

Chapter 1 Health Reforms in South East Europe

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Introduction

This book aims to contribute to the analysis of health reforms in South East Europe (SEE). Over the past two decades, the health systems of this region have undergone far-reaching reforms, triggered by the search for more effective and efficient health care provision, attempts to introduce new sources of revenues, upward cost pressures associated with new technologies and population ageing, and the overall context of transition from socialist to market economies. Deteriorating population health in the early 1990s was another major concern, with life expectancy decreasing in several countries of the region, due to the economic collapse in the early years of transition, the effects of war and conflict in the Yugoslav successor states, and a breakdown in basic health services (Adeyi, Chellaraj et al. 1997; Rechel et al. 2004; Rechel and McKee 2006).

Health reforms in South East Europe have involved in most cases the creation of social health insurance systems, the privatisation of primary health care, and the introduction of family medicine delivered by general practitioners. There were also attempts to reduce costs through introducing various forms of (quasi-) market arrangements which promoted competition between providers of both primary and secondary care. This sometimes resembled reforms seen in the United Kingdom in the late-1980s, when the quasi-market model had been promoted by the Thatcher government, alongside with a purchaser-provider split and the contracting of services from competing hospitals (Le Grand and Bartlett 1993; Ham 1996)(Allen, Turner et al. forthcoming). Many of these ideas were picked up by policy-makers in SEE, both in the early 1990s and thereafter. Policy transfer from Western Europe was clearly evident in the number of countries throughout Central and Eastern Europe that introduced capitation payment for primary care and payment based on diagnosis-related groups (DRGs) for secondary care services. In several countries of SEE, however, reforms were delayed by various political factors: in Croatia due to the aggression that started in 1991, in Bosnia and Herzegovina, due to the war that afflicted the country in 1993-95, in Bulgaria and Romania due to the lack of firm political agreement on the speed of reforms until about 1997, and in Serbia and Montenegro (including Kosovo) due to lack of any reformist political change during the 1990s and a virtual freezing of the reform process. In all countries of the SEE region, the transition led to severe social and economic disruptions associated with falling levels of GDP during the 1990s,

although in former Yugoslavia this was already preceded by economic crisis and deteriorating population health in the 1980s (Kunitz 2004). This economic decline severely impacted the ability of governments to organize effective and affordable health systems. After the fall of the Milosevic government in Serbia in 2000, and the electoral rejection of the Croatian Democratic Union (HDZ) government in Croatia, a new wave of reforms began, often assisted by foreign donors.

Such policy transfer may not always have been appropriate to the countries of the region. Initially it seemed that the public were enthusiastic for reforms, especially in the countries of the formerly centrally planned economies which were keen for change (Balabanova and McKee 2004). Public support for reforms was less apparent in the Yugoslav successor states which already had an extensive health system that performed far better than the systems which were in place behind the iron curtain (Mastilica and Babic-Bosanac 2002). Since the health reforms – faced with a challenging fiscal climate and declining government revenue – often restricted the scope of health care free at the point of use, this outcome may not be surprising. Policy makers too, by and large, supported the reforms, especially when they were promoted by such influential international organisations as the World Bank. Resistance to the reforms from health professionals, however, was evident in nearly all the countries of the region, and accounts to some degree for delayed reforms in several of the countries (Scott, Powles et al. 2011). Often, reforms failed to reach their proclaimed goals or to improve the accessibility and quality of health care, and robust evaluations of reform efforts have generally been lacking (Rechel and McKee 2009). In the wake of the global economic crisis the need for governments to ‘do more with less’ has become even more urgent, underlining the challenge of improving the quality of health care, reducing costs, and ensuring equity and accessibility.

Many accounts of the economic and social transition in the former socialist countries emphasise the importance of path dependency, and the influence of the legacy of the past on contemporary policy decisions (Rechel 2008). This perspective is also relevant in the case of health reforms. It is important to understand the key features of the health systems which were in place under the socialist systems in South East Europe, and in relation to which health reforms in the transition period were designed. Two main types of health systems were established under communism in South East Europe: the Yugoslav health system and the Soviet-style Semashko system in Albania, Bulgaria and Romania. There were two main differences between these systems. Firstly, the former was based on a system of national health insurance (mainly based on payroll taxes paid by employers and employees and on state contributions), while the latter was based on central budget funding (similar to the national health systems in the United Kingdom, the Netherlands and the Nordic countries). Secondly, family medicine played an important role in the Yugoslav system, where it was delivered through local

polyclinics known as community health centres, whereas family medicine was generally not officially recognized or promoted in the Semashko system, which instead relied on a system of specialist polyclinics (Svab, Pavlic et al. 2004). In the centrally planned economies the health systems suffered from lack of patient rights, low quality of care, and little technological improvement (Kornai and Eggleston 2001). On the other hand, they provided universal service and equal access, at least formally, since political connections and informal payments could often speed up access to higher quality treatment.

In all these countries, health reforms were carried out following the fall of the communist regimes. Broadly speaking, health systems underwent three major changes (Rechel and McKee 2009). Firstly, those countries that had relied on taxation as the main mode of financing introduced social insurance systems as another source of revenue. Secondly there was an increase in out-of-pocket payments, both formal and informal. Formal co-payments were introduced for many services in most countries, in an attempt to ration the use of services and control the growth of public expenditure. Informal payments have also increased, partly due to the low salaries of medical professionals in many of the countries, and building on practices developed under the communist regimes. Thirdly there has (at least formally) been an increased emphasis on primary health care and a move away from the provision of specialist care at primary level towards family medicine provided by general practitioners (GPs). This sometimes had the awkward side effect of providing an incentive for primary care physicians to supply less care themselves and instead increase referrals to specialists working in hospitals; in response to this development both Bulgaria and Croatia introduced limits on specialist referrals. Other changes have been important too. In some countries (Albania, Bosnia and Herzegovina, and Romania), some aspects of the health system have been decentralised to sub-national units of government, while in others a process of centralisation has occurred (Croatia, Macedonia). There has also been a process of privatisation, in particular with regard to pharmacies and dental care, but also with regard to primary health care and, increasingly, secondary care

The socialist health system in former Yugoslavia

The health system of former Yugoslavia had been founded before the Second World War with the establishment of public health services under Andrija Štampar and the introduction of health insurance organizations. It was based upon a network of community health centres (*Dom zdravlje*) staffed by mixed teams of general practitioners, specialists such as gynaecologists, and nurses. In

1960, a specialization in family medicine was introduced (Skupnjak and Novosel 1976). Although the role of specialists in these community health centres increased during the socialist period, general practitioners continued to play an important role¹. Typically, within the community health centre, primary health care was delivered through seven distinct functions: (a) general practice, (b) occupational medicine, (c) pre-school paediatrics, (d) school medicine, (e) gynaecology and obstetrics, (f) laboratory diagnostics (including for X-rays) and (g) hygiene and epidemiology (Atun, Kyratsis et al. 2007), with community nurses also playing an important role. Secondary care was provided in hospitals which had been established alongside the community health centres, but often received more funding and were better staffed. Hospital specialists had a higher social status than physicians in primary health care and resources often went into advanced medical equipment for hospitals, at the expense of investment in basic equipment for community health centres.

Under the socialist system in Yugoslavia, health care providers (both hospitals and community health centres) were autonomous organisations managed by a director and an elected staff committee under the direction of a Supervisory Council composed of elected representatives of the employees and the local community (Shain 1969). Health services were largely free of charge, with the exception of some small user fees, such as prescription charges, that were introduced in 1966. The health system was financed to about three-quarters through the national insurance system, supplemented by budget grants, user fees, and donations from local businesses². The standard social insurance tax rate in 1967 stood at 21 per cent of gross wages, which included a health insurance contribution of 5.2 per cent. The health insurance contributions were collected at the district level and distributed by district social insurance institutes, which acted as commissioners of services and were governed by elected assemblies of insured persons. The provider organisations in each district negotiated their budgets with the local social insurance institute (Shain 1969).

In 1974 the system was further decentralised with the creation of local health parliaments (so-called 'self-managing communities of interest') at the level of republics and communes, bringing together representatives of the local community and local businesses. These were in effect local commissioners of care; they decided on capital investment and drew up agreements with health care providers on the level of services to be provided, subject to minimum standards set at the republican level. This arrangement was designed to give greater leverage to preferences of the local community over the interests of specialists in hospitals, and to lead to a greater emphasis on

¹ The ratio of specialists to generalists fell from 1:2 in 1953 to 1:0.8 in 1984. During the socialist period the university of Zagreb became the WHO centre for primary care and technical cooperation among developing countries, see: Himmelstein, D. U., S. Lang, et al. (1984). "The Yugoslav Health System: Public Ownership and Local Control." *Journal of Public Health Policy* 5(3):423-431.

² Farmers were included in the national insurance system for the first time in the 1960s

community health services. Owners of small private businesses and self-employed professionals paid for health insurance on a voluntary basis. Further decentralisation resulted from a law on health care and health insurance passed in Croatia in 1980 which permitted socially-owned businesses to contract directly with health care providers, a practice that eventually covered 15% of health expenditure in Croatia. These direct contracts funded specialised clinics providing primary health care services mainly for the employees of large social-owned companies, bypassing the community health centres and establishing what in effect became a 'parallel health system' providing high quality services to a selected part of the population (Saric and Rodwin 1993). Thus, despite the intended emphasis on community health, general practice and preventative services were relatively neglected, due to a lack of effective institutional advocates (Himmelstein, Lang et al. 1984). Furthermore, there were widespread health inequalities among regions (republics) of former Yugoslavia. Decentralisation of the health system seems to have had a mixed impact on health outcomes, with regional inequalities in infant mortality increasing between 1950-54 and 1986, although regional inequalities in life expectancy at birth decreased over time (Mastilica 1990).

In order to control costs, which threatened to escalate with the loss of central control resulting from decentralisation, the system of co-payments was extended (Simić, Doknić-Stefanović et al. 1988). However, cost-sharing had little effect in reducing health expenditure, but led to increased inequalities, with higher rates of cost-sharing being introduced in poorer districts in order to raise revenues. However, partly due to widespread exemptions, these revenues rarely exceeded three per cent of total health expenditure. Some argued that decentralisation had gone too far, and that in order to establish control over costs some sort of recentralisation and central state control was essential (Parmelee 1985; Parmelee 1992).

Health systems behind the iron curtain

The health systems in Albania, Bulgaria and Romania developed rather differently to that in Yugoslavia during the communist period. In these countries, the health system was organised according to the so-called 'Semashko' model, based on central planning, state ownership and command. Health care was provided through hospitals, polyclinics, primary care dispensaries and, in rural areas, through single physicians or feldshers (medical assistants). The systems tended to be dominated by specialists and hospital-based care, with no clear gate-keeping role for district physicians. Health care was provided on the basis of a universal entitlement to care, although, as in other areas of the Soviet-style economy, shortages and queues for services abounded. Medical staff

were usually poorly paid and had little motivation to improve quality of care (Borissov and Rathwell 1996). Resource allocation was determined by planned inputs, such as beds or staff numbers, rather than patient needs or the quantity and quality of services provided. Health received an overall low priority and a comparatively small proportion of GDP was dedicated to the health system. In addition, health care behind the iron curtain remained cut-off from developments in the West, both in terms of medical technologies and evidence-based clinical practice (Rechel et al. 2011).

In Albania, during the communist period the number of hospitals, hospital beds and physicians per population increased significantly. Over half the physicians were non-specialists, indicating a concern for primary health care, and every village came to have its own health centre (Gjonca, Wilson et al. 1997). With the expansion of organised health services in this poor agricultural country, health indicators improved dramatically, with a continuous increase in life expectancy. However, low overall investment on health and the isolation of the country from developments in other parts of the world caused the quality of health services to fall behind other European countries, so that by the end of the 1980s the Albanian health system was in poor shape, with high rates of child and maternal mortality compared to neighbouring countries.

In Bulgaria, life expectancy stagnated during the 1970s and 1980s, as the health system was unable to respond to the high cardiovascular disease burden among the population. People increasingly preferred self-treatment at home, before visiting the local polyclinic. Access to primary health services remained egalitarian, with the probability of consulting a health professional being related to age and level of illness rather than income (Balabanova and McKee 2002). However, the quality of care beyond the primary level varied with income, with the poor being treated in low quality facilities. The poor also faced significant difficulties in accessing secondary care services due to problems of affordability, bureaucratic procedures, lack of choice and unresponsive staff.

In Romania the Semashko system of universal health care provision based on central planning, state financing and universal provision free at the point of delivery was introduced in 1949. Private practice was forbidden, and primary health care was delivered through dispensaries which were administered through local hospitals. Free choice of doctors was introduced in 1983, along with a system of co-payments for some ambulatory services. The system functioned well in the early post-war years, with improved health outcomes resulting from better control of communicable disease. Life expectancy increased steadily between the 1950s and early 1970s, but, similar to Bulgaria, largely stagnated in the second half of the 1970s and the whole of the 1980s, with a growing gap to gains achieved in Western Europe (Bara, van den Heuvel et al. 2002; Vlădescu et al. 2008).

Health reforms during transition

In Albania, Bulgaria and Romania, where the Semashko-type tax-financed health systems had dominated, various systems of social health insurance were established after the fall of communism, and health institutions were decentralised, in line with the general aim of transition reforms to reduce the power of the central state. In contrast, in the former Yugoslavia the main aim was to centralise the already existing yet fragmented and decentralised health insurance institutions so as to enhance the power of the newly formed states. This involved transforming the autonomous 'self-managed communities of interest' into centralised state-managed social health insurance funds.

Popular attitudes towards health reforms and social health insurance varied correspondingly. In Romania, an opinion poll carried out in 2000 found that most people were generally happy with the reforms, while about one third of respondents thought that the reforms had a negative effect on the quality of care (Bara, van den Heuvel et al. 2003). Similarly, in an opinion poll carried out in Bulgaria in 2000, Balabanova and McKee (2004) found that most people preferred social health insurance over taxation-based financing, a preference deriving from dissatisfaction with the quality of health care under the previous system. Over half of respondents also advocated universal state provision free at the point of use (as in the former Semashko system). In contrast, a survey carried out in 1999 and 2000 in Croatia revealed sharply divided views (Mastilica and Babic-Bosanac 2002). Most respondents favoured a social health insurance system, but most also disagreed with the announced reduction in the basic service package covered by health insurance.

As health systems were being reformed throughout the region to meet the challenges of transition and post-conflict reconstruction, the alarming outflow of skilled medical personnel presented another challenge. While this had been a traditional issue facing the former Yugoslavia, which had open borders with the West since the mid-1960s, it was a new experience for those countries which had previously restricted migration behind the 'iron curtain' of their communist systems. As Ognyanova documents in this volume (see **Chapter 4**), this issue has been especially serious in the case of Bulgaria.

Case studies: former centrally planned countries

Albania

In Albania, a Health Insurance Institute was established in 1995 to manage a social health insurance system which insures for primary health care services, hospital care and part of the price of

medicines based on a restricted list. However, a Demographic and Health Survey carried out in 2008-09 revealed that 70 per cent of respondents were not covered by health insurance, leading to a high rate of out-of-pocket payments, estimated to account for around 60 per cent of total health expenditure in 2008 (WHO 2011). Pensioners, children, disabled, beneficiaries of social assistance, and people on unemployment benefit are insured through the state budget for a minimum service package. Those who are not covered by health insurance often bypass primary care and go straight to the accident and emergency services which are required to treat all who show up, leading to overcrowding and reduction in service quality. The poor quality of care at primary care level also encourages people to bypass this level of care, but Hotchkiss et al. (2005) reported that interventions in some areas designed to improve the quality of primary care have reduced the extent of such bypassing.

On the provider side, ownership of primary health care centres and polyclinics in urban areas was transferred to the local government, while the hospital sector remains under the administration and control of the central government. The public health system consists of about 400 health centres in the primary care sector, while there is a hospital in each district, along with twelve regional hospitals. Ten years after the civil unrest of 1997 which had resulted in extensive damage to many primary care facilities, observers reported that, although many primary health care centres had been rehabilitated, many still suffered from lack of running water, electricity and basic equipment (Hotchkiss, Piccinino et al. 2007). Primary health care facilities were reported to have little funding for maintenance or running costs, apart from those related to salaries.

Bulgaria

In Bulgaria, the health reforms introduced in 1989 involved decentralisation of health care institutions and permitted the entry of private health care providers (Borissov and Rathwell 1996). However, financing remained the responsibility of the state until 1998 when a Health Insurance Law was passed by parliament, with implementation beginning in 2000. A National Health Insurance Fund was established to administer and coordinate the work of 28 regional offices. The National Health Insurance Fund was funded by payroll contributions by both employers and employees, while the self-employed were required to pay the whole contribution themselves. The contributions were supplemented by per capita grants from the state and local government budgets, and the contributions of retired people and the unemployed were paid by state funds. The reforms envisaged that the NHIF as purchaser of health services would guarantee a basic package of care, available from competing providers in both the public and private sector. General practitioners were paid through both fee-for-service and capitation payments, and were envisaged to act as

gatekeepers to secondary care, although patients were also permitted to access specialists in hospitals directly.

Although it was recognised that the existing system needed improvement, commentators pointed out that social health insurance might be financially unsustainable, owing to the low employment rate and the high level of informal employment, which would provide a narrow base for raising revenue (Pavlova, Groot et al. 2000). These fears were borne out in practice as it became clear that the system had some negative impacts on equity of health service provision: firstly, the scope of coverage is limited, owing to a continually reduced basic insurance package, and secondly, people on low incomes often cannot afford to pay health insurance contributions, effectively excluding them from health care provision, a situation which particularly affects the Roma minority (Atanasova, Pavlova et al. 2011). Furthermore, in making the transition to a health insurance system in which centralised bureaucracy would be replaced by a more pluralistic competitive system, the country lacked skilled managers to play the role of purchasers and providers of health care. In an article preceding the reforms, Borissov and Rothwell (1996) identified this lack of administrative and managerial capacity, along with an underdeveloped information system, as the main difficulties the reforms would encounter.

In **Chapter 3** of this volume, Dimova et al. review the Bulgarian health reforms to date. They show that, despite the attempt to move towards a more pluralistic system, the health care quasi-market has been dominated by the national health insurance fund which is a monopsonistic purchaser of services, while there was a large increase in private health financing in the form of out-of-pocket expenditures. The system also suffers from significant gaps in the breadth of coverage, excluding a significant part of the population, and from overall underfunding, leading to popular dissatisfaction with the effects of reforms.

In **Chapter 10**, Georgieva and Moutafova show that the hospital sector in Bulgaria has undergone profound changes, including the introduction of contracting, the diversification of providers, new forms of ownership, strengthened managerial autonomy, new forms of financing and improved patient choice. The introduction of a purchaser-provider split and a contracting mechanism introduced market or quasi-market conditions into the health sector. However, performance management in hospitals is relatively unknown and poorly implemented, so that, even with hospital autonomy and quasi-market incentives, health reforms are unlikely to improve either efficiency or effectiveness in secondary health care.

Romania

In Romania, health financing was decentralised at the start of transition through the Public Administration Law of 1991, which established 42 district health directorates responsible for funding primary care (Bara, van den Heuvel et al. 2002). Reforms during the 1990s were carried out under the influence of World Bank projects and advice from the United Kingdom's King's Fund. Under the previous system, primary care physicians had worked in dispensaries as salaried employees of hospitals. Following the reforms, they became general practitioners working in private practices as independent operators, contracted by the district health directorates to provide services. GP payment changed to a mix of age-adjusted capitation, fee-for-service and bonuses. GPs began to perform a gatekeeper role for secondary care, and were allocated their own budgets as 'fund holders', emulating earlier reforms in the United Kingdom that were subsequently found to have failed to improve efficiency or quality of care (Wyke et al. 2003).

Following adoption of the Law on Social Health Insurance in 1997, the directorates were transformed into District Directorates for Public Health and responsibility for financing health care was transferred to newly established District Health Insurance Funds. These health insurance funds are responsible for collecting contributions from employers and employees and for contracting health services from providers in their district. The National Health Insurance Fund administers and regulates the health insurance system, establishes the minimum package of care, and is responsible for a solidarity fund which redistributes up to 25% of the National Health Insurance Fund's financial resources to underfinanced districts. Social health insurance contributions for the unemployed are paid by the unemployment insurance budget, for pensioners from the social security budget, and for those with low incomes or on maternity leave by the District Health Insurance Fund itself. Deficits in the funds are filled from the state budget. However, in practice not everyone is covered by health insurance, as there is a large informal economy in which employers and employees do not pay contributions.

A Law on Hospital Organisations was passed in 1999 which granted autonomy to hospital management led by a Council Board. Privatisation has been mainly limited to dentistry and pharmacy, although private hospitals have been allowed to operate. The basis of hospital funding changed from historic resource inputs to financing based on performance and the profile of the hospital. In **Chapter 7** of this volume, Scintee et al. argue that the main shortcomings of the reforms have been their lack of flexibility and adaptation to specific contexts and conditions, a disregard of the specific and complex health needs of the population, and a lack of simultaneous reforms in other parts of the health system. They suggest that the new health strategy proposed by the Presidential

Commission might enable further progress by placing the patient at the heart of the health system. According to the proposed strategy, family doctors would be required to provide a 24-hour service by working after-hours in continuous care centres, while hospitals are to be re-organized and a co-payment system has already been introduced. By taking simultaneous action in both the primary and the hospital sector, it is hoped that patients will be more willing to attend primary care clinics, decreasing the pressure on hospitals.

Case studies: health reforms in the Yugoslav successor states

In the Yugoslav successor states several countries introduced primary health care reforms in the 1990s. Croatia and Macedonia were the first to introduce reforms. At primary care level these have involved the introduction of the private sector into the delivery of health services and the use of capitation as a model of payment for primary care teams. Since then, similar reforms have been introduced in Bosnia and Herzegovina, Serbia and Kosovo (Simic, Milicevic et al. 2010: 167). At secondary care level, hospital ownership has been transformed from social to state ownership, while privately owned hospitals have been permitted and been set up in most countries. All Yugoslav successor states have also reformed their health insurance system. In the cases of Croatia, Macedonia and Serbia they have done so through centralising the previously decentralised health insurance system, while in the Federation of Bosnia and Herzegovina a new decentralised system has been instituted, alongside a centralised system in the Republika Srpska. Kosovo has been alone in adopting a tax-financed system.

Croatia

The main aims of health reforms in Croatia were to reduce the costs of health services without adversely affecting the health status of the population (Mastilica and Chen 1998). The reforms involved bringing the health insurance system under central government control; this occurred in 1990 with the creation of the Croatian Institute for Health Insurance. A Health Care Act and a Health Insurance Act were passed in 1993 under which the services provided by the public health system were restricted to a basic package of services, limiting the number of visits to community health centres and the number of prescriptions that could be written for each patient. The list of prescribed drugs was restricted and a uniform sick-leave rate introduced. Primary care physicians were confined to providing a limited standard and quantity of services through 'utilization control'. Cost-sharing was introduced for almost all services and prescriptions, with exemptions for children, the

unemployed, the elderly, war veterans and other vulnerable groups of the population. Alongside compulsory health insurance, a system of voluntary health insurance was introduced for those who wished or could afford to supplement the basic package of health care services. Private health insurance was permitted for those on highest incomes, covering about one per cent of the population.

Not surprisingly, in view of the replacement of the previous system of health care provision by one restricted to a basic package of health services, an opinion survey carried out in 1994 showed that people were generally dissatisfied with the outcomes of reforms (Mastilica and Chen 1998). By 1994, average expenditure on co-payments had reached five per cent of income in urban areas. The distribution of these payments across income groups was highly regressive, with the poor paying a share of income six times higher than the rich (Mastilica and Bozikov 1999). Particular dismay was registered over the reduced list of prescribed drugs, which increased the burden of out-of-pocket payments, especially for lower and middle-income groups (Chen and Mastilica 1998). In **Chapter 2** of this volume, Miroslav Mastilica summarises the findings of these studies and shows that the level of dissatisfaction has not diminished over subsequent years.

A new health insurance law adopted in 2002, renaming basic insurance as mandatory insurance, further restricted the range of benefits covered by the insurance scheme. Opting out of the system was prohibited, and the use of private health insurance consequently fell. Co-payment rates were increased and widened, and exemptions were reduced. Complementary health insurance was introduced to cover the risk of co-payments, an option taken up disproportionately by pensioners (Voncina, Kehler et al. 2010). In 2005, 'administrative charges' were introduced for all health services, including ambulance services. By the end of the 2000s, these restrictive measures had turned the Croatian Institute for Health Insurance around from a position of deficit to one of surplus, but the effect was to seriously undermine the universal nature of the statutory financing system in Croatia.

On the provider side, primary health care was subjected to a process of privatisation which established (or rather extended, as this had also been permitted under the communist regime) a system of private practice. General practitioners could become self-employed and deliver services under contract with the Croatian Institute for Health Insurance, in premises rented from community health centres. By 2001, about four-fifths of primary care practitioners were operating independently under contract to the Croatian Institute for Health Insurance, and only one fifth remained salaried employees of community health centres (Katic, Juresa et al. 2004). However, by restricting the services which could be provided, and by changing the payment mechanism for

primary care physicians to a capitation basis, the reforms removed the incentives for primary care physicians to carry out home visits and to make preventive checks among vulnerable groups. Although the number of visits to GPs per patient per year increased from 4.7 to 6.0 between 1990 and 2001, the number of home visits fell continuously and the number of preventive checks stayed low at just 0.05, lending some justification to a critique of the capitation model (Katic, Juresa et al. 2004: 547). The capitation model also provided an incentive for non-salaried physicians to cherry-pick young and healthy patients and to discourage registration by more costly patients with chronic diseases. This led potentially to gaps in coverage, and it was estimated in 2004 that at least 300,000 people in Croatia fell through the net of social health insurance (Katic, Juresa et al. 2004: 545). In **Chapter 14** of this volume Katic et al. propose a payment model for primary care practitioners designed to overcome some of these difficulties. Their proposed payment formula consists of a mix of per capita payment (amounting to four-fifths of the income of primary care physicians) and fees for service, covering diagnostic and therapeutic procedures and preventive activities (each amounting to 10 per cent of income). They argue that this combined model of payment would act as an incentive for improving the quality and performance in primary health care.

A survey carried out in 2003 revealed that significant health inequalities had emerged between low and high income groups (Mastilica and Kusec 2005). At the secondary care level, the highly centralised model of health financing in Croatia was recognised as a problem and the government announced a decentralisation of health financing in 2000. Since counties and county hospitals had limited capacity to implement decentralized financing, a training programme was delivered by the Andrija Štampar School of Public Health, called the 'Healthy Counties' programme. In **Chapter 12**, Dzakula, Sogric et al. report on the success of this programme. One of the important achievements was the creation of a new legal framework for decentralization. The new Health Care Act that was announced at the end of 2008 was based at least in part on the results of the Healthy County programme. It provided for the drawing up of annual and triennial plans on prevention and health promotion, the development of comprehensive stakeholder collaboration and the establishment of county "Health Councils". The implementation of these changes is currently in progress.

Macedonia

In Macedonia, a national Health Insurance Fund was established by the 1991 Health Care Law, based on payroll contributions. People with large families (more than 4 additional members) were required to pay supplementary insurance contributions (Donev 1999). The law also provided for supplementary and voluntary health insurance. The social health insurance system began to function in 1994, with compulsory health insurance covering a basic package of health services. However, by

1999, only about four-fifths of the population was covered by the social health insurance system (Donev 1999), implying a large gap in the breadth of coverage.

In 1996 the World Bank provided a loan of US\$ 19.4 million to support further health reforms. Among the aims of the programme was a switch of funding primary care to a capitation basis, and a reform of the co-payment system to fill gaps in funding. Deficits in the Health Insurance Fund were covered by transfers from the central government budget. In 2004 amendments were passed on the Law on Health Care which provided for the privatization of pharmacies and dental services on the basis of leasing facilities from the state. The amendments coincided with the agreement on a new US\$ 10 million loan from the World Bank to finance the strengthening of health sector management, with a focus on reforms in the provision of day care and primary health care services, as well as on improving revenue collection. The Health Insurance Fund began to negotiate contracts with hospitals that contained fixed budgets, in an attempt to reduce cost over-runs. The 2001 Ohrid Framework Agreement mandated the decentralization of health care responsibilities to the municipal level, and representatives of municipalities have begun to be involved in the management of primary health care centres (Gjorgjev, Bacanovic, Cicevalieva, Sulevski and Grosse-Tebbe 2006).

Private practice in primary health care, under contract to the Health Insurance Fund through fee-for-service payments, was permitted by the 1991 Health Care Law. Unlike in Croatia, private physicians work from their own premises; however, these are costly to equip and require greater investment than in Croatia where doctors rent their premises from the local community health centre. By 2002, around one-fifth of primary care physicians in Macedonia were working in private practice (Nordyke and Peabody 2002). While private practices face strong performance incentives linked to their ability to charge fees for service and retain income, in the public sector the number of patient visits is regulated and capped by the Health Insurance Fund, providing little incentive to treat more patients. A survey comparing the performance of public and private primary health care clinics in 1997-8 found that the private sector had a higher productivity in terms of numbers of patients treated and that private clinics tended to be better equipped (Nordyke 2002). The World Bank-funded Health Sector Transition project sought to further develop the private sector in the provision of health services in Macedonia. One of its key aims was to introduce capitation payment systems into the primary care sector. Consultants to the project recommended the rent or outright sale of community health centres to the private sector (Nordyke and Peabody 2002). However, due to resistance against the reform from health professionals, the capitation system was applied only to physicians working in the private sector, replacing their previous fee-for-service contracts (World Bank 2003).

In **Chapter 8** of this volume, Lazarevik and Donev argue that the politicisation of Macedonia's health system has distorted decision-making on financing hospitals, recruitment of staff, and the hiring and firing of directors in public hospitals. Lack of investments in new technologies and equipment, deterioration of facilities and low motivation of staff have reduced the quality of care in the public sector. Out-of-pocket expenditure has increased, with a negative impact on access to health care providers for lower income groups. The public hospitals are left with large debts and many senior health personnel have moved to work in the private sector. The poor conditions in public hospitals and government failure to address them have created opportunities for the development of the private hospital sector. Private entrepreneurs have invested in new state-of-the-art health facilities, and in the latest medical equipment and technology. Thus, the transition has created a two-tiered hospital system, composed of an over-politicised and inefficient public hospital system alongside a modern private hospital system that relies on out-of-pocket payments. Lazarevik and Donev argue that solutions to prevent the collapse of public hospitals should be oriented towards a locally tailored transformation of public hospitals into corporate enterprises, through a careful process of privatisation that does not transfer the ownership of facilities to investors.

Bosnia and Herzegovina

In Bosnia and Herzegovina, during the war, separate health insurance funds had been established in areas controlled by the three main ethnic groups, Bosniaks, Croats and Serbs. Under the Dayton peace agreement, two sub-national entities were set up to govern the country. The Serb entity, Republika Srpska, established its own centralised health insurance fund. In the Federation of Bosnia and Herzegovina early advice on health reform was provided by the British Know How Fund (Ljubic, Hrabac et al. 1999), while the World Bank drafted a health reform programme.

In the Federation of Bosnia and Herzegovina a Law on Health Care and a Law on Health Insurance were adopted in 1997. The latter stipulated that each of the ten Cantons would have their own insurance fund. The revenues are raised through a payroll tax, on a compulsory basis. Supplementary and voluntary contributions may also be made. In 2001, a separate fund that had been established during the war in the Croat-majority Cantons was merged into the general arrangements in the Federation of Bosnia and Herzegovina. The breadth of coverage by health insurance has been low, with many population groups falling through the gaps, including refugees, some pensioners, and people working in the large informal sector (Deets 2006). Attempts to extend population coverage by improving the administration of the system have been resisted by politicians and 'street-level bureaucrats' at cantonal level, and example of what Deets calls the 'passive-aggressive state' at work.

At primary care level, reforms designed to emphasise the role of family medicine were introduced in 2001. This involved the introduction of family medicine teams, consisting of a doctor and a nurse, in community health centres. These teams were contracted under capitation payment by the respective health insurance fund, and were gradually introduced on a voluntary basis. By 2005, about one quarter of the population was covered by family medicine practitioners (Atun, Kyratsis et al. 2007).

Serbia

In Serbia, the health system deteriorated significantly during the 1990s under the impact of sanctions and an overall economic deterioration. Following the democratic transition which began in 2000, a set of health reforms has been adopted. A Health Care Law and a Health Insurance Law were passed in 2005. The Health Care Law introduced the model of a 'chosen doctor' which required people to register with a single medical practitioner in a community health centre (Dom zdravlja). Ownership and management of community health centres have been decentralised to the municipal level, along with responsibility for capital investment, and the distinction between specialists working in community health centres has remained in place. Although the reforms were supported by significant donor funds, the recommendation of donor organisations to replace the system of specialist practitioners at primary level by a system of family medicine was rejected, due to opposition from specialist doctors (Simic, Milicevic et al. 2010: 168). The Health Insurance Act ensured the continuation of compulsory health insurance as the main statutory source of health financing, with priority given to vulnerable groups. The law also supported output-based contracting, and the introduction of capitation payment in primary health care. In **Chapter 5** of this volume, Simić et al. argue that health reforms in Serbia were largely driven by international donor organisations, but that resistance by an anti-reform coalition has held back the implementation of reforms. Reform delays have also been related to a lack of administrative and managerial capacity in the Ministry of Health, the Health Insurance Fund and the community health centres at the local level. The deteriorating quality of health services in the public sector has led to the growth of a poorly regulated private sector. This has taken on significant proportions and it was estimated that almost one-third of health services in 2007 were provided by unregulated private practitioners (Bartlett 2008).

In 2009 a Plan for Health Care Development was published that aimed to strengthen the gate-keeping role of primary care practitioners and improve access to primary health services. In **Chapter 9** of this volume, Jekić et al. argue that Serbia's health infrastructure, particularly with regard to hospital care, is over-sized, inefficient and expensive. The country's hospitals are generally

characterized by excess physical capacity and staff, cumbersome delivery of services, difficulties in human resource management, and high levels of medical interventions of sometimes dubious clinical quality. Jekić et al. report on attempts to modernise the hospital system in Serbia. They conclude that the process will need to go beyond completion of master plans, that the long timeframe involved creates a danger of reform fatigue, and that there is a need to prepare stakeholders for a more modern, efficient and patient-centred hospital system led by clinical centres.

Kosovo

In Kosovo, health reforms were introduced by the UNMIK administration in the immediate aftermath of the war in 1999. New policy guidelines drawn up by international policy advisors from the World Health Organization (WHO) started from a 'year zero' perspective with the aim of establishing a new health system in line with an imagined European model. This involved replacing the previously existing system of community health centres with a system of (yet to be trained) family medicine specialists at primary care level, who would act as gatekeepers to the provision of specialised care. Specialised practice at the primary care level was to be abolished. Notwithstanding the fact that, following the war, most Serbian medical staff had fled the country, and that the Albanian staff who took over had been working for the previous ten years in a parallel health system, it was decided to press ahead with the introduction of this new system in a situation of post-war chaos and emergency. Not surprisingly, the policy to over-ride previously existing arrangements led to much resistance. In Decani for example, UNMIK closed down the maternity ward of the community health centre, arguing that it would be more efficient to provide maternity services from the local district hospital. This led to virulent protests from staff and the local community (Bower 1999).

Private practice was legalised, and, in the absence of an effective funding system for the public sector, a significant private health sector is emerging in Kosovo (Bartlett 2008). Dean Shuey, the WHO's health policy advisor at the time, later wrote with others that "the health system of Kosovo is at risk of being unofficially privatised in an unregulated fashion" and that "there was a lack of direction regarding the appropriate mix of public and private funding" (Shuey, Qosaj et al. 2003). Objecting to the externally imposed family medicine model, many primary care specialists set up their own private clinics, undermining the system of community health centres (now renamed 'family medicine centres') (Percival and Sondorp 2010:8). Under the new system, statutory health financing was changed to general taxation, despite the advice of the World Bank to rebuild the Health Insurance Fund and re-establish a system of social health insurance. However, due to the low

financial capacity of the government, public health expenditure accounted for only 2.4 per cent of GDP in 2005 (amounting to a puny €22 per capita), while private health expenditure accounted for 3.1 per cent (Percival and Sondorp 2010: 9). To support the reforms, a Health Care Commissioning Agency was established which was charged with drawing up contracts with provider organisations at secondary care level, and signing performance contracts with municipalities for primary care provided through their family medicine centres.

Montenegro

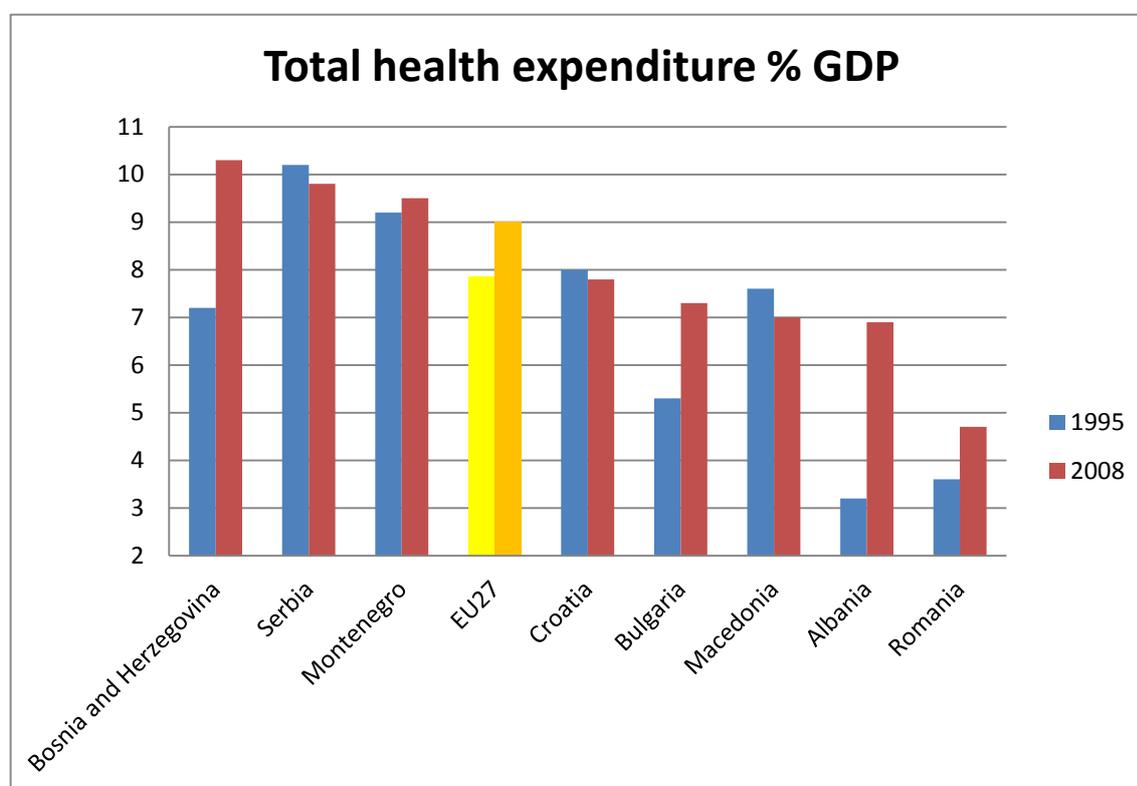
Health system developments in Montenegro mirrored those in Serbia until Montenegro became independent in 2006. Since then, the country has moved to the provision of primary health care by chosen medical practitioners and community health centres. As Ostojić and Andrić in **Chapter 15** of this volume describe, chosen medical practitioners work as teams in group practices and patients are free to choose their doctor and dentist. There are four different categories of chosen medical practitioners: doctors for children up to 15 years (paediatricians), doctors for women (gynaecologists), doctors for adults, and dentists. More specialist services are provided separately and located in community health centres, which act as reference centres of primary health care and provide support to chosen medical practitioners. Primary health care services are paid for based on a mixture of capitation payment and payment for health services provided.

The health system continues to rely on health insurance as the main statutory form of health financing. The Health Insurance Fund of Montenegro is responsible for pooling health insurance funds and purchasing health services. Population coverage with health insurance is high, reaching 97% in 2010. The ongoing World Bank-funded Healthcare System Improvement Project aims to initiate further steps towards reforming the health system, and aims to stabilize health financing and improve the delivery of primary health care.

Health financing

In terms of total expenditure on health as a percentage of GDP, there are significant differences across the region, with generally higher rates in 2008 than in 1995. The highest rates of total health expenditure can be found in the Yugoslav successor states Bosnia and Herzegovina, Serbia, and Montenegro, even exceeding the EU average. Romania had the lowest total health expenditure in 2008, amounting to only 4.8% of GDP (Figure 1).

Figure 1 Total health expenditure as a percentage of GDP, WHO estimates, 1995 and 2008



Source: WHO (2011) European Health for All database, July 2011 edition, Copenhagen: World Health Organization Regional Office for Europe

Table 1 Characteristics of health expenditure, 2000 and 2008

	General government expenditure on health as % of total expenditure on health ^b		Private expenditure on health as % of total expenditure on health ^b		Social security expenditure on health as % of general government expenditure on health		Per capita total expenditure on health (PPP int. \$)	
	2000	2008	2000	2008	2000	2008	2000	2008
Albania	36.1	39.4	63.9	60.6	20.4	38.2	262	569
Bosnia and Herzegovina	57.6	58.2	42.4	41.8	97.7	95.1	313	937
Bulgaria	59.6	57.8	40.4	37.7	12.7	60.3	373	974
Croatia	86.1	84.9	13.9	15.1	97.6	91.0	843	1 553
Macedonia	57.5	68.2	42.5	31.8	97.4	94.9	520	738
Montenegro	69.1	67.0	30.9	33.0	99.0	97.9	446	1 162
Romania	67.7	78.9	32.3	18.0	89.4	86.6	297	840
Serbia	70.1	62.5	29.9	37.5	92.5	92.4	313	867

Source: WHO (2011) World Health Statistics, Geneva: World Health Organization.

Considering the composition of health expenditure, it is striking that in several countries of the region private expenditure constituted a major share of total health expenditure in 2008, reaching 60.6 per cent in Albania, 41.8 per cent in Bosnia and Herzegovina, 37.7 per cent in Bulgaria and 37.5 per cent in Croatia. There are also considerable differences across the region in terms of total expenditure on health per capita, with levels in Croatia in 2008 almost three times higher than those in Albania (Table 1).

Social health insurance has been (re-)introduced in all SEE countries apart from Kosovo as the main statutory source of health financing and accounts for most government expenditure on health, with the exception of Albania, where it only accounted for 38.2% of government expenditure on health in 2008 (Table 1). Yet, social health insurance is increasingly seen as being inappropriate to transition economies with ageing populations and large informal sectors. In Croatia for example, the revenue base for the social health insurance system has been narrow, due to the low employment rate, and the Health Insurance Fund has until recently been in constant deficit. High rates of payroll tax have placed an additional cost on labour, reducing the willingness of employers to hire. The high contribution rates also encouraged employers to operate in the informal economy. There are also equity concerns, as the burden of payment is heaviest on those in formal employment, although taxation-based financing also faces the problem of raising revenue in economies with large informal sectors. In Croatia, one emphasis of reforms has been on reducing the range of benefits covered by health insurance, through for example reducing the range of exemptions and raising the proportion of revenues obtained from non-public sources such as patient co-payments. This has been criticized as a creeping privatisation of health financing (Voncina, Kehler et al. 2010), although it should be noted that private health expenditure constitutes only a small share of total health expenditure in Croatia (Table 1). Nevertheless, critics argue that less attention has been given to improving the efficiency and effectiveness of services provided at both primary and secondary level, which they believe would have allowed to offer a wider scope of services, even in an environment of financial stringency.

A study of the effects of introducing social health insurance in 28 transition countries in 1990-2004 carried out by Wagstaff and Moreno-Serra (2009) found that social health insurance typically increased the costs of providing health services, with no evidence of improvements in quality. The increase in costs appears to be associated with higher salaries of medical practitioners, the administrative and transaction costs associated with administering individual insurance accounts, and the costs of contracting the provider organisations. No improvements in amenable morbidity and mortality were discovered that could be attributed to the introduction of social health

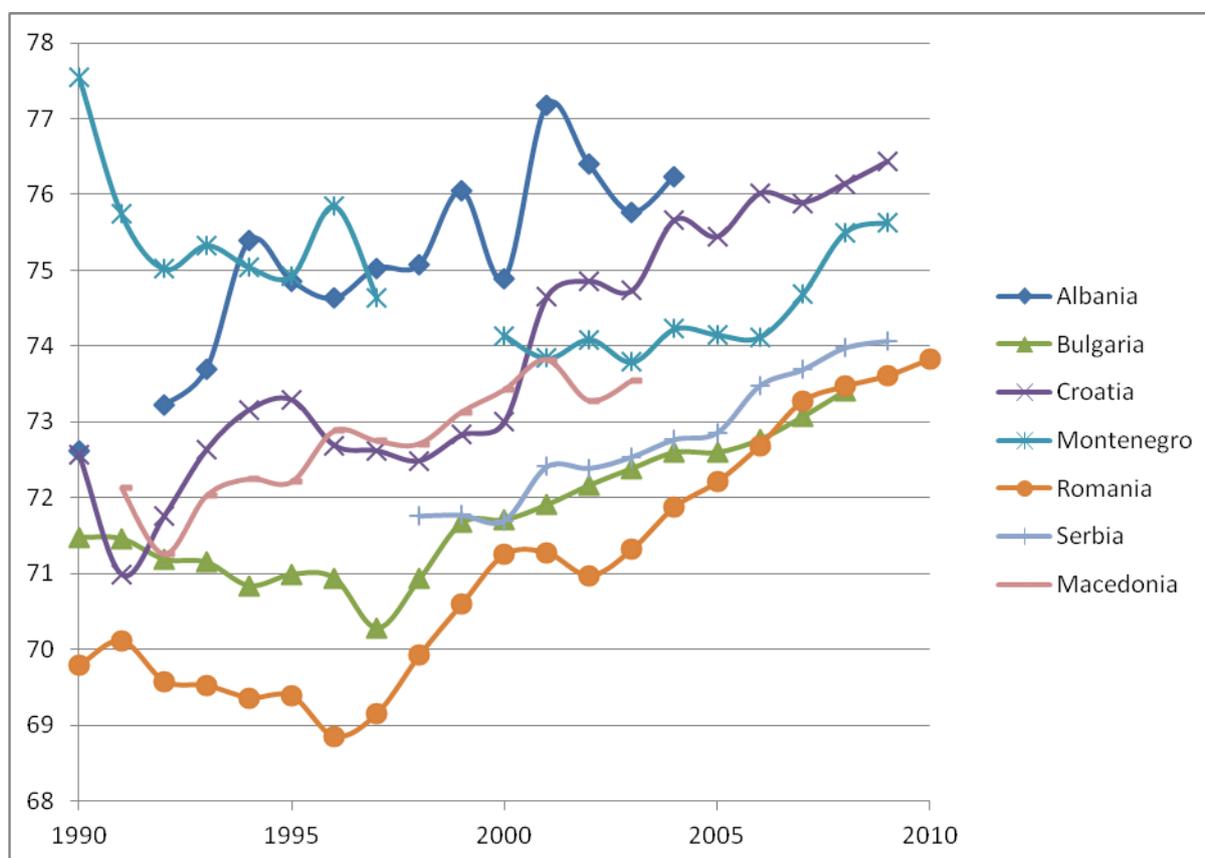
insurance, although there was typically a decrease in average hospital length of stay, increased bed occupancy rates and an increased rate of hospital admissions. A major reason for the failure of social health insurance systems in transition countries were the gaps in population coverage, such as those affecting the Roma minority, leading to a greater incidence of cases in which patients had not attended primary health care until their illness had progressed to a later stage, requiring avoidable (and more costly) hospitalisation. There is also anecdotal evidence that formal sector workers avoid signing up for health insurance until they become ill (Wagstaff and Moreno-Serra 2009).

Population health

With the collapse of Yugoslavia and the wars of the 1990s, the health systems in all Yugoslav successor states came under immense strain. Conditions in many hospitals and community health centres deteriorated dramatically, especially in Bosnia and Herzegovina and Croatia which were directly affected by the wars, and where enormous damage was inflicted on both health infrastructure and medical personnel. Health services in Serbia and Montenegro, although not directly affected by war, suffered from the imposition of UN sanctions between 1991 and 1995 (Black 1993). Despite the formal exemption of medical supplies from sanctions, the need to apply to the UN sanctions committee in New York for permission to import supplies led to an acute shortage of medicines in hospitals, although some could be bought in private pharmacies (Kazic 2001).

The health status of the population deteriorated dramatically in the 1990s, due to economic transition and the direct and indirect consequences of war, with increased rates of adult mortality and stagnating or falling life expectancy in several countries (Rechel and McKee 2003)(Rechel, Schwalbe et al. 2004). Since then, the region has experienced a surge in economic growth following democratic changes in Croatia and Serbia in 2000, and the accession of Bulgaria and Romania to the EU in 2007. Health indicators show encouraging trends, with life expectancy increasing across the region (Figure 2).

Figure 2 Life expectancy at birth, 1990-2010



Source: WHO (2011) European Health for All database, July 2011 edition, Copenhagen: World Health Organization Regional Office for Europe

Note: no recent data available for Bosnia and Herzegovina

More detailed analyses will be required to establish how much of these improvements are due to improvements in health systems. Dimova et al. argue in **Chapter 3** of this volume that health reforms in Bulgaria failed to achieve reductions in the very high premature mortality among those aged 40-59 years, while death rates from circulatory system diseases in Bulgaria were the highest in the European Union in 2008. This indicates substantial scope for health system interventions, in particular those related to public health and lifestyle changes, but also with regard to treatment of hypertension and stroke.

Conclusion

Health reforms throughout Central and Eastern Europe have often been driven more by political pressures and ideology than by research evidence on the effectiveness of different approaches (Rechel and McKee 2009). This is equally true of the transition countries of South East Europe. The widespread (re-)introduction of social health insurance has led to gaps in coverage in several countries, and there is reason to ask whether it would have been better to switch to or retain a model based on general taxation and universal population coverage. Only Kosovo has moved in this direction, in part because of the large size of its informal economy, making it difficult to raise contributions from employers and employees (there is also no income tax for this reason). The widespread adoption of general practice at primary care level has also been questioned, and doubts raised as to whether the polyclinic model inherited by the communist countries behind the iron curtain or the model of community health centres bequeathed to the Yugoslav successor states was really as ineffective as suggested by foreign advisors in the 1990s (Rechel and McKee 2009; Rechel and McKee 2008). The disbandment of polyclinics and their replacement by general practitioners working in single practice goes against the grain of recent trends in the West towards group practices in primary care. Fortunately, the model of community health centres is still in place in several of the Yugoslav successor states. It can be developed and, if properly resourced and regulated, turned into a basis for the development of primary health care in the future.

With the global plunge into economic crisis which began to affect the region in 2008, the period of strong economic growth between 2000 and 2007 has come to an end, unemployment and poverty have started to rise again, and it can be expected that there will be adverse effects on the health of the population. As governments seek to reign in budget deficits and restrict public expenditure on health services, it is more important than ever that the countries of the region improve the effectiveness and efficiency of their health systems.

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