

**REVIEW ARTICLE**

**Governance and management of health care institutions in Serbia: An overview of recent developments**

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### **Abstract**

In order to promote awareness of factors that affect social services, their quality, effectiveness and coverage, the term “governance” is frequently used. However, there is no agreement on definitions, frameworks and how it relates to the health sector.

In this overview, two interrelated processes in Serbia will be analyzed: governance and management at the macro-, meso-, and micro level.

Key messages are as follows: i) Continue decentralization and support to an effective national decision-making body (Health Council of Serbia) with all relevant stakeholders; ii) Reduce the well-known implementation gap and agree on a binding time frame for reforms, and; iii) Establish obligatory schemes for education and training of managers and support sustainability of state institutional capacity to teach, train and advise on a scientific basis.

**Keywords:** governance, health sector, management, Serbia.

**Conflict of interest:** None.

## Introduction

Governance and management of health care institutions encompass a series of regulatory measures undertaken for planning, organizing, functioning and evaluation of all the numerous and interrelated system elements by which the set objectives are brought into effect (1). Although it is considered as a multidimensional and interdependent process, there are differences between governance and management. How to apply in particular the term “governance” to the health sector? In order to promote awareness of factors that affect social services, their quality, effectiveness and coverage, the term “governance” is frequently used. However, there is no agreement on definitions, frameworks and how it relates to the health sector (2). In general, governance relates to decisions on the framework that defines expectations, grants power, or verifies performance. The debate over this terminology began in the early nineties when the World Bank defined governance as: *“the exercise of political authority and the use of institutional resources to manage society’s problems and affairs”* (3). In recent years, the avenues towards effective governance are described in more detail: good governance in health systems promotes efficient delivery of health services. Critical are appropriate *standards, incentives, information, and accountabilities*, which induce high *performance* from public providers (4). The United Nations led a debate on the understanding of good governance. Referring to the World Bank definition, good governance entails sound public sector management (efficiency, effectiveness, and economy), accountability, exchange and the free flow of information (transparency), and a legal framework for development (justice, respect for human rights and liberties) (5). WHO summarizes it as follows: *“The leadership and governance of health systems, also called stewardship, is arguably the most complex but critical building block of any health system. It is about the role of the government in health and its relation to other actors whose activities impact on health. This involves overseeing and guiding the whole health system, private as well as public, to protect the public interest. It requires both political and technical action because it involves reconciling competing demands for limited resources, in changing circumstances”* (6). Governance represents the owners, or the interest group of people, who represent an organization or any institution (7,8). The governing body, on the other hand, appoints personnel for the (executive) management. While governance is relevant for the vision of an organization, and translation of the vision into policy, management is related to making decisions for implementing the policies. Governance also includes the relationships among the many players involved (the stakeholders) and the corporate goals. The principal players include the shareholders, the board of directors, and the management. Other stakeholders include employees, suppliers, customers, regulators, the social environment and the community as a whole. Management comes only second to the governing body, and it is bound to strive as per the wishes of the governing body.

## Aim of this review

In this overview, two interrelated processes in Serbia will be analyzed: governance and management. To summarize the terminology, which will be used in the overview, as an official translation from Serbian, “macro,” “meso” and “micro” levels are discussed.

At the “macro” level, (usually at the state level) governance of health care system in Serbia is performed by Government, Ministry of Health and Republic Fund of Health Insurance. In addition, some governance functions in Serbia (without Kosovo and Metohija) are also at the level of (9,10):

- Autonomous Province of Vojvodina and its six cities and 39 municipalities; Governing bodies are “Province Government of Vojvodina”, “Province Secretariat for Health Social Policy and Demography” and “Province Fund of Health Insurance”.
- City of Belgrade and its 17 municipalities; Governing bodies are “City Council with the Mayor, Deputy Mayor and members” and “City Secretariat for Health Care”, and 23 cities (including those in Vojvodina with its 28 urban municipalities) and 150 municipalities (including those in Vojvodina); Governing bodies are the city and municipality authorities.

At the “meso” level (at the facility/institutional level), governance is performed by the Managerial Board of each facility/institution (in Serbian: “Upravni odbor”). Also, some governance functions with very weakly defined ToR (terms of references) at the institutional level are performed by the Supervisory Board (in Serbian: “Nadzorni odbor”). At the “meso” level management is performed by the Director and his/her management team.

At the “micro” level, we can observe only management processes.

A framework for assessing governance and management of health institutions in Serbia is based on a set of criteria to cover assessment of institutional, financial and accountability arrangements, together with decision-making capacity and responsibility during the last decade (11,12). Besides the “macro” level determining the basic structure, organization and finance of all publicly owned health institutions in the Serbian context, this overview particularly deals with the description of the “meso” level: the functions/responsibilities of health managers at primary, secondary and tertiary care level of organization (see Figure 1). However, the “micro” level dealing with operational management of staff and services inside the organization is also highlighted. This overview is prepared based on the following sources of information (data):

- published health policy and legal documents in Serbia, health legislation and guidelines from the Ministry of Health (MoH), published papers in the Serbian and international health management literature, internationally funded project reports (EU and WB projects’ reports dealing with health management, financing (capitation), quality improvement and local governance), health management conferences in the country and the region, training curricula and programmes of work;
- published general health statistics, national electronic databases and WHO/Eurostat database for comparison, and;
- results of national survey of all health institutions’ directors and matron nurses done by the Health Council of Serbia in 2010 and 2011.

## **I. Governance and management at macro level**

The essential characteristics of the external environment in which today’s governance and management of health service organizations in Serbia are taking place include population aging, costly medical technologies, lifestyle intervention, and advance health promotion and prevention. Also, the health care system, as in some other transitional countries, is faced with ethical and economic crises of unpredictable outcome. Political, social and, predominantly, professional groups attempt to introduce changes in health legislation and functioning of health service organization, however, with variable success.

At the macro level of governance, the most important was the adoption of the Health Policy Document (13) by the Serbian Government. No similar document has ever been adopted in Serbia, hence the process of bringing health in Serbia closer to the relevant policy of the

European Union was at this moment initiated. The Health Policy Document defined the main directions of development of the health care system. As such, it was essential as a foundation of laws and bylaws conducive to the reforms of the health care system, including governance and management at all levels. According to this Document, the reform of the health care system in Serbia, being a continuous process of the transition of the entire socio-economic system, presupposes the implementation of the following goals of the health policy:

- a) Safeguarding and improving the status of health of the population in Serbia and strengthening of the health potential of the nation;
- b) A just and equal accessibility to health care for all the citizens of Serbia and improvement of the health care for vulnerable populations;
- c) Putting the beneficiaries (patients) into the centre of the health care system;
- d) Sustainability of the health care system while ensuring transparency and a selective decentralization in the field of resource management, and diversification of sources and methods of financing;
- e) Improvement in functionality, efficiency and quality of the health care system and definition of specialized national programs to advance human resources, corporate networks, technologies, and provision of medical supplies;
- f) Defining the role of private sector in provision of medical services to the population;
- g) Improvement of the human resources for health care.

However, more than a decade after the adoption of this Document, achievements of the health policy proves still to be variable in the sense of governance and implementation, due to the lack of specific objectives and priorities adopted by all parties. In practice, the implementation of the proposed framework of health policy of Serbia presupposes consensus thereon of all the key actors in the health care system (beneficiaries, providers of services and mediators in the provision of health care – health insurance and ministry). Following the adoption of the new system laws in 2005 (Health Care Law and Health Insurance Law), intended decentralization has been considered to play a major role in the portfolio of possible activities to improve governance and management of health care organizations in Serbia. The actual organizational structure of the health care system in Serbia as a framework for governance and management at “macro level” is presented in Figure 1.

Serbia, as other parts of former Yugoslavia, inherited a centralized state health system financed by compulsory health insurance contributions. The system was intended to provide access to comprehensive health services for all citizens with an extensive network of health institutions. At the end of 2013, the publicly owned health care system in Serbia employed 112.202 persons in a total of 354 institutions (14).

Currently, in Serbia, looking at the governance at “macro” level as the process by which authority is exercised, still many functions related to strategic directions/planning, legislation, and financing are at the national – Republic level (Ministry of Health and Health Insurance Fund, see Figure 1).

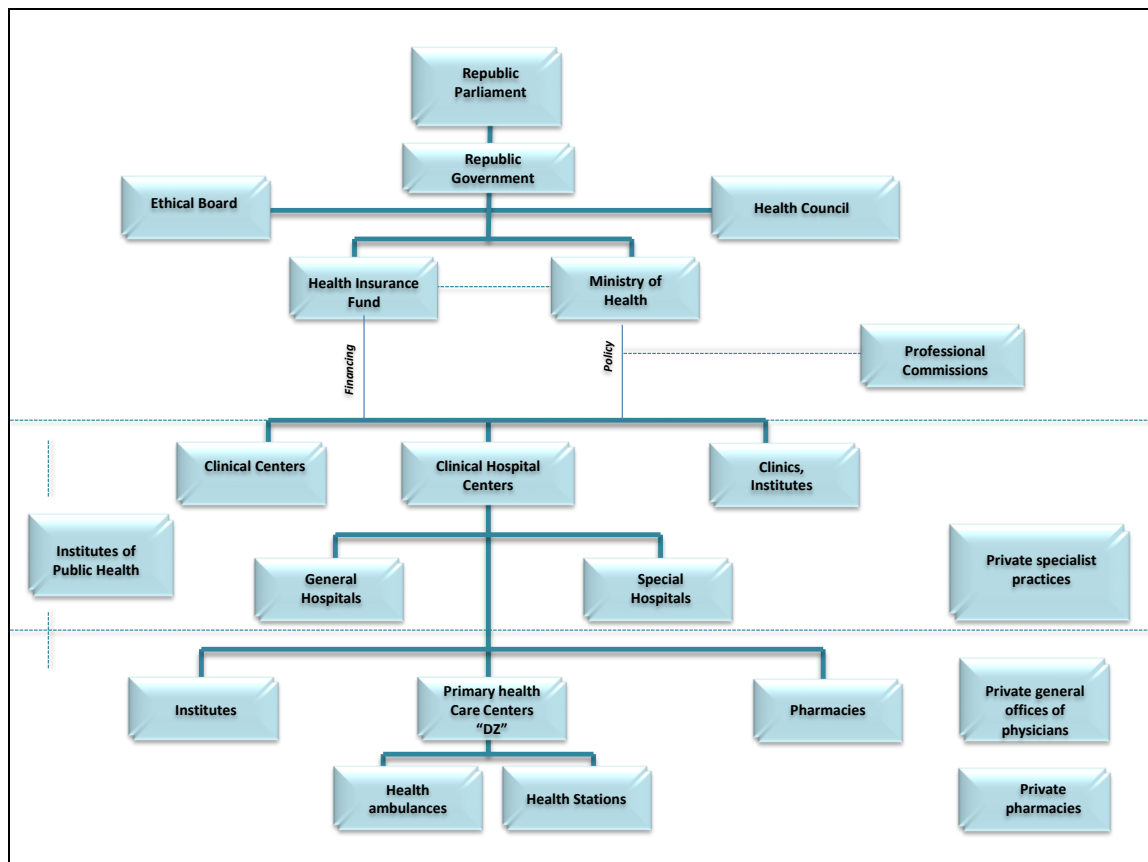
However, with the beginning of the process of decentralization, important players at “macro level” could also be seen at Vojvodina Province level, within its Provincial Secretariat for Health Care, Social Policy and Demography (15), City Belgrade Secretariat for Health Care (16), and the respective Provincial Health Insurance Agency (17). Social care for health at the level of an autonomous province, a municipality, or a city, includes measures for the provision and implementation of health care according to the interest of the citizens in the territory, as follows (Article 13 of Health Care Law) (18):

- i. *Monitoring of the state of health of the population and the operation of the health service in their respective territories, as well as looking after the implementation of the established priorities in health care;*
- ii. *Creating of conditions for accessibility and equal use of the primary health care in their respective territories;*
- iii. *Coordination, encouraging, organization, and targeting of the implementation of health care, which is exercised by the activity of the authorities of the local self-government units, citizens, enterprises, social, educational, and other facilities and other organizations;*
- iv. *Planning and implementation of own program(s) for preservation and protection of health from polluted environment, which is caused by noxious and hazardous matters in air, water, and soil, disposal of waste matters, hazardous chemicals, sources of ionizing and non-ionizing radiation, noise and vibrations in their respective territories, as well as by carrying out systematic tests of victuals, items of general use, mineral drinking waters, drinking water, and other waters used for production and processing of foodstuffs, and sanitary and hygienic and recreational requirements, for the purpose of establishing their sanitary and hygienic condition and the specified quality;*
- v. *Providing of the funds for assuming of the foundation rights to the health care facilities it is the founder of in compliance with the law and with the Plan of the network of health care facilities, and which includes construction, maintenance, and equipping of health care facilities, and/or capital investment, capital-current maintenance of premises, medical and non-medical equipment and means of transport, equipment in the area of integrated healthcare information system, as well as for other liabilities specified by the law and by the articles of association;*
- vi. *Cooperation with humanitarian and professional organizations, unions and partnerships, in the affairs of health care development.*

Decentralization implies a transfer of authority and competencies, as well as responsibilities from higher to lower levels. The transfer of authority from the central administration to smaller and local communities does not necessarily deprive the central government from all authority and power. The central administration should retain some control along with essential tasks in the sense of governance, such as legislative, financial, and regulatory duties. Any excess, whether it refers to total centralization or total decentralization, can harm the health care process (19). In the Health Insurance Act of 2005 (articles 208 et seq.), the Serbian Government (20) admitted that the reorganization of the Serbian Health Care System has to take into account the following key issues: *“The compulsory health insurance is provided and implemented by the Republic Fund of Health Insurance, with its official seat in Belgrade”* (article 208), and: *“The Republic Fund is managed by the insured that are equally represented in the Board of Directors of the Republic Fund in proportion to the type and number of the insured established by this act”* (article 209).

According to the Serbian legislation, health care facilities with funds in state ownership (hereinafter referred to as: state owned health care facility) are funded in accordance with the Plan of the network of health care facilities, which is adopted by the Government. Health care facilities that provide emergency medical care, supply of blood and blood derivative products, taking, keeping, and transplantation of organs and parts of human body, production of serums and vaccines and patho-anatomical and autopsy activity, as well as the healthcare activity in the area of public health, shall be funded exclusively in state ownership.

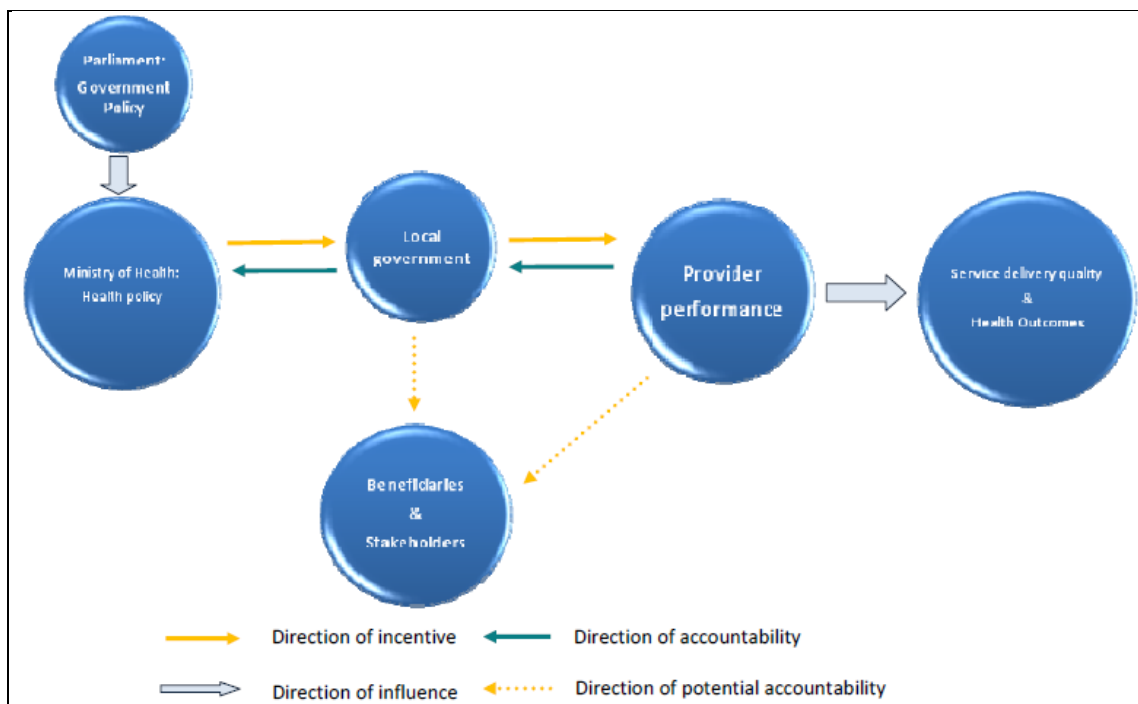
**Figure 1. Organizational structure of the health care system in Serbia**



Otherwise, health care facilities can be established by legal or natural persons at any level. The complex interrelationships between the macro-, meso-, and micro level are illustrated in Figures 2 and 3.

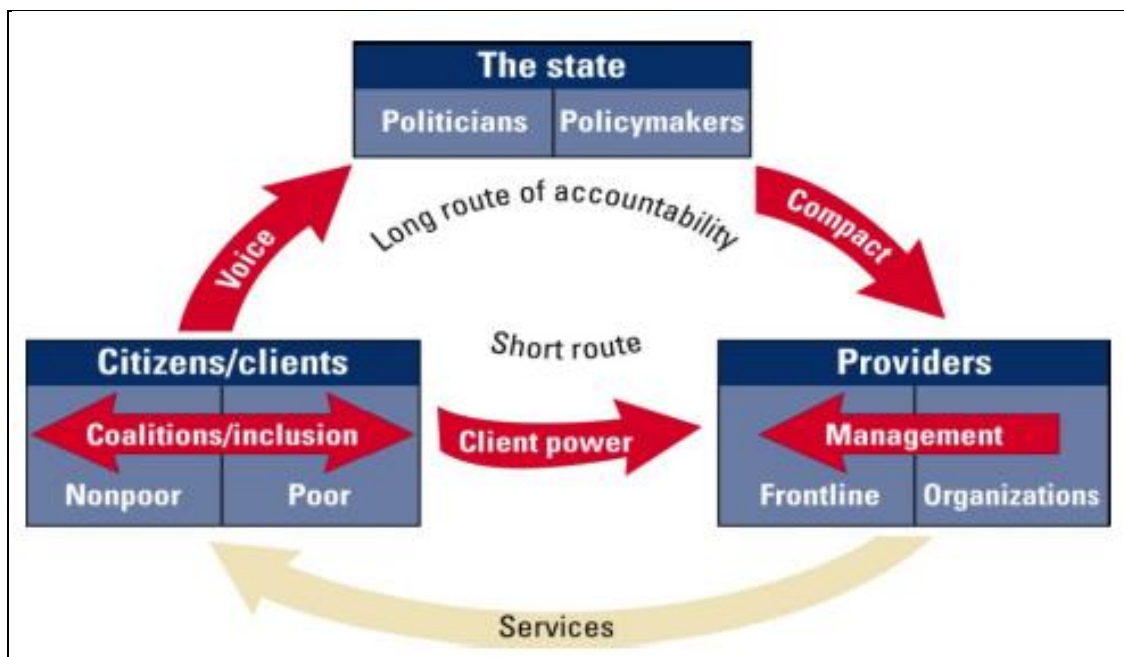
However, governance at the level of municipalities predominantly has been exercised only regarding appointments of the directors, deputy director, the members of the management board (board of directors), and the supervisory board of health care institutions, at the same time with low capacity/competencies to exercise the decision making process at the local level and use responsibilities in the decision making space. Execution of financial functions at the local/municipality level could be observed within some municipalities and their annual programme budget planning, which engages resources mainly to meet infrastructure needs of primary health care at the local level. Besides the adopted Law on Local Self-Governance (23) which is providing decision space for local authorities to exercise more responsibility in governance at the local level, decision capacity stays limited. Therefore, the main objective of the recent international projects, such as: DILS – “Delivery of Improved Local Services” [managed by ministries of health, education, labour and social policies (24)] and “Support to Local Self-government in Decentralization” [managed by Standing Conference of Towns and Municipalities (25)] are meant to increase decision capacity of multidisciplinary teams at municipality level, both in governance and management.

**Figure 2. Overview of the governance process**



**Source:** Original copy from: Lewis W, Pettersson G. Governance in Health Care Delivery: Raising Performance. Policy Research Working Paper 5074. Washington: The World Bank Development Economics Department & Human Development Department 2009 (21).

**Figure 3. The long and short routes of accountability**



**Source:** World Bank. World Development Report 2004: Making Services Work for Poor People, Washington, DC: World Bank 2004 (22).



Several factors contributed to this type of evolvement of governance at “macro” level. Firstly, Serbia is still in economic crisis, inherited from the past and aggravated by the world economic crisis. The poor performance of economy has a deep negative impact on the social sectors, including the health sector. Political involvement at almost all administrative levels has also affected in a negative way the proper governance and management of the health system. It induced changes in the human resources structure (especially top managers) affecting the continuity of governance at “macro” level and strategic thinking (26,27). Besides financial and legislative problems, many other weaknesses in the area of organization and functioning of the health care sector are present at “macro” level governance:

- rigid normative regulation of the health care system;
- centralized and bureaucratized management with limited autonomy of managers lacking necessary management skills;
- still not fully developed and operational health information system and up-to-date information as basis for decision-making processes;
- undeveloped “market” in the health sector with deprivation of private health care providers and still “passive” approach to privatization in the health care system;
- development of health facilities beyond economic possibilities, their duplication, lack of coordination of activities according to levels of health care organization, poor maintenance of equipment and buildings, lack of sufficient operational budgets;
- low professional satisfaction of health workers caused by low salaries with the consequence of bad motivation for providing efficient and quality health services;
- dehumanised relationships between medical personnel and patients followed by absence of citizens’ responsibility for their own health;
- curative orientation of the health care system with priority in development of secondary (hospital) and tertiary (sub-specialized) levels of care, despite formal support to primary health care orientation;
- unrealistic objectives for prevention with formal and non-effective programs and activities in health promotion despite widespread risk behaviour and numerous environmental hazards;
- lasting postponement of implementation of legal and administrative decisions, with lack of SWAps (Sector Wide Approaches) as necessary for development and implementation of regulations connected to the authority of other ministries, such as those dealing with economic affairs and regional development.

However, certain achievements of “macro” level governance during the last decade have to be acknowledged, such as the introduction of the Health Council of Serbia as advisory body to the Ministry of Health, development of a transparent process for continuous quality improvement in health care and the agency for accreditation, trying out new payment mechanisms in primary health care (“performance-based payment” as a step towards capitation), preparation for more efficient financing of hospitals by development of a DRG system, and the like.

## **II. Governance and Management at meso-level**

### ***Institutional arrangements***

A review of health service legislation and the regulatory environment related to governance and health management shows weak areas that should be addressed and opportunities that

exist to make governance and management the mainstay of health sector reform in Serbia. Contrary to a typical business organization, the authority structure in managing a health services organization is divided among three authority and responsibility centres: Board of Directors, Doctors, and Administration represented by the Director and his Management Team (28,29). The Managerial Board is legally responsible for the organization as a whole, including provision of health care, public relations and assistance in supply of resources for its functioning. If basic social roles of a health service are under consideration, it is the *Managerial Board* that most commonly reflects the profile of the community and its health services organization. It means that the former consists of delegates from various social groups of certain educational level and experience and in this way is executing governance at the “meso” level. *Doctors*, comprising a medical board, but others as well, have a powerful role in management, since they are hold responsible for the majority of cost rendering decisions made. *Administration*, composed of director, heads of departments and chiefs of assisting services, is the third and last authority centre in managing health services organizations, responsible for operational management.

The authority and responsibility structure in managing the health services organization in Serbia is defined in the Health Care Law and bylaws together with the role and current and expected function of health managers at “meso” level. According to the Health Care Law (Article 130), a typical health care organization in Serbia has the following management structure: the director, the managerial board (corresponding to the board of directors), and the supervisory board. It may also have a deputy director, who is appointed and relieved under the same conditions and according to the same procedure, which is specified for appointment and relieving of the director of the health care organization. The director, deputy director, the members of the management board, and the supervisory board of health care organisations are appointed and relieved by the founder. As an example, the director, deputy director, the members of the management board, and the supervisory board of an institute, clinic, institute, and clinical center, or the Health Care of Employees Institute of the Ministry of Interior Affairs, the founder of which is the Republic, are appointed and relieved by the Government. The director, deputy director, the members of the management board, and the supervisory board of health care facilities the founder of which is the Republic, except for the specifically mentioned institutions, are appointed and relieved by the Minister.

The director of a health care facility is appointed on the basis of a vacancy publicly announced by the management board of the health care organisation. The management board of a health care organization makes selection of the candidate and submits the proposal to the founder, which then makes the appointment. However, should the management board of a health care organization fail to elect the candidate for the director of the health care facility, or should the founder of a health care facility fail to appoint the director of the health care facility, in accordance with the provisions of the Law, the founder shall appoint the acting director for a period of six months. In practice, it was not unusual that “acting director” stays for couple of years; whereas the Law (article 135) also prescribed criteria for appointment, as well as conditions in which the director of a health care organization should be replaced.

Furthermore, the same Health Care Law defines responsibilities and duties of the respective managerial bodies. The director is organizing the work and managing the process of work, representing and acting as proxy of the health care facility and is responsible for the legality of work of health care facility. In this way, contrary to established theory and practice, it seems that in Serbia the director has also some governance function. If the director does not

have medical university qualifications, the deputy, or assistant director shall be responsible for the professional and medical work of the health care facility. The director shall submit to the management board a written quarterly, and/or six-monthly report about the business operations of the health care organization. The director shall attend the meetings and participate in the work of the management board, without the right to vote.

Contrary to the position of the director, the Law does not prescribe such detailed instructions as regards who should be appointed for management board and supervisory board. It is only stated (article 137) that the management board in primary health care centres - DZ, pharmacies, institutes (see Table 1 for details), and the national public health institute have five members of whom two members are from the health care organization, and three members are the representatives of the founder, whereas the management board in a hospital, clinic, institute, clinical hospital, and clinical centre has seven members of whom three members are from the health care facility, and four members are the representatives of the founder. Responsibilities of the management board are the following:

- i) Adopt the articles of association of the health care organization with the approval of the founder;
- ii) Adopt other bylaws of the organization in compliance with the law;
- iii) Decide on the business operations of the health care organization;
- iv) Adopt the program of work and development;
- v) Adopt financial plan and annual statement of account of the health care organization in compliance with the law;
- vi) Adopt annual report on the work and business operations of the health care organization;
- vii) Decide on the use of resources of the health care organization, in compliance with the law;
- viii) Announce vacancy and implement the procedure of election of the candidates for performing the function of the director;
- ix) Administer other affairs specified by the law and the articles of the association.

A supervisory body as the third centre of authority is appointed in a similar way as the management board (with three members for less complex health care organizations and five for those at secondary and tertiary level of organization). Contrary to the management board, the Law does not prescribe in detail responsibilities of the supervisory board, except for the following (article 138): *“The supervisory board of health care organization shall exercise supervision over the work and business operations of a health care organization”*. In practice, such formula is producing a rather passive role for this body.

A recent survey of all directors of health care organizations conducted by the Health Council of Serbia in 2010 and 2011, pointed to some general and some specific characteristics of management at “meso-level”. The study used a questionnaire designed on the basis of similar studies in Serbia, which comprises five groups of questions: general characteristics that define the manager profile, the problems of management, assessment of the importance of motivational factors, carrying out the management goals and self-evaluation of managerial skills. According to this survey, the managers of health care organizations in Serbia are mostly experienced specialists, slightly more often males than females, who usually have some form of management education (Table 1). In comparison with the period of the nineties, the structure of health organizations’ managers in Serbia improved in terms of management training and gender sensitivity.

**Table 1. General profile of directors of health care organizations in Serbia**

| CHARACTERISTICS                        | Directors of outpatient institutions (n=140) |         | Directors of hospital institutions (n=90) |         | P      |
|--|--|---------|---|---------|--------|
|  | Number                                       | Percent | Number                                    | Percent |        |
| <b>Gender</b>                          |  |         |   |         |        |
| Male                                   | 76   | 54.3    | 61  | 68.5    | 0.032  |
| Female                                 | 64   | 45.7    | 28  | 31.5    |        |
| <b>Age (years)</b>                     |  |         |   |         |        |
| <35                                    | 3  | 2.1     | 1   | 1.1     | 0.033  |
| 35-45                                  | 14   | 10      | 11  | 12.5    |        |
| 46-55                                  | 92   | 65.7    | 42  | 45.7    |        |
| 56-65                                  | 31   | 22.1    | 34  | 38.6    |        |
| <b>Occupation</b>                      |  |         |   |         |        |
| Physician with specialization          | 104  | 76.3    | 87  | 96.7    | <0.001 |
| Physician without specialization       | 6  | 4.3     | 0   | 0       |        |
| Dentist                                | 8  | 5.7     | 0   | 0       |        |
| Pharmacists                            | 19   | 13.6    | 1   | 1.1     |        |
| Economists, lawyers, other             | 3  | 2.1     | 2   | 2.2     |        |
| <b>Working experience</b>              |  |         |   |         |        |
| up to 15                               | 8  | 5.9     | 7   | 8.1     | 0.135  |
| 15-19                                  | 21   | 15.4    | 7   | 8.1     |        |
| 20-24                                  | 44   | 32.4    | 20  | 23.3    |        |
| 25-29                                  | 38   | 27.9    | 27  | 31.4    |        |
| over 30                                | 25   | 18.4    | 25  | 29.1    |        |
| <b>Managerial experience (years)</b>   |  |         |   |         |        |
| <1                                     | 21   | 15.2    | 7   | 8       | 0.265  |
| 1-2                                    | 43   | 31.2    | 28  | 31.8    |        |
| 3-4                                    | 25   | 18.1    | 10  | 11.4    |        |
| 5-6                                    | 18   | 13      | 14  | 15.9    |        |
| 7-9                                    | 24   | 17.4    | 23  | 26.1    |        |
| over 10                                | 7  | 5.1     | 6   | 6.8     |        |
| <b>Education in management</b>         |  |         |   |         |        |
| Yes                                    | 110  | 79.1    | 60  | 67.4    | 0.047  |
| No                                     | 29   | 20.9    | 29  | 32.6    |        |
| <b>Type of education</b>               |  |         |   |         |        |
| Self-empowerment                       | 13   | 11.2    | 12  | 18.2    | 0.212  |
| Courses                                | 73   | 62.9    | 43  | 65.2    |        |
| Master programmes                      | 30   | 25.9    | 11  | 16.7    |        |
| <b>Satisfaction with social status</b> |  |         |   |         |        |
| Very satisfied                         | 99   | 70.7    | 65  | 72.2    | 0.959  |
| Moderate satisfaction                  | 35   | 25      | 21  | 23.3    |        |
| Not satisfied                          | 6  | 4.3     | 4   | 4.4     |        |
| <b>Member of a political party</b>     |  |         |   |         |        |
| Yes                                    | 85   | 63      | 37  | 42.5    | 0.003  |
| No                                     | 50   | 37      | 50  | 57.5    |        |

Source: Health Council of Serbia Survey of Directors of Health Care Organizations 2010-2011 (30).

A situation analysis performed within a recent EU project found that given the opportunity, some health workers would choose management roles in the health services. They may also choose project-based work with international organisations and NGOs, and when the funding for such projects ends may seek to return to the health services in management positions.

There are also managers in legal services, human resources, utilities management and other professional categories. The issues of general management and non-medically trained managers are complex and have not yet been addressed in Serbia as a debate about health management has only recently started. The need for new management skills is being partially met by existing institutions and universities, on the job training, projects funded by international organisations and NGOs, and, in a very limited way, education programmes by newly emerging private providers. A large boost is required to create a cadre of managers who can bring about change in the health services.

Responsibilities of managers in Serbia will request change with decentralisation, requiring more knowledge and skills at municipal level. Private/public partnerships are likely to develop within the next five years, requiring more skills in contracting out. As of now, there is no clear career structure or progression pathway for health managers. However, this is likely to be mapped out within the next five years and will increase demand for formal training and accredited courses.

It is expected that the old style bureaucratic and very hierarchical structure will change and for this managers with change management skills will be required. The following have been identified by key informants as priority areas for the introduction of change management:

- Team working will enable a more effective approach to cross-disciplinary tasks.
- Better use of information technology is likely to produce information that is more relevant to decision-making.
- Financial tracking will shift to output-based methods and efficiency will be measurable.
- Individual accountability, currently weak, will be required to increase; there will be a shift to benchmarking rather than a reliance on blame and, therefore, criteria for positive results will become more transparent and measurable.
- Transparency in decision making and better planning and consultation processes.
- Prioritizing of scarce resources while protecting access to services for the poor and uninsured.
- Project management skills will be applied within the health service.
- There will be a shift from development support from the international community towards loans and credits; managers who understand how to use such funds will be required.
- There will also be a shift towards contracting out services.
- Increased individual accountability and managers who understand client-focused services will be required.

This will require a cadre of managers with a very new set of skills. By producing large numbers of change managers it is also expected that they will be able to support each other in a system that is currently quite hostile to change. This has been a positive experience from the EAR funded and Carl Bro implemented project, where team-based working and problem solving has also provided professional support for the managers involved.

There is a frequently expressed belief in the health services that hospital management is very different to general management of other organizations. There is likely to be little acceptance of general managers in the health system; actually, this has not been tried out in Serbia to date, but it should not be excluded. There is also a practice that amongst health professionals, only senior specialist doctors have the authority required for senior management and leadership positions in the health services; again, this should be questioned and tested (27).

### ***Financial arrangements***

Besides the main financial arrangements in Serbia and implementation of ongoing changes in the financial management system, particular attention is given to the managerial aspects of decision making related to capital investment, adjustment of capital and operational expenses and ability to incur debt, sometimes considered by managers (directors and management teams) as deficit carried over from the last fiscal year and due to introduction of a new budget system for reporting based on the new Law on Budget System, which is ongoing from 2009 and adopted in the Serbian Parliament each year (31). According to real practice examples, strengths and weaknesses are obvious in planning and reporting on institutional financial flows. Typically, the managerial board (“Upravni odbor”) is responsible for the adoption of financial reports and annual budget plans at the beginning of each calendar year, after which a report and a plan is processed to the Republic Fund of Health Insurance for approval and serves as a base for contracting with the health care organization. Those institutions which have also financing directly through the Republic Budget (such as Institutes of Public Health) are obliged to send their plan of activities including a budget in the foregoing calendar year for the next calendar year. Although it should be activity-based costing, very often the correlation between activities and budget lines is not clear and visible. Examples from practice indicate that the managerial board (“Upravni odbor”) does not have always direct responsibilities in financial arrangements, as sometimes changes in contractual agreements with the Republic Fund of Health Insurance, as well as with the Ministry of Health during the year are reported by directors only post factum. This is also an indication of the relatively weak role (responsibility) of the managerial board within health care organizations of Serbia regarding governance.

### ***Accountability arrangements***

Health Managers are not defined as a separate profession in Serbia. Senior staff in the health services has management functions and responsibilities, and these are noted under the Health Law of 2005 and under various other procedural documents in the legislation. With very few exceptions, senior health services managers in the country are doctors, there is more variety at middle management level, although the two levels have not till now been clearly defined. In the study of managing health services organizations in Serbia over the last decade, apart from the triple power and authority distribution between management and supervisory board, administrative director with his collegiums, workforce particularly doctors, *specific accountability and responsibilities* include the following:

- accountability and responsibility *for the patient*, above all, within the scope of modern medicine and health promotion movement, with provision of the best possible health care, with minimal costs. Only recently in Serbia - within the development of different patient NGO's;
- accountability is increasing in this regard, apart also from recently established the so-called “protector” of patients' rights in each institution. Reports about patients' complaints are regularly presented both to directors and managerial boards. However, regular monitoring during five years within the reporting about quality indicators has pointed to a low level of complaints and consequently few actions by management for corrections;
- accountability and responsibility *for the employed workforce* by recognizing their sensible requirements for safety in terms of wages, appropriate working conditions,

promotions, but also identifying their fears caused by uncertainty regarding positive effects of their work (outcomes concerning the treated patients' health). Usually, this is exercised through trade unions, sometimes several per one health care organization;

- accountability and responsibility *for a financier* and different social groups (donors, sponsors) supplying resources for functioning of the institution;
- accountability and responsibility *for the community (public)* in determining means for meeting the population health care needs, and;
- accountability and responsibility *for oneself* by making efforts to perfect one's knowledge and skills related to management as well as readiness to make effective responses under conditions of continuing changes and threats.

The national survey of directors is offering assessment of the last bullet point referring to managerial skills (Table 2). There are no differences between outpatient and hospital managers in this regard, however, this is a very subjective assessment indicating surprisingly high competences, which should be further investigated and verified.

**Table 2. Self-assessment of managerial skills (on a 5-point scale)**

| SKILL  | Directors of outpatient institutions (n=140) |       | Directors of hospital institutions (n=90) |       | P     |
|--|--|-------|---|-------|-------|
|  | Average                                      | SD    | Average                                   | SD    |       |
| Evidence based situation analysis                    | 4.39   | 0.862 | 4.37                                      | 0.788 | 0.859 |
| Application of SWOT analysis                         | 3.59   | 1.293 | 3.42                                      | 1.277 | 0.350 |
| Development of mission and vision                    | 4.20   | 1.052 | 4.30                                      | 0.866 | 0.450 |
| Development of flow-charts for specific work process | 3.28   | 1.227 | 3.25                                      | 1.199 | 0.833 |
| Development of SMART objectives                      | 3.57   | 1.290 | 3.39                                      | 1.216 | 0.322 |
| Development of diagrams                              | 3.15   | 1.321 | 3.10                                      | 1.234 | 0.805 |
| Development of WBS                                   | 3.46   | 1.332 | 3.23                                      | 1.180 | 0.217 |
| Assessment of employees                              | 4.26   | 0.930 | 4.17                                      | 0.865 | 0.476 |
| Public relations skills                              | 4.30   | 0.852 | 4.25                                      | 0.918 | 0.700 |
| Change management skills                             | 4.29   | 0.862 | 4.30                                      | 0.714 | 0.944 |
| Project management skills                            | 4.26   | 0.864 | 4.33                                      | 0.769 | 0.536 |
| Conducting effective meeting                         | 4.45   | 0.704 | 4.54                                      | 0.724 | 0.374 |
| Searching through internet                           | 4.14   | 0.928 | 4.17                                      | 0.950 | 0.811 |
| Communications with employees                        | 4.60   | 0.560 | 4.51                                      | 0.642 | 0.222 |
| Fund raising and donor searching                     | 4.10   | 1.046 | 3.84                                      | 1.127 | 0.087 |

Source: Health Council of Serbia Survey of Directors of Health Care Organizations 2010-2011 (30).

### ***Decision-making capacity versus responsibility***

This section is based mainly on the national health management survey executed among directors of health care institutions and matron nurses. There are few exclusive health service managers, as it is an insecure profession. Often doctors take up a management role but continue to wear their "clinical hats" and keep a base in their clinical work. This gives them a safety net in the event that they do not keep their management posts, the most senior of which are subject to political appointment. According to the national survey results in Serbia, priority objectives for managers are: improving health care quality, increasing patient

satisfaction and professional development, as well as improving employee satisfaction and work organization (Table 3).

Significant differences were found between managers of primary healthcare organizations and hospitals: outpatient facilities' managers are much more likely to improve in the areas of management, are significantly more often members of a political party and more frequently state that the problem of management is the lack of coordination in health care institutions. The major objectives for hospital managers are familiarizing new employees with the work process, introducing new technologies and developing scientific research.

**Table 3. Assessment of importance of institutional objectives by directors (on a 10-point scale)**

| OBJECTIVE                          | Directors of outpatient institutions (n=140) |       | Directors of hospital institutions (n=90) |       | P     |
|------------------------------------|--|-------|---|-------|-------|
|                                    | Average                                      | SD    | Average                                   | SD    |       |
| Improvement of work organization   | 73.17  | 26.59 | 78.30                                     | 21.88 | 0.132 |
| Decreasing of operational costs    | 63.31  | 31.10 | 64.77                                     | 31.28 | 0.733 |
| Increasing staff satisfaction      | 76.26  | 23.38 | 75.17                                     | 24.82 | 0.740 |
| Increasing consumer satisfaction   | 79.14  | 22.89 | 80.80                                     | 24.08 | 0.603 |
| Multidisciplinary team work        | 69.78  | 26.80 | 74.89                                     | 24.02 | 0.148 |
| Empowering of newly employed staff | 57.55  | 30.30 | 65.34                                     | 26.78 | 0.050 |
| Continuing education               | 78.06  | 23.68 | 77.84                                     | 25.12 | 0.948 |
| Introduction of new technologies   | 71.09  | 28.40 | 78.60                                     | 24.02 | 0.042 |
| Research and development           | 52.07  | 33.61 | 68.50                                     | 32.20 | 0.001 |

Source: Health Council of Serbia Survey of Directors of Health Care Organizations 2010-2011 (30).

Considering the main player in the setting of institutional objectives, the situation is very interesting pointing to very low authority of managerial boards in this process, which is mainly governance function. According to the national survey conducted in 2010-2011, the situation is as follows:

- Ministry of Health 7.4%
- Director alone 2,6%
- Director after discussion with collaborators and staff 65,7%
- Management team and its discussion 22,6%
- Other players 0.4%
- Without answer 1,3%

Managerial problems (Table 4) are grouped into factors, based on which it is possible to define future interventions such as improvement of work organization and coordination, control systems and working discipline.

Strategic management comprises drafting, implementing, and evaluating cross-functional decisions that enable an organization to achieve its long-term objectives together with solving strategic and operational daily problems of management. In this process, a strategic plan is laid out that encompasses the organization's mission, vision, objectives, and action plans aimed at achieving these objectives.



**Table 4. Assessment of management problems (on a 4-point scale)**

| Type of problems                       | Directors of outpatient institutions (n=140) |       | Directors of hospital institutions (n=90) |       | P     |
|--|--|-------|---|-------|-------|
|  | Prosečna vrednost                            | SD    | Prosečna vrednost                         | SD    |       |
| Planning                               | 2.78   | 0.942 | 2.65                                      | 0.871 | 0.314 |
| Work organization                      | 2.79   | 0.832 | 2.72                                      | 0.750 | 0.514 |
| Coordination of services               | 3.17   | 0.731 | 2.85                                      | 0.847 | 0.003 |
| Replacement of staff                   | 2.75   | 0.884 | 2.63                                      | 0.949 | 0.363 |
| Professional development               | 3.06   | 0.923 | 2.93                                      | 0.997 | 0.329 |
| Procurement of equipment               | 2.09   | 1.062 | 1.84                                      | 0.931 | 0.067 |
| Keeping of equipment                   | 2.39   | 1.036 | 2.21                                      | 0.935 | 0.199 |
| Financing                              | 1.86   | 0.938 | 1.76                                      | 0.905 | 0.413 |
| System of control                      | 2.90   | 0.851 | 2.84                                      | 0.838 | 0.589 |
| Information System                     | 2.46   | 0.992 | 2.38                                      | 1.053 | 0.598 |
| Working discipline                     | 2.96   | 0.734 | 2.80                                      | 0.733 | 0.108 |
| Cooperation with Ministry of Health    | 2.80   | 1.105 | 2.87                                      | 1.120 | 0.664 |
| Cooperation with Health Insurance Fund | 2.70   | 1.057 | 2.63                                      | 1.083 | 0.658 |

**Source:** Health Council of Serbia Survey of Directors of Health Care Organizations 2010-2011 (30).

A recent study of 40 hospital management teams in Serbia proved capacity of managers who are trained to improve strategic management competences and accept clear responsibility in strategic management. During the workshop done with the same 40 general hospitals managers they did a SWOT analysis and possible strategic options for development of their organizations. Examples are presented in Table 5.

Continuing education on health care management is being offered in Serbia at an increasing scale, in response to the health care system's well-known deficits. Recently, at the Belgrade School of Medicine, a postgraduate Master's program in health care management was established. However, in Serbia, such programs have been evaluated very rarely if at all. Exceptions are the results of the training programme for hospital and primary health care managers, offered by the Centre School of Public Health and Management in Belgrade, with providing evidence, for the first time in Serbia, of effective support to the directing managerial teams with respect to their strategic planning abilities.

During those studies, the measurement and evaluation of hospital performance were recognized as essential, partly as a consequence of the recently established reporting system of quality indicators and partly due to recognition of the usefulness for benchmarking. Only a few stakeholders, e.g., the Ministry of Health, the Republic Health Insurance Fund, and project agencies, were considered relevant for the hospitals. Those key partners directly affect hospital services and financial flows and, therefore, were highly correlated to hospital managers' ability to plan strategically. This demonstrates that the managerial teams were predominantly oriented toward the fulfilment of legal obligations and contracts. The second independent component was a detailed analysis of the internal environment (staff, their training and development, management, information system, equipment, customers and their satisfaction, and kind and quality of health services).

The hospital's internal environment was included in the government's health reform initiatives (32). In Serbia, defining a hospital's mission, vision, action plan, and especially its

SMART objectives (33) seems to be dependent on the political environment and the existing legislation.

**Table 5. Strategic management thinking in Serbian general hospitals**

|  |  |
|--|--|
| <b>Example of vision and mission statement:</b>  |  |
| <i>“We are here to provide optimal methods in health care services with respect to the demands of our patients and to apply new technological accomplishments for the faster and more efficient treatment of our customers.”</i> |  |
| <b>Examples of goals:</b>  |  |
| Development of quality and efficiency of health care services  |  |
| Establishing new diagnostic and therapeutic methods  |  |
| Implementation of procedures for ambulatory surgery  |  |
| <b>Examples of strengths:</b>  | <b>Examples of weaknesses:</b>                                     |
| Highly educated staff  | Medical staff holding second jobs in private practice              |
| Introduction of clinical guidelines  | Medical equipment out of date                                      |
| Renovation of some parts of our facilities   | Low motivation of staff  |
| Good relationship with the media   | Negative financial balance   |
| <b>Examples of opportunities:</b>  | <b>Examples of threats:</b>  |
| Rationing of hospital staff and facilities   | Lack of treatment standards and protocols                          |
| Support from the local community and from NGOs   | High number of refugees and internally displaced people            |
| Participation in international projects  | Lack of effective gatekeeper function in primary health care       |
| <b>Proposals of strategic options</b>  |  |
| <b>Comparative advantage (Strength/Opportunity):</b>   | <b>Investment/Divestment (Weakness/Opportunity):</b>               |
| Widen the spectrum of services to gain additional income   | Promotion of cooperation with local authorities                    |
| <b>Mobilisation (Strength/Threat):</b>   | <b>Damage control (Weakness/Threat)</b>                            |
| Improvement of communication with customers  | Note: The teams could not or did not want to imagine this scenario |

**Source:** Workshop with 40 general hospital teams done in 2009 by the School of Public Health and Health Management University of Belgrade, within an EU project (see also Terzic-Supic et al. (32).

In order to increase further management capacity to deal with management problems, numerous training have been organized since 2007 supported by several projects which resulted in the development of strategic plans:

- “Capacity building of hospital management teams”, supported by EU project (result: 40 hospitals developed strategic plans);
- “Programme for management development in primary health care institutions of Belgrade” Project funded by the City Secretariat of Health Care Belgrade, 2007-2009 (result: 14 primary health care centres in Belgrade developed strategic plans);
- Working group of Serbian Basic Health Project – Ministry of Health (WB) – education of 7 primary health care managers (result: 9 primary health care centres in Belgrade developed strategic plans);
- “Politics of Primary Health Care in Balkans”, project managed by CIDA (result: 7 primary health care centres developed strategic plans);

- “Support to the implementation of capitation payment in primary health care in Serbia”, EU financed and managed project (result: 29 primary health care centres developed strategic plans);
- DILS – “Delivery of Improved Local Services” (managed by PIU of ministries of health, education, labour and social policies (result: 28 primary health care centres developed strategic plans).

Looking at primary health care organizations up to 2012, in total, 78 out of 157 have developed strategic plans based on this capacity building (predominantly with the support of the School of Public Health and Management, Faculty of Medicine, University of Belgrade). In addition, strategic plans for capacity building of management teams in primary health care as support to the new method of payment of providers in primary health care are developed since 2010. It is also proven (34-37) that the training courses offered to management teams in Serbia by the Centre School of Public Health and Management in Belgrade had positive effects on the teams’ ability to formulate their organizational mission and vision, strategic objectives, and action plan as learning outcomes and to implement monitoring and adjustment of their strategies. Nevertheless, the research evidences in Serbia also demonstrates that improving strategic planning practices can be effective, but many health care organizations have difficulties in translating their strategic plan into actions that result in successful performance.

### **III. Management at micro-level**

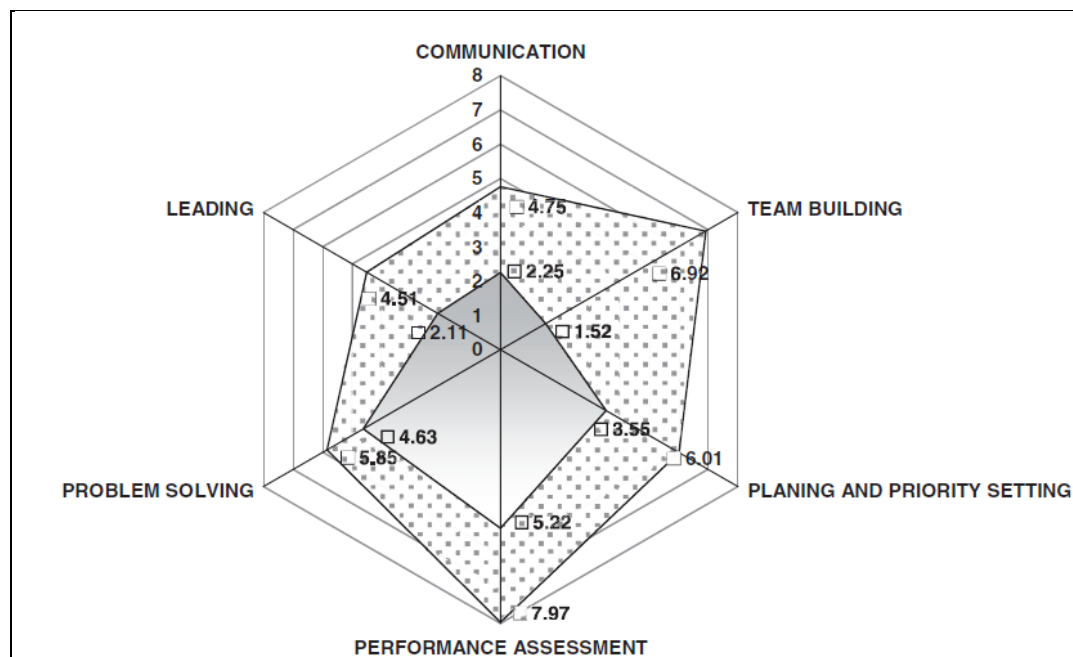
As physicians and to a lesser extend nurses regularly execute management functions at micro-level, it is of great relevance for a smooth operation of services as well as for the satisfaction of patients and staff, that these functions are not only performed with good will but also with knowledge and skills.

The example of gaps in management competence before and after training for physicians and nurses illustrated in Figures 4 and 5 highlight a key problem at the micro-level: training! Female managers in our studies, here following Santric-Milicevic (36), developed higher competency levels after training in communication skills and problem solving.

Managers rated assessing performance of higher importance, while chief nurses emphasized the importance of leading. Before training, the estimated competency gap was generally the highest in assessing performance, followed by team building and planning and priority setting.

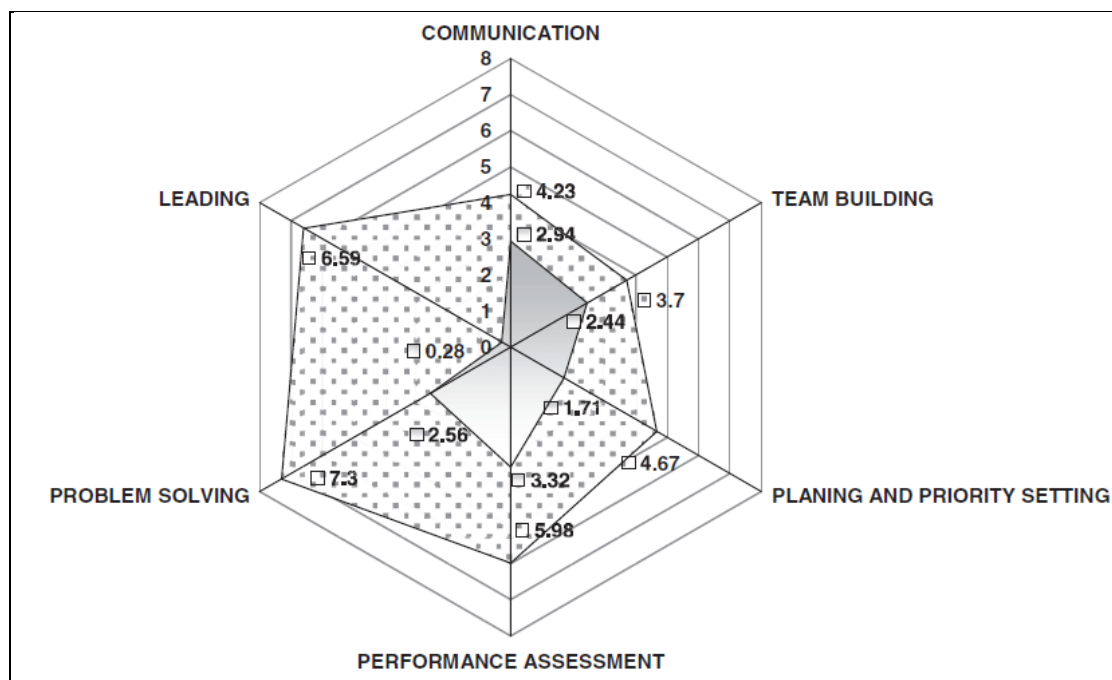
Terzic et al. (35) came to similar conclusions but added the analysis of predictors: *“The biggest improvement was in the following skills: organizing daily activities, motivating and guiding others, supervising the work of others, group discussion, and situation analysis. The least improved skills were: applying creative techniques, working well with peers, professional self-development, written communication, and operational planning. Identified predictors of improvement were: shorter years of managerial experience, type of manager, type of profession, and recognizing the importance of the managerial skills in oral communication, evidence-based decision making, and supervising the work of others.”*

**Figure 4. Core management competences of top managers (physicians): Competence gap before and after training (the confetti pattern of radar indicates the area of improvement after training)**



Source: Santric Milicevic M, Bjegovic-Mikanovic V, Terzic-Supic Z, Vasic V. Competencies gap of management teams in primary health care. The European Journal of Public Health 2011; 21(2):247-53 (36).

**Figure 5. Core management competences of chief nurses: Competence gap before and after training (the confetti pattern of radar indicates the area of improvement after training)**



Source: Santric Milicevic M, Bjegovic-Mikanovic V, Terzic-Supic Z, Vasic V. Competencies gap of management teams in primary health care. The European Journal of Public Health 2011; 21(2):247-53 (36).

## **Challenges and recommendations for possible improvements of governance and management of health care institutions in Serbia**

Challenges ahead for the governance and management of health institutions in Serbia are derived from the situation analysis and recommendations are made based on actual examples of good practices in Europe and the world and in the light of management opportunities/threats and strengths/weaknesses in Serbia.

The Serbian Health System is by tradition highly centralized. However, providing health services of high quality on a regular basis requires a high degree of complexity and interaction between various levels of management and different stakeholders. Keeping all relevant decisions at the national level and organizing complex tasks centrally cannot be perceived without establishing a highly trained, numerous and well-paid central bureaucracy. This does not seem to be a realistic option for Serbia and many other countries as well. Therefore, the issue of far reaching and effective *decentralization* is on the table which at the same time introduces a certain degree of competition between service institutions. The term “*horizontal, not vertical management*” has been introduced in this context. However, each country coming from a specific historical background has to find its own way forward.

The concept of decentralization according to Bossert (38-41) comprises three elements at the macro-level, namely allowing for “decentralist decision space”, “corresponding institutional capacity”, and “local accountability” (towards the community). At the managerial meso-level this has to be translated into operational planning, budgeting, human resources management, and service organization, where this last element is considered to be a matter of the micro-level.

In order to strive for the implementation of this concept in Serbia, the following activities are recommended to be carried out timely and successfully:

### **Macro-level:**

- i. The Ministry of Health should revise the valid legislation allowing for a stepwise transfer of more decision making powers within a limited time period to the “decentralist level”, defined as municipality authorities.
- ii. The Republic Fund of Health Insurance is to become fully independent and has likewise to defer financial powers to the lower levels – branches. However, there should be a compensation mechanism between poorer and richer municipalities in Serbia, maybe supported from tax money allocated by the budget or by the Ministry of Finance, or through the Ministry of Health.
- iii. The service facilities (hospitals and others) within a district (= region = “okrug”) negotiate their service profile and budget directly with the local partners – the branch of the Republic Fund of Health and municipal authority.
- iv. Insured patients can select a chosen physician wherever they want.
- v. In order to harmonise the various elements of the health system in terms of a horizontal management, a national decision making body composed of the HIF and the representation of the service providers together with the professional chambers should meet chaired by the Ministry of Health in order to adapt permanently the governance. The package of basic health services is to be defined at this level, as well as the care to be provided to uninsured persons.
- vi. The number of institutional managers required nationwide has to be determined and trained accordingly in postgraduate programmes for Public Health and Management

(based on defined competences required to provide good performance). Otherwise, they will not be able to make use of the larger decision space provided.

- vii. Likewise, short-courses in community health management for mandated civil servants and politicians at the community level should be regularly offered.

**Meso-level:**

- i. Standard models of terms of references for all management staff categories have to be developed and harmonised to correspond to the new legislation and practice in educational sector and linked to corresponding programmes of Continuous Professional Development (CPD) offered by the four Serbian medical/health faculties in close cooperation with the faculties of management and organization.
- ii. Satisfaction of patients and employees which is measured by standard instruments every year at the institutional level should be improved both in the way of assessment and tools for improvement.
- iii. Development of a guideline on change management and decentralist accountability towards the local elected community representatives.
- iv. Promotion of the employment of non-medical managers and managers coming from non-medical environments.

**Micro-level:**

- i. Allowance of intra-institutional opportunities for increased decision space of staff, especially nurses, and encouragement of training options up to postgraduate levels.
- ii. Regular negotiations with the trade union representatives to agree on payment schemes which correspond to the qualification and position of staff, especially nurses.

**Key messages**

- Continue decentralization and support to an effective national decision making body (Health Council of Serbia) with all relevant stakeholders.
- Reduce the well-known implementation gap and agree on a binding time frame for reforms.
- Establish obligatory schemes for education and training of managers and support sustainability of state institutional capacity to teach, train and advise on a scientific basis.

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