEALTH CARE POLICIES AND REFORMS IN THE REPUBLIC OF MACEDONIA, 1991–2011

ABSTRACT

Aim of the paper is to present main features of the healthcare policies and reforms in R. Macedonia since the independence of the country in 1991. Beside selected papers from the scientific literature some relevant documents about healthcare reforms from the Ministry of Health and the Health Insurance Fund of Macedonia were reviewed. Official data on demographic and health status indicators were collected mainly from the Institute of Public Health and the State Statistical Office. There are three periods of specific healthcare policies and health system reforms in R. Macedonia: post-socialistic, pro-market and manifesto-driven period.

Key words: Healthcare reforms, Health Insurance System; Health management education; Republic of Macedonia

COUNTRY OVERVIEW, HEALTH STATUS OF THE POPULATION AND HEALTH SYSTEM INDICATORS

Macedonia is located in the middle of the Balkan Peninsula, bordering Bulgaria, Greece, Albania, Serbia and Kosovo (Map 1), covering an area of 25,713 km². According to the 2002 census, the country's population was 2,022,547. Data on the declared ethnic affiliation from the 2002 census reported that 64.1% of the population identify themselves as Macedonians, 25.17% Albanians, 3.95% Turks, 2.66% Roma, 1.78% Serbs, 0.84% Bosniacs, 0.48% Vlachs and 1.04% others. The country seceded peacefully from Yugoslavia after an independence referendum, held in September 1991. The Constitutional name of the country is the Republic of Macedonia, but it was recognized by the United Nations on April 8, 1993 under the provisional name of the Former Yugoslav Republic of Macedonia. The country's title and heritage were the subject of a sharp disagreement with Greece, whose Northern Province is also called Macedonia. This dispute has not yet been fully resolved although a trade embargo was lifted in 1995 and the two neighbours' relations have since improved considerably. In 2007 Greece veto prevented R. Macedonia to become a member of the NATO and because of that the process for starting negotiations for European Union integration is continuing to be postponed.

At the time of independence, Macedonia was economically one of the least developed of the six republics of the SFR Yugoslavia and in the years immediately following independence, the economy contracted even more. From an

international perspective, poverty in Macedonia is moderate with about 30% of the population living below the official poverty line of US\$ 75 per month per capita consumption or below the international standard of US\$ 2.15 per day (Box 1)

MAP 1. – Geographic location of Macedonia



Box 1. Republic of Macedonia, demographic and socio-economic aspects, and health care system indicators, 2008-2010

- Land area: 25,713 sq km / population density 82.2/km²
- Population (2002 Census): 2,022,547 / urban 60%
- Life expectancy at birth (2009): 74.17 years (male 72.12; female 76.29)
- Birth rate (2009): 11.5 per 1,000 population
- Mortality rate (2009): 9.3 per 1,000 population
- Population growth rate (2009): 0.23% / Index of ageing 0.62
- Infant mortality rate (2009): 11.7 per 1000 live births
- GDP per capita (US\$, 2008): 3,283; PPP US\$ (HDI, 2008) 9,477
- Unemployment rate/ World rank (2009): 32.2%/ 77th
- Population below poverty line (Index Mundi 2009): 29.8% / Rank # 74th
- UNDP Human Development Index / World rank: 0,808 / 68th
- Gini Index / World rank: 39 / 61st; Income Gini coefficient (2000-2010): 42,8 / 61st
- Physicians (2008): 5323 / Physicians per 100.000 population: 262.5
- Dentists (2008): 1630 / Dentists per 100.000 population: 67.6
- Pharmacists (2008): 720 / Pharmacists per 100.000 population: 35.2
- Nurses (2008): 7033 / Nurses per 100.000 population: 344.2
- Public health institutes (2010): 11 (one at national and 10 at regional level)
- Hospitals (2008): 56 (public 52 and private 4)
- Hospital beds (2008): 9306 / Hospital beds per 1000 population: 4.6
- Inpatient care admissions per 1000 population (2008): 98.6

Sources: State Statistical Office-Skopje and Institute of Public Health-Skopje

The population groups identified as being most at risk of poverty are the unemployed, socially imperilled households, retired persons and farmers. UNDP reported that the unemployment rate in Macedonia was 32.1% of the labour force in 2001, 36% in 2006, and 32.2% in 2009, placing Macedonia in the rank of countries with an extremely high unemployment rate in Europe. Basic demographic and socioeconomic indicators, as well as some health care system indicators for Macedonia are presented in Box 1.

Poverty has a serious impact on the health status of the population and accessibility to health services. Among the most important indicators are the morbidity due to cardiovascular diseases, diabetes, malignant neoplasms, respiratory system and other diseases, mental breakdowns and suicides, alcohol and other dependencies, etc. Leading causes of death are circulatory diseases and malignant tissues, which jointly made up 77.2% of all causes of death in 2009 as opposed to 2002 when they had made up 74.4% (Table 1).

TABLE 1. – Most common causes of death of the population in Macedonia in 2009 and 2002

Rank	Causes of death	Died persons			
		2009		2002	
		Number	%	Number	%
1	Diseases of the circulatory system	11031	57.9	10236	57.0
2	Malignant neoplasms	3673	19.3	3129	17.4
3	Symptoms/undefined causes of death	1264	6.6	1508	8.4
4	Endocrine and metabolic diseases	709	3.7	557	3.1
5	Diseases of the respiratory system	670	3.5	592	3.3
6	Injuries and poisoning	613	3.2	750	4.2
7	Diseases of the digestive system	368	1.9	379	2.1
	All other causes	732	3.8	811	5.5
	T o t a l	19060	100.0	17962	100.0

Source: Statistical Yearbook of the Republic of Macedonia, 2010 and 2003

INTRODUCTION

After the independence in 1991, R. Macedonia inherited from the former SFR Yugoslavia the social model of obligatory health insurance and highly decentralized and locally funded public health system. The weak points of that system were a tendency toward further fragmentation and duplication of services, excessive staffing, interregional differences and inequities in the amount and quality of care. That system became unsustainable, particularly in actual social and political changes toward developing parliamentary democracy, economic circumstances and economic transition toward creating welfare state based on citizens participation and right to private ownership. Up to 1991, there were 35 independent self-management communities of interest for health care on municipal level and one on nation-

al level. All of them were replaced with single centralized Health Insurance Fund of R. Macedonia (HIFM) within the newly created Ministry of Health (MOH), with branch-offices of the HIFM at local level. The new organization and financing of the healthcare system was established by the adoption of Healthcare Law in 1991 [Donev D, 1999]. Aim of the paper is to present main features of the healthcare policies and reforms in R. Macedonia within the past two decades, since the independence of the country in 1991. Beside the scientific literature review some relevant policy documents about healthcare reforms from the Ministry of Health and the Health Insurance Fund of Macedonia were reviewed. Official data on demographic and health status indicators were collected from the Institute of Public Health-Skopje and the State Statistical Office-Skopje.

THREE PERIODS OF HEALTH CARE POLICIES AND REFORMS IN R. MACEDONIA

Within the last two decades three specific periods in the development of healthcare reforms in R. Macedonia might be determined [Lazarevik V et al, 2010]:

- post-socialistic period (1991–1998);
- pro-market period (1998–2006); and
- manifesto-driven period (late 2006–continuing).

Each of these periods carries its own characteristics of the decision-making process on revenue allocation and political power and influences over the healthcare system, even some aspects overlap within different periods.

POST-SOCIALISTIC PERIOD OF HEALTH CARE REFORMS IN R. MACEDONIA (1991–1998)

After independence of R. Macedonia, health care reforms started by the adoption of Health Protection Law in 1991 with shift from high decentralized to high centralized healthcare system with newly created Ministry of Health and Health Insurance Fund within it. All decisions for allocation of resources, financing of health care providers, and planning of investments came from politics, represented by the minister of health. Centralization appeared as an attempt, first of all, for stronger control of resource utilization and more equitable distribution during the transition period and economic crisis with tendency to maintain some characteristics of the old socialistic system such as strong prevention, broad access to care, and solidarity in financing. The Health Protection Law also authorized private health services and pharmacies in order to stimulate competition and to improve quality of care and health services, but on the other hand did little to streamline the public health system, to create incentives for increasing efficiency or to define the legal and regulatory environment for the private providers.

In the period after 1991, both the health insurance system and health care system, were faced with numerous problems, as a result of: (a) the war conditions in former SFR Yugoslavia, (b) the economic and transportation blockades, (c) the drained inflow of funds from health services given to patients coming from other places - out of Macedonia, (d) the decreased funds from the insurance for more than 40% in real terms, due to the great number of unemployed persons, downfall of socially-owned enterprises which were working with losses, and reduction of employee income, (e) different types of tax evasions and other manipulations of non-payment or substantially decreased payment of contributions, etc. [Donev D, 1999].

In the beginning of independence, there emerged an inevitable necessity to undertake urgent measures for preventing further erosion of the health system, for providing sustainable volume and quality of the health services, and for urgent long-term reforms of the health care system and health insurance system as well.

The main features of the post-socialistic period of health care reforms in R. Macedonia were oriented primarily to prevent the collapse of the health care system by allocating resources on areas with an immediate impact on health status of the population and for maintaining the basic healthcare services operational, provision of adequate drugs and other consumables. Ministry of Health requested the World Bank assistance for further defining and implementing this reform process, and Macedonia became a member of the World Bank in December 1993 (Box 2).

Box 2. Post-socialistic period of health care reforms in R. Macedonia (1991 – 1998)

- 1991, Health Care Law was adopted;
 - MOH & HIF created;
 - shift to centralization;
 - promotion of private practice
- Creating medical chambers
- 1993, Macedonia became a member of the World Bank
- 1993, co-payment for health services introduced
- Private practice ownership was promoted
- 1994–1995 crisis peak
- 1995, tenders and bidding for drugs were introduced
- Humanitarian assistance programs
- 1995, referral system & physician of choice
- Increasing financial debts of HC Providers
- 1996, the first Loan-agreement with the World Bank (US\$ 19,4 million)

In order to prevent excess utilization of services and to alleviate severe shortage of funds for health care system financing, co-payments for health care services were introduced in 1993, with long list of exemptions determined by age, sex and disease [Ivanovska, L., et al, 1999]. Financial effects of co-payments were very poor, only 4-5% of the revenues of the health institutions.

In the domain of urgent measures, an extreme rationalizing of medicines consumption was undertaken, as well as of medical necessities and other material expenses of all health organizations. In 1995 tenders and bidding for central purchase of drugs, sanitary materials and equipment were introduced, which resulted in price reduction and savings that slightly improved the global financial situation of HIFM [Donev D, 1999].

During 1991-1995, the revenue collected from health insurance contributions decreased by approximately 40% in real terms as a result of the decreased salaries, bankruptcy of socially-owned enterprises, evasion of payments by many enterprises, and increased unemployment. Consequently, the revenues of the Health Insurance Fund reduced significantly which resulted in decreased funding of the health care institutions. Health care providers started acquiring financial debts that by 1997 totaled US\$40 million. The first Loan Agreement with the World Bank for health sector reforms was signed in 1996 and the Ministry of Health was awarded a loan of US\$ 19.4 million. The basic goals of the reform were to achieve universal access to high quality primary health care and to establish cost effective finance and delivery systems. Technical assistance was provided by the RAND Corporation from USA through team work together with policymakers in the Ministry of Health, Health Insurance Fund and other health professionals in R. Macedonia in order to initiate reform analysis and strategies. The proposed new health care policies were directed to: (a) identification of the health care priorities; (b) reduction of the overall health expenditures and put them in balance with revenues; (c) shift the health care utilization patterns away from expensive forms of care; (d) produce a benefits package that is more cost-effective and co-payment structure that improve sectoral efficiency in order to reduce the existing gap between financial resources and given health benefits to the citizens; (e) development of a capitation plan for primary health care providers and a concept of family medicine in PHC or reorganization of concept of GP's; (f) establishing of an integrated and automated health information system as a support for better management in health care system; (g) proposing of an advocacy information strategies that facilitates the reform process [The World Bank, 2006].

Previous referral system was soon abandoned after Macedonia gained independence, as part of the changes in the socio-economic and political context and general movement to increase personal freedom and freedom of choice. This aggravates the budget problems to the HIFM because of the increase in specialist costs and hospitalizations. Referral system to access specialist-consultative and hospital services was reintroduced in 1995 by amendments of Health Protection Law. The same revision of the Law required that each insured person need to select a primary health care physician (general medicine, occupational medicine, pediatrics, school-age children medicine or gynecology) from the same municipal area, who will be responsible to follow-up the health of the insured, providing medical assistance, prescription

of medicines, issuing the certificate for sick leave and referral for higher level services. It was widespread opinion that many doctors in Primary health care function more as „traffic policemen“ - directing patients toward specialists - than as „gate keepers“ or doctors who are motivated and empowered to treat and cure broader scope of illnesses and conditions at Primary health care level. According to the results of a survey for doctors, done by the Doctors' Chamber of Macedonia in 1998 [Donev, D., 1999], low payments and bad working conditions led to doctors' frustration and low self-esteem, as well as low motivation and satisfaction from work (the average salary of the physicians-GPs at Primary health care level was about USD \$ 200).

Activities for acquiring humanitarian aid and other kinds of support from many international donors were very intensive during 1990s. Macedonia also entered several programs of the European Union (PHARE) for solving few substantial problems through non-refundable financing. This period was marked with huge humanitarian assistance for the healthcare sector from international donor agencies and friendly countries in pharmaceuticals, medical devices and equipment.

The main principle of the reallocation mechanism of the funds from HIFM to health institutions in the private health sector was financing on contractual basis and invoicing of services according to the Price list. The public health institutions funds were allocated by HIFM in order to cover the wage costs, material costs and maintenance, even without signing any contract for the scope and quality of the services. Because of this, organizational and management restructuring measures in the public health sector were delayed, and the quality of health services and motivation of the health workers were decreased, resulting in inefficient use of the resources [Donev D, 1999].

Total national health expenditure as a percentage of GDP decreased from 6.2 in 1990 to 4,8 in 1992, compared with 7.6% of GDP in 1995. Per capita health spending decreased from US\$ 66.8 in 1990 to 39.2 in 1992, compared with US\$ 97 in 1995. In the period from 1990 to 1993, health consumption was decreased for about 60%.

Health care reforms undertaken in 1990s have proved unsustainable, and have in practice largely been abandoned or revised. The development and implementation of policies and plans for reform have been hampered by weak capacity in the state health sector agencies (the Ministry of Health, the HIFM and the Republic Institute for Health Protection), and the lack of data and information systems for surveillance, monitoring and analysis. The result of this situation was that available efficiency indicators of the public health care institutions were below EU norms and Macedonia has been slower to undertake health care reform than many EC countries [The World Bank, 2004; Donev D, 2006; HIFM, 2008]. In general, all undertaken measures and activities resulted in partially and temporary alleviation of the occurred problems during the painful post-socialistic transitional period in R. Macedonia.

PRO-MARKET PERIOD OF HEALTH CARE REFORMS IN R. MACEDONIA (1998–2006)

This period was marked with very intensive health sector structural and financial reforms [Box 3], mainly initiated and guided by the World Bank Health Sector Transition Project [The World Bank, 2006]. Formal separation of the Health Insurance Fund from direct control by the Ministry of Health was introduced by the Health Insurance Law [HI Law, 2000], which was adopted in March 2000, and modified and supplemented by the amendments in the subsequent years. The Health Insurance Law replaced the articles of the 1991 Health Protection Law related to the health insurance [Ivanovska L, et al, 1999]. New elements are the way of regulating relationships within the health insurance concerning obligatory and voluntary insurance, the scope of the insured persons and their benefits and obligations, the way of calculating and payment of the contributions and the other sources of revenues for health insurance, new policy for user participation in health care expenses, reform of provider payment methods, as well as public accountability measures and defining the scope of activities and responsibilities of the Health Insurance Fund that was established as an independent institution outside of the Ministry of Health [Donev D, 2006]. HIFM was established as semiautonomous health insurance agency governed by managing board of 13 members, appointed by the Parliament of R. Macedonia (including representatives of the insurees/patients 6, employers 2, health providers delegated by the medical chambers 3, and by one representative of the Ministry of Finance and Ministry of Health [HI Law, 2000]. Reforms were directed toward extending HIFM greater independence in financial arrangements and weakening its accountability to the Ministry of Health, as the institution responsible for health policy making and implementation. Also, it was important to link the purchase of health care services according to defined volume and scope of services, and to replace previously politically driven internal budget allocations [Lazarevik V, et al., 2010]. The HIFM position was centralized, hospitals were in practice subject to detailed Ministry of Health and HIFM controls. Technical efficiency has improved as the average length of stay in hospitals has decreased. Public providers were in practice paid on the basis of global budget contracts. Adoption and enforcing the new Health Insurance Law and separation of the HIFM from the Ministry of Health were the key and the most successful implemented reform processes suggested by the international consultants of The World Bank.

Preparations for the privatization of the primary health care clinics started with implementation of the capitation-based model with risk adjusted formula for payment of physicians. Four training centers for continuing medical education for perinatal care improvement were opened and over 40% of primary physicians in the country completed the program and received certificates, as well as personal medical equipment [The World Bank, 2003; Zisovska E, 2007]. Decentralization of the country followed after the internal armed

Box 3. Pro-market period of health care reforms in R. Macedonia (1998 – 2006)

- Reforms initiated and guided by the World Bank (Health Sector Transition Project)
- Capitation model at the PHC level introduced (risk adjusted formula);
- Continuous medical education for PHC physicians on perinatal care;
- 2000, Health Insurance Law adopted;
- Separating Health Insurance Fund from the Ministry of Health;
- Purchaser provider split;
- 2001, Internal armed conflict – Ohrid Framework Agreement signed;
- 2002, Law on local self-governance and a new territorial organization adopted;
- Decentralization of HC sector, too;
- 2004, Privatization (dentistry, pharmacies, PHC clinics);
- 2004, privatization of PHC physicians 2005, and salaries were replaced with capitation;
- Opening big private hospitals (2000, 2002, 2005);
- 2004, the World Bank Health Sector Transition Project 2nd loan (US\$ 10 million)

conflict in 2001 as a tenet of the Ohrid framework agreement. A new Law on local self-governance was adopted and basic healthcare was decentralized to municipal level. However, the health insurance remained under central government control [Menon S, 2006] in order to prevent further fragmentation of the scarce healthcare resources.

The second World Bank financed project for continuation of the health care reforms in Macedonia was initiated in 2003 and approved in 2004 with the following specific objectives: 1) to upgrade Ministry of Health and HIFM capacity to formulate and effectively implement health policies, health insurance, financial management and contracting of providers; and 2) to develop and implement an efficient scheme for restructuring of hospital services with emphasis on developing day-care services and shifting to primary care [The World Bank, 2004].

In 2004 the Ministry of Health introduced changes in the Health Care Law (HCL) to open for the first time the possibility for privatization of parts of the public healthcare system including dental clinics and pharmacies. In 2005 additional amendments of the law were adopted to initiate privatization of the primary health doctors [HC Law, 2005]. PHC reform has increased patient choice through patient enrolment and capitation-based payment to physicians. The capitation is calculated on the basis of numbers of insured persons that have chosen a certain physician as their own primary care physician, the determined number of points for each category of population group and the determined value of each point. Additional incentive is provided for physicians' practices that are located in remote rural areas. The invoicing for provided health services is undertaken once per a month, that is 70% of the calculated amount of capitation, whereas the remaining 30% of calculated monthly amounts of capitation is invoiced after each quarter, based on the results presented in the quarterly reports in accordance with the

aims determined in the contracts. The manner of payment for primary dental care services is regulated by a special rulebook, according to which the method of capitation is used [The World Bank 2004; HIFM, 2007].

In 2004, in accordance with the World Bank recommendations, the HIFM began concluding contracts with the public health institutions, defining the volume and the type of health services they should provide during the year, thereby setting the maximum monthly amount the HIFM should transfer to them. The large medical centers were envisaged to be transformed, i.e. separated in hospitals and PHC institutions [Bogdanovska M, 2007].

By October 2007, less than three years since the adoption of the changes in the legislation, a total of 3,521 health workers (doctors 944, dentists 616, pharmacists 64 and nurses 1897) were privatized [Lazarevik V et al, 2010].

The pro-market initiatives emerged also in the private hospital sector by opening of big private hospitals for cardio-surgery (2000), gynecology and obstetrics (2002), and one general hospital (2005). Patients who choose to search services in the private hospital sector in most of the cases have to pay out-of-pocket for the services provided.

MANIFESTO DRIVEN PERIOD OF HEALTH CARE REFORMS IN R. MACEDONIA (LATE 2006–2011)

The third period of health sector reforms in Macedonia started toward the end of 2006, after the parliamentary elections and constitution of the new government, led by the political party VMRO-DPMNE. Health system reforms were included as an integral part of the political program/ manifest of the upcoming government. Main features of the manifest were to decrease OPE for health, to improve efficiency and transparency on the side of health care providers, to advance patients rights in health services delivery, and to strengthen the position of the HIF as strategic purchaser of health care services [Box 4].

Previous system of traditional appointment of medical doctors as directors was replaced with a new concept in the governance of the public health institutions by amendments to the HCL in early 2007, introducing a diarchal system of two directors with shared responsibility but different backgrounds – one of them medical doctor, the other one economist [Healthcare Law, 2007]. Ministry of Health of R. Macedonia, in collaboration with the Faculty of Medicine in Skopje, in Fall 2006 initiated and designed an intensive Health Management and Leadership Training Program for senior managers in the health sector. The intention was to build a well informed and responsible core group of top health leaders equipped to reshape the health care governance from previously command and control input based system according to number of beds, staff and infrastructure, towards system with high autonomy and output oriented (quality and volume of medical inter-

Box 4. Manifesto driven period of health care reforms in R. Macedonia (late 2006–2011)

- Promotion of political platform (manifesto) for HC reforms (VMRO political party won the parliamentary elections in 2006);
- Aims of HC reforms:
 - to decrease out-of-pocket expenditure for health;
 - to improve efficiency and transparency at the level of HC providers at all levels;
 - to advance patient rights in all medical interventions;
 - to strengthen the HIFM position as strategic purchaser;
- Health management and leadership training program, started in Fall 2006;
- 2007, HC Law: two directors in each PH institution;
- Reorganization of the University Clinical Center in 31 clinics;
- Reference and set-pricing of pharmaceuticals;
- Contracting process – global budgeting to hospitals;
- Development of DRG system started 2007, implemented 2009;
- Decreasing of contributions for HI from 8.6 to 7.5%, Jan 2009;
- Universal health insurance coverage, June 2009 (no additional Budget funds);
- Renovating health facilities and purchasing new equipment;
- 2010, Constitutional Court decision – Money follow the patients;
- Politization of HC administration, appointment of doctors and new personnel.
- Migration of health personnel to private hospitals.

ventions). Since October 2006 till June 2010, seven health management and leadership training programs were organized and around 750 participants (medical doctors and economists) participated in this education and training program. In addition, from March to June 2007, Program for Continuous Professional Development for Mid-level Managers in the Health Sector in R. Macedonia was implemented in collaboration between Project Hope and the Ministry of Health. The total number of participants included in this Program was 60, organized in 20 teams of 3 people. Both programs confirm willingness and commitment of the Ministry of Health of R. Macedonia to introduce mandatory health management education and practice in the health sector, as well as to initiate entrepreneurial spirit in the work of the public health care institutions [Donev D, et al, 2010].

Transformation of public hospitals into autonomous corporations was announced by the Government in 2008. However, political interest not to give away power has prevented adoption of the final version of the law for autonomy of health providers. Even health management was officially part of the government strategy to improve the performance of public health institutions, direct interference by the political parties blocked all mechanisms for successful reforms. In early 2010 many public hospitals started to acquire new debts, followed by many scandals in the local media about poor quality in the provision of health care by many general hospitals in the country.

Although the initial government policies were in favor to increase providers autonomy, in practice public healthcare organizations were forced to follow narrow interests of the political parties. These had direct negative consequences over the healthcare system in stimulating inefficiency, nepotism and poor management that lead to systematic degradation of the public hospitals [Lazarevik V, et al, 2010]. HIFM has not signed contracts with the private hospitals (except with the Cardiosurgery Private Hospital „Philip II“ in Skopje).

Public health institutions in 2007 were paid on the basis of public bid and the interest shown by health institutions responsible for providing health care at all levels. Contracts were signed for the first time with all public health institutions (total number of 115 contracts) with the HIFM on the basis of appropriate legal acts. The relations between the HIFM and the health institution responsible for providing health care services to insured persons have been regulated in these contracts, as well as the manner of payment, responsibilities and rights of agreed parties and other issues related to the mutual relationships between the agreed parties. Private health institutions delivering primary and specialist-consultative health care were paid on the basis of signed contracts with the HIFM. At the beginning of 2007, the HIFM signed a total of 2,203 contracts with private health institutions responsible for primary and specialist-consultative health care [HIFM, 2008].

The majority of doctors and other health care professionals in the public health sector until 2007 were paid a salary on scales negotiated by the Union of Health Care Workers and the Ministry of Health. Some of the physicians in the private sector at PHC level, starting from 1999, were paid based on the principle of capitation. In 2007, after the performed transformation of public health institutions and privatization of chosen physician, the method of capitation for doctors is applied for health services payment at PHC level.

The proportion of GDP recorded as spent in the formal health care system appears to be about 6,5% in 2008. But, in the context of remarkable inflation figures vary, and the GDP figure also has to be treated with caution. Nearly all health expenditure (more than 95%) is reported by HIFM to be in the public sector but this figure seems to be overestimated as some analysts point out that out-of-pocket payments for health services and medicines contribute about or more than 30% of overall health expenditures.

CONCLUSION

Common features of all three periods of healthcare reforms in R. Macedonia are health policy trends with many initiatives and short-term and fragmented actions, absence of long-term vision and strategy, as well as strong politicization of the healthcare sector. Public health care sector is characterized with slow reforms, poor maintenance of the public healthcare facilities and dete-

rioration of the infrastructure, low efficiency and quality of services and high operational costs. Because of poor conditions in public healthcare institutions, followed by media criticism, and unsatisfaction of the citizens with the quality of services, patients are often oriented to purchase services in high-standard private health care facilities with much higher contribution in coverage of the costs from their own funds, which contributed to continuous increasing of out-of-pocket expenditures for health. Health financing reforms and recently the newly introduced methods of payment to health care providers at the primary health care level (capitation in 2007) and at the public hospital sector (global budgeting, DRGs in 2009), as well as the universal health insurance coverage for the entire population, introduced in June 2009, was expected to lead to improved equity, increased efficiency and quality of health care in hospitals and higher efficacy of the overall health care system.

Healthcare reforms in R. Macedonia within the last two decades were influenced by many external and internal factors. Policy pressures and defined project activities financed by the World Bank loans were the most influential factor from the external side. Changes initiated in the health system were confronted with internal political instability and frequent changes, interest of the political parties, various interest groups struggles and lack of continuous political will to provide sustainability of the long-term reforms.

All three periods of healthcare reforms in R. Macedonia provide a mixed picture of some successes and many failures. The first, post-socialistic period healthcare reform was mainly focused to the consolidation and preservation of positive values of the healthcare system, prevention of fragmentation and collapse of the healthcare sector due to rising unemployment in the country after the collapse of the socialist enterprises. In addition, this period promoted the possibility for private ownership of medical practices. The second, pro-market period, which was strongly influenced by the World Bank, promoted adoption of the Health Insurance Law and establishment of HIFM outside of the Ministry of Health, capitation payment and privatization of the PHC. The third, manifesto-driven period had a promising start and created great enthusiasm and social atmosphere for change in the public health sector, profusion of activities, and political promises to improve health system delivery, but overall with limited successes. Increased role of the state was dominant in regulation and control of the healthcare reforms in R. Macedonia.

Finally, even slowly and behind, with many problems and difficulties, R. Macedonia is catching up with the international trend in healthcare reforms. If this trend continues in the future, with possible diminished influence by politics, it is expected that the next phase of Macedonian healthcare reform to be focused more towards the demands, interests and preferences of the patients.

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PROTECTION OF THE DIGNITY OF DYING PATIENTS – RECOMMENDATION OF THE COUNCIL OF EUROPE NO. 1418

ABSTRACT

In April 4, 1997, following the initiative of the Council of Europe, the convention on the protection of human rights and dignity of human being titled the Convention on human rights and biomedicine was prepared in Oviedo (Austria, Spain). This Convention aimed at promoting biology and medicine. It was signed by Member States of the Council of Europe, the remaining states and the European Union. The Convention has determined a number of significant principles, but has not been tackling directly the issue of incurable terminal patients, which has been elaborated in recommendations.

The Council of Europe, on the 24th sitting of the Parliamentary Assembly, as of July 25, 1999 adopted the Recommendation No 1418 – Protection of human rights and dignity of incurable terminal patients. The fifth clause of the Recommendations sets forth that “The obligation to respect and to protect the dignity of a terminally ill or dying person derives from the inviolability of human dignity in all stages of life. This respect and protection find their expression in the provision of an appropriate environment, enabling a human being to die in dignity”.

The concluding clauses of the Recommendation No 1418 call upon Member States to respect and protect dignity of incurable patients, which substantially means introduction of the philosophy of palliative care in the health system, i.e. in the medical legislation.

To that end, it is also worth mentioning the Recommendation Rec (2003) 24 of the Committee of Ministers of the Council of Europe to Member States, related to organization of palliative care, which was adopted by the Committee on November 2003. When medical treatment is useless and the death is inevitable, the priority goal of the medical care is to alleviate pain and suffer. The obligation of mitigating suffer aims at improving quality of life of the patients in terminal phase of their lives by means of palliative care.

Key Words: Terminal patient, palliative care, human rights, human dignity, Council of Europe

INTRODUCTION

Scientific and technological achievements of the present time in the field of bioethics introduce quite new relations concerning their appliance and impact on human life (both in human and non-human directions), and at the same time imply series of moral dilemmas. Should all things that could be done, actually be done? For, if some scientific and technological action could be (technically) implemented, is it (ethically) correct?

There is a radical theoretical agreement among scientists, ethicists and lawyers, pointing out the necessity of restraining technological researches and

their appliance. There is a few of them, (at least in theoretical researches), who consider that there should be limitless confidence in scientific progress, searching for full freedom in making choice of scientific researches.

Following the European Convention on human rights, right to life is the main right, and without it all other rights are pointless. It is imperilled not only by murder, but also by each force, doing or non-doing, resulting in termination of life. It is illegal to take life away, but also to take the steps contrary to its preservation. Right to life can not be interpreted in negative sense – there is not right to death.

Therefore, a great majority of people in the world of science, anticipating risk of evoking limitless freedom and confidence in science, speaks about science confines. But what confines here are all about? It is truly specific question occupying ethic philosophy. However, phylosophic idea in this field is distinguished by variety of standpoints: moral standpoints differ in the choice of principles and values of subjects they are dealing with. There is no absolute general consent in ethics: different moral “trends” impose (or better say justify) usage of different principles and values, which present the frontier wall separating accurate from wrong in scientific practice.

In other words, the ethic philosophy is not occupied with epistemological issue of bioethics justification, but with the issue of justification of the metabioethics. Because the mere metabioethics tries to give a rational explanation of the ethical choice of principles and values, which determine human behavior at that very moment, when the human being would influence the human life by means of biological and scientific achievements. Hence, it is obvious that if metabioethics is developed in one direction, this necessarily means that also bioethics will be developed in the same direction.

Due to all the aforesaid, the key issue raised in the phylosophic debate in the field of bioethics is not anymore “is it necessary to introduce ethical principles into science and technology?”, but the question is: Which ethics for bioethics?” Namely, what are those absolute ethical values that human being have to cling to, which must not be deviated from in scientific researches? Right at this level (of metabioethics), the role of philosophy is quite clear, because this is where the philosophy is dealing with making distinctions between good and evil.

HEALTH CARE OF TERMINAL PATIENTS

For more than three decades now scientists have been pointing out that human being is increasingly leaving nature and natural obligations. When there is no hope for recovery and the quality of life is very important, it is possible to prolong ones life by applying sofisticated technology and persistance in receiving therapy.

In current bioethics debates there is less speaking about disthanasia (prolonged agony, suffer and death postponing) and more about direct or indirect euthanasia. Many of bioethicists consider that between these two utmost points, there is orthotanasia, implying dignified death “at the proper time”, without terminating life, but also without additional suffers.

Assessment of the quality of life is very significant in the health care. The issue is raised what happens when one's life has no quality or when on making decision it is recognized that “life is not worth living”. There is no criterion based on which patients who feel that “life is not worth living” could be reliably identified.

From bioethics standpoint, dilemmas on the quality of life are particularly raised when competent or incompetent persons are to make decision about: pregnancy termination due to difficult embryo malformation, procedures to be taken with newly born child with anomalies inconmensurate with life, refusal or withdrawal of the vitally important medical procedures, permanent vegetating conditions and about the end of life of the patient. However, prior to all these procedures, patients should give their consent, which is in some cases impossible when the consent is given by parents, family members, legal representative or tutor.

Within the health care, bioethics and legally correct decision is based on free decision of the patient. Bioethics doctrine of the informed consent rests upon the consent of patients, which preceded by proper information provided to them as well as their correct understanding of the received information, in order to make possible appliance of any treatment.

Information and recommendation should provide patients with basic knowledge about possibility of making free choice among several options of medical interventions i.e. about their right to refuse interventions. Patients should be educated about how interventions will be carried out, possible risks, inconveniences and effects. Right to participate in making decisions implies right of patients to be informed and accept or refuse certain diagnostic or therapy procedure, which is the essence of the concept of informed consent.

The situation is more specific during pregnancy and after delivery, for the reason that the embryo, i.e. newly born child can neither make nor refuse any decision. This decision about the best for the embryo or newly born child is made by doctor and mother, or parents. Even upon the consent of parents, there are bioethics dilemmas such as: should all be done when the newly born child is barely surviving or has difficult malformations, while it is quite clear that the life will have no quality of normal living.

As for the patients who are not conscious while making decisions on life prolonging procedures, their will should be taken into account, if declared, prior to falling under such conditions. Interests of patients and their legal representatives or tutors sometime may be confronted. Regardless of the partnership between doctor and patients, when it comes to difficult diseases or dying pa-

tients, a question is raised about extent of information and about what can be absorbed by patients considering their conditions. As there is no explicit rule or standard on the extent to which information must be detailed, according to some researchers, it is necessary to provide such information, which could be provided by an average specialist doctor in the related case.

In April 2002, the Netherlands has become the first country in the world to legalize euthanasia. On following serious legal requirements in committing euthanasia, or in assisting commitment of suicide, the doctor will not be pursued. Belgium become second country to legalize euthanasia in September 2002. Apart from these two countries, currently euthanasia is allowed by part of Austria, American State of Oregon and Columbia. Introduction of euthanasia is currently considered by France and Scandinavian countries.

The following are main conditions to be met in committing euthanasia without legal consequences:

- a) Patient should be for some time under medical protection or care of the doctor to commit euthanasia.
- b) Several resources should confirm the fact that there is no possibility or hope for recovery of the patient.
- c) The patient should leave the written track on the reasons for making decision to be subjected to euthanasia. This document should also be signed by the doctor to commit euthanasia.
- d) The doctor should make consultations with colleagues and while the hospital staff should confirm whether all conditions to commit euthanasia have been met.

In April 4, 1997, following the initiative of the Council of Europe, the convention on the protection of human rights and dignity of human being titled the Convention on human rights and biomedicine was prepared in Oviedo (Austria, Spain). It was signed by Member States of the Council of Europe, the remaining states and the European Union. Article 16 sets forth conditions to be met to protect persons subject to researches. Paragraph 2 of this Article provides for that “the risks which may be incurred by that person are not disproportionate to the potential benefits of the research”, which means that existing quality of life must not be deteriorated. The Convention on human rights and biomedicine has determined a number of significant principles, but has not directly been tackling the issue of incurable terminal patients, which has been elaborated in recommendations.

The Council of Europe, on the 24th sitting of the Parliamentary Assembly, as of July 25, 1999 adopted the Recommendation No 1418 – Protection of human rights and dignity of incurable terminal patients. The fifth clause of the Recommendations sets forth that “The obligation to respect and to protect the dignity of a terminally ill or dying person derives from the inviolability of human dignity in all stages of life. This respect and protection find their ex-

pression in the provision of an appropriate environment, enabling a human being to die in dignity”.

In the Recommendation No 1418, the Assembly of the Council of Europe called on Member states to provide incurable and terminal patients with necessary legal and social protection against dangers, in particular against risks of: a) being victim of inevitable symptoms (pain, suffocation etc) on approaching death; b) prolonging their lives against their wills; c) dying in loneliness and abandonment; d) terminating their lives in a fear that they present burdens for society; e) lacking funds to survive due to economic reasons; f) lacking funds necessary for care and assistance to be provided to incurable and terminal patients.

The concluding clauses of the Recommendation No 1418 call upon Member States to respect and protect dignity of incurable patients, which substantially means introduction of the philosophy of palliative care in the health system, i.e. in the medical legislation. To that end, it is also worth mentioning the Recommendation Rec (2003) 24 of the Committee of Ministers of the Council of Europe to Member States, related to organization of palliative care, which was adopted by the Committee on November 2003. When the medical treatment is useless and the death is inevitable, the primary objective of the medical care relates to alleviation of the pain and suffer. The obligation of mitigating suffer aims at improving, by means of palliative care, the quality of life of the patients in terminal phase of their lives.

Like other forms of medical care, palliative care should also be considered as preventive. Many suffers at the end of life may be avoided or successfully reduced if recognized during certain chronical disease.

Definition of all terms related to euthanasia and palliative care of incurable and terminal patients, along with the assessment of all possible risks, presents the prerequisite for adequate consideration of bioethics dilemmas on the quality of life in relation to euthanasia and disthanasia.

DISTHANASIA, ORTHOTANASIA AND EUTHANASIA IN LIGHT OF THE PRINCIPLES OF BIOETHICS

There are two conceptions in bioethics: conception of „secularism“, and conception of „personality“. The first conception tries to justify ethical choice in autonomous and empirical manner in relation to human being. Each individual makes personal moral choice, without any relationship or responsibility toward God. Secular method of ethical analysis is „factual“ (or empirical), in a sense that the truth is confirmed by empirical verification of facts: truth (and, above all moral truth), can only be physical (and not at all metaphysical). This conception is searching for logically viable arguments having primacy on making ethical choice.

On the other side, conception of “personality” in bioethics is based on ontological personalism as the philosophical attitude, which appreciates human life in all its aspects. Ontological personalism observes personality as the center of bioethics. According to ontological concept of personality it is possible to justify fundamental principles of personalistic bioethics: a) fundamental values of life, b) principle of totality or therapeutic principle, c) principle of freedom and responsibility, d) family principle, e) social principle. The most important moral idea of this concept says that human life must be respected from the moment of inception until total (cerebral, medical) death. The most recent study has thrown the new light on euthanasia in the Netherlands, the first country to legalize “mercy death” for terminal patients, discovering that one in eight patients who requires euthanasia, at the very end changes his or her mind. However, at the end almost a half of the patients are “killed”.

This study came at the moment of detailed analysis of euthanasia – especially after officials in the Netherlands announced that in the previous year they had euthanased a few of newly born children who were diagnosed with some of incurable or difficult disease.

Belgium has enacted one regulation very similar to Euthanasia Law in the Netherlands, while currently the state of Oregon is the only one to legalise it in the USA.

Nevertheless, even the state of Oregon will not apply it for the time being, until the Supreme Court in America makes the final decision.

The Study, published in the journal *Archives of internal medicine*, is a research over 3,614 experienced Holland's doctors who were asked to describe their feeling when requested by certain patient to commit euthanasia.

The research has shown that more than a half doctors had not accepted the request, while around 20% of them received even more than one request for “mercy death”; out of that number 44% resulted in euthanasia. 13 % of patients died soon after requested euthanasia and therefore it was not committed. Twelve percent of doctors did not accept patient's request, while new 13 % of patients have changed their mind.

Leader of the Project, Ms Brehže Onvuteaka – Filipssen says she was surprised by the fact that most important reasons causing patients to request “urgent death” were often non-medical. Some of the reasons, reported in the research, were nonsense of the suffer, loss of dignity, weakness... Reasons, due to which doctors refused commitment of euthanasia were explanations of patients that they wanted to spare family the burden of their diseases, or that they were tired of life or depressive.

Researches have shown that it is very important to ask patients during the whole procedure if they are sure they want to undergo euthanasia due to the reason that more than 10 percents of them, in spite of initial “yes, I am sure” change their mind at the end. Else, the Netherlands have a long history re-

garding euthanasia, because this phenomenon has not been recognized by law for decades. In spite of this, it was rather frequent phenomenon which was rarely pursued.

Systemic risk analysis, analysis of critical points in the health system as well as the analysis of ethical dilemmas make possible prognoses of negative effects of euthanasia in the early phase and thus prediction of preventive measures, preparedness, mitigation of suffer and improvement of life of the patient in terminal phase of life by means of palliative care.

Discussion on euthanasia and concept itself has not been finished. In its original meaning, euthanasia implied desire and prayer of human being for good, i.e. mild, fast and painless death, better say good death. On the next level, euthanasia means positive concern, interceding, as well as care to make dying without physical pain or mental unrest to greatest possible extent – while respecting both life and forthcoming death. Thirdly, modern understanding comprises above mentioned two meanings assigning them an aggressive content. This concept is mainly used in its more precise and distorted meaning in terms of deliberate and violent life deprivation.

One of the most powerful socially accepted motives in support of euthanasia regularly mentioned is the value of human dignity. Namely, it is claimed that difficult conditions of diseases and dying are in irreconcilable opposition with human right to dignity in dying. To avoid violation of the right to dignity in dying, it happens that the main, elementary and basic right i.e. basis for all other rights, which is right to life is thereby violated. It sounds more than strange that it is allowed, moreover it is desired, in the name of humanity, to kill the human being.

The beginning of life, so as the dying and the death are topics of central interest for each society. Growing daily appliance of the most recent technical achievements over patients with difficult diseases or terminal patients is the issue of medical, philosophical, theological, legal, societal, bioethics and other discussions of numerous experts and public media. Clearly it is not possible to answer the question of appliance of some therapy or termination of the treatment to prolong the life only on the basis of medical arguments.

Three decades ago bioethics had already started pointing out the complexity of that problem in applying the so-called therapy persistence. On applying such therapy, it is necessary to consider the effectiveness of some intervention, what are its advantages and disadvantages for the patient and what is its economic and social price. All of the aforesaid is to be done with the aim of improving quality of life.

Even in ancient Greece a doctor was obliged to leave certain procedure if the applied medical skill was inefficient for curing certain chronic disease, revival of certain functions, improvement of the quality of life or prevention of death. Dysthanasia as the concept of bioethics is discussed by Leo Pessini in his book *Dysthanasia: Até quando prolongar a vida?* (Dysthanasia:

How long should life be extended?) (2004). According to this author, it is an old Portuguese word and it is about neologism of Greek origin where prefix "dys" means fault action, and "thanatos" means death. Thus disthanasia implies excessive extension of agony and suffer and excessive death postponement. In Angloamerican literature this word implies medical futility, futile treatment or futility i.e. treatment with no positive effects (Halliday, 1997; Ardagh, 2000). In European literature, the term disthanasia (or dysthanasia) is rarely mentioned. There is more frequent usage of the term therapy persistence (*l'acharnement thérapeutique, accanimento terapeutico*).

According to Gampel (2006) most doctors believe that their professional autonomy protects them from the pressures made by patients and their families asking them to apply ineffective treatments, which are mere waste of financial resources. Argument on professional autonomy in relation to medical futility has been elaborated in many articles, but has not been carefully examined. Author makes difference among three arguments: 1. Each doctor should be free to apply his or her own medical deliberation, 2. Medical profession as a whole may determine standards of futility as guidelines in practical work of its members, 3. Moral integrity of each doctor serves as a limit when ineffective treatment is requested. Author makes conclusion that none of those arguments may deny basic criticisms on deliberation of medical futility. Decision about one procedure, which is the only way of prolonging life, depends on the patients themselves or their tutors and is directly dependant from patients' personal view on the fact that life is not worth living.

Almost ten years ago it became clear that social context with respect to medical futility should be included in the consensus about purpose of medicine and nature of doctor-patient relationship. As modern technology successfully manages to solve medical problems, it gives the impression that all diseases may be cured thereby creating technically fixed attitude toward body (Halliday, 1997). Thus the death becomes failure of medicine instead of inevitable end of biological life.

In some cases where decision on certain procedure is allowed by family or it is made by medical worker, "all possible things" should be done. So, appliance of the technology becomes the most powerful way of expressing affection toward patient as well as extent of that affection. In addition, religious beliefs make some patients, their families and health workers try, in all possible manners to support certain hopeless procedures while anticipating miracles.

Therapy persistence is perhaps the best example, which does not imply equitable access to health care, bearing in mind that there is a lack of financial resources to apply preventive programs. Equitable access to health care is defined in the Article 3 of the Convention on human rights and biomedicine, which sets forth that "parties, taking into account health needs and available resources, shall take appropriate measures with a view to providing, within their jurisdiction, equitable access to health care of appropriate quality".

Religious, ethical, medical, culturological, social and legal concepts influence our attitudes towards euthanasia. Current focus of the discussions about euthanasia was moved from disapproval of immoral procedures encouraging this action to opinion that it is necessary to provide palliative care to persons with difficult diseases and improve the quality of their lives thus making euthanasia unwanted in a number of cases. Although in last decades the increasing attention has been paid to euthanasia, this problem has been actual from the earliest beginning of medical deontology. The opinions about euthanasia are shared and there has been supporters and oponents of this concept from the Old Age until nowadays. The word euthanasia is of Greek origin and has a meaning of artificial causes of the “good death” with incurable patients. Namely it is deliberate termination of life in order to quit suffers and pains of the patient. The “good death” would quit suffers and therefore preserve human dignity. The concept of euthanasia was firstly used by Francis Bacon in his work *Novum organum* (New Instrument) (1620.) (Körbler, 1967).

According to certain scientists, euthanasia is presented as care for patients, and not as a wish of the environment to stop caring for them. Quill and sur. (2000) consider that euthanasia is a rational option of solving unendurable suffer after ineffective exhaustion of all medical procedures. When saying the “death is pleasant”, according to popular understanding of all civilizations, it implies all about natural death while sleeping. However, euthanasia became quite medicalized technical term.

Apart from the concepts of pleasant death and death with dignity, euthanasia is also called mercy killing. This latest concept in its unambiguity perhaps is the best explanation of what euthanasia exactly is. Withholding of therapy is considered as passive euthanasia, while therapy interruption or administering murderous injections are considered as active euthanasia.

Practice in the Netherlands unambiguously pointed out the reality of introducing euthanasia, even prior to its legalization in 2002. Zurak (2001) considers that decriminalization of euthanasia and the way it appeared in the Netherlands actually present a triumph of relativism and liberal nihilism.

Raising question why ethics of euthanasia is wrong, Narbekovas and Mylius (2004) consider that appliance of euthanasia presents an action with specific intent to make someone become no one. It is the main delusion of general abnormality in human relations. Committing euthanasia means failing to see essential value or dignity of person. Assessment that something which is worthy in its essence, immediately becomes unworthy is logically and morally wrong. Nowadays, solution in fight with euthanasia and assisted suicide is a better care for the diseased and dying patients. Dignity of the diseased may not be cancelled by disease and suffer. These actions are not private decisions, but has an impact on whole society. Death with dignity, at the end of life, is a realization of the fact that human being is a spiritual being.

Most of the world religion (christianity, islam, buddhism, judaism) do not approve euthanasia as acceptable. All these religions consider life as holy, inviolable, untouchable and the gift of God (the latest is less assigned to buddhism).

In 1987 the World Medical Association (WMA), on its General Assembly in Madrid, passed the Declaration on euthanasia. The Declaration says that: "Euthanasia, i.e. willing interruption of the life of patients, be it at their own request or at the request of their close relatives, is nonethical". However, this does not impede doctor in respecting patients' wish for natural death, when they are in terminal phase of their diseases. With this, the World Medical Association proved it was aware of the situation regarding euthanasia, which is actually medical ethical problem. In 1992, the World Medical Association passed additional Rationale of the above mentioned Declaration in the form of the Statement that medically assisted suicide is opposity to medical ethics and should be convicted by medical profession.

CONCLUSION

Qulaity of life is a wide concept and has no unique definition. It is dependent upon numerous factors. It is rather difficult to scientifically investigate the quality of life based on the statements of persons in terminal phase of life. However, in that phase of life, some persons can also find the quality in the life itself, though based on the existing indicators, the situation can be rather hopeless. The priority goal of medical procedures is to mitigate pain and suffer when medical treatment is useless and the death is inevitable. When there is no hope for recovery, therapy persistance with numerous medicines and appliance of sofisticated devices can make the life last longer. Such a useless treatment has little or no benefit for patient and increases suffer of both patients themselves and their relatives. Decision of the informed patient when refusing useless treatment must be respected.

Euthanasia should clearly differ from mitigation of pain and suffer, so as interruption of useless medical therapy. Following declarations and codexes of medical ethics and deontology, euthanasia and its forms are nonethical actions, due to the fact that doctor should appreciate human life from its very begining until the death. Medical obligation of mitigating suffer contributes to improving quality of life of the patients in terminal phase of their lives by means of palliative care.

There is, also the issue of freedom as the special human feature. There are some rumours that decision on the appliance of euthanasia will be left for the free choice of individual. Nevertheless, it may happen that this exactly would imperil freedom. Namely, if pains of the patients become unbearable, then, how much is the patient really "free" to make such a precedent decision? So far experience proves that prayer of difficult and dying patients, in

most of the cases, are not their wish to terminate their lives, but desperate appeal against inappropriate care and attendance. Whereas difficult and dying patients are more cumbersome for environment than for themselves, it may happen that they just receive the message from the environment to get rid of their situation freely. The trouble is increasing in the cases where patients are not able anymore to make decisions themselves and this must be done by someone else: to whose best interest?!

It is obvious that legalization of euthanasia, in its current meaning, is incommensurate to the values of our modern culture. Namely, if one has a legal right to euthanasia, the others all around would be obliged to make possible exercise of that right, i.e. to commit a murder on personal request if failed to be done personally. On the contrary, the right of the person could not be exercised. It is unimaginable, at least for the time being. The rule of law has an inevitable obligation to protect human life in all its stages.

At the same time, we are witnesses that the law takes primacy over moral and conscience. Reasonably or not, the law encroaches more and more into the scope of medicine. To be protected from various inconveniences, apart from the knowledge and conscience, nowadays doctor is obliged to know and respect legal rules. The rules of evaluation and efficiency are increasingly required by law, and not in moral rank of values. As if moral depends on the law, and not the other way around. This introduces ethical relativism. The question is raised: What will be precedent for doctor on making decision about life and death of the patient – the conscience or the law?

In light of religion, the main attitude toward life says that God gave life to human being and that human being is requested to be aware of the priceless value of that gift and to be responsible for it. Human being should express its gratitude for gift by respecting life, protecting and improving it. This implies fight against pain, suffer and early death.

The problem of requiring or imposing euthanasia, or the issue of the main human right to life, human dignity in suffering and dying, is rather practical than theoretical academic issue. At the practical request of the life, it is necessary to give practical response of the life. Euthanasia as the violence against life and dying, does not solve the problem in the manner worthy of human dignity, rather it creates new painful problems. One of possible efficient and verified responses, in compliance with human right to life and dying with dignity, is provided by hospitalization.

The Culture of Death mentality requires legalization of euthanasia on behalf of defense of the human dignity. In pluralistic society, moral problems are finally solved by law, while the basis for legal regulations is the consensus, not the morality. Nevertheless, positive attitude toward life at all its stages may overcome and eradicate this negative one. The culture of life and civilization of love give answers fit for human being.

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DIRECTIONS OF THE SECONDARY AND TERTIARY HEALTH CARE REFORM IN MONTENEGRO

ABSTRACT

The health system reform is a mass phenomenon nowadays. Both developed and developing countries try to find the way of building their efficient health system. Certain countries endeavour to achieve this by maximalization of total output of health services, while some of them try to achieve this by minimization of inputs. The most common goal of those reforms is to reduce the increase in healthcare expenditures. These are the expenditures of the social community spent for providing healthcare to its population. When it comes to health, the population is referring to the basic human and moral-ethical right to timely and quality healthcare provision. On the other side, day after day the health care (most frequently for impartial reasons) becomes more and more expensive and, due to growing respect of health, requires more financial resources (as a result of aging of population, and in particular due to new and thereby more expensive technologies). This results in overlapping of needs, requests, offers and possibilities in the provision of health care.

Bearing in mind these developments, this work provides an analysis of the situation and possible problem solution in Montenegrin health system so as the main directions of the secondary and tertiary health care reform.

Results of the work may be observed through the syntagma of „4E“. Evolution of efficiency in the health system is evaluated by „4E“, the initial letters of the words: equity (equal access to health), empower (right to decide), effectiveness (of the health programs) and efficiency (in terms of the costs and quality of health services).

Key words: health policy, health reforms, secondary health care, tertiary health care, Montenegro

INTRODUCTION

Although the health policy is one of a number of public policies, it is of great social significance and frequently it is a topic of both various public debates and everyday practical life decisions. There are three key reasons. The first is related to the fact that it tackles very sensitive human factor – the issue of health and disease, due to which possibilities of successful treatment, as well as all other forms of health care, are considered with close attention because possible mistakes in this field may have considerable social consequences. Second reason lies in the fact that health systems are rather expensive, whether they are public or private. Commonly, the health system, together with pension system, relies on the greatest part of social exuberance. Third

reason, deriving from previous two reasons, is that the health systems, in current modern societies, are mostly socialized, thus being one of the main fundament of social countries.

Most important and standing goal of the health policy is permanent improvement of health of population and promotion of the health-affecting conditions. Concepts of the health policy and reform in Montenegro are usually based on the assumption that access to health care is universal, equal for all and free of charge. However, in public and political circles, ethical principles on the health care as absolutely necessary goods of special characteristics are often get confused with basic economic laws that also have impacts on health. Health is not a free resource and may not be preserved without any expenditure. The health sector is made of about ten mutually related markets – for different forms of health care and treatment, different insurance types, medicines, medical equipment, labor market for health workers and the like. If one of these markets is operating on the basis of distorted prices – for example, if the healthcare is free for the most beneficiaries – there will be disturbances in other markets and the whole health system will become financially untenable.

Montenegrin health system has been changing more or less since '90s. Comparing to the conditions at the beginning of transition, current health system is more centralized, efficient and better financed. Health services are provided by both public and private sectors. However, apart from positive changes that have been made, there are many problems in the health system of Montenegro. Recently, the reforms were primarily directed to various aspects of fund-raising. Efforts have been made to reduce public expenditures, and therefore major part of those expenditures are transfers to citizens, and endeavors in solving problems are constantly dislocated from one to another segment of the health system.

1. TRANSITIONAL CHALLENGES

Economic and political goals of transition are quite clear. They are market and democracy. During last decade of twentieth century, many European countries have started changing their health policies and systems. Overall reforms of the health systems and health care in neighboring countries aimed at improving health of population and promotion of the health care by means of changing their organization, operation and financing. Like other countries in transition Montenegro is facing similar problems. In modern society the process of changes and transition from old to new system is connected with a great number of interrelated problems, which make difficult achievement of the overall social development.

In the period of transition, the health system, as well as the whole Montenegro, were affected by serious problems: sanctions and wars in the region. Unlike traditional model, in which health institutions were exclusive ownership

of the society, in accordance with social changes, all institutions have been proclaimed as state-owned, public institution, while private practice has also been introduced at the same time. Financing of the health care to great extent remains in the scope of public financing and participation of the citizens.

Restrictions in the public expenditures make the health reform quite complex, due to the reason that functioning of the health care and health security of the population should be provided while overcoming problems of financial instability and ensuring permanent and stable fund-raising for the overall health system. Thus the process of prioritization in the health system is the best way of governance and efficient health system.



IMAGE 1. – Montenegro is moving toward creation of modern health system.

2. CURRENT HEALTH SYSTEM IN MONTENEGRO

Health care system is an overall system, which, apart from the health activity, comprises regulations to govern obligations and rights of the state and its health insurance agencies. One of important function of the state is to ensure the right to health care of the citizens. Within this function, one of the main tasks relates to enactment of laws and by-laws as the prerequisites for ensuring right to health care, establishment of the size of those rights and provision of financial resources to exercise those rights. The role of the state within the health system is also provision of the resources for functioning and providing health care. Pursuant to adopted Law on Health Insurance, the health insurance system is based on the principles of mandatory insurance and social health insurance as per Bismarck model. The Republic Health Fund is the bearer of health insurance functions.

Though organization of the health system has already been designed through current reform process, it will be briefly presented here. According to the Law on Health Care (official Gazettes of the Republic of Montenegro No 39/2004) the health care has been defined as a system of social, group and individual measures, services and activities for preservation and promotion of health, prevention of disease, early detection of disease, due treatment, health care and rehabilitation. It was organized at three levels: primary, secondary and tertiary.

At the *primary level* it implies: monitoring of the population health conditions and proposal of measures for protection and promotion of the health of population, prevention and detection of diseases, as well as treatment and rehabilitation of patients, specific preventive health care of children and youth, health care of women, preventive health care of the risk and other groups in compliance with programs on preventive health care, counseling, health education of the population aiming at health preservation and promotion, hygienic and epidemiological protection, prevention, detection and treatment of diseases of the teeth and mouth, rehabilitation, health rehabilitation of children and youth with physical and mental disorders, public health nursing, visiting nurse services, labor medicine, urgent medical care and mental health protection.

Health care at the *secondary level* comprises services provided by specialists, advisory council and hospital.

Institutions at *tertiary level* (clinical institutions) provide the most complex forms of health care, implying interventions of the specialists, advisory council and hospitals. They also carry out scientific and research work, being at the same time sources for tuition at the health faculties. Tertiary health care is a part of health activity providing population with most complex health services, which can not be provided by hospitals or specialist services at secondary level or which, due to professional or economic reasons could not be organized at secondary level.

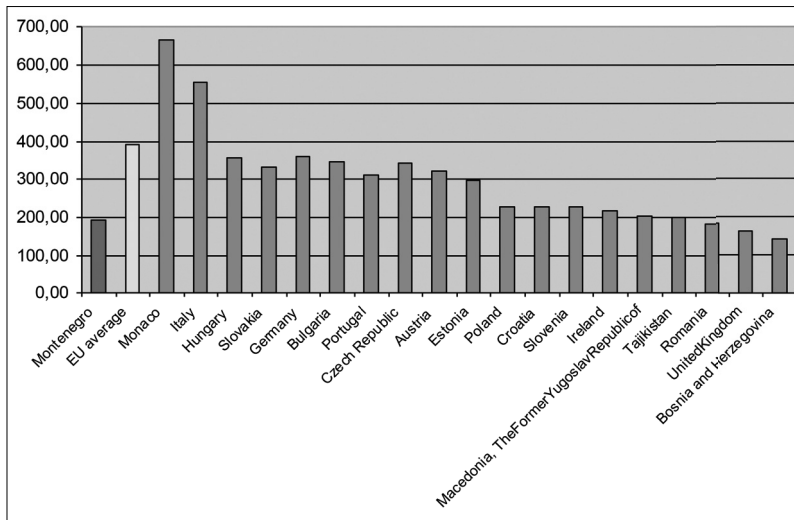
Content and scope of tertiary health care has not been standardized due to the reason that criteria for the most complex health activity depend on the size of population, number of complex medical interventions, equipment and organization of the whole health service. In addition, tertiary health care is usually combined in the medicine with scientific and research work. Besides, scientific and research work is financed by budget resources.

Montenegro is a founder of all health institutions dealing with health services as the public ones. Health institutions, which are founded to provide legally established rights of the citizens within the health care, provide health services and they are competent for professional segment of the health care. Network and capacities of the health institutions have been planned on the basis of normative provisions and according to the health needs of population and possible health services in compliance with principles of accessibility and

equality within the health care. Network of the health institutions in Montenegro comprises: 18 Health Centers and 3 health station units, 7 general hospitals, 3 special hospitals, the Clinical Center of Montenegro, the Public Health Institute and the Pharmaceutical Institution of Montenegro.

Out of 7414 employees in public health institutions in Montenegro in 2005, there were 5655 (76,27%) health workers and associates and 1759 (23,72) non-medical workers. Out of those 5655 health workers and associates, 1644 (29,07%) have university education and include 1203 (21,27%) doctors, 272 (4,81%) stomatologists, 104 (1,84%) graduate pharmacists, while the remaining 65 (1,15%) are health workers. Among health workers and associates 224 (3,96%) have higher education, 3781 (66,86%) have secondary education and 66 (0,1%) workers¹ have low education.

TABLE 1. – Number of doctors in the Republic of Montenegro and other European countries per 100.000 inhabitants



Source: Eurostat (2003), Statistical Yearbook 2005, Podgorica, Montenegro

3. PROBLEMS OF MONTENEGRIN HEALTH SYSTEM

On evaluating current situation in the health system, factors to be assessed must be a resultant of the health system effectiveness and reflect purpose of its functioning. In other words this means that on evaluating Montenegrin health system, it is necessary to assess to which extent the system has contributed to achievement of the main goals of each health policy, which is focusing on several components including: longer life expectancy, life free of

¹ Data were collected from Statistical Yearbook for 2005. of the Public Health Institute, Podgorica, Republic of Montenegro 2007.

harmful impact on health, improvement of health conditions, quality of life and functional and working capacities of Montenegrin population.

So far the health care system in Montenegro has been based on the principles of social equity, equality and availability, thus providing the largest scope of right to health care, which is financed from public resources with minimal participation of the insured persons. Equality of the beneficiaries in the system, equal availability for all were only assertive principles established by the Law, which created high expectations of citizens from the health system itself, who require quality care and higher standard of that care. This has also led to the increase of expenditures above real possibility.

The gap among rights, i.e. requests for health care and impossibility of their realization has made a strong pressure to both health institutions and the Health Fund. Impossibility of provision of the health care to the extent established by the Law caused inequality in providing health care of the population, both regional and urban-rural inequality, as well as differences in accessing health care with regard to social and economic status of the population. Also, the lack of clear goals and strategy for health development at the central level make possible ascendancy of the capacity and resources in hospital care, bias in the structure of the resources and financial funds.

Also, the nonexistence of clear goals and health development strategy at the central level make possible capacity and resources domination within hospital protection, bias between resources and financial means.

Problems coming from the above-mentioned factors, which were the very reasons for the reform include:

Increased costs for the health care caused by aging of population, the increase of chronic diseases and requirements for quality services, economic situation and real decrease of the funds for health protection,

Impossibility to provide health care services to the extent established by the Law,

Deterioration of indicators of the health conditions primarily due to deterioration of the quality of life, living standard and poverty,

Underdeveloped economic relations within the health system and financing of the health activities with rather low level of professional satisfaction and motivation for work of the health staff,

Excessive expenditures and obligations of the Health Fund,

Weak regulation in the private health sector with no objective benchmarks on privatization effects,

Lack of developed information system to support governance

Health conditions of Montenegrin population, measured by health indicators, is at the level of East and Central Europe countries. However, the values of most frequently used health indicators are lagging behind the values of West European countries. It should be emphasized that, apart from the numerous problems, the main health resources have been preserved, material basis for work has been improved and accordingly, the health service has been providing health protection to the population of the Republic as well as numerous displaced persons.

On considering the aforesaid factors, it is necessary to observe the world developments, in particular those of the developed countries, with special attention to West and North Europe, or more precisely to the EU Member states, pointing out trend of decreasing number of hospital beds, compensated by either different organization of the work in hospitals (with rather justified and highly cost effective usage of the so-called "daily hospitals") or establishment of social-medical institutions like palliative hospitals, or organization of the home treatment and care, aiming at decreasing high costs of hospital treatment.

4. DIRECTIONS OF THE HEALTH SYSTEM REFORM

The main goal of the reform is to make the health system be optimally functional in order to achieve, within available resources, greatest positive effect on the health conditions of Montenegrin population. The World Health Organization (WHO) set forth in the Ljubljana Charter 1996, the European principles of the health reform. To that end, the health care systems should be: driven by values of human dignity, equality, solidarity and professional ethics, oriented toward health, i.e. contributing to health promotion, population oriented, focused on the quality and reasonable financing and oriented toward primary health care. Role of the health system is to provide health services and produce goods to maintain and improve health of the population. WHO experts have defined 28 types of functions existing in each national system, which were grouped as: production of the health resources, provision of the health services, economic support mechanisms and governance of the health activities.

Health policy should be directed toward considerably higher level of decentralization and combination of the systems of public and private practice, wherever it is possible, in particular at the primary health care level. Not only in written, but also in practice the primary health care must be "the entrance guardian", namely the guardian of entry into the system. Primary health care should meet 85% of health needs so that secondary and tertiary levels are approached only by those who really need them. There is neither efficient nor sustainable health system without designing clear model and stable financing sources.

The bearers of the reform of health care system and health insurance are: the Ministry of Health, Labor and Social Welfare of Montenegro, the Health Insurance Fund and the Public Health Institute of Montenegro, along with active participation of the remaining health and other institutions. To implement the reform, it is also necessary to include international institutions and organizations, especially IMF, World Bank, ICRC and the like. Implementation of the reform will comprise realization of short and long-term measures to be based on the projects. Establishment and organization of more efficient health care system must be followed by defined human resources development policy and planning of education and necessary number of the qualified health staff structure in accordance with needs of the health service and employment possibilities. Within the realized incomes, the management of health institutions must be given the possibility to determine wage of each individual in compliance with the skills, size and quality of their work.

Montenegro is obliged to harmonize its legislation and practice with health conventions passed by the authorities other than European Commission, which are obligatory for EU accession. Undoubtedly, the most popular is the Convention of the Council of Europe for the protection of human rights and dignity of human beings with regard to the application of biology and medicine (ETS, No 164, Oviedo 1997.). Second important convention for health is the Convention for the protection of individuals with regard to automatic processing of personal data (ETS, No 108, Strassbourg, 1981.).

Negotiations with EU have increased the intensity of accession activities and pressure on the state administration and institutional infrastructure for reforms. Within its realization, the reform will affect all segments of the health system: organization and work in the Ministry of Health, Labor and Social Welfare, network of health institutions and their functioning, private health sector, organization and work of the Health Fund, financing health care, manner of payment, monitoring and control.

5. DIRECTIONS OF THE SECONDARY HEALTH CARE REFORM

Hospitals must be exempted from performing certain activities, i.e. providing services, which are in the domain of primary health care. They also must change their organization of work and take new responsibilities. The analysis of hospital capacities will be elaborated, which will lead to making decision about what activities or hospital capacity will no longer be in the public health care system, but will be privatized. Division of labor makes secondary and tertiary health care services separated, so that tertiary health care services will exclusively be provided by the Clinical Center and the Public Health Institute.

At the secondary health care level, the primacy will be given to treatment in outpatient department, which will be in charge for all procedures prior to

hospital admission. Admission of patients into hospitals will be carried out only upon the completion of all necessary investigations. Specialist outpatient department activity will be organized only within general and special hospitals of the Clinical Center. Though specialist outpatient department and hospital activities will not be separately organized, each hospital department will have working hours to work with patients in outpatient department.

Work in outpatient department and hospital will be separately recorded. Number of outpatient departments, namely number of their workers will be determined on the basis of normative provisions and size of the population in competence of certain hospital or certain hospital departments. The primacy of outpatient department means reorientation of the capacities and way of work of secondary and tertiary activities. In this way, interventions will be provided without unnecessary stay in the hospital and waiting for surgical operation. Emergency cases are exempted from these rules.

This approach, which only requires changes in the work organization, will make possible changes in relations between outpatient and institutionalized treatment of persons on behalf of the outpatient services while decreasing number of hospitalized patients. Decrease in number of unnecessary hospitalization will make cost effective capacities of secondary level institutions. Hospitals will introduce the form of “daily hospitals” or rather “hospitals without beds” within which the patient, due to certain treatment will be hospitalized for only one day, or for a couple of hours during the day. A great part of the patients’ accommodations in daily hospitals will relate to the planned surgical interventions. That kind of services requires neither “classical hospital beds” nor complete services needed during the stay.

Hospital activity at secondary level will be performed in general and special hospitals, as well as in the Clinical Center. Henceforth, general hospitals will also include four basic specializations: internal medicine, surgery, pediatrics and gynecology with midwifery. Their activities will be supported by suitable laboratory, radiology and other functional diagnostics services, transfusiological service, anesthesiological services and internal pharmacy.

Hospitals will have specialist services in other specializations for the needs of consultative and outpatient services (dermatovenerology, orthopedics, otorhinolaryngology, ophthalmology, urology...) if they meet equipment and staff prerequisites in relation to the required real number of citizens and patients in the related field, as well as other conditions defined and determined by normative provisions. Special department with hospital beds will not be established for these activities.

Subspecializations will be organized at tertiary level in the Clinical Center, while some specializations for certain areas of the state will be organized in special hospitals. Computerized tomography and other complex procedures will probably be introduced depending on the results of analysis carried out in certain hospitals or if there is no such possibility in some other hospital in

Montenegro. The criteria for new equipment will be anticipated size of services to be provided by the team working at least one, but as a rule in two shifts.

6. DIRECTION OF THE TERTIARY HEALTH CARE REFORM

Synthesis of different roles in tertiary health care causes obscurity in both its definition and function. Tertiary health institution is an institution, which performs activities within the most complex health services as well as education of health workers, scientific and research works, while tertiary health activity is related just to the provision of the most complex health services or programs. This activity can be performed by health institutions, which provide the most complex and specialized health services that are not organized within other health institutions and are not occupied with research work.

The Clinical Center of Montenegro has a status of tertiary health institution. However, the Clinical Center provides services at secondary and tertiary level, and these two activities have not been marked off. The problem does not lie in organizational separation of secondary and tertiary activities, but it is not quite clear what tertiary activity really means, that it cannot be organized and provided in general hospitals. This is necessary for several reasons. First, in order to provide quality health services, then to plan those capacities in the country as well as due to financial services, having in mind that provision of these services imply different team membership, more complex technology and thereby different costs, work and materials.

Tertiary health protection has been defined in the Clinical Center on the basis of current situation analysis and includes:

- Services of complex cardiological diagnostics, non-surgical and surgical heart interventions, (dilatation, PTCA, stent, pacemakers, bypasses...);
- Neurosurgery services;
- Services of thoracic and plastic surgery with specialized hospital departments;
- High risk vascular surgery patients;
- Transplantations;
- Combined oncology therapy – surgery, radiation, chemotherapy;
- Surgical spine and peripheral nervous system interventions;
- Treatment of polytraumatized conditions requiring intensive therapy and permanent surveillance of vital functions;
- Diagnostics and treatment of most complex conditions and complications, which can not be successfully treated in general hospitals or the treatment would not be cost effective due to the small number of cases;
- Services of maxillofacial surgery, including reconstruction of the lower jaw with various injuries;

- NMR diagnostics; PET; Gamma camera;
- Nuclear medicine services;
- Services of immunology, virusology and genetics;
- Intensive therapy for premature underweight children and children with inborn malformations;
- Services of transfusiology, blood processing and preparation of blood derivatives;

Subspecialist services, which will not be organized in general and special hospitals

The Clinical Center in Podgorica will be the bearer of tertiary health activity, which will also provide secondary level services for the insured persons living in its surroundings (population from municipalities of Podgorica, Danilovgrad and Kolašin) and tertiary health services for the whole Montenegrin population.

Apart from the Clinical Center, the Public Health Institute will also have the status of tertiary health institution. The role of the Institute has been established in the Strategic Development Plan, thus comprising promotion, prevention and protection in the scope of public health. The Institute will coordinate the health promotion plans for the country. It will also be the bearer of professional tasks such as: development of national programs and development strategies, development of public health programs to overcome most serious health problems, analysis of the health conditions of population, health economics, management and health informatics and development of appropriate indicators for the aforesaid fields as well as assessment of the quality of health care. The Institute will particularly be involved into the planning of the health protection, providing professional and methodological assistance and assessment of the plans of all health subjects. In the field of communicable diseases prevention, the Institute will develop a unique immunization program for the whole country and will monitor its implementation in each Health Center. In compliance with the Law, the Institute will perform the monitoring and control of the environmental benchmarks of particular importance for the health of population.

The Institute has a great significance in implementing the Convention on bioterrorism and other form of protection. It will be the reference laboratory in the fields of microbiology, parasitology and sanitary chemistry and will provide standards of other laboratories within microbiology, virusology and control of foodstuffs. To that end, the Institute will provide accreditation for its laboratories, to meet the standards within safe food and HACCP principles. Importance of this job lies in the fact that food from Montenegrin territories is oriented toward European market and fulfillment of all standards of foodstuffs quality.

CONCLUSION

The health is a subsystem of the social system whose structure, organization, goals and functioning are determined by political and economic structure of the state, its economic potential, health conditions of the nation, health problems, tradition, culture and numerous other factors. Health system, which is burdened by inherited problems, requires serious process of changes harmonized with possibilities of the overall economic development, aiming at promoting health conditions of the citizens and achieving financial stability of the system. The fact is that only real GDP growth may be the framework to support rights to health protection within which the health programs and capacities will be adjusted.

The health care system in Montenegro will be based primarily on the public health capacities. These capacities will be strengthened by private health capacities, out of which one part will become the integral part of the network of health institutions in the country, in compliance with legal regulations. Capacities of both public and private sectors will be integrated in accordance with the Program of the Ministry of Health, Labor and Social Welfare, i.e. the Government of Montenegro. Reform of the primary health care is based on a clear separation from secondary and tertiary health care level. The main goals of the health policy include: decrease in differences in the health condition and availability of the health care for population with respect to geographical area and social-economic group, promotion of the health conditions and increase in availability of the health care for vulnerable groups, reorientation of the overall health protection to the improvement of health and prevention of diseases as well as raising efficiency and quality of the health care.

Health care system in Montenegro has to provide preservation and improvement of health of the whole Montenegrin population through series of continuing activities and measures directed toward prevention of diseases, treatment and rehabilitation of patients. Health system should remain equally accessible for all citizens of Montenegro, thus respecting its basic principle of equality. Quality of the health services will be promoted by introducing continuing education of health workers, their licensing and accreditation of the health institutions as well as by development of clinical protocols. Introduction of an integral health information system will be one of the priorities within health in order to provide the quality support to better governance, improvement of the quality of work and technological development.

An integral (global) health informatization has been initiated in Europe with the aim of providing better health care for patients, achieving better mobility of people and creating prerequisites for control and analysis of the whole health system in both economic and qualitative aspect, which finally results in possible quality governance in huge health systems.

In this short review it can be noticed that there is no joint or unique approach within this area. Each country, depending on its social and economic circumstances finds the best way to solve the problem of governance and surveillance of the health system.

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$$R = P \times V \quad (1)$$

where

- P is the selling price, and
- V is the volume of sales in units.

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