BOSNA I HERCEGOVINA
FEDERACIJA BOSNE I HERCEGOVINE
FEDERALNO MINISTARSTVO ZDRAVSTVA

BOSNIA AND HERZEGOVINA
FEDERATION OF BOSNIA AND HERZEGOVINA
FEDERAL MINISTRY OF HEALTH

STRATEGIC PLAN FOR HEALTH CARE DEVELOPMENT IN THE FEDERATION OF BOSNIA AND HERZEGOVINA BETWEEN 2008 AND 2018

Sarajevo, April 2008

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Foreword

This document is aimed at showing the strategic trends in health care development in the Federation of Bosnia and Herzegovina for a ten-year period. By means of this document, the Federation Ministry of Health wishes to demonstrate that it has a clear vision of the long-term development of health care in the Federation. The health sector must have a consistent health care policy, which will persevere with the ongoing reforms in health care, taking into account the current changes of our surroundings.

Pursuant to European orientation, the Ministry has remained consistent with the fundamental principles and values of the development of our health care system, which in turn means focusing on the following facts:

- the health care reform must be governed by values such as human dignity, equality, solidarity and professional ethics,

- the reform must be directed at people's health, which means shifting the focus of health care measures towards health promotion and illness prevention, i.e. towards better health status indicators,

- the reform must be people-focused, which means recognising citizens' needs to take part in health-related decision-making processes via a democratic process, but also to assume part of the responsibility for their own health,

- the reform must be quality-focused, which means continuous development of the quality of the provision of health care services, as well as an appropriate efficiency level,

- the reform must be based on a sustainable system of funding, which means universal health insurance coverage, equal accessibility of health care services in all regions, and efficient use of health resources through the strengthening of solidarity, both between different social groups and between different regions,

- the reform must be orientated towards primary health care based on the principles of the World Health Organisation; the principles of *fairness* in distribution of means for health, *universal coverage* with basic preventive and curative services, *multi-sectoral approach* taking into account the significance of other sectors in influencing health determinants, *promotion of community participation* in health-related activities with a view to mobilising hidden resources in the community, and emphasis on *health promotion*, not only on absence of illness,

The Federation Ministry of Health's mission may be defined as the development of an efficient and effective institution which is committed to improve the health status of citizens of the Federation of Bosnia and Herzegovina. This Ministry is a governmental institution which, through the

development and implementation of the health policy, drafting of strategic development trends and creation of the legal framework, affects the development of a quality, sustainable, and cost-effective health care system, with a view to improving the health status of the population, all based on the principles of transparency, solidarity and fairness. Modern trends in science and health care system management skills entail a complex notion of informed management. The informed management of the health sector in the Federation of BiH implies clearly determining the vision and future health policy development trends and, in relation to that, undertaking legislative, political, fiscal, expert, and social measures which are to ensure the optimal level of patients' rights, equally in all Cantons. In addition, informed management implies a series of important aspects, and these are as follows:

- defining improvements in human and patients' rights in the Federation of BiH health sector as a clear vision,
- regulating the domain of reorganisation and rationalisation of the health care network in terms of a clear and defined distribution of work in the health care organisation,
- developing the concept of public-private partnership in health care,
- modernising the health care sector from the aspect of introducing new medical technologies and the manner of managing these technologies,
- supporting informed management in health care in a stable and financially sustainable health care system,
- eliminating the lack of adequate managerial skills in health care institutions and reducing the possibilities for the occurrence of corruption,
- investing in human resources in health care and improving specialist training of health professionals,
- working continuously on quality assurance in health care.

Strategic management can be of the above type and can proceed in the direction and to the extent determined by the legal framework. That is why it is essential to align the legal framework with the needs of the community while abiding by the principles of alignment with the EU regulations which we assumed in the process of adopting and signing the Stabilisation and Association Agreement between Bosnia and Herzegovina and the European Union, pursuant to the Decision on the Procedures and Process of Aligning the Bosnia and Herzegovina Legislation with ACQUIS COMMUNAUTAIRE ("BiH Official Gazette", no. 44/03).

The development of democratic societies in the world strives to regulate social systems within society; not only by adopting laws, but also by using a series of other methods. Thus, for example, measures of a competitive and stimulating nature may result in effects which are, in terms of organising the health care system, better than legal measures using instruments of coercion and punishment. Being aware of such possibilities for regulating social systems, we have opted for managing a health care development process on the basis of a combination of both binding regulatory/legislative measures and measures stimulating for development stakeholders.

I would like to use this opportunity to invite all stakeholders in the health system reform and development process in the FBiH, both local and international, to

build up a partnership for the promotion of this important assignment. The Federation Ministry of Health obliges itself to persevere with the principles and underlying values of the reform and the objectives set forth in the present document. I would also like to ask all participants to abide by the professional opinions of experts for health care system development in the fields of public health care, health insurance, health management, health care quality assurance, etc. It is possible to achieve positive effects on both the population health and the organisation of an efficient health care system by taking into account the plurality of interests of health care development stakeholders.

Federation Minister of Health

Safet Omerović

1 INTRODUCTION

"The Strategic Plan for the Health Care System Reform" offers a strategic approach and objectives of the FBiH health system reform for the period between 2008 and 2018. The document was developed during 2007 by a working group established by the Federation Ministry of Health.

The document is based on the analysis of the system's functions: informed management, resources in health care and service provision, pursuant to the World Health Organisation (WHO) recommendations.

The document is aimed at clearly defining the vision and objectives for the development of a modern, high quality, rational and economically viable health care, which, according to the estimations of many local and international experts, implies the establishment of an integrated health care, with a concurrent, effective quality and expenditure control and an accountable management of resources available.

Only the development of such health care system could lead to a complete psychological and physical well-being and create the assumptions for improving the social status of the individual, which in turn constitutes the basis for the economic development of the society.

The concept of health development bears a strong resemblance to economic development. Both of the stated processes are the result of activities involving many social sectors, as well as the population as a whole, through individual and collective decisions and actions. An interesting piece of information is the fact that the contribution of medical services of a well-developed health care system to the improvement in the population health is estimated at only 10%, while the remainder is the result of the work of other sectors.

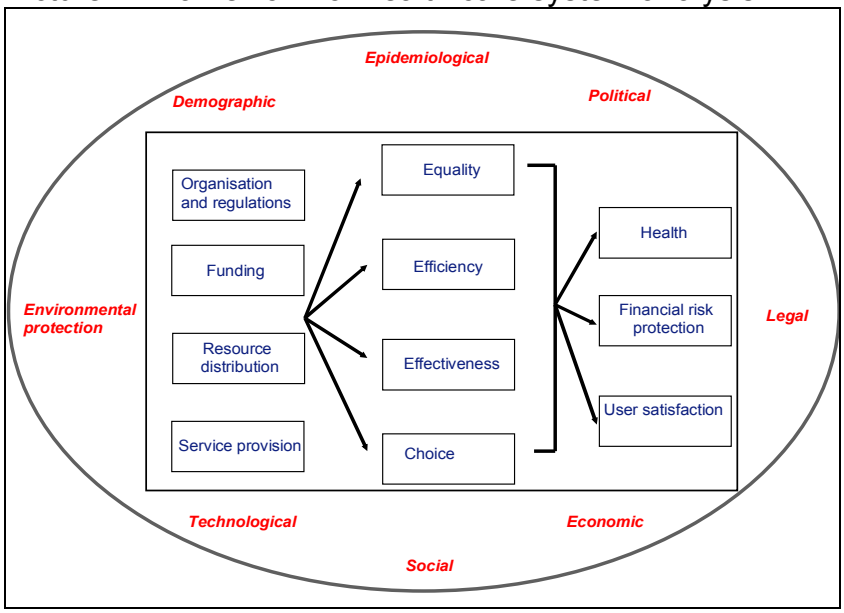
This document mentions the key principles which will guide us when implementing the Strategic Plan, as well as the goals and objectives we wish to attain within the set deadline.

A more complete review of the situation in the health care field itself, but also in the environment affecting health, and the findings on the characteristics and problems to which health care system reforms will refer, is provided in the situation analysis document, attached to this document and drafted by the working group as part of the activities on identifying the areas and priorities on which attention should be focused.

2 METHODOLOGY

Basically, the analytical framework, based on the approach of the analysis of health care system functions and the context in which the health care system is placed, is used in the drafting of the document. This approach uses health, financial risk protection and user satisfaction as the final objectives of the health care system and is based on the analysis of demographic, economic, political, legal and regulatory, epidemiological, environmental, and technological conditions. (Picture 1)

Picture 1: Framework for health care system analysis



This analytical framework identifies the four functions of a health care system: **informed management and organisational arrangements; funding** (what way are the contributions collected and put together); **distribution of funds and systems for payment of service providers** (what way are collected funds distributed, and the mechanisms and methods used for the payment of health service providers); **generation/distribution of resources** and **service provision** function**,** referring to the content, i.e. services provided by the health care system.

The health policy maker's influence on these functions of the health care system facilitates the improvement of the functioning of the health care system itself, and in turn the improvement of the population health.

The advantages and weaknesses of the health care system of the Federation of BiH were considered by analysing the mentioned functions, which was the basis for setting strategic objectives in the present document.

3 ENVIRONMENT SUMMARY ANALYSIS

3.1 DEMOGRAPHIC CHANGES

As no census has been conducted in BiH since 1991, the population data based on the FBiH Statistics Bureau (FBiH SB) estimations for 2006 have been used for the purposes of the present document.

In 2006, the Federation of BiH had a population of 2,328,434 inhabitants, living in the territory of 26,110.5 km^2. The FBiH population falls within the regressing category, with a small share of children between 0 and14 years of age (18.1%), and with an increasing number of people aged 65 and over (14.1%). In terms of sex, women constituted 51% of the population.

Estimated life expectancy at birth in the Federation of BiH ranges between 71 and 75 years of age, and is similar to the 1990 BiH data and the average in the countries that became EU member states by 2007.

The birth rate is low, 9.3‰, it is continually falling and is similar to the birth rates in the surrounding countries.

The mean value of the general mortality rate was 8.0 per 1,000 inhabitants and has been slightly and continually rising in recent years.

Infant mortality is one of the best indicators of the health status of the population, particularly children, and at the same time it is the reflection of the health care organisation. In 2006, it added up to 9.5 per 1,000 livebirths, which is low. Natural increase is on the fall, as a consequence of the decline in the birth rate and slight rise in the mortality rate, and at 1.3‰ in 2006 it is extremely unfavourable.

According to the FBiH Ministry of Displaced Persons and Refugees, in 2006 there were 57,770 displaced persons registered in the territory of the Federation of BiH and the number of displaced persons is continually declining.

Persons with different levels of disability constitute around 10% of the population, and they are mostly disabled veterans and civilian victims of war.

According to the data of the FBiH Pension and Disability Insurance Bureau, the total number of pensioners in the Federation of BiH amounted to 314,462 in the end of 2006.

Due to the continuous rise in the share of persons aged 65 and over in the total population, the rate of the dependant population (population too young or too old to work) amounts to 47.5%. The rise in this rate is a major problem from the aspect of securing the funds for social security and health care services.

It is obvious from the given data that the Federation of BiH is undergoing major demographic changes, which affects the health status of the population and the organisation of health care.

As population movements, i.e. changes taking place in the population are the basis for planning in all sectors of society, demographic changes in the Federation of BiH are disturbing and they demand the interest and involvement of the entire community.

3.2 EPIDEMIOLOGICAL CHANGES

In addition to giving rise to demographic changes, the process of socio-economic and political transition in the Federation of BiH also gives rise to other major changes affecting the population health. The population health is poor in many ways. Previous health problems have not been resolved, and new ones have emerged (HIV, hepatitis C, avian flu, etc.). Unhealthy life habits are becoming ubiquituous, which contributes to the higher incidence of chronic diseases.

Negative health indicators, of which death rate (dying) and morbidity rate (contraction) are available, are used for evaluating the health status of the population.

The mean value of the general death rate (mortality) in 2006 was 8.0 per 1,000 inhabitants and has been on the slight rise in recent years. The leading causes of death are diseases of the circulatory system (53.7%) and malignant neoplasms (19.2%). Endocrine and metabolic diseases with nutritional disorders have a high incidence rate (4.0%).

The leading diseases (morbidity) registered in outpatient-policlinical care are characterised by a significant share of chronic diseases, and that particularly refers to hypertensive diseases, diabetes, dorsopathies, etc., which can be linked with the high prevalence of smoking, excess body weight, physical inactivity, stress and other risk factors among the population in the Federation of BiH.

Mental disorders are on the continuous and slight rise. The leading illnesses registered in adults in the primary health care are neurotic illnesses, connected with stress, and somatic disorders (43%), followed by affective (mood) disorders (24%). Mental health care should be a priority because of the bad socio-economic status of the population, constant rise in unemployment and bad living habits (alcoholism, drugs).

Respiratory diseases still make up the major share of registered cases of contagious diseases due to the manner of transmission and contagion, while intestinal infections are on the rise.

Although the incidence rate of pulmonary tuberculosis in the Federation of Bosnia and Herzegovina had been reduced from 100/100,000 inhabitants in 1998 to 52/100,000 in 2006, we still fall within the category of high-incidence European countries. The latest researches on resistance to antitubercular drugs

were conducted in the year 2000 and these showed 0.1% and 2% incidence of multidrug-resistant tuberculosis in newly detected and previously treated cases, respectively. The DOTS Strategy was introduced in 1995, with a tendency to be implemented gradually in the territory of the FBiH. In recent years, antituberculosis drugs are supplied through the Global Drug Policy Programme.

There is a noticeable growth trend in registered HIV/AIDS cases. In the period between 1999 and 2006, there were a total of 81 registered HIV positive persons, out of which number 53 had developed AIDS. Out of all registered cases, 37 persons have died. This may also be the consequence of the improved HIV supervision and changes in the manner of reporting, because a well-structured network of local coordinators has been established in the Federation of BiH and due to the treatment facilities, more and more people are tested for HIV every year. Additional funds have been secured through the Global Fund to Fight AIDS, Tuberculosis and Malaria for the implementation of the strategies for both of the above diseases.

DTP^3 coverage in 2006 amounted to 91%. In the period between 2002 and 2006, there was an evident decline in the morbidity rate due to all vaccines against preventable diseases, particularly with children, despite the fact that the statutory immunisation coverage minimum (95%) was not attained. The failure to achieve the statutory minimum was partly due to insecure and unstable sources of funding for the mandatory immunisation programme. Non-registration of newly-born children poses yet another problem, as well as migrations of particular population categories (e.g. Roma).

The challenges and threats to the population health are currently many. In addition to the current socio-economic situation, there are many global theats to health – natural disasters (earthquakes, floods, fires, global warming), accidents (radiological, chemical, biological, etc.), and epidemics of new contagious diseases in the region and the world (SARS, avian flu, etc.).

3.3 POLITICAL ENVIRONMENT

A decentralised health care system is established in the Federation of BiH, pursuant to its Constitution, which implies that the competencies in the health care field are split between the Federation of BiH and the Cantons.

In the conditions of a decentralised health care system, the Federation is given the role of the designer of the relevant FBiH policy and laws, with the consensus of the Cantons, and the Cantons are given the role of implementing institutions, as well as the role of the principal financiers of the mapped-out directions. However, very often in practice disagreements arise between the Federation and Cantonal levels in terms of their functions. It has been noticed that particular Cantonal health regulations are not aligned with the FBiH regulations, that is, in some cases they regulate the same issues in opposite manners. Furthermore, Cantonal policies which are incompliant with the Federation level are often implemented at the Cantonal level, while the Federation of BiH has no mechanism for taking actions against lowel authority levels.

3.4 LEGAL AND REGULATORY ENVIRONMENT

The policies and strategies in the health care field adopted hitherto have been primarily based on strengthening the primary health care, on activities for strenghthening health care prevention, improving public health care status, and improving the quality of health care, as well as on reforming funding arrangements. However, the reform of the funding arrangements did not follow the other reforms, thus we still have not got clear mechanisms for fund raising, resource allocation, service purchase and contracting and fund allocation is therefore detrimental to the primary health care. In general, a conclusion may be drawn that what is missing after the adoption of a certain strategy and policy is the final result, i.e. amendments to the respective legislation, drafting and implementation of operational plans, as well as monitoring, evalution and reporting on the implementation. Insufficient funds for the implementation of adopted strategies and policies pose a separate problem.

The Federation of Bosnia and Herzegovina health care laws originate in international conventions, declarations and treaties. The two fundamental laws regulating this field are the Health Insurance Act and the Health Care Act. The Health Care Act regulates the principles, manner of organisation and implementation of health care. The Health Insurance Act regulates health insurance as part of social insurance, based on the principles of citizen mutuality and solidarity.

In the upcoming period, it will be essential to align the legal framework with the EU regulations we took over in the course of adopting and signing of the Stabilisation and Association Agreement between BiH and the EU, pursuant to the Decision on the Procedures and Process of Aligning the Bosnia and Herzegovina Legislation with ACQUIS COMMUNAUTAIRE (“BiH Official Gazette”, no. 44/03).

It should also be pointed out that the entity Ministries of Health are taking part in the negotiations with the EU in the segment of free movement of people, in as far as health care and health insurance are concerned. However, other state and entity ministries are charged with negotiations in this field, whereby the need to coordinate the work within the BiH Council of Ministers, but within the entity Governments as well, increases.

The limitations of the decentralised health care system in the Federation of BiH, be they political, administrative or fiscal, endanger the financial sustainability of the health care sector in the Federation of BiH, and raise the issue of inefficiency of the organisational model in the health care and health services provision sector, the issue of limitations of institutional capacities, and the issue of institutional fragmentations, which in turn triggers different approaches to health care.

In order for the health care sector to attain the objectives and requirements set before it, it is necessary to improve informed management at all levels.

3.5 ECONOMIC DEVELOPMENT

The current transitional moment in BiH has a direct impact on the organisation of health care, sustainability of the health care system and, eventually, on the health status of the population.

It is estimated that the BiH GDP amounts to approximately three fourths of its pre-war level. The gross domestic product in 2006 in the Federation of BiH amounted to 12,058,191 KM, 4,238 per capita. In 2006, the number of employed people was 398,601 and it is slightly rising. The number of unemployed people was 355,102 and kept increasing compared to previous years. The problem of the grey economy is still present on the labour market.

There is a great confidence in the currency, which is indicated by the constant rise in the deposits made in the local currency. The successful negotiations on the re-structuring helped to reduce the foreign debt to a sustainable level. With the net capital income exceeding the deficit on the current account, the foreign currency reserves have increased, although at a slower pace of accumulation than previously.

Although the measures of the macro-economic policy in the period between 2001 and 2005 made it possible for the poverty status not to deteriorate and there was an increase in salaries, pensions and the number of employed people, the gravity of poverty has remained a major problem and disparity is increasing. The last data available from the Living Standard Measurement Survey (LSMS) have shown that around 15% of the FBiH population lives under the general poverty line, and another 30% are in danger of being reduced to poverty. The most endangered population categories are young people, displaced persons, persons in social need, unemployed people and pensioners on low income.

3.6 ECONOMIC DEVELOPMENT AND HEALTH

The relationship between economic development and health can be illustrated with two terms, “economy of health” and “health of economy”. The perspective of “economy of health” is focused on the effects of poor health and early death on economic development, and on the loss of productivity. Many countries are more concerned about the financial costs of health services and social security schemes than about the effects of the total costs of illness and early death on the society and individuals. “Health of economic strategies” should focus on the health effects of different economic policies. The main criterion for evaluating the health effects of economic policies is how they affect vulnerable groups.

The concept of health development bears a strong resemblance to economic development. Both of the mentioned processes are the result of activities involving many segments of society, as well as the population as a whole, through individual and collective decisions and actions. Social indigence, with economic disparities and living conditions, results in a lower life expectancy and higher infant mortality in lower social strata.

3.7 SECTOR'S COMPETENCE

The health sector is not directly competing for the budget funds with other sectors as for the most part it is financed from the mandatory health insurance funds. This manner of financing gives the health sector relative security in the competitive environment of users of public expenditure funds. However, to a small extent, the funds for financing health care, pursuant to laws, are provided from the budgets of governments at all levels. When competing for those funds (e.g. co-financing of the FBiH Solidarity Fund, resources for the implementation of immunisation programmes, prevention programmes, providing resources for particular categories of health insurance users, etc.), the health care sector is in an unfavourable position compared to other budget beneficiaries, which in part contributes to the large percentage of uninsured persons, deficient implementation of promotional and prevention programmes, and the total financial instability of the health care sector.

This position of the health care sector derives from the fact that the governments have failed to recognise the similarities between the health development concept and economic development and that both processes are the result of activities or interactions involving all sectors of society, as well as the population as a whole.

3.8 SOCIAL AND CULTURAL ENVIRONMENT

The main health determinants are correlated with living conditions, environmental factors, lifestyles and biological factors, such as age, sex and genetics. Thus, for example, the policy in the fields of housing, agriculture, education, working conditions, employment, water and sanitary conditions, transport, fiscal regulations and social care often has a greater impact on the population health than the heath care sector. An interesting piece of information is the fact that the contribution of medical services of a well-developed health care system to the improvement in the population health is estimated at only 10%, while the remainder is the result of the work of other sectors. It is therefore particularly important to emphasise the significance of an inter-sectoral cooperation in the population health care which should, pursuant to the Ottawa Charter, be based on five (5) health promotion actions, and these are as follows: building healthy public policies, creating supportive environments, strengthening community actions, developing personal skills in public health care system and reorienting health services.

Researches have shown that social exclusion ("excluded" means to be left outside the majority and be deprived of social, economic and political rights guaranteed to others) still remains a major issue since disparities in income, educational attainment and health underlie this issue. According to researches, every second citizen is in some way socially excluded. Particularly endangered are displaced and disabled persons, old and young people, since they run the highest risk of becoming poor and unemployed and they have difficulty accessing public services.

3.9 ENVIRONMENT

Of all environmental risk factors (polluted water and air, waste, contaminated food, polluted soil, mines, etc.), insufficient drinking water (particularly water from local water-supply facilities) and food control is the biggest public health problem, along with inadequate disposal of waste, chiefly medical waste. The existing equipment and personnel are insufficient for the introduction of complete monitoring of the stated environmental risk factors in the FBiH.

Although Bosnia and Herzegovina manages considerable water resources, the quality of drinking water in certain parts of the Federation of BiH is not satisfactory. The latest researches (MIC S3) show that 73.2% of households in the FBiH are connected to the central water-supply system (waterworks), where the water safety is continuously controlled.

The basic air pollution parameters are continuously controlled in a number of FBiH cities (Sarajevo, Tuzla, Zenica, Mostar). Between 2003 and 2006, the SO_2 and NO_2 concentrations in these cities did not exceed the high limit values stipulated in the Book of Rules and the annual averages of these pollutants were within the urban area limits. However, in the given period, the smoke concentration in the city of Sarajevo exceeded severalfold the high limit values (C_{98}-60 micrograms/m^3).

The management of hazardous and medical waste is particularly critical, and these two pose the most serious health threats. Waste is collected in an unselective manner, and often one can find certain categories of industrial and medical waste in utility waste. Therefore, the disposal of solid and liquid waste constitutes one of the major problems of the public health system and community as a whole. The biggest problems in terms of solid waste are its uncontrolled disposal and creation of “illegal” dumps.

An important risk factor for the population health in the FBiH are mines left behind after the war. The latest data show that, during 2005, there was a total of 21 casulties from mines and unexploded ordnances (casualties and fatalities).

Compared to previous years, the traffic safety in the territory of the Federation of BiH in 2006 was characterised by an increase in the number of traffic accidents (25,287), decrease in the number of fatalities and severely injured people, and increase in the number of people lightly injured in traffic accidents.

All of the above affects the population health and is the jurisdiction of different sectors. The elimination/reduction of their respective impacts on the population health requires multi-sectoral and coordinated actions.

4 SUMMARY ANALYSIS OF HEALTH CARE SYSTEM FUNCTIONS

4.1 INFORMED MANAGEMENT (ORGANISATION AND REGULATIONS)

The informed management of the health sector in the Federation of BiH means clearly determining the vision and future health policy development trends and, in relation to that, undertaking legislative, political, fiscal, expert, and social measures which are to secure the optimal level of exercising patients' rights, equally in all Cantons.

Therefore, when defining the policies and strategies, it is necessary to determine the minimum joint activities of both the authorities and other participants in health care, respecting the specific characteristics of each Canton's health care system, and to reach a consesus on these issues between the Federation of BiH and the Cantons.

So far, no satisfactory results have been achieved in the sphere of re-organisation and rationalisation of the health care network from the aspect of a clear and defined distribution of work in the health care organisation. The distribution of work in the structure of health institutions by health care level should ensure the establishment of a single health care system in the Federation of BiH, accessibility of every health care level to health care service users; rational and cost-effective distribution of work in health care, based on the principles of functional, technical and economic correlation and inter-dependability of each level and type of health care services and institutions; elimination of double procedures in the provision of health care services, deployment of capacities to provide the rational use of medical equipment and personnel and eliminate the doubling of capacities in health care development, which in the end means achieving a more rational, efficient and quality health care. That is the reason why clear principles of work distribution in the health care system, principles that can be financed, serviced and further maintained, should be established.

Informed management in health care is possible only in the conditions of a stable and financially sustainable health care system.

Another major weakness in the business activities of health care institutions is the lack of adequate managerial skills of managers, most of whom do not possess the adequate knowledge and experience required for strategic management, financial planning and other activities required for the management of hospitals in market conditions. The control and audit functions in the financial operations of health institutions are neglected and should be significantly strengthened.

The strategic management in health care means also the management orientated towards providing quality and safe health services which will provide security to both patients and health professionals. Besides, the safety of patients and health professionals can be seen through the prism of determining the rights

and obligations of these groups in separate laws. Therefore, in the upcoming period, it is necessary to regulate the rights of patients using health care, the manner of care, as well as the promotion of these rights in a separate Patients' Rights Protection Act. The general and equal right to a quality and continuous health care, suited to the patient's health status, must be guaranteed to each patient, pursuant to the universally accepted standards and ethical principles and in the best interest of the patient, taking into account his/her personal attitudes. The type and scope of health professionals' rights, their respective obligations and responsibilities would be determined by regulating their rights in a separate law.

4.2. FINANCIAL STRUCTURE

4.2.1. HEALTH CARE FUNDING

Health care funding in the Federation of Bosnia and Herzegovina is based on the principle of uncompetitive, regionally established system of social health insurance. It is an integral system within cantons, where citizens exercise their right to health care by compulsory investment of resources, on the principles of reciprocity and solidarity.

Resources for health care funding are ensured by health insurance contributions from employees' salaries, payroll contributions, farmer contributions, unemployment contributions and contributions for other categories. Although the law recognises other forms of funding (cantonal budgets, Federation budget, donations, health institution revenues, co-payments, etc.), funding from the contributions is the only and basic source of health care income. The cantonal Health Insurance Funds and the Federation Health Insurance and Re-Insurance Institute collect the compulsory health insurance resources.

The greatest share in the income structure (76% for 2006) is that of the income from compulsory health insurance. Budgetary resources in the total resources include 3-4.5%, while in 2006 they decreased by 26% in relation to 2005, and by 15% in relation to 2004. One part of the resources is collected through co-payments, which is not financially significant, because most beneficiaries are exempt from co-payments. Along with co-payment, beneficiaries pay for some health services directly, for instance, for the drugs not dispensed by a prescription.

Compulsory health insurance ensures the right to health care to HIF members. Besides the compulsory health insurance, the law also recognises other forms of insurance, complementary and voluntary, which do not compete with the compulsory health insurance. So far, none of the cantons has either introduced complementary or voluntary health insurance.

The Solidarity Fund was founded in 2002. It is funded with 9% of the cantonal compulsory contributions and with the same amount from the Federation budget, which was never fully realised in the past years. Those resources serve to fund priority vertical health care programmes of interest to FBiH and priority and most complex forms of health care in certain specialist branches.

The law prescribes salary bases and contribution rates, which are 13% of employee's net salary and 4% of the gross salary at the expense of employer, with the provisional Decision of the FBiH Government defining the single rate for pensioners of 1.2%, which is applied in the entire Federation of Bosnia and Herzegovina. However, the health insurance contribution rate has now been decreased from the planned 13% to 12.5% of the net salary. In the process of discussing the Profit Bill, Income Tax Bill and Act on Changes and Amendments to the Contributions Bill, one may expect further decrease in the health insurance contribution rate for the purpose of unburdening the economy and increasing the number of employees, which might threaten the financial stability of the health sector.

Another fact should be added here: right now, we are having a public analysis of the documents "Basic package of health rights" and "Rationing of service provision". The financial challenge will be to provide the missing resources for equitable funding of the basic package of health rights in all cantons, i.e. the balance of health care standards for HIF members in each canton, under such conditions. Besides, the duty to ensure resources for implementing the Collective Agreement in the field of health care that will ensure equal standards of health care employees in the Federation of BiH is still ahead of us.

For other HIF member categories, such as the unemployed, socially vulnerable categories, farmers and other categories, determining the bases and rates is the competency of cantons, and it is not well balanced. It depends on a series of factors such as the number of employees and amount of average salaries, size of the population, structure of HIF members, etc. Unemployment contribution is determined as a lump sum in most cantons, but the amount of the lump sum varies, which is unjustified, taking into account the fact that the same percentage for unemployment contribution is charged to employee salaries in the entire Federation of Bosnia and Herzegovina.

Significant problems in revenue collection are grey economy, contribution avoidance, failure to pay contributions, decrease of rates by decisions of governments for certain HIF member categories.

It should be pointed out that the contribution collection control is the competency of the FBiH Tax Administration and that the health insurance funds do not have the possibility of forced contribution collection. The only possibility at their disposal is to deprive of health rights those who the contributions were not paid for.

There is still a high percentage of uninsured persons (16%) in the FBiH. The structure of HIF members shows the trend of increase in the number of HIF

members from the categories that contributions are paid for only in token amounts (pensioners and the unemployed) in relation to those employed by the employers who carry the burden of providing resources for health care from the compulsory health insurance. This is why the question arises until when the employees, i.e. their employers will be able, under such disproportionate conditions, to carry the burden of health care solidarity, which is the main principle of the established health insurance system.
The question of health sector financial stability arises in such conditions and trends.

In order to consolidate the health sector, but also to increase insurance inclusion by incentives through contribution rates and bases and other employer benefits, it is necessary to undertake measures to improve the contribution collection in the forthcoming period in the entire Federation. Establishing a registration system of contribution payers and contribution collection control for the entire Federation of Bosnia and Herzegovina, as proposed through SITAP, would contribute to that. Moreover, we believe that health care should be subsidized by the resources collected through VAT. In addition, as it is done in other countries, it is necessary to allocate the certain percentage from excise taxes on tobacco and alcohol, which are harmful to health, for social and health care programmes.

Besides improving the compulsory health insurance, which should be used to fund the basic package of rights, it is necessary to develop complementary and voluntary health insurance. Also, the FBiH Government should in the upcoming period perform its legal obligation, i.e. pay the full amount to the solidarity fund for the determined programmes, for the purpose of the solidarity fund's stability and expanding the risk sharing among the rich and the poor.

4.2.2. DISTRIBUTION OF FINANCIAL RESOURCES AND SERVICE PROVIDER PAYMENT SYSTEMS

Collection and distribution of resources from compulsory health insurance, i.e. the purchase of health services is the competence of cantonal funds.

The system of contracting and funding the provided health services varies across cantons. Most of the cantonal health insurance funds make contracts based on the annual budget based on the historical expenditures transferred from the previous period (for salaries and material expenses). Although it is a simple and acceptable model in terms of planning and distribution, it does not give an opportunity for adequate control of the provision of the scope and quality of provided health services. At the same time, it is discouraging for health institutions in terms of rationing. A certain number of funds perform the funding of health care based on the programmes determined in line with the standards and norms, which enables a form of better control. The Federation Institute for Health Insurance and Re-Insurance performs funding based on the health care programme, i.e. at the health service prices.

Health service funding, records on achieved results, systems of control, evaluation and reports are not well balanced, which is why the indicators on achieved results and successfulness in providing health care in individual cantons, and specifically in health institutions may not be adequately evaluated and controlled. The biggest downside is the absence of spending by HIF member categories, which is very important for establishing the policies, both in the field of international agreements and in the country.

According to the data from the Overview of Accounts for 2006, the total expenditures presented in the health sector amounted to 1,004,403,211 KM, out of which amount 877,851,110 KM went to health care. The spending increased by 6% in relation to the previous year. Costs of health care professionals amounted to 43% in the overall expenditures, while 26% went for the costs of medicines, and the rest for all other costs.

In the scope of the overall spending presented by forms of health care, 15.8% was spent on primary health care, 10.7% on drugs dispensed by a prescription, 31.6% on hospital health care, 6.5% on consultative – specialist services, 0.8% on treatment abroad and 1.9% on sick leave over 42 days. Allocations for primary health care show the decreasing trend, while the costs of hospital health care are increasing at the same time, which is contrary to the previous reform commitments.

This is where we must emphasise the negative effects of VAT in the health sector in 2006 and 2007, which were obvious and resulted in negative financial effects on health institutions and certain funds. This is because health institutions and HIF, which are not taxpayers pursuant to the VAT Act, do not have the right to VAT refund for all the things on which VAT was paid (medicines, expendable supplies, energy sources, food, etc.).

Average total spending from the compulsory health insurance per HIF member in the Federation of BiH in 2006 amounted to 370 KM and was higher by 11% in relation to 2005. Studied by cantons, significant differences could be observed and the average spending ranged from 251 KM in the Central Bosnia Canton to 592 KM in the Sarajevo Canton. Average consumption of drugs dispensed by prescription in 2006 amounted to 55 KM and was higher by 22% in relation to 2005. Average expenditures on prescription drugs ranged from 23 KM in the Herzegovina-Neretva Canton to 118 KM in the Sarajevo Canton.

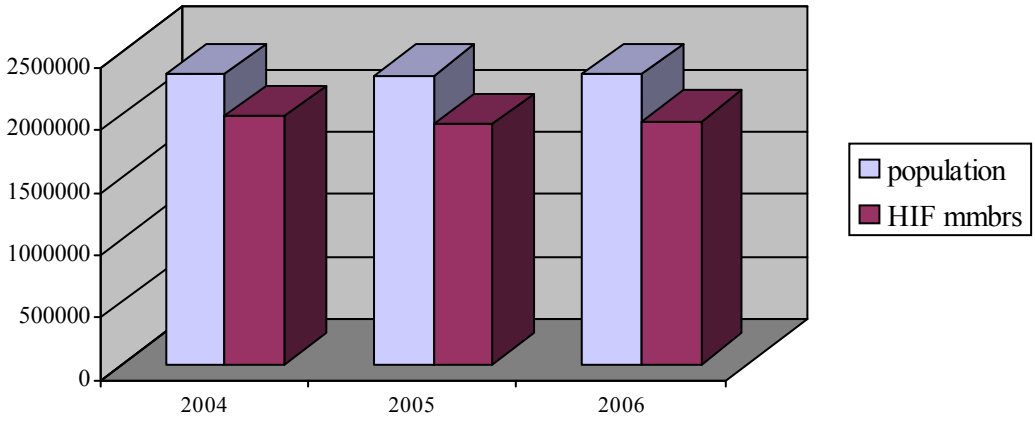
These indicators suggest the flaws in the system of management and use of health-related resources in public health institutions. This is why changes are necessary in the upcoming period in the manner of contracting and funding the services by establishing uniform criteria. It also calls for the allocation of greater resources in accordance with the reform commitments for primary health care, development of well-balanced control system, evaluation and reporting.

4.2.3. EQUAL ACCESS AND COVERAGE OF HEALTH INSURANCE

One of the important goals of health policy is primarily to ensure equitable health care to HIF members, seen through the prism of coverage and equitable funding.

According to the valid legal provisions, there should not be the population without health insurance coverage, but unfortunately, the laws are not obeyed. Health insurance coverage in 2006 in the Federation of BiH was 84%, or 1,954,460 HIF members and their family members. If we compare this to the total number of inhabitants in FBiH (according to the Federation Institute of Statistics) which amounts to 2,327,466 inhabitants, it derives that 373,006 Federation inhabitants do not have health insurance or access to exercising the health rights.

The following diagram shows the health insurance coverage in the period 2004-2006:



Observed by cantons, the differences in health insurance coverage in 2006 varied from 63% in the Herzeg-Bosnia Canton to 93% in the Sarajevo Canton.

The principle of equality and availability is also disturbed in terms of the amount of realised spending per HIF member in exercising the health rights and right to prescription drugs at the expense of health insurance. The differences in average consumption of prescription drugs within cantons are extremely big, which can be seen in the following table (Table 1):

R.br.	Kanton	2004.			2005.			2006.		
		Br.sig.lica	Prosj. potrošnja iz ob. osig. po osig. licu	Prosj. potr.na recept po osig.licu	Br.sig.lica	Prosj. potrošnja iz ob. osig. po osig. licu	Prosj. potr.na recept po osig.licu	Br.sig.lica	Prosj. potrošnja iz ob. osig. po osig. licu	Prosj. potr.na recept po osig.licu
1	*Unsko-sanski*	*204.275*	*260*	*24*	*205.034*	*269*	*31*	*206.841*	*294*	*38*
2	*Posavski*	*30.758*	*385*	*23*	*30.984*	*355*	*24*	*31.286*	*375*	*27*
3	*Tuzlanski*	*433.216*	*274*	*35*	*445.555*	*327*	*38*	*446.830*	*323*	*56*
4	*Zeničko-dobojski*	*391.491*	*214*	*27*	*337.476*	*257*	*35*	*344.763*	*294*	*36*
5	*Bosansko-podrinjski*	*24.307*	*307*	*44*	*25.727*	*323*	*48*	*25.975*	*361*	*58*
6	*Srednjo-bosanski*	*223.151*	*199*	*20*	*220.757*	*212*	*21*	*212.399*	*251*	*25*
7	*Hercegov.-neretvanski*	*166.558*	*380*	*17*	*171.674*	*347*	*19*	*179.151*	*402*	*23*
8	*Zapadno-hercegovački*	*69.990*	*255*	*19*	*60.754*	*319*	*32*	*65.756*	*340*	*41*
9	*Sarajevski*	*398.172*	*490*	*87*	*387.600*	*508*	*98*	*389.715*	*592*	*118*
10	*Hercegbosanski*	*47.854*	*328*	*24*	*49.206*	*315*	*20*	*51.744*	*316*	*35*

Besides the health insurance coverage, availability of health care, as one of the parameters of equality depends on the size of individual canton territories, health institution network, degree of infrastructural development and connectedness of territories, and it varies across cantons, so, as it can be seen from the analysis of providing services, inequality is present in this respect too.

The time of waiting for specific services may not be expressed quantitatively because there are no records of that type of data, apart from some programmes of the Federal Solidarity Fund, which are implemented in the entire Federation of BiH territory and for which there are no waiting lists. Based on those lists, one can determine the period of waiting for provision of health services, although they are not entirely respected.

For achieving equality in exercising the health rights from compulsory health insurance, the Federal Ministry of Health initiated activities within SITAP related to the creation of the “basic package”, which also includes the essential drug list, as well as orthopaedic aids.

Apart from the previously proposed measures that would improve the collection, distribution and control of financial resources, and increase the coverage of compulsory health insurance, it is necessary to intensify activities for adopting the “basic package” and defining financial resources for it.

Furthermore, in order to improve equality and availability, it is necessary to define a network of health institutions, taking into account the specificities of each canton, as well as to establish the mechanisms of the transfer of rights on account of health insurance between the cantons and entities.

4.2.4. FINANCIAL AND HEALTH CARE INDICATORS

NO.	INDICATORS	2006
1	Degree of health insurance coverage	83.97%
2	Total resources in FBiH health care	999,606,049
3	Total resources in health care per capita	429
4	Total resources in health care per HIF member	511
5	Total resources in compulsory health insurance	760,491,486
6	Total resources in private sector	130,542,038
7	Total health spending in FBiH	1,004,403,211
8	Total spending in compulsory health insurance	739,414,016
9	Total spending in private sector	126,552,101
10	Total health spending as % of GDP	8.,8%
11	Total health spending per capita	432
12	Total health spending per HIF member	514
13	Spending charged to the compulsory health insurance as % of the total health spending	73.6%
14	Public sector spending as % of the total health spending	90.6%
15	Hospital spending funded from the compulsory health insurance as % of the total health spending	31.6%
16	Pharmaceutical spending as % of the total health spending	25.4%
17	Pharmaceutical spending per capita	110
18	Prescription drug consumption per HIF member	55
19	Salaries and other personal income in health institutions as % of the total health spending	42.9%
20	Depreciation as % of the total health spending, etc.	4.7%

4.3. RESOURCE GENERATION

4.3.1. HUMAN RESOURCES

Human resources have the main role in improving the health sector and are essential to the successful implementation of the health care reform. There is a great body of evidence that the number, qualifications and quality of health professionals, as well as their regional distribution, correlate with positive outcomes of children and mothers' survival rate, cardiovascular diseases, immunisation coverage, greater coverage of primary health care, etc. It is no less important that a significant part of the budget allocated for health care goes for human resources.

Employees in FBiH health care in 2005 and 2006
Rate per 100,000 inhabitants

	2005	2006
Health professionals	694	710
Health care associates	15	15
Administrative staff and technicians	155	154
Support staff	174	164
Total employees	**1038**	**1043**

The total of 24,273 persons was employed in the health sector in the Federation of BiH in 2006, which is 6.2% of the total number of employees in the Federation. Out of the total number of health care employees, one third of them are administrative staff, support and technical staff, and their representation in relation to the surrounding countries is greater despite the rise in their number by 6% in relation to the previous year.

Women traditionally make up the largest number of employees in health care with two thirds of all employees, but according to the available data, they are very little or not at all represented in managerial structures of health institutions.

Health professionals in FBiH in 2006 rate/100 000 inhabitants		
	Federation of BiH	**European average**
Medical practitioners (total)	167	261.2
General practitioners	22	102
Dental practitioners	25	40.8
Pharmacists	13	42.3
Medical technicians	505	547.5

Out of the total number of medical practitioners, most of them (75.6%) are specialist in various disciplines. 50% of all medical practitioners work in hospital health care, which is a 6.5% increase in relation to 2005. One third of the total number of medical practitioners work in primary health care, out of which number 65% are specialists. This high percentage of specialists in primary health care is the result of primary health care organisation.

463 dental practitioners are employed in the Federation of BiH (23/100,000 inhabitants), 263 pharmacists (13/100.000 rate), 11,300 technicians (496/100.000 inhabitants).

It can be noticed from the above table that the number of health professionals per 100.000 inhabitants is considerably smaller in relation to the European average. The number of dental practitioners and pharmacists is lower because, upon rule, they opt for private practice, for which no systematic data have been collected yet. A smaller number of students enrolling in such faculties also contribute to this.

The data on the average rate of technicians quoted in the table include the personnel of all qualification profiles with secondary, college and university education (nurses/technicians, obstetricians/midwives, physiotherapists, laboratory, sanitary, pharmaceutical and dental technicians, etc.) and they do not provide the actual information about the number of direct health care providers (nurses/technicians and obstetricians).

There is geographical inequality in the distribution of medical personnel of all qualification profiles between cantons, within the cantons themselves, rural and urban areas, i.e. between economically richer and poorer areas. For instance, the biggest number of medical practitioners is present in the Sarajevo Canton, and the smallest number of them is in the Una-Sana Canton. This can be explained not only by the lack of good planning, but also by the migrations caused by the economic situation in the country.

No formal, permanent or stable mechanisms of personnel planning have been established in the Federation of Bosnia and Herzegovina. Given the constitutional structure of the FBiH which results in health care system decentralisation, these mechanisms are missing at the central level (Federation level) and at the level of cantonal administrations (cantonal assemblies, governments and ministries of health). Planning is currently done at the level of health institutions and is based on the degree of health professionals' workload in providing services to beneficiaries/patients.

As there are no unified records on private practice, the relevant data on the number of employees in the private sector are not available either.

Complicated and different approaches of payment to health service providers and chronic lack of financial resources in health care cause considerably low salaries of health professionals in relation to certain other occupations. There are numerous examples of dissatisfaction of health professionals and a growing number of requirements that the reform confronts them with.

4.3.2. EDUCATION OF HEALTH PROFESSIONALS

Demographic and epidemiological changes, introducing new technologies, changes in beneficiaries' expectations, changes in political and economic environment, globalisation, economic restrictions, European integration and enlargement are the challenges that both the European and FBiH health services face. With that regard, education of health professionals should be viewed as a dynamic process, which requires constant improvement and adaptation to the changes. The most important progress made in this direction is the education of doctors and nurses in family medicine.

Undergraduate and graduate curricula at schools/faculties which have mainly been taken over from the previous period must be brought in line with the reform commitments and health care needs as soon as possible, and harmonised with the EU standards including the WHO recommendations, with the EU

requirements to facilitate the mobility of labour force, and with the Bologna process.

The previous poor cooperation between the sectors of health, education and labour market slows down the reform processes. In the upcoming period, it is necessary to establish the mechanisms of coordination and closer cooperation among these sectors in order to ensure an adequate number of quality personnel.

Health care organisation and management has become a more specialised field where health care evolved, demanding specific, additional professional training. All analyses imply deficient development and qualifications of the capacities for health management that are unable to cope with the challenges and requirements deriving from the health sector reform. Those skills must be improved in all sector fields and at all health care levels, including all qualification profiles of health professionals. The Public Health Management Centre was established within the FBiH Public Health Institute under the Basic Health Project, which has educated a number of health care managers according to the international concepts and practices. However, when the project finished, activities of the Centre terminated, so it is required to establish its continued operations in the upcoming period.

4.3.3. CONTINUING EDUCATION

The changed requirements of the health care system pose new challenges to health professionals demanding their constant professional improvement. In accordance with the valid legal provisions, advanced training for the purpose of maintaining and improving the quality of health care is the right and duty of all health professionals, but also the duty of employees to provide them further improvement. Unfortunately, we still do not have a common approach to continuing medical education, nor do we have a defined permanent professional development ("lifelong learning"). Continuing education is currently provided through advanced lectures, courses, seminars, whose contents are mainly dictated by pharmaceutical companies. The level, availability and quality of additional education differ from place to place, but it must be concluded that those activities are still not implemented in the sufficient volume. Chambers and associations of health professionals should in a more significant manner initiate the implementation of continuing education. This is why it is necessary to define permanent professional development in the upcoming period, identify the implementing agencies for those activities, and identify the priority education programmes for all health professionals.

4.3.4. LICENSING AND REGULATIONS

Although it is a legal duty for all health professionals to join chambers, as well as professional associations, they have not been established in all cantons of the Federation of BiH to this day.

One of the tasks of all chambers is to conduct licensing and relicensing, which should be based on agreed criteria. Relicensing for physicians, dental practitioners and nurses was established in only a few of the ten cantons based on continuing medical education, but without any official coordination at the Federation level. There are differences in licensing and relicensing between occupations and cantons, which additionally emphasizes unsettled conditions in this important field.

The official code of ethics of certain professional chambers in the Federation of BiH, as an expression of class self-regulation, does not sufficiently keep up with the development of science and line of work, insufficiently or not at all treats the issues of medical error or patient autonomy, etc. With reference to this, it is necessary to revise the code of ethics of the medical profession and define the values of good medical practice.

The limited self-regulation of the medical profession and undeveloped institutional structures in FBiH, the evidence of which are the deficient number of professional chambers and no connection or unity between them, present the main reasons for unequal solution of the issue of medical profession regulation.

4.3.5. NURSE'S ROLE

Although the health sector reforms have been implemented for a long period, the development of nursing and obstetrics/midwifery has hardly started. Traditionally, nursing and obstetrics/midwifery are subordinated to medicine and cannot develop their own potentials to the extent required by modern medical practice. A serious obstacle to this profession's development is also the fact that nurses and obstetricians/midwives are not acknowledged as fully functional, independent professionals, nor do they have enough authority. Their public image is generally poor but it is improving. Their joint learning with other professionals is minimal. Their salaries are usually below the national average, and their career prospects are poor.

Starting from the aforementioned, the Nursing Action Plan for nurses and obstetricians in BiH was developed with the assistance from the WHO and EU. Both the FBiH Government and the Council of Ministers adopted it, and it should contribute to the promotion of nursing. Measures recommended by this plan should be the priority of this Ministry.

Even though the importance of human resources in health sector has been acknowledged, there has not been any significant progress. That is why it is required to strengthen the function of human resource planning at all levels, establish the coordination mechanisms, primarily between health, education and labour market sectors.

4.3.6. PHARMACEUTICAL SECTOR

Pharmaceuticals make up a very important segment of our and any other public health, not only for disease treatment but also for big health spending of available

resources on pharmaceuticals. The Western European countries of today, where pharmaceutical policies and strategies have for the most part been defined, spend 15% of the total health care resources on medicines, while in our country that percentage goes up to even 22%. The situation analysis mainly shows that huge financial resources are spent on medicines, which actually do not have an appropriate therapeutic value; therefore, the pharmaceutical sector, as well as the entire health care in the Federation of BiH demand reforms.

Previous analyses have implied the need for changing the concept of rational drug consumption, which includes regular drug consumption, reduced dispensing of drugs, dispensing of drugs with unproven efficacy or dispensing of the drugs effective for wrong indications. The consequences are absence of treatment effects, exposure of people to harmful effects of medicines and waste of scarce resources.

The essential drug concept was recommended by the World Health Organization with an effort to find mechanisms for most equal availability of the basic medicines to the population. The included medicines are intended to ensure the treatment of the most common diseases affecting the most population, and to be available at all times in appropriate amounts. In mid 2000, the FBiH Government adopted the Decision on adopting the essential drug list as a positive list of health insurance funds. However, availability of drugs from this list is not equal in all cantons due to the inability to finance it. The 2005 Essential Drug List is currently in effect and it contains around 200 generic drugs. A reviewed essential list is being prepared, which will be an integral part of the basic package. Hospital boards within cantonal hospitals propose the list of hospital drugs and monitor their consumption.

The drug quality assurance system includes the following as its inevitable segments: drug quality standard assessment on registration, performance of the state drug quality control laboratory, granting operating permits to producers, transporters and pharmacies, effective pharmaceutical inspection and withdrawal of faulty medicines from the market. It is necessary to apply good manufacturing practices (GMP), good pharmaceutical practices (GPP), good laboratory practices (GLP) and good clinical practices (GCP).

Rehabilitation of space and procurement of modern equipment for the FBiH Medicines Control Agency, which is available for the control of medicines in both entities, was completed in 2000 with international assistance. The FBiH Medicines Control Agency is intended to enable reliable control of medicines before placing them in the market, control of medicines already present in the market and control of domestic product quality. BiH will not work on national pharmacopoeia, but will use the European ones. This decision has been provided for by the Drugs Act.

As of the first six months of 2007, the total of 580 drugs were registered according to INN in the Federation (for the sake of comparison, there are 677 such drugs in Croatia according to the Registry no. 50/2007), 1030 drugs according to the brand names, and 2170 drugs according to dosage forms,

dosage strength and primary containers. It is estimated that over 90% of our *materia medica* has been registered so far.

It is necessary to provide a strong pharmaceutical inspection, to have it well organised and strictly respect the rules and regulations. Since the control over drugs and pharmaceutical inspection is currently deficient in FBiH, it is necessary to fix the situation.

Undergraduate **education programmes in pharmacotherapy for doctors and pharmacists** are deficient, it is necessary to review the student curricula in accordance with the national drug policy. The public should be correctly informed about the correct use of drugs, as well as about the risks and harmful consequences in case of wrong administration of drugs.

Prescribing, dispensing and administering drugs must be **monitored and evaluated.** Drugs with frequent side effects must be pointed out, as well as the institutions and doctors practicing irrational pharmacotherapy. If there is a generic equivalent with the same effects, the cheapest drug should be selected. One should opt for a more expensive drug only if the total costs of health care become lower (shorter hospitalisation, preventing the disease from getting worse, absence of side effects, shorter duration of illness).

It is necessary to speed up the process of establishing the **Drug Centre** in FBiH that would collect and analyse the latest drug information, which should be available to all health professionals and patients. It is also necessary to provide a place where all undesired reactions to drugs would be reported, as well as the reactions in the course of treatment, in the course of clinical studies, and to evaluate the Periodical Reports on undesired reactions to drugs in post-marketing period, submitted by the persons in charge of pharmacovigilance of pharmaceutical manufacturers in accordance with the regulations.

Decreasing the country's dependency on import and financial savings demands the support of domestic pharmaceutical manufacturers. However, a reliable quality control system will have to ensure European standards in drug manufacturing, while the cost-effective human potential will contribute to the preservation of domestic pharmaceutical industry.

A part of the drug selection from abroad should be registered in FBiH in order for import to be supervised by competent bodies. This will prevent any delivery of drugs of dubious origin. Essential drug groups are supplied through competitions. A uniform act for the entire BiH territory would establish better control of drug sales in the market.

In the field of passing legal provisions on drugs, it must be pointed out that regulations on drugs must ensure good quality, safety and efficacy of pharmaceutical products and regulate their availability and distribution. Passing the act on drugs and medical supplies is a priority for BiH to join the EU. The act should primarily provide Bosnia and Herzegovina with modern drug legislation and put an end to the duplication of regulatory procedures in the country this

small. The uniform act for Bosnia and Herzegovina would also mark the end of unsettled conditions in the BiH drugs market. The act has been prepared and is waiting to be passed.

4.3.7. TECHNOLOGIES IN HEALTH CARE

Huge resources were invested in the post-war period in the physical reconstruction and equipping of health institutions through donations, loans, and budgetary resources of the Federation of Bosnia and Herzegovina, the cantons and municipalities.

In line with the reform commitments, most projects were focused on strengthening primary health care, which included big investments in reconstruction, adaptation and equipping of health centres and accompanying local outpatient clinics, including the centres for mental and physical rehabilitation. Diagnostic and laboratory equipment was modernised in primary health care. Reconstruction and equipping of family medicine outpatient clinics continue within the Health Sector Enhancement Project. It is estimated that these investments will bring the technological environment of primary health care to a satisfactory level.

With regard to dentistry, dental equipment is in poor condition, extensively depreciated and obsolete. Apart from sporadic donations and health centres' own and rare investments, there have been very little investments in these services within health centres. One of the reasons for a small number of investments in dental equipment, supplies and infrastructure is the proposal of previous strategic plans to make these services the first ones to go through the privatisation process.

Unlike primary health care, the hospital sector has managed, through donations and loans, to replace only a small amount of depreciated equipment. The biggest investments were in radiology, laboratory diagnostics, orthopaedic and reconstructive surgery and gynaecology. All hospitals in FBiH must speed up the process of renewing their equipment. This is why it is necessary to create clear development plans.

Assessment of the laboratory network for supervision over infectious diseases conducted within the EU/WHO project in 2005 pointed to the main weaknesses of microbiological laboratories: facilities often require reconstruction, safe water and power supply, equipment is often missing or is obsolete and requires maintenance. Mechanisms of systematic quality control are not applied, nor those for quality assurance; biological protection standards do not exist, nor do the protection procedures, biological protection documentation or safe facilities. Formal personnel training programmes for improving the knowledge and skills do not exist, nor does the reporting of external institutions/in charge of health care results. Specific procedures for cases of epidemics do not exist, and sometimes even medical supplies are missing. A small number of laboratories are supervised, and they operate in isolation (there is no actual network, except in the case of TBC laboratories).

These are the reasons that laboratories should be reconstructed and equipped in the upcoming period, special attention should be devoted to biological protection standards, written procedures should be provided for biological protection, result-reporting analyses should also be provided, and systematic quality control should be ensured.

The data show that the medical equipment **write-off level** was 76.3% in 2006. Out of the total expenditures, 3% was spent on capital investments and 4.72% on depreciation costs, which was less than in 2005. Expenditures for capital investments in health institutions were not brought in line with the actual needs expressed through the equipment write-off rate, which directly influences the safety and quality of health services. The situation is more favourable in richer cantons where possibilities for investing in equipment are greater.

It is important to mention that there are no legal regulations on maintenance, i.e. servicing the medical equipment, and there are no rules of equipment standardisation, which again directly influences the quality and safety of health care.

4.3.8. INFORMATION TECHNOLOGY

It is hard to expect that the health care reform may be implemented without the assistance of quality health care information system.

Equipping health institutions with information equipment (hardware and software) is still disorganised and left to the desires and knowledge of individuals. Development of cantons and resources they can provide are the decisive factors in procuring equipment, without monitoring the needs of the entire health care system. A great amount of that equipment was received through donations and that is the reason why there could not have been any influence on equipment standardisation, even at the health institutions that received the equipment.

Certain kinds of equipment (CT, MRI, X-rays machine, various types of analysers) function at many medical institutions, which can autonomously process parameters they are intended for, but because they are not a part of a common information system network within the institution, they lose the advantages provided by the system (data distribution within the institution, saving data in databases, using data and information for scientific activities, etc.). Certain medical institutions and outpatient clinics possess local programmes organised on various types of databases, which are mainly used for monitoring economic parameters or health insurance data, and less or not at all used for medical or health care purposes.

Existence of databases and knowledge in all health sector levels is necessary as a basic prerequisite for connection, adequate and timely exchange of information, supported by appropriate computer and information structure. This includes vertical and horizontal exchange of data and information of all health

sector participants, passing legal provisions in the field of statistical reporting in health care, act on patient data protection, etc.

The Federation Ministry of Health has already initiated activities through the Rationing of Service Provision project (SITAP) on developing a database for hospital sector. The same activities are underway for primary health care too. All these will be important for health care monitoring, supervision and planning.

4.4. SERVICE PROVISION

In line with the Act on Health Care, health care is organised and provided at the levels of primary, specialist – consultative services and hospital health care, according to the principles of comprehensiveness, continuity, availability and integral approach, regardless of age, sex or religious background.

4.4.1. PRIMARY HEALTH CARE

One of the basic determinants of health care reform in FBiH is strengthening primary health care with the focus on health promotion and disease prevention.

Primary health care services are provided in 79 health centres with accompanying local outpatient clinics.

Research results have shown that the distance between the place of residence and the closest PHC outpatient clinic of one-half of the FBiH population (54%) is less than 1500 m; the same distance is between 1,500 and 5,000 m in one quarter of the population (24%), and 5,000 m in one fifth of the population (22%). This implies inequality of primary health care in the Federation of BiH in terms of geographical distribution.

One third of the total number of physicians in the Federation of BiH provided services in primary health care in 2006, out of which number 65% were specialists. On average, there were 1,782 inhabitants per one physician and 24 visits per day.

In relation to the first-time visits, 75.2% patients were referred to a specialist. This high percentage of referrals to specialist care is contrary to the strategic orientation of primary health care development. In the first-time visits, preventive services were provided in 31.1% cases, and according to the primary health care standards and norms, 40% working hours should be devoted to preventive services.

Regardless of the officially proclaimed equal legal rights, there are considerable differences between urban and rural areas in terms of coverage and availability of dentistry services, with extremely poor availability in rural areas. Unequal distribution of teams in relation to the number of inhabitants is also noticeable.

Despite significant health projects that were implemented or are still implemented in FBiH, which mainly focus on family medicine development and its

infrastructure, there still are some differences in the coverage by primary health care teams in cantons. The biggest number of physicians is in the Sarajevo Canton (86/100,000) and the smallest in the Una-Sana Canton (35/100,000).

The mental health reform started in the post-conflict and transitional period. It is oriented towards community-based rehabilitation. Community mental health centres were established accordingly. Due to the present needs, community physical rehabilitation centres were also established. The law does not clearly define their role, which presents a threat to those services of losing their original purpose to be active in community, and of turning into psychiatric services and physical therapy departments. In order for those centres to be able to respond to the demands and needs of the population, which are increasing daily, it is required to redefine their role through changing the Act on Health Care and passing appropriate by-laws.

It is also provided for by the law to form, in exceptional cases, maternity wards or inpatient clinics for temporary patient accommodation. Their position must be redefined in the future, in accordance with the Primary Health Care Strategy and Hospital Rationing, guided by the geographical characteristics of a certain area, as well as the needs and demands of the population.

In the end of 2006, the FBiH Government passed the Primary Health Care Strategy that is oriented towards the development of family medicine and community-based services. According to this strategic document, the key services, apart from family medicine and community-based services, are the following: mother and child health services, mental health centres, physical rehabilitation centres, polyvalent dental health care, community nurses, laboratories, X-ray diagnostics, emergency medical services and other community-based services that would be defined according to the population's needs, as well as on the basis of the opinions of the public health institutes and health insurance funds.

4.4.2. CONSULTATIVE – SPECIALIST SERVICES

Pursuant to the Health Care Act, consultative – specialist services are provided at polyclinics, hospitals and health centres. Health centres may organize these activities if there are specific needs for them, taking into account the health status of the population, or if providing health care at polyclinics or hospitals overburdens the provision of health care. Nevertheless, this possibility provided for by the Act is widely used, oftentimes unreasonably, which has led to the overgrowth of consultative – specialist services at health centres, partly as the result of inherited circumstances, and partly as the result of poor management.

On the other hand, lack of financial stimulation on purchasing services for family doctors has caused disproportion in the number of family doctors and specialists in other services and discouraged the choices of family medicine specialisation. This is why it is necessary to apply new payment mechanisms as soon as possible, and especially to encourage the health professionals at both the PHC level and other health care levels.

4.4.3. HOSPITAL HEALTH CARE

The FBiH population exercised hospital health care in 2006 in 24 hospitals (general and cantonal hospitals, clinical hospitals, clinical centres, specialist hospitals, sanatoriums, medical centres) where around 50% family doctors and 44% of all medical technicians were employed.

	EU*	FBiH
Hospitals (per 100,000 inhabitants)	2.6	1
Hospital beds	643.7	350
Annual admissions (per 100 inhabitants)	20.8	9.6
Average length of stay	8.3 days	9.2 days

*WHO data, HFA database, for EU member countries until 2007

The Federation of BiH has a significantly smaller number of hospitals per capita in relation to some European countries. There is geographical disproportion in the distribution of medical personnel of all qualification profiles between cantons, with significant differences in the number of beds per capita.

The number of hospital beds decreased in the Federation of BiH from 4.0/1000 inhabitants in 1998, to 3.5/1000 inhabitants in 2006, which is in accordance with our previous reforms and European trends. However, there are still big differences in the number of beds across cantons. The Sarajevo Canton (5.6/1000 inhabitants) and Central Bosnia Canton (5.1/1000 inhabitants) have a considerably bigger number of beds in relation to other cantons, and the Western Herzegovina Canton does not have any hospital beds.

Using hospital health care does not show any changes in relation to the previous years. The bed occupancy rate in the Federation of BiH was 69.4% in 2006. Observed by the hospital types, bed occupancy is the highest in clinical centres, which provide the most complex degree of health care (75.8%), while the lowest bed occupancy is recorded in medical centres (52.9%). The lowest bed occupancy rate is dissatisfactory in terms of efficiency.

Hospital admission rate is extremely low in comparison to the EU countries, and it was 9.6 per 100 inhabitants for the same period.

Such a deficient bed occupancy rate does not reflect the population's health status, but rather some other unfavourable factors, such as high participation of patients in treatment costs, dissatisfactory scope of services at certain hospitals, as well as the geographical unavailability of hospital beds in certain parts of FBiH.

Average length of stay in that period was 9.2 days, and it did not experience any significant changes by hospital types in relation to the previous years. The

shortest length of stay in 2006 was recorded at general hospitals (8.1 days), and the longest one at specialist hospitals (25.8 days), where health care is provided to psychiatric patients, tuberculosis patients and those suffering from chronic pulmonary diseases.

Failure to reduce the length of stay is the result of the current organisation of work at hospitals, absence of the discharge planning system, unpreparedness of outpatient services to provide appropriate post-acute care. Furthermore, most countries acknowledge that a longer period of staying in the hospital is socially and clinically undesirable, and that is why day hospitals were introduced. However, that has not become a practice in FBiH. For the purpose of providing services on the day hospital principle, it is necessary to regulate it by law.

Low hospital admission rates, length of stay and bed occupancy rates are dissatisfactory in terms of efficiency and are the result of many factors. Besides the aforementioned ones, insufficient flexibility of hospitals to redistribute the number of beds per wards, as well as the obsolete way of funding also contribute to them.

Although the data imply deficient hospital capacity utilisation, one should have in mind that we do not dispose of the data on hospital morbidity or consultative – specialist services in hospitals, which hampers a full insight into the provision of hospital services.

In order to improve the provision of hospital services in the upcoming period, it is necessary to rationalise the hospital sector, build up the hospital network equally available for acute care to everybody, improve the work organisation and management, as well as the coordination within the hospitals, but also between the hospitals and primary health care services, as well as with the social welfare sector, etc. For the purpose of increasing efficiency and improving quality, it is necessary to introduce evidence-based medicine in everyday practice. New payment mechanisms need to be established, which would enable financial sustainability of the hospital sector. To plan and implement reforms, it is necessary to improve the reporting system and form an integrated information system.

Inadequate definition of hospitals in the present legislation has been a specific problem in the process of previous reforms, and it requires thorough changes and amendments.

4.4.4. PUBLIC HEALTH

Public health in the BiH Federation is institutionally organised from the municipal to the Federation level. Public health activities at the municipal level are carried out through the Hygienic and Epidemiological Services of Health Centres, and at the cantonal and Federation level through the work of Public Health Institutes. There are only several Public Health Institutes in larger Cantons that have good infrastructure (staff, facilities, equipment), while the remainder have numerous difficulties resulting from the lack of the basic prerequisites for the self-

sustainability of Public Health Institutes. The network of the FBiH Public Health Institutes employs 431 people, 258 (60%) of which are health professionals.

The basic public health activities concern the preservation and improvement of health by planning and implementing the measures to control infectious and non-infectious diseases, ensure the quality of food, water, air and items of general use, measures of environment control, health promotion and disease prevention, as well as carrying out regular health and statistical research. Informing the general public and politicians of the leading health-related problems and priorities, as well as proposals for their solutions, constitutes a significant public health activity.

Demographic changes and epidemiological changes, increase in disabilities, rapid technological development, as well as pharmaceutical industry development, lead to an increase in health-related costs, which is the reason why all countries are undergoing health care system reforms. However, the effects of health services to the global health status are relatively limited. The health of general population is conditioned by interaction between factors linked to individual behaviour and lifestyles; social-economic and cultural level; biological factors and environment. For this reason, growing importance has been attached to the promotion and prevention of diseases, that is, to public health that should be brought closer to the community. It is therefore necessary to undertake activities in the upcoming period aimed at devising a public health strategy.

The leading diseases in the BiH Federation are those that can be prevented or cured by early detection. For this purpose it is necessary to continuously design and implement promotional and preventive programmes. This has, to the present date, been done sporadically, because so far, despite the fact that the BiH Federation's obligation is to fund promotional and preventive programmes, as is the case in other countries, the funds set aside have been minimal and insufficient to support these activities. We are of the opinion that resources to fund these programmes must be provided in the upcoming period.

One of the functions of Public Health Institutes is the collection of data and reporting. Unfortunately, we must note that this segment does not meet and does not honour commitments to reform, and should therefore be improved in the forthcoming period. In this context it is particularly necessary to emphasize the forthcoming obligations arising from the Stabilisation and Association Agreement, that is, alignment with the EU.

An important function of Public Health Institutes is to control infectious and non-infectious diseases, ensure the quality of food, water, air and items of general use, control environment. However, the equipment available to Institutes is largely outdated and insufficient. It is necessary to improve this segment of Institutes for the purpose of both the preservation of the health of the BiH Federation population and the forthcoming obligations in the context of EU integrations.

4.4.5 PRIVATE PRACTICE

The Health Care Act and the Health Insurance Act do not distinguish between the private and public sector. These Acts have allowed scope for private practice and private health care activity, but owing to the imprecise legislation regulating this issue, there is a range of outstanding status issues that have enabled a large number of abuses, causing at the same time dissatisfaction of both patients and health professionals. Private health care institutions get registered for performing one or more medical activities, while they deliver dozens of various health services. A private health care institution is registered by one or two doctors at most, while health experts, employees from public health care institutions (the so-called additional work defined by the PRSP as one of the reasons for corruption within the health care sector, i.e. deliberate and unlawful referral of patients from the public to the private sector) are engaged to provide health services. For this reason there are often significant abuses reflected in the illegal transfer of part of the costs from the public health care sector to the private health care sector.

The data on the number of employees with private health care institutions are incomplete because they do not cover all private institutions, although according to the current laws, private health care institutions are bound to deliver data to the Health Insurance Funds and Public Health Institutes. They have no self-responsibility in terms of these obligations, and the competent authorities in Cantons and municipalities do not take measures against a failure to meet the legal requirements. Also, a large number of medical staff employed with public health care institutions work for private institutions, and the possibility of private sector health care institutions failing to report staff engaged from public health care institutions as their employees is not ruled out either. A special problem is posed by the additional work of public sector doctors in private practice. This results in the provision of health services of poorer quality in the public sector, patients who wait longer for examinations, as well as “out-of-pocket” payment.

The issue of privatisation in health care will also pose one of the major challenges for the reforms, because this issue has not been regulated. The Health Care Act has given the right to the founder of a health care institution to sell, that is, rent, the facilities or part of the facilities of the health care institution, but there is no further elaboration of this provision, i.e. the manner of privatisation and rental of public health care institutions by potential beneficiaries. The Act does not provide for the obligation of issuing a by-law to further regulate these issues either.

EFFICIENCY

Given the inequality in terms of the manner of collecting and allocating health-related funds, as well as in terms of the manner of reporting and presenting achieved results, it is difficult to measure and compare the technical efficiency of the health care system. The indicators for measuring allocation efficiency are not defined either.

Regardless of that, we can claim with certainty that the currently applicable health care system is not sufficiently efficient, which is primarily reflected in the relatively high share of health care spending in the GDP (8.8%), while on the other hand, the health status of the population has been assessed as poor in many ways. It is the reflection of high costs resulting from the structure fragmented at several levels, inefficient allocation of expenditures, clinically inefficient approaches to care and a poor health care sector management system.

The share of allocations for primary health care has had a declining trend over the past few years, while the allocations for drugs dispensed by a prescription and hospital health care have increased, which is contrary to the intentions and proclaimed health care reforms.

On the other hand, the length of stay in hospitals is unfavourable, the bed occupancy rate is low, the number of hospital admissions is low. Same day surgery (surgical interventions performed on the same day) is sporadically practised, there is no discharge planning system, which may speak of a poor clinical practice. Furthermore, we do not have developed outpatient services for post-acute hospital care, which affects the length of stay in hospitals.

Significant fragmentation and poor links between different levels of health care result in the frequent repetition of diagnostic tests and procedures, and uneconomical use of drugs. The absence of clinical pathways and clinical guidelines, and non-compliance with these, contribute to this.

The reforms so far have almost exclusively been aimed at providing services by public institutions, although the legislation also allows the provision of services by private institutions. Health insurance does not cover the services provided by the private sector. However, the data show that more than 10% of patients needing ambulatory services have used private service providers.

In midterm, health planning and the rationalisation of the service providers' system should take into consideration the increasing importance of the private sector, given the fact that it may provide the possibility for the withdrawal of the public sector from certain areas, thus releasing funds for ensuring a better access to care for vulnerable groups.

With the aim of enhancing the efficiency, apart from the aforementioned measures, it is necessary in the upcoming period to establish a better coordination between the private and public sector, all levels of health care, and within the same institution, strengthen the managerial skills within both health care institutions and the entire health care system, practise evidence-based medicine, introduce and develop health care institutions' network, as well as new technologies and services, in a planned manner, establish a single reporting and records system, including the definition of indicators for monitoring technical and allocation efficiency.

QUALITY OF HEALTH CARE

The improvement of the quality of health services has had an important role in the health care system reform and the provision of services in the BiH Federation.

The Health Care Act guarantees all citizens the right to accessible health services of standard quality and equal content. The quality of health services is ensured through internal professional control measures, inspection and the right of a citizen to complain about the quality.

There is evidence suggesting that the approach to “quality control” through inspection does not stimulate the improvement-oriented behaviour, but leads to blame and punishment, which do not motivate staff and managers. It has also been proved in the BiH Federation health care system that this approach can not contribute to improving quality. The Federation Ministry of Health has therefore launched activities, within the project “Basic Health”, aimed at establishing a system to improve health care quality. The result of these activities is the document “Policy on Health Care Quality and Safety in the Federation of Bosnia and Herzegovina”, which constitutes the main framework for guidelines, strategic planning and management, as well as for the overall activities aimed at improving the quality of health care. Some of the issues of the Policy are addressed in the Act on Quality and Safety Improvement System and Accreditation in Health Care. The Act regulates the system of improving the quality and safety of health services, the health care institutions accreditation procedure on a voluntary basis, and identifies the participants in improving the quality and safety of health services. Pursuant to the Act, the Agency for Health Care Quality and Accreditation (AKAZ) has been established as an authorised body in the field of improving quality, safety, and accreditation.

In cooperation with international partners, AKAZ has developed the quality standards for all health care levels – hospitals, health centres, and family medicine teams. A significant number of those standards concern human resources management. Regardless of the development of the accreditation standards, in practice the clinical standards still concern the structure and resources (e.g. beds, staff, equipment), and not the way they are used, or what results are achieved at the level of service providers or population level.

The recently completed analysis of the hospital sector within the SITAP project sub-component “Rationing Health Services” has shown that there are many examples of the insufficient practice of evidence-based medicine, and that guidelines and clinical pathways are not used in clinical practice. However, some Cantons, as well as some health care institutions, have begun to develop clinical practice guidelines at their own initiative on the basis of relevant international documents. These individual activities have proved insufficient for a wider practice of evidence-based medicine. The process has not been coordinated from a single centre, which pointed at the need to establish a single Federation system for the development, adaptation and implementation of clinical guidelines in the upcoming period. The Federation Ministry of Health has therefore launched

activities aimed at designing clinical pathways for hospital and primary health care.

Despite the establishment of the regulatory framework for the improvement of the quality system, and the establishment of AKAZ, no significant progress has as yet been made in this respect. The inadequate use of medical technologies, unacceptable level of performance, practice and outcome variances, unnecessary costs resulting from a poor service quality, lack of performance indicators, insufficiently developed risk management system – patient adverse events, are still present. Health professionals are insufficiently educated and trained in the field of quality improvement. On the other hand, the quality of health services has not been recognized by health service financiers either, there is therefore no stimulation aimed at improving quality.

The implementation of the Policy and the Act on Quality has so far been unsatisfactory. There are no mechanisms at the Federation, Canton and level of service providers for the systematic adoption, dissemination and supervision of practice in everyday work, which partly results from insufficient cooperation between AKAZ and other participants in the quality system.

In the upcoming period, it is necessary to consistently implement the Policy and the Act on Quality and Safety Improvement System and Accreditation in Health Care, improve the organisation of safety and quality structures, and the coordination mechanisms of all participants. It is necessary to improve the information system for quality, establish institutional and professional self-regulation and enhance professional competences and ethics. The Federation Ministry of Health, in coordination with other participants, should further develop and implement clinical guidelines and pathways, and in cooperation with Health Insurance Funds, introduce quality stimulation. It is also necessary to pay due attention to the further development of AKAZ.

CAPACITY TO RESPOND TO NON-MEDICAL NEEDS

Despite the reforms advocating increased public involvement in making decisions, as well as respect for patients' rights, it must be noted that no major progress has been made in this respect. Closely related to this is the issue of the protection of patients' privacy, protection of personal information and confidentiality. Although the European Charter of Patients' Rights, as well as our legislation, explicitly protects these rights, there are still cases, though not frequent, of disclosing information without prior consent of the patient.

In terms of the patients' right to be involved in making a decision on the form and manner of therapy administration, some progress has been made recently, but a lot needs to be done in order to make this a universal rule.

Although the Health Care Act stipulates that care for one's own health is a duty of every individual, the number of educational actions or programmes to support this is not sufficient.

Access to social support networks– access to family and friends – by people receiving treatment, is underdeveloped in the Federation of Bosnia and Herzegovina. Social support networks are not developed, which is the result of the generally underdeveloped social welfare sector, as well as the insufficient awareness of the need to establish such networks even under the conditions where the existing resources allow that.

Strengthening the awareness of health as a fundamental human right, as well as information of patients' rights to timely and accurate information on their condition and the selection of treatment should be part of the activities of any health care system, including ours.

CONSUMERS' SATISFACTION

Although researches into patients' satisfaction have become a standard for Western Europe, they are sporadically carried out in the BiH Federation. One such research was carried out within the Basic Health project in 2004 through interviews with health care consumers and employed health professionals.

The general assessment of the sector given by consumers is that the health care system is in an equally bad position and situation as the environment where they live. The consumers are of the view that health care services are expensive, frequently of poor quality, that prices of drugs are too high, and that the essential drug list is not satisfactory in terms of quality and variety, and is not in accordance with the real consumer needs. The treatment and diagnosis procedures often take too long and the consumers are of the view that they spend more time and money than necessary.

A part of consumers share the opinion that doctors' attitude is poor, the reason for which they see in their insufficient work motivation, caused by law incomes, as well as simultaneous work in private health care institutions, which results in neglecting the work in the public sector. They consider bribe and corruption a reason for poor-quality and untimely services, which particularly concerns secondary-level doctors.

Respect for consumers' privacy and protection of their dignity is often not provided (absence of partitions and screens, facilities that are not sanitary sound, etc.), which particularly concerns members of very vulnerable and marginalised groups. This is often followed by a stigma and discrimination against certain groups of patients or patients suffering from a certain disease.

Working conditions in health care institutions are thought to be poor, equipment outdated, cleanliness, food quality, appropriate diets or nutrition rules in what we call "hotel accommodation" in hospitals are not conformed to.

As for the availability of primary level health services, health professionals and consumers share the view that the financial requirement constitutes the main reason that makes differences in the unavailability of health care to consumers,

and all those who do not have sufficient incomes find themselves in a situation where they can not afford health care.

BASES FOR SETTING STRATEGIC OBJECTIVES

The bases for setting strategic objectives have derived from the SWOT analysis (strengths, weaknesses, opportunities and threats).

SUMMARY OF HEALTH CARE SYSTEM'S STRENGTHS AND WEAKNESSES

INFORMED MANAGEMENT	
Strengths	***Weaknesses***
• *Health care system legal framework defined* • *Public administration reform* • *Primary Health Care Strategy adopted by the BiH Federation Government* • *Nursing Action Plan adopted by the BiH Federation Government* • *SITAP project recommendations*	• *Current laws and by-laws not aligned with commitment to reforms and EU* • *Non-compliance with the rule of law* • *Insufficient functional connection and coordination between de-centralised levels of authority* • *Fragmentation and absence of coordination between certain health care sector "sub-systems"* • *Lack of appropriate managerial skills at all levels* • *Deficient mechanisms for protection of patients' rights and their promotion, as well as unregulated rights and obligations of health professionals* • *Deficient monitoring and evaluation system*
FUNDING AND ALLOCATION OF FINANCIAL RESOURCES	
Strengths	***Weaknesses***
• *Health care sector does not compete with other sectors in governments* • *Entire BiH Federation territory covered by cantonal non-competitive health insurance funds* • *Resource pooling at BiH Federation level with the Solidarity Fund*	• *Disproportion between available funds and guaranteed rights* • *Inadequate allocation of resources to health care levels* • *Undeveloped mechanisms for contracting and payment of health services* • *Absence of necessary additional mechanisms for health care funding* • *Negligence of the control and audit function in the financial operations of*

	health functions • *High VAT share in health care spending* • *Deficient monitoring of health care spending* • *Deficient coverage by compulsory health insurance* • *Lack of basic rights package*
GENERATING RESOURCES	
Strengths	***Weaknesses***
• *Well-educated health professionals*	• *Unequal distribution of human and technological resources* • *Lack of resource planning in health care in accordance with needs* • *Absence of coordination between educational system, labour market and health care system* • *Absence of a single ICT strategy* • *Lack of information and communication technologies* • *Absence of equipment standardisation* • *Underdeveloped drugs supply and distribution system* • *Inequality in use-of essential drug list*
SERVICES	
Strengths	***Weaknesses***
• *Advanced primary health care reform through family medicine model* • *Sufficient availability of health care institutions' facilities* • *Agency for Quality and Accreditation in Health Care established*	• *Inequality in distribution of health services* • *Dominance of treatment over preventive-promotional activities* • *Absence of public-private partnership* • *Non-integration of private sector in health care system* • *Insufficiently developed mechanisms for following patients through health care system* • *Lack of indicators for measuring quality and efficiency in health care system* • *Uneconomical use of existing resources* • *Undeveloped health services safety and quality system*

SUMMARY OF ENVIRONMENTAL OPPORTUNITIES AND THREATS	
Opportunities	***Threats***
• *Support by international institutions* • *More active involvement of civil society in reform processes* • *Process of European Union association* • *Educational system reforms commenced* • *Adoption of Social Inclusion Strategy* • *Identifying possibilities for VAT refund in health care sector* • *Development Strategy of Bosnia and Herzegovina*	• *Political instability* • *Demographic changes (depopulation, population aging, existing migrations)* • *Epidemiological changes (emergence of new diseases, increase in non-infectious chronic diseases)* • *Risk factors from environment (water, air, waste, mines, etc.)* • *Absence of census* • *Rise in unemployment* • *Lack of support to development of "healthy public policies", as well as involvement of other sectors in implementation of health policies* • *Lack of political will to introduce changes and health professionals' resistance to reforms* • *Macroeconomic indicators may undermine the financial power of health insurance funds, such as lower GDP growth, decrease in health insurance contributions rate*

All the aforementioned weaknesses ensuing from the health care system analysis result from the current health care system organisation, poor management, insufficient commitment to the development and planning of human and technological resources, as well as from a range of problems arising from ensuring and collecting funds to finance health care. Although a significant progress has been made, the necessary level of solidarity has not as yet been achieved.

One should not forget the political establishment of the Federation of Bosnia and Herzegovina either, where the role of the policy and law maker is given to the BiH Federation with a consensus from the Cantons, while the Cantons are given the role of the policy and law implementing agency, as well as the role of the majority financier, which contributes to the mentioned weaknesses.

The current situation is also significantly affected by external factors such as the social and economic situation, demographic and epidemiological changes, poor involvement of the local community, insufficient awareness of the importance of

health for the economic and any other development of the country, as well as the poor inter-sectoral cooperation.

All the above mentioned weaknesses result in the unequal availability of health care between Cantons, socio-economic and other excluded categories of population, as well as in the insufficient efficiency and quality of both the system and health services, which affects the health status of the population.

Over the past years, progress has been made in terms of the development of the BiH Federation health care system as a result of the implementation of the reform strategic plans from the previous period. However, the results of the analysis indicate that it is necessary, in the upcoming period, to undertake a series of activities and put in effort aimed at the further development of the health care system that will be accessible, efficient, of good-quality and comparable to the EU countries. In order to attain this goal it is necessary to have the active involvement of all levels of the BiH Federation authorities, all participants in the health care system, as well as society in general.

VISION

IMPROVED HEALTH STATUS OF POPULATION THROUGH EFFICIENT, ACCESSIBLE AND TRANSPARENT HEALTH CARE SYSTEM THAT IS QUALITY-ORIENTED, BASED ON THE PRINCIPLES OF SOLIDARITY AND EQUITY

6.1 PRINCIPLES AND VALUES

The Health Care System Reform Strategy is based on the general principles and values agreed on during the 1996 Ljubljana Conference of WHO European Region and signed by all member countries, including BiH. The principles and values below will enable the attainment of the defined vision.

- driven by values: health care reforms must be governed by the principles of human dignity, equity, solidarity and professional ethics.

- targeted on health: any major health care reform should relate to clear targets for health gain. The protection and promotion of health must be a prime concern of all society.

- centered on people: health care reforms must address citizens' needs taking into account, through the democratic process, their expectations about health and health care. They should ensure that the citizen's voice and choice decisively influence the way in which health services are designed and operate. Citizens must also share responsibility for their own health.

- focused on quality: any health care reform must have as its aim – and include a clear strategy for – continuous improvement in the quality of health care, including its cost-effectiveness.

- based on sound financing: the financing of health care system should enable such care to be delivered to all citizens in a sustainable way. This entails universal coverage and equitable access by all people to the necessary care. That, in turn, requires the efficient use of health resources. To guarantee solidarity, governments must play a crucial role in regulating the financing of health care systems.

- oriented towards primary health care: reforms, with primary health care as a philosophy, should ensure that health services at all levels protect and promote health, improve the quality of life, prevent and treat diseases, rehabilitate patients and care for the suffering or terminally ill. They should reinforce joint decision-making by the patient and care provider and promote the comprehensiveness and continuity of care.

GENERAL STRATEGIC OBJECTIVE

Improve access, quality and efficiency of health care of population led by increasing solidarity and decreasing inequity.

Increase access

Ensure that health services and information may be obtained when and where necessary. Therefore, physical distance, socio-economic differences, cultural and bureaucratic obstacles should not hinder access to appropriate health care.

Enhance safety and quality of health services

Ensure purchase, development and use of services and facilities meeting the highest possible standards of quality and safety throughout the entire health care system. The staff will therefore be adequately educated, services will be adjusted to needs and the best practice, while the facilities and equipment will match the purpose.

Improve efficiency

The improvement of efficiency in the process of collection, allocation and management of available resources (financial, human, technical) will result in achieving their optimal utilization, ensuring better-quality health care for all citizens.
With the aim of building a reformed health care system, it is necessary by attaining each of these objectives to define a certain number of sub-objectives and interventions. These are discussed in the following sections.

Increase solidarity

Ensure that money and other resources in the health care system are equitably allocated, in accordance with needs. Risks will therefore be divided in an adequate way, between the relatively rich and poor, the sick and healthy, while the physically and economically weaker will not carry too heavy burden.

Decrease inequity

Ensure that appropriate health care is delivered to those who need it.
Relative wealth, position, orientation and other external factors should therefore not influence access to health care.

SPECIFIC OBJECTIVES

The vision and the general objective will be attained through the implementation of specific objectives that directly influence the strengthening of the four levers of the health care system: informed management, health services, resources and financing, and these are:

1. **strengthening mechanisms necessary for the establishment of efficient and informed health management**
2. **alignment of the legislative framework with reform objectives and EU regulations**
3. **strengthening the protection of patients' and health professionals' rights**
4. **improvement of health care system management**
5. **strengthening primary health care oriented to family and community based on the promotion of health and prevention of diseases**
6. **rationalisation of specialist-consultative and hospital health care**
7. **strengthening the role of public health**
8. **strengthening human resources in health care system**
9. **improvement of the pharmaceutical sector in order to ensure optimal access to efficient, safe, good-quality and cost-effective drugs**
10. **improvement of health care technologies management**
11. **improvement of contracting and health service payment system**
12. **by pooling risks, increasing solidarity – to improve equity in financing heath care**
13. **increase health insurance coverage**

	SYSTEM FUNCTION – INFORMED MANAGEMENT				
NO: 01	• SPECIFIC OBJECTIVE: *STRENGTHENING MECHANISM NECESSARY FOR ESTABLISHMENT OF EFFICIENT AND INFORMED HEALTH MANAGEMENT*				
NO.	**ACTIVITY**	**RESOURCES**	**RESPONSIBILITY**	**TIME PERIOD**	**EXPECTED RESULT**
1.	IMPROVING MECHANISMS OF COORDINATION BETWEEN ENTITIES AND BRČKO DISTRICT	HUMAN INFORMATION AND COMMUNICATION TECHNOLOGIES (ICT) FINANCIAL	ENTITY MINISTRIES OF HEALTH BRČKO DISTRICT HEALTH DEPARTMENT BIH MINISTRY OF CIVIL AFFAIRS	12 MONTHS	DOCUMENTS ON COORDINATION THROUGH CONFERENCE OF MINISTERS ADOPTED
2.	ENSURING MECHANISMS OF COORDINATION BETWEEN CANTONS AND FBIH IN THE FIELD OF HEALTH CARE	HUMAN ICT FINANCIAL	FMoH CMoH HIF PHI	6 MONTHS	FULL COORDINATION ESTABLISHED BETWEEN FMoH AND CMoH THROUGH DEFINED PROTOCOLS OR OTHER DOCUMENTS ON COOPERATION
3.	STRENGTHENING COOPERATION WITH OTHER SECTORS OF INTEREST TO HEALTH CARE	HUMAN ICT FINANCIAL	BRANCH MINISTRIES	36 MONTHS	COOPERATION WITH OTHER SECTORS ESTABLISHED
4.	STRENGTHENING COOPERATION WITH CIVIL SOCIETY	HUMAN ICT FINANCIAL	FMoH CMoH NGO	12 MONTHS	IMPROVED COOPERATION WITH CIVIL SOCIETY IN THE FIELD OF HEALTH CARE

5.	IMPROVING PUBLIC RELATIONS	HUMAN ICT FINANCIAL MEDIA	FMoH CMoH PHI HIF HEALTH CARE INSTITUTIONS	24 MONTHS	PUBLIC RELATIONS STRATEGIES DEVISED PUBLIC RELATIONS (PR) OFFICERS EMPLOYED IN FBIH HEALTH CARE IMPROVED COOPERATION WITH THE PUBLIC
6.	RAISING ALL REFORM PARTICIPANTS' AWARENESS OF THE IMPORTANCE OF REFORM	HUMAN ICT FINANCIAL MEDIA	FMoH CMoH PHI HIF HEALTH CARE INSTITUTIONS	60 MONTHS	ALL PARTICIPANTS AWARE OF REFORM PROCESSES AND INVOLVED IN DECISION-MAKING PROCESSES

	SYSTEM FUNCTION – INFORMED MANAGEMENT				
NO: 02	• SPECIFIC OBJECTIVE*: ALIGNING LEGISLATIVE FRAMEWORK WITH REFORM OBJECTIVES AND EU REGULATIONS*				
NO.	**ACTIVITY**	**RESOURCES**	**RESPONSIBILITY**	**TIME PERIOD**	**EXPECTED RESULT**
1.	ADOPTION OF PRIORITY POLICIES AND STRATEGIES FOR HEALTH CARE SECTOR	HUMAN (EXPERT GROUPS) FINANCIAL	FMoH	CONTINUOUS	POLITICAL AND STRATEGIC DOCUMENTS ADOPTED
2.	ADOPTION OF NEW HEALTH CARE ACT	HUMAN (EXPERT GROUPS) FINANCIAL	FMoH CMoH	24 MONTHS	NEW HEALTH CARE ACT ADOPTED
3.	ADOPTION OF NEW HEALTH INSURANCE ACT	HUMAN (EXPERT GROUPS) FINANCIAL	FMoH CMoH	24 MONTHS	NEW HEALTH INSURANCE ACT ADOPTED
4.	ADOPTION OF MISSING LEGISLATION	HUMAN (EXPERT GROUPS) FINANCIAL	FMoH CMoH	CONTINUOUS	LEGISLATION ADOPTED

	SYSTEM FUNCTION – INFORMED MANAGEMENT				
NO: 03	• SPECIFIC OBJECTIVE*: STRENGTHENING PROTECTION OF PATIENTS' AND HEALTH PROFESSIONALS' RIGHTS*				
NO.	**ACTIVITY**	**RESOURCES**	**RESPONSIBILITY**	**TIME PERIOD**	**EXPECTED RESULT**
1.	ADOPTION OF PATIENTS' RIGHTS ACT	HUMAN FINANCIAL	FMoH CMoH PATIENTS' ASSOCIATIONS	24 MONTHS	ACT ADOPTED
2.	CONTINUOUS, TIMELY AND ACCURATE PUBLIC INFORMATION OF HEALTH-RELATED RIGHTS AND OBLIGATIONS	HUMAN ICT MEDIA FINANCIAL	FMoH CMoH PHI HIF HEALTH CARE INSTITUTIONS	CONTINUOUS	ADOPTED INFORMATION STRATEGIES AT ALL LEVELS PUBLIC INFORMATION SYSTEM ESTABLISHED
3.	ADOPTION OF PROFESSIONAL SELF-REGULATION ACT	HUMAN (EXPERT GROUPS) FINANCIAL	FMoH CMoH PROFESSIONAL CHAMBERS AND ASSOCIATIONS	18 MONTHS	ACT ADOPTED
4.	STRENGTHENING FUNCTION OF CHAMBERS AND ASSOCIATIONS	HUMAN FINANCIAL	FMoH CMoH CHAMBERS AND ASSOCIATIONS	24 MONTHS	STRENGTHENED WORK OF CHAMBERS AND ASSOCIATIONS
5.	IMPROVING WORKING CONDITIONS OF HEALTH PROFESSIONALS	HUMAN FINANCIAL ICT TECHNICAL	GOVERNMENTS FMoH CMoH HIF HEALTH CARE INSTITUTIONS	CONTINUOUS	IMPROVED WORKING ENVIRONMENT

	SYSTEM FUNCTION – INFORMED MANAGEMENT				
NO: 04	• SPECIFIC OBJECTIVE: *IMPROVING HEALTH SYSTEM MANAGEMENT*				
NO.	**ACTIVITY**	**RESOURCES**	**RESPONSIBILITY**	**TIME PERIOD**	**EXPECTED RESULT**
1.	ESTABLISH MECHANISMS FOR HEALTH SYSTEM MANAGEMENT BASED ON STRATEGIC MANAGEMENT PRINCIPLES	HUMAN FINANCIAL	FMoH CMoH	60 MONTHS	LEGISLATION HARMONISED WITH ADOPTED MANAGEMENT PRINCIPLES
2.	IMPROVE WORK PROCESS MANAGEMENT BASED ON SAFETY AND QUALITY	HUMAN ICT FINANCIAL	FMoH CMoH AKAZ HIF HEALTH CARE INSTITUTIONS CHAMBERS AND ASSOCIATIONS	60 MONTHS	IMPROVED QUALITY AND SAFETY OF HEALTH CARE PROVISION
3.	IMPROVE MONITORING AND EVALUATION SYSTEM	HUMAN ICT FINANCIAL	FMoH CMoH PHI HIF HEALTH CARE INSTITUTIONS	CONTINUOUS	IMPROVED MONITORING AND EVALUATION SYSTEM AT ALL LEVELS
4.	STRENGTHEN PUBLIC-PRIVATE PARTNERSHIP	HUMAN FINANCIAL ICT	FMoH CMoH HIF HEALTH CARE INSTITUTIONS PRIVATE	48 MONTHS	PUBLIC-PRIVATE PARTNERSHIP ESTABLISHED

			PRACTITIONERS		
5.	IMPLEMENTATION OF ANTI-CORRUPTION PLAN	HUMAN FINANCIAL ICT MEDIA	GOVERNMENTS FMoH CMoH INSPECTIONS MoI HEALTH CARE INSTITUTIONS CHAMBERS	CONTINUOUS	DECREASED CORRUPTION IN HEALTH CARE

	SYSTEM FUNCTION – SERVICES				
NO: 01	***SPECIFIC GOAL: STRENGTHENING OF FAMILY AND COMMUNITY ORIENTED PRIMARY CARE BASED ON HEALTH PROMOTION AND PREVENTION***				
NUMBER	**ACTIVITY**	**RESOURCES**	**RESPONSIBLE**	**TIME FRAME**	**EXPECTED RESULTS**
1.	SET UP OF ORGANIZATIONAL MODEL IN ACCORDANCE TO THE PRIMARY CARE HEALTH STRATEGY	HUMAN FINANCIAL MATERIAL-TECHNICAL AND TECHNOLOGICAL	FBIH PARLIAMENT ASSEMBLIES GOVERNMENTS FMH CMH HCI	60 MONTHS	PHC ORGANIZATIONAL MODEL SET UP
2.	IMPROVEMENT OF REFERRAL SYSTEM EFFICACY FROM PHC LEVEL TO THE HIGHER LEVELS	HUMAN ICT FINANCIAL	FMH CMH HEALTH.INSUR.INST. PUBL.HEALTH INST. HEALTH INSTITUTIONS	CONTINUOUS	INCREASED PRIMARY HEALTH CARE EFFICACY
3.	IMPROVEMENT OF PHC RESOURCES (PERSONNEL, FACILITIES, EQUIPMENT)	HUMAN FINANCIAL	FBiH PARLIAMENT ASSEMBLIES GOVERNMENTS FMH CMH PUBL.HEALTH INST.	CONTINUOUS	CONTINUOUS IMPROVEMENT OF RESOURCES IN PHC
4.	SET UP OF FINANCIALLY SUSTAINABLE PRIMARY HEALTH CARE	HUMAN FINANCIAL ICT	GOVERNMENTS MINISTRIES OF HEALTH HEALTH INSTITUTIONS HEALTH WORKERS	CONTINUOUS	PHC FINANCIAL MECHANISMS IMPLEMENTED WITH FINANCIALLY SUSTAINABLE PHC
5.	QUALITY IMPROVEMENT IN PRIMARY HEALTH CARE	HUMAN FINANCIAL ICT TECHNOLOGICAL	FMH CMH AKAZ PUBL.HEALTH INST.	CONTINUOUS	QUALITY IMPROVED

			HEALTH.INSUR.INST. HEALTH INSTITUTIONS CHAMBERS AND ASSOCIATIONS		
6.	INTRODUCTION OF MEASURES FOR RATIONAL AND EFFICIENT USE OF PHARMACEUTICALS IN PCH	HUMAN FINANCIAL ICT	FMH CMH FII PUBL.HEALTH INST HEALTH INSTITUTIONS CHAMBERS AND ASSOCIATIONS	60 MONTHS	MORE RATIONAL AND EFFICIENT USE OF PHARMACEUTICALS ESTABLISHED
7.	LOCAL COMMUNITY INVOLVEMENT IN HEALTH CARE AND DETECTION AND/OR ELIMINATION OF RISK FACTORS	HUMAN FINANCIAL	GOVERNMENTS FMH CMH PHI HEALTH INSTITUTIONS LOCAL COMMUNITIES	60 MONTHS	LOCAL COMMUNITIES ESTABLISHED HEALTH COUNCILS AND THEY ACTIVELY PARTICIPATE IN HEALTH CARE OF THE POPULATION
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	SYSTEM FUNCTION: SERVICES				
NUMBER: 02	**SPECIFIC GOAL: *RATIONALIZATION OF SPECIALIST-CONSULTATIVE AND HOSPITAL HEALTH CARE***				
NUMBER	**ACTIVITIES**	**RESOURCES**	**RESPONSIBLE**	**TIME PERIOD**	**EXPECTED RESULTS**
1.	SET UP AND CARRYING OUT OF MEASURES FOR MORE RATIONAL AND EFFICIENT USE OF THE AVAILABLE RESOURCES	HUMAN FINANCIAL ICT	FMH CMH HEALTH INSUR INST AKAZ HEALTH INSTITUTIONS	36 MONTHS	MORE RATIONAL AND EFFICIENT USE OF THE RESOURCES
2 .	MANAGERIAL SKILLS STRAIGHTENING	HUMAN FINANCIAL	FMH CMH MANAGEMENT HOSPITAL HEALTH WORKERS	CONTINUOUS	MANAGERIAL SKILLS IMPROVED
3.	SET-UP OF NEW PAYMENT MECHANISMS FOR HEALTH CARE SERVICES IN HOSPITAL HEALTH CARE	HUMAN FINANCIAL ICT	FMH CMH HEALTH INSUR. INS. PHI HEALTH INSTITUTIONS	60 MONTHS	NEW PAYMENT MECHANISMS ESTABLISHED
4.	QUALITY AND SAFETY IMPROVEMENT IN HOSPITAL HEALTH SERVICES DELIVERY	HUMAN FINANCIAL ICT TECHNOLOGICAL	FMH CMH PHI HEALTH INSTITUTIONS AKAZ HEALTH INSTITUTIONS	CONTINUOUS	HOSPITAL HEALTH CARE QUALITY AND SAFETY IMPROVED
5.	IMPROVEMENT OF THE RESOURCES IN HOSPITAL HEALTH	HUMAN FINANCIAL ICT	GOVERNMENTS FMH CMH	CONTINUOUS	WORK CONDITIONS IMPROVED

	CARE	MATERIAL- TECHNICAL TECHNOLOGICAL	HEALTH INSUR. INS. AKAZ HEALTH INSTITUTIONS		
6.	SET-UP OF FUNCTIONAL AND EFFICIENT SPECIALIST-CONSULTATIVE HEALTH CARE	HUMAN FINANCIAL ICT MATERIAL- TECHNICAL TECHNOLOGICAL	FMH CMH HEALTH INSUR. INS. PUB.HEALTH INST. HEALTH INSTITUTIONS	60 MONTHS	EFFICIENT AND FUNCTIONAL SPECIALIST-CONSULTATIVE HEALTH CARE SET UP
7.	IMPROVEMENT OF REFERRAL SYSTEM EFFICACY FROM THE SECONDARY LEVEL TO THE TERTIAL LEVEL AND TREATMENT ABROAD	HUMAN ICT FINANCIAL	FMH CMH HEALTH INSUR. INS. PUB.HEALTH INST. HEALTH INSTITUTIONS	CONTINUOUS	SPECIALIST-CONSULTATIVE AND HOSPITAL HEALTH CARE EFFICACY AND QUALITY IMPROVEMENT

	SYSTEM FUNCTION – SERVICES				
NUMBER: 03	**SPECIFIC GOAL: *STRENGTHENING OF PUBLIC HEALTH ROLE***				
NUMBER	**ACTIVITY**	**RESOURCES**	**RESPONSIBLE**	**TIME PERIOD**	**EXPECTED RESULTS**
1.	ADOPTION OF PUBLIC HEALTH DEVELOPMENT STRATEGY AND LEGISLATION ADJUSTED TO EU	HUMAN FINANCIAL ICT	FMH CMH PUBLIC HEALTH INST	24 MONTHS	PUBLIC HEALTH DEVELOPMENT STRATEGY ADOPTED
2 .	ADJUSTMENT OF REPORTING TO THE INTERNATIONAL STANDARDS AND EUROSTAT	HUMAN FINANCIAL ICT	PUBLIC HEALTH INST	48 MONTHS	REPORTING SYSTEM ADJUSTED TO THE INTERNATIONAL STANDARDS AND EUROSTAT
3.	STRENGTHENING OF PROMOTION-PREVENTION PROGRAMS AND INTERVENTIONS FOR RISING OF AWARENESS ABOUT HEALTH SIGNIFICANCE	HUMAN FINANCIAL MEDIA	GOVERNMENTS PHI	CONTINUOUS	PROMOTION AND PROMOTION-PREVENTION PROGRAMS SYSTEM DEVELOPED
4.	ENHANCEMENT OF IDENTIFICATION, PREVENTION AND CONTROL OF ENVIRONMENTAL RISK	HUMAN FINANCIAL ICT MATERIAL-TECHNOLOGICAL TECHNICAL MEDIA	GOVERNMENTS FMH CMH PHI AUTHORITIES/PERSONS RESPONSIBLE FOR ENVIRONMENT	CONTINUOUS	SYSTEM OF IDENTIFICATION AND CONTROL OF RISK FACTOR ENHANCED WITH THE AIM OF PREVENTION AGAINST HARMFUL EFFECTS

5.	STRENGTHENING OF ECOLOGICAL AWARENESS	HUMAN FINANCIAL MEDIA	GOVERNMENTS FMH CMH ZZJZ OTHER SECTORS	CONTINUOUS	IMPROVED PUBLIC HEALTH AND ECOLOGICAL AWARENESS WITH HEALTH WORKERS AND POPULATION OF FBiH
6.	PUBLIC HEALTH INSTITUTIONAL CAPACITY DEVELOPMENT AT ALL LEVELS	HUMAN FINANCIAL MEDIA	GOVERNMENTS FMH CMH PHI OTHER SECTORS	CONTINUOUS	PUBLIC HEALTH RESOURCES DEVELOPED IN ALL RELEVANT SECTORS

	SYSTEM FUNCTION – RESOURCES				
NUMBER: 01	**SPECIFIC GOAL: STRENGTHENING OF HUMAN RESOURCES IN HEALTH CARE SYSTEM**				
NUMBER	**ACTIVITY**	**RESOURCES**	**RESPONSIBLE**	**TIME FRAME**	**EXPECTED RESULTS**
1.	SETTING UP OF THE PROCESS OF PLANNING AT ALL LEVELS ACCORDING TO THE REAL NEEDS	HUMAN ICT FINANCIAL	FMH CMH PHI HEALTH INSTITUTIONS MINISTRIES OF EDUCATION EDUCATIONAL INSTITUTIONS	48 MONTHS	PROCESS OF PLANNING SET UP
2.	EDUCATION SYSTEM IMPROVEMENT FOR ALL HEALTH WORKERS PROFILES (UNDERGRADUATE AND POSTGRADUATE)	HUMAN ICT FINANCIAL	FMH CMH MINISTRIES OF EDUCATION CHAMBERS AND ASSOCIATIONS EDUCATIONAL INSTITUTIONS	48 MONTHS	HEALTH WORKERS KNOWLEDGE AND SKILLS IMPROVED
3.	INTRODUCTION OF SUSTAINABLE AND EFFECTIVE MECHANISMS FOR HUMAN RESOURCES MANAGEMENT	HUMAN FINANCIAL	GOVERNMENTS FMH CMH PHI MIN OF EDUCATION HEALTH AND EDUCATIONAL INSTITUTIONS	48 MONTHS	MECHANISMS FOR HUMAN RESOURCES MANAGEMENT INTRODUCED

	SYSTEM FUNCTION – RESOURCES
NUMBER: 02	**SPECIFIC GOAL: IMPROVEMENT OF PHARMACEUTICAL SECTOR FOR ENSURING THE OPTIMAL ACCESS TO EFFECTIVE, SAFE, HIGH-QUALITY AND COST-EFFECTIVE DRUGS**

NUMBER	ACTIVITY	RESOURCES	RESPONSIBLE	TIME FRAME	EXCEPTED RESULTS
1.	ESTABLISHMENT OF COOPERATION WITH THE STATE AGENCY FOR PHARMACEUTICALS	HUMAN ICT FINANCIAL	BiH AGENCY FOR PHARMACEUTICALS FMH	12 MONTHS	COOPERATION ESTABLISHED
2.	IMPROVE THE SYSTEM THAT WILL ENSURE PROVISION AND DISTRIBUTION OF EFFECTIVE, SAFE AND HIGH-QUALITY DRUGS WHICH GIVE POSITIVE EFFECTS AND CONTRIBUTE TO HEALTH CARE COSTS REDUCTION	HUMAN MATERIAL TECHNICAL	AGENCY FOR DRUGS FMH CMH PHARMACIES DRUG STORES HEALTH INSTITUTIONS	48 MONTHS	SYSTEM OF PROVISION AND DISTRIBUTION IMPROVED
3.	ENABLE EQUALITY IN ACCESS TO HIGH-QUALITY, EFFICIENT, SAFE DRUGS FOR ALL THE POPULATION ON FBIH TERRITORY	HUMAN FINANCIAL TECHNICAL	GOVERNMENT FMH CMH FZE	48 MONTHS	EFFICIENT AND HIGH-QUALITY DRUGS AVAILABLE TO ALL POPULATION OF FBIH
4.	IMPROVEMENT OF DRUGS QUALITY ASSURANCE SYSTEM	HUMAN MATERIAL-TECHNICAL TECHNOLOGICAL	FMH STATE INSTITUTE OF DRUG CONTROL AKAZ	48 MONTHS	DRUG QUALITY ASSURANCE SYSTEM IMPROVED

		FINANCIAL	DRUG STORES		
5.	STRENGTHENING OF COOPERATION WITH PHARMACEUTICAL INSPECTION	HUMAN FINANCIAL ICT	RELEVANT INSPECTIONS FMH CMH HEALTH INSTITUTIONS	CONTINUOUS	COOPERATION OF FMH AND RELEVANT INSPECTIONS IMPROVED
6.	ESTABLISH MONITORING AND EVALUATION IN THE FIELD OF PHARMACY	HUMAN FINANCIAL ICT	FMH CMH DRUG CONTROL INSTITUTE PHI INSPECTORATE AKAZ DRUG STORES PHARMACIES	36 MONTHS	MONITORING AND EVALUATION SYSTEM ESTABLISHED
7.	ESTABLISHMENT OF DRUG CENTER FOR ENSURING TIMELY INFORMING ON DRUGS	HUMAN FINANCIAL ICT MATERIAL-TECHNICAL TECHNOLOGICAL	FMH CMH	36 MONTHS	DRUG CENTER ESTABLISHED

	SYSTEM FUNCTION-RESOURCES				
NUMBER: 03	**SPECIFIC GOAL: IMPROVEMENT OF HEALTH TECHNOLOGIES MANAGEMENT**				
NUMBER	**ACTIVITY**	**RESOURCES**	**RESPONSIBLE**	**TIME FRAME**	**EXPECTED RESULTS**
1.	FORMATION OF MEDICAL AND INFORMATION EQUIPMENT REGISTER IN HEALTH CARE SYSTEM	HUMAN ICT FINANCIAL	FMH CMH PHI HEAL. INSUR. INST. HEALTH INSTITUTIONS	60 MONTHS	REGISTER FORMED
2.	PLANNED INTRODUCTION OF MODERN, EFFICIENT AND COST-EFFECTIVE MEDICAL TECHNOLOGIES	HUMAN MATERIAL-TECHNICAL TECHNOLOGICAL FINANCIAL	GOVERNMENTS CMH F INSUR. INSTITUTE HEALTH INSTITUTIONS LOCAL COMMUNITY	CONTINUOUS	TECHNOLOGIES THAT ARE INTRODUCED ARE MODERN, EFFICIENT AND COST-EFFECTIVE
3.	MAKING OF PLATFORM FOR ICT DEVELOPMENT IN HEALTH CARE SYSTEM IN FBIH	POTENTIAL FINANCIAL	FMH CMH	24 MONTHS	PLATFORM FOR ICT DEVELOPMENT MADE
4.	ICT PLATFORM IMPLEMENTATION	HUMAN TECHNICAL MATERIAL FINANCIAL	FMH CMH HEALT INSUR. INST PHI HEALTH INSTITUTIONS	48 MONTHS	ICT PLATFORM IMPLEMENTED
5.	IMPROVEMENT OF TECHNOLOGY MANAGEMENT AND MAINTENANCE SYSTEM	HUMAN FINANCIAL TECHNICAL	FMH CMH HEALTH INSTITUTIONS	60 MONTHS	EFFICIENT SYSTEM FOR TECHNOLOGY MAINTENANCE AND MANAGEMENT IN HEALTH CARE SYSTEM

					ESTABLISHED
6.	ADOPTION OF CRITERIA ON TECHNICAL CHARACTERISTICS OF MEDICAL EQUIPMENT FOR PURCHASE OF EQUIPMENT IN ACCORDANCE WITH EU REGULATIONS	HUMAN FINANCIAL	FMH CMH OTHER RELEVANT INSTITUTIONS (AGENCY FOR STANDARDIZATION AND MEASUREMENT)	60 MONTHS	CRITERIA ADOPTED

	OVERALL OBJECTIVE: SYSTEM FUNCTION–FINANCING				
NUMBER: 01	**SPECIFIC GOAL:** ***IMPROVEMENT OF SYSTEM OF HEALTH SERVICES CONTRACTING AND PAYMENT***				
NUMBER	**ACTIVITY**	**RESOURCES**	**RESPONSIBLE**	**TIME FRAME**	**EXPECTED RESULTS**
1.	ESTABLISH AND ADOPT NEW MECHANISMS FOR HEALTH SERVICES' CONTRACTING AND PAYMENTS	HUMAN TECHNICAL FINANCIAL	FMH CMH ZZO	18 MONTHS	BY-LAWS FOR THIS ACTIVITY IMPLEMENTATION ADOPTED
2.	IMPLEMENT NEW CONTRACTING MODELS AND PAYMENT MECHANISMS FOR HEALTH CARE SERVICES IN OUT-PATIENT HEALTH CARE	HUMAN ICT FINANCIAL	FMH CMH HEAL. INSURAN. INST. HEALTH INSTITUTIONS	5 YEARS	NEW MODELS OF CONTRACTING AND PAYMENT IMPLEMENTED
3.	IMPLEMENT NEW CONTRACTING MODELS AND PAYMENT MECHANISMS FOR HEALTH CARE SERVICES IN HOSPITAL HEALTH CARE	HUMAN FINANCIAL ICT	FMH CMH HEAL.INSUR.INSTIT. HEALTH INSTITUTIONS	7-10 YEARS	NEW MODELS AND PAYMENT MECHANISMS IMPLEMENTED
4.	PROMOTION OF NEW MODELS OF PAYMENT	HUMAN TECHNICAL FINANCIAL MEDIA	FMH CMH HEAL.INSUR.INSTIT. HEALTH INSTITUTIONS	CONTINUOUS	PROMOTION ACTIVITY ARE IMPLEMENTED IN FBiH TERRITORY

	OVERALL OBJECTIVE: SYSTEM FUNCTION- FINANCING
NUMBER: 02	**SPECIFIC GOAL: TO IMPROVE EQUITY IN HEALTH CARE FINANCING THROUGH RISKS POOLING AND INCREASED SOLIDARITY**

NUMBER	ACTIVITY	RESOURCES	RESPONSIBLE	TIME FRAME	EXPECTED RESULTS
1.	ESTABLISH SUSTAINABLE SOURCES OF HEALTH CARE FINANCING FOR ALL POPULATION IN FBIH	HUMAN TECHNICAL FINANCIAL	GOVERNMENTS FMH CMH HEALTH INSUR. INST. OTHER RELEVANT	36 MONTHS	SUSTAINABLE FINANCIAL FRAMEWORK ESTABLISHED
2.	ADOPT BASIC HEALTH RIGHTS PACKAGE	HUMAN FINANCIAL TECHNICAL	PARLIAMENT GOVERNMENTS FMH CMH HEALTH INSUR. INST. OTHER RELEVANT	12 MONTHS	BASIC HEALTH RIGHTS PACKAGE ADOPTED
3.	IMPLEMENT BASIC HEALTH RIGHTS PACKAGE	HUMAN FINANCIAL TECHNICAL	GOVERNMENTS FMH CMH HEALTH INSUR. INST. OTHER RELEVANT	36 MONTHS	BASIC PACKAGE IMPLEMENTED

	OVERALL OBJECTIVE: SYSTEM FUNCTION- FINANCING				
NUMBER: 03	**SPECIFIC GOAL: *INCREASE OF POPULATION COVERAGE BY HEALTH INSURANCE***				
NUMBER	**ACTIVITY**	**RESOURCES**	**RESPONSIBLE**	**TIME FRAME**	**EXPECTED RESULTS**
1.	CONSISTENT IMPLEMENTATION OF THE LAW ON HEALTH INSURANCE	HUMAN TECHNICAL FINANCIAL	FMH CMH HEALTH INSUR.INST. OTHER RELEVANT	CONTINUOUS	LAW ON HEALTH INSURANCE IMPLEMENTED
2.	IMPROVE THE SYSTEM OF RECORDING, COLLECTION AND CONTROL OF CONTRIBUTION PAYMENT FOR COMPULSORY HEALTH INSURANCE	HUMAN TECHNICAL ICT FINANCIAL	TAX AUTHORITY HEALTH INSUR.INST. CONTRIBUTION PAYERS	24 MONTHS	SYSTEM IMPROVED
3.	COMPULSORY HEALTH INSURANCE PROMOTION	HUMAN TECHNICAL FINANCIAL MEDIA	FMH CMH HEALTH INSUR.INST.	CONTINUOUS	PROMOTION ACTIVITIES ARE IMPLEMENTED
4.	INTRODUCTION OF VOLUNTARY AND EXPANDED HEALTH INSURANCE	HUMAN TECHNICAL ICT FINANCIAL	GOVERNMENTS FMH CMH HEALTH INSUR.INST. OTHER RELEVANT	36 MONTHS	VOLUNTARY AND EXPANDED HEALTH INSURANCE IMPLEMENTED

STRATEGIC PLAN OPERATIONALIZATION AND IMPLEMENTATION

The Minister of Health of the Federation of BiH will nominate the expert teams for each lever of the system or for one or more specific strategic goals. The teams will be tasked with the development of a detailed operational plan as well as the indicators for each of the specific goals within the field they are nominated for.

Each expert team will be led by an appointed official of the Federal Ministry of Health who will be, at the same time, responsible for coordination and work of the team and for the regular reporting on the Strategic Plan implementation to the Federal Minister of Health.

It is foreseen for the cantonal ministries to establish the same or similar bodies that will be responsible for the implementation at the cantonal level.

The expert teams' leaders will be responsible to prepare the regular reports for the meetings of the Federation BiH Minister.

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