The European Union's CARDS Programme for Bosnia and Herzegovina

Functional Review of the Health Sector in Bosnia and Herzegovina

EuropeAid/116649/C/SV/BA

Final Report

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GLOSSARY AND ACRONYMS

AAQI	Agency for Accreditation and Quality Improvement
ALOS	Average length of stay
BD	Brcko District
BHP	Basic Health Project
BiH	Bosnia and Herzegovina
CARDS	Community Assistance for Reconstruction, Development and Stabilisation
CEEC	Central and Eastern European Countries
CoM	Council of Ministers
Consultant	The consortium consisting of SOFRECO and DJIKIC Consulting Service represented by the Project team
DFID	Department for International Development
DZ	Dom Zdravlja
EC	European Commission
EU	European Union
FBiH	Federation of Bosnia and Herzegovina
FR	Functional Review
FYROM	Former Yugoslav Republic of Macedonia
GDP	Gross Domestic Product
HC	Health Care
HCM	Health Care Management
HIF	Health Insurance Fund
HIS	Health Information System
HR	Human Resources
HRA	Human Resources Administration
HRM	Human Resources Management
HQ	Headquarter
IBRD	International Bank for Reconstruction and Development
IT	Information technology
MO	Medium-term Objectives
MoCA	Ministry of Civil Affairs
MoH	Ministry of Health

MoHSW	Ministry of Health and Social Welfare
MoU	Memorandum of Understanding
MPCU	Management of Primary Care Units
MTEF	Medium-Term Expenditure Framework
PA	Public Administration
PAR	Public Administration Reform
PHARE	EC pre-accession instrument
PHC	Primary Health Care
PHI	Public Health Institute or Institute of Public Health
PHS	Primary Health Service
Project	Functional Review of the Health Sector in BiH
PRSP	Poverty Reduction Strategy Paper
RS	Republika Srpska
SAA	Stabilisation and Association Agreement
SAP	Stabilisation and Association Process
SC	Steering Committee
SEE	South East-Europe
SITAP	Social Insurance Technical Assistance Project
SO	Strategic Objectives
TA	Technical Assistance
TOR	Terms of Reference
UNDP	United Nations Development Program
WB	World Bank
WHO	World Health Organisation

TABLE OF CONTENT

1. INTRODUCTION 7

2. EXECUTIVE SUMMARY 9

3. THE METHOD OF FUNCTIONAL REVIEW OF THE PUBLIC ADMINISTRATION OF THE HEALTH SECTOR IN BIH 13

3.1 Functional Review Methodology 13

3.2 The Methods used for the Functional Review of the BiH Health Sector 15

3.2.1 The Organisations Involved in the Functional Review 15
3.2.2 Implementation of the Functional Review by a Participative Approach 17
3.2.3 Consultation and co-ordination 18
3.2.4 Implementation of the Review 18
3.2.5 The Steps of the Functional Review of the health sector in BiH 19
3.2.6 Review of the Entities and Brcko District 21
3.2.7 State level 22

4. DESCRIPTION OF THE ORGANISATION AND THE SYSTEM 23

4.1 Overall Structure of the Health Sector in BiH 23

4.2 Federation of Bosnia and Herzegovina 23

4.2.1 Organisation of the Health Sector in FBiH 24
4.2.2 Distribution of functions 25

4.3 Republika Srpska 26

4.3.1 Organisation of the Health Sector in RS 26
4.3.2 Distribution of Functions 26

4.4 Brcko District 28

4.4.1 Organisation of the Health Sector in Brcko 28
4.4.2 Distribution of Functions 28

5. ANALYSIS OF THE PUBLIC ADMINISTRATION OF THE HEALTH SECTOR 30

5.1 Analysis of the Human Resources in the Health Sector Administration 30

5.2 Analysis of the Financial Resources in the Health Sector Administration 35

5.3 Analysis of the Organisational Set-up 39

5.4 Main Functions of the Public Health Sector Administration 41

5.4.1 The State Administration of the Health Sector 41
5.4.2 The Entity Administration and District Brcko 42
5.4.3 The Cantonal Health Sector Administration 48
5.4.4 The Municipal Health Sector Administration 50

5.5 Conclusion of the Analysis of Functions 52

6. RECOMMENDATIONS 57

6.1 Recommendation 1: Strengthen functions at BiH level 64

6.1.1 Recommendation 1.1: Establish a Separate Department for Health within MoCA 64

6.1.2 Recommendation 1.2: Establish a BiH Accreditation and Quality Improvement Agency. 68

6.1.3 Recommendation 1.3: Establish a BiH Drug Agency. 68

6.1.4 Recommendation 1.4: Establish a BiH Health Insurance Agency. 69

6.1.5 Recommendation 1.5: Establish a BiH Public Health Agency. 69

6.1.6 Recommendation 1.6: Establish a BiH Inspectorate. 70

6.2 Recommendation 2: Rationalise functions that are outdated or not performed rationally 72

6.2.1 Recommendation 2.1 (MoHs): Transfer functions related to inspection to two new Entity Inspectorates 72

6.2.2 Recommendation 2.2 (PHIs): Functions related to common standard laboratory tests should be considered outsourced 73

6.2.3 Recommendation 2.3 (HIFs): Rationalise the function for contracting of health care providers 75

6.2.4 Recommendation 2.4 (HIFs): Abolish monthly invoicing and strengthen performance monitoring 76

6.2.5 Recommendation 2.5 (HIFs): Rationalise the function for verification of health insurance status 77

6.2.6 Recommendation 2.6 (HIF): Abolish the regional offices of the health insurance funds in RS and transfer the remaining functions to the HQ and to the local offices 79

6.3 Recommendation 3: Strengthen functions related to policy formation and EU integration 80

6.3.1 Recommendation 3.1 (all): Strengthen functions necessary for a coherent system of evidence based planning and decision-making 80

6.3.2 Recommendation 3.2 (all): Strengthen/establish all functions required for EU integration 81

6.3.3 Recommendation 3.3 (PHIs): Strengthen all core public health functions that should be fully financed by the budget. 82

6.3.4 Recommendation 3.4 (HIFs): Strengthen functions required for broadening the contribution collection basis. 83

6.3.5 Recommendation 3.5 (HIFs): Strengthen functions required for universal health insurance coverage within BiH 83

6.3.6 Recommendation 3.6 (HIFs): Strengthen functions required for macroeconomic sustainability 85

6.4 Recommendation 4: Strengthen functions needed for improving good governance 85

6.4.1 Recommendation 4.1 (all): Strengthen functions related to vertical and horizontal coordination 85

6.4.2 Recommendation 4.2 (all): Strengthen/establish functions required for strategic management 86

6.4.3 Recommendation 4.3 (all): Strengthen/introduce functions related to human resources management 86

6.4.4 Recommendation 4.4 (all): Establish the functions needed for a uniform health information system in BiH 87

6.4.5 Recommendation 4.5 (all): Strengthen functions required to establish a uniform accounting ledger 88

6.5 Recommendation 5: Donor support 89

6.5.1 Support establishing the Department for Health 89
6.5.2 Support introducing strategic management at all levels 89
6.5.3 Support introducing evidence based decision-making 89
6.5.4 Support introducing HRM at all levels 90
6.5.5 Strengthening the universal health insurance system in BiH 90
6.5.6 Strengthening the sanitary and the pharmaceutical inspection 91

6.6 Legal impacts 92

7. ANNEXES 93

7.1 Summary of Functional Review and Recommendations - State 94

7.2 Summary of Functional Review and Recommendations – FBiH 105

7.3 Summary of Functional Review and Recommendations – RS 115

7.4 Summary of Functional Review and Recommendations – Brcko 125

7.5 Overview of the impact (staffing and recurrent budget) of the recommendations 135

7.6 List of Reviewed Institutions 137

7.7 Overview of content of CD 140

1. INTRODUCTION

This Final Report covers the project *Functional Review of the Health Sector in BiH* (EuroAid/116649/C/SV/BA) financed by the European Commission via the CARDS Programme.

The implementation of the project is regulated by the Memorandum of Understanding signed on July 7th 2004 by the Prime Ministers of BiH, the FBiH and the RS on one side and the EC Delegation to BiH on the other. Hence, the project has to be seen in relation to the comprehensive public administration reform support provided by the EC and is only one of the altogether nine functional reviews. To this end, it is important to stress that the Project is exclusively concerned with the public administration part of the health sector and does not deal with the provider structure (hospitals, Dom Zdravlja[1], etc.)

The aim of the Report is to summarise the findings, the analyses and the recommendations provided by the Project in order to facilitate a better public administration of the health sector, prepare the BiH health sector for EU integration and to enable the public administration to address the deficiencies existing in the health care sector. Hereby, the Report serves as a basis for the reform of the health sector and for a PAR strategy that follows the BiH authorities' pledge of March 2003.

The materials developed by the project-team during the 8 months of implementation, on which this Report is elaborated, consist of the detailed analyses of approximately 2.300 functions within 230 departments in 56 organisations and they comprise approximately 100 documents with around 3.000 pages (included on the CD attached to the Report).

In general, this type of report can either be detailed and comprehensive (and voluminous) or only resume the key issues (and therefore be short). Voluminous reports tend not to leave a deep impact as busy decision-makers do not have the time for detailed studies. Short and concise reports, on the other hand, might go directly to the point but tend not to give the "full story" and not to be precise enough. However, short reports and well presented reports better match the political decision process. The project team has chosen the short report form, on the expense of the details. We see this report as predominantly a guide for decision-makers who are the driving force for the EU integration, for the employees in the public administration that will be concerned with the implementation of the changes and with its enforcement and for the academics who will participate in conceptualising the development of the health care sector.

The report is, however, composed in a way that also the reader who has a need for studying the details can do this by looking at the attached CD which includes the complete Project documentation. For the reader requiring an overview of the BiH health system and the project methodology, the report can be read from the beginning to the end. And for those who are fully familiar with the system but would like to focus on the analysis and the recommendations it is proposed to go directly to chapter five and six. Those concerned with the PA reform at entity level can turn to the annexes

[1] Health Centres, predominatly providing primary health care service

7.1 to 7.4 presenting a summary of the findings and consequences of the recommendations.

In order to avoid repetition and long sentences the Report uses a simplified terminology. The notion "Entities" is used throughout the Report as a short form for "the Entireties and District Brcko" and "Public Health Institute" or PHI covers both "Institute of Public Health" and "Public Health Institutions".

Functional review is a "helicopter method" looking at organisation from the big perspective and does not deal with technical details of how a function could be improved. However, ideas for strengthening functions have been discussed with the relevant counterparts. The result of these discussions and the project-team's own experience of good practice are presented in the so-called "example boxes". The example boxes should therefore not be seen as project recommendations but represent just ideas of how the tasks and projects required to implement a recommendation could be realised. Nevertheless, further conceptual decisions would be required and elaboration of action plans is needed before the recommendations can be implemented. To that end, the project has, although not required by the TOR, elaborated the action plan related to the implementation of the recommendations provided for the state level. The Action Plan is included on the CD.

After the introduction and the executive summary, chapter three provides a summary of the Functional Review methodology used by the project team. Chapter four describes the overall structure of the health care system in BiH and places the functional review in its context. Chapter five presents the summary of the findings and the analysis with respect to the resources used by the public administration of the health sector (both human and financial), its organisation and with respect to the core issue for this project, namely the analysis of the functions. Finally, chapter six presents the recommendations.

2. EXECUTIVE SUMMARY

This Final Report covers the project *Functional Review of the Health Sector in BiH* (EuroAid/116649/C/SV/BA) financed by the European Commission's CARDS Programme.

The implementation of the project is regulated by the Memorandum of Understanding signed on July 7th 2004 by the Prime Ministers of BiH, the FBiH and the RS on one side, and the EC Delegation to BiH on the other. Hence, the project has to be seen in relation to the comprehensive public administration reform support provided by the EC and is but one of the altogether nine functional reviews.

A health care system can be divided into two main components:

1) A component providing health care services, such as diagnostics, medical treatment, nursing care, to the public. This component includes hospitals, Dom Zdravlja[2], family doctors, etc.[3]
2) A component that is 'governing' the provision of health care services by means of policy development, planning, legislation and regulation, financing etc. This component includes the Ministries of Health, health financing agencies (HIFs), public health bodies (PHIs), etc.

In general, the first component is called 'health care providers', the second 'health care administration' and where it is financed from public finances, 'public administration'.

As requested by the Terms of Reference for the Project, the Consultant has focussed the FR entirely on the PA of the health sector.

The Consultant is convinced that a reformed public administration system is a prerequisite for improved performance of the health care provider system and the key to successful EU integration.

The approach and focus of the Project were discussed with the main stakeholders.

The **analysis shows** that altogether 2.205 employees are engaged in the public administration of the health sector in BiH equal to 5,7 employees per 10.000 inhabitants and amounting to 6% of the total health sector staff. In comparison with other countries (e.g. Poland, Holland and Denmark), data indicate a significant overstaffing amounting to approximately 13%.

The overall public administration of the health sector in BiH is characterised by duplication of functions that are to a certain degree, outdated or could be rationalised. Further, a lack of functions has been identified that could provide for a rational use of resources attuned to the need of the single patient or citizen. HRM, consistent planning, policy development and

[2] Health center providing predominantly primary health care servcies

[3] In general the health care provision component can be subdivided in Primary Health Care, where family doctors and nurses are providing the point of first general contact with the health system for a patient; Secondary Health Care where policlinics and hospitals, after referral by PHC, provide specialised medical services, and Tertiary Care where specialised hospitals or departments provide treatment for complicated health problems.

coordination as well as mechanisms for EU integration are weak or not identified.

With 1,5 employees to perform all functions at the **state level,** it is the conclusion that almost none of the functions required for planning, monitoring, for running a sustainable and coherent health care system exists with universal coverage, equal access, equity and ability to guide the EU integration.

With 823 employees to perform the public administration functions of the health sector in **RS** (equal to 5,6 employees per 10.000 inhabitants or 7% of the total health sector expenditures), a need exists for streamlining the existing functions. Especially separation of the policy functions from the service provision functions and rationalisation of functions to match recent years' reform which has transferred functions away from the regional level within the health insurance fund are to mention. Further, functions for planning, monitoring the preferences of the patients, rational use of resources and evidence based decision-making should be strengthened to prepare for a successful EU integration. Almost no functions that could guide the implementation of the RS health sector strategies and policies as well as the PRSP have been observed. Functions to ensure that a bigger proportion of the population is insured and to participate in carrying the burden of health insurance are found to be too weak. Coordination, internally, between entities and with the state is found to be too weak.

The public administration of the health sector in **FBiH** involves 1.332 employees (equal to 5,8 employees per 10.000 inhabitants or 4% of the total health sector expenditures). The performance of the functions is characterised by a mixture of service delivery (sanitary inspection, standard laboratory services) and policy functions requiring a streamlining of the functions. Functions related to planning, preference monitoring, rational use of resources and evidence based decision-making are performed to a too low extent. Further, functions that could provide for successful implementation of EU integration are almost not existing and functions for implementation of FBiH health sector strategies and the PRSP are too weak. Functions to ensure increasing health insurance coverage, broadening the health insurance contribution basis, better capacity utilisation are weak or not existing. Coordination internally, with the state as well as between entities, is weak.

The public administration of the health sector in **Brcko** employs 48 fulltime employees (equal to 5,7 employees per 10.000 inhabitants or approximately 10% of the total health sector expenditures). The functions for planning, HRM and coordination are weak.

Based on the above mentioned situation, the project team has identified **recommendations** to be implemented during the next half decade (before the end of 2010) that would establish the capacity required for EU integration and address the problems prevailing in the health system. These recommendations can be clustered under the following four headings:

- **Establish or strengthen functions at the state level** required to ensure a sustainable, coherent health care system with universal health insurance coverage, equal access, equity and readiness for EU integration. This includes recommendations for: establishing a separate department for health within Ministry of Civil Affairs, a BiH Accreditation and Quality Improvement Agency, a BiH Drug Agency, a BiH Health Insurance Agency, a BiH Public Health Agency, and a BiH Inspectorate. An Action Plan to guide the implementation of these recommendations is attached on the CD.

- **Strengthen all functions related to policy formation**, evidence based planning,; performance monitoring, functions related to strategic issues (PRSP and Entity strategies) as well as functions for successful EU integration. This group of recommendations also includes strengthening of functions related to public health functions, broadening the health insurance contribution basis, universal health insurance coverage throughout BiH and macroeconomic sustainability.

- **Rationalise functions within the entities/cantons/municipalities** that are outdated or not performed rationally or efficiently. This includes the recommendations for establishing Entity Inspectorates (sanitary inspections), proposal for outsourcing of standard laboratory analyses, rationalising of the health insurance functions in both RS and FBiH related to contracting health care providers, health institutions monthly invoices, verification of health insurance status. Therefore the functions of the regional offices of the HIF in RS and the PHIs within the FBiH would have to be significantly rationalised.

- **Reinforce all functions related to good governance** including strategic management, HRM, coordination, education/workforce planning, curriculum coordination and a uniform health information system.

The above-mentioned recommendations are developed with due consideration to the limited resources available for the health sector in BiH. Fully implemented, the total impact will be a net saving of 225 fulltime employees or 4,3 mil. KM, equal to approximately 10% in terms of both staff and financial resources.

	Existing staff and Budget		**Consequences of recommendations**	
	Staff	**Budget in mil. KM**	**Staff**	**Budget in mil. KM**
FBiH	1.332	32,7	-215	-5,3
RS	823	16,4	-178	-3,7
Brcko	48	1,9	-6	-0,2
Other changes	1,5	0,7	174	4,9
TOTAL	2.205	51,7	**-225**	**-4,3**

*) For further information see annex 7.5

It is, therefore, an integrated conclusion of the Functional Review that it is possible, without additional resources, to achieve a better and more efficient public administration, ready for EU integration and which takes the preferences of the population into account in its decision-making. This is a real win-win situation.

However, the project has also identified that the change management capacity indispensable to implement the PA reform and to obtain the intended results, is not present at the moment. Therefore, the Project has elaborated a set of core recommendations that donors should consider in designing their assistance to the authorities in BiH. This includes support for: establishing Department of Health (within MoCA), introduction of strategic planning, strengthening of evidence based decision-making, introduction of HRM, introduction of universal health insurance coverage, and restructuring of the sanitary and pharmaceutical inspection.

3. THE METHOD OF FUNCTIONAL REVIEW OF THE PUBLIC ADMINISTRATION OF THE HEALTH SECTOR IN BIH

This section presents the approach the Consultant has used to deliver the requested results and achieve the objectives of the project. It describes the Functional Review Methodology and actions undertaken by the Consultant to conduct the Functional Review.

An elaborate account of the FR methodology has been presented in the Inception Report that has been accepted by all the stakeholders in the project and approved by the Contracting Authority and the Steering Committee.

Therefore, the Consultant here only presents the main characteristics.

3.1 Functional Review Methodology

Functional Review (FR) is the term used to describe the process of identifying all functions undertaken by a specific organisation, of examining them in respect to their contribution to the organisation's strategic and medium-term objectives and their resources requirements, of classifying them and of providing recommendations[4].

In this respect, FR is related to strategic management and it is part of the process of linking the vision of an organisation with prioritisation of its daily activities. FR combines the setting of strategic goals with the elaboration of the annual action plan that details the specific activities, responsibilities and deadlines that will lead to realisation of the Medium-term Objectives.

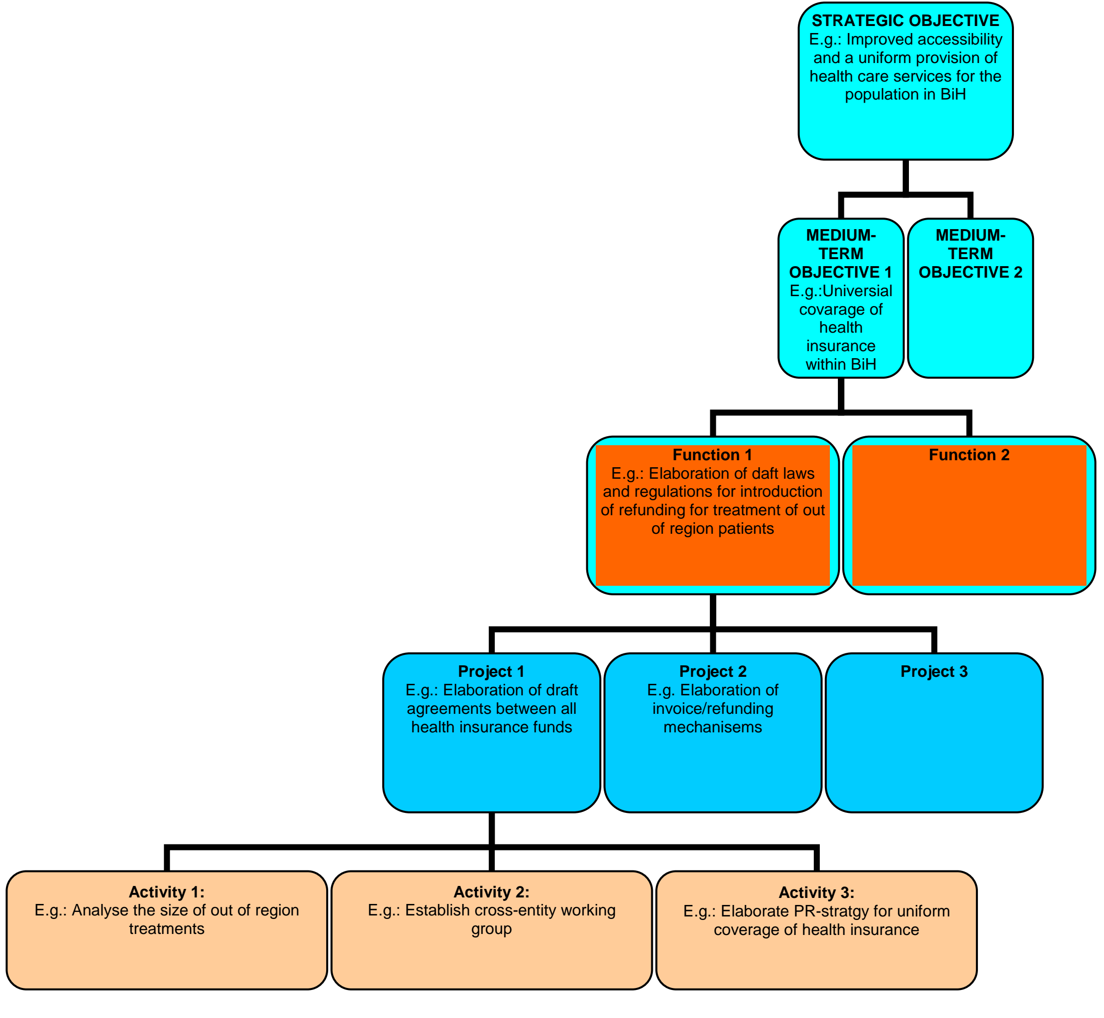
FR takes its theoretical outset in the hierarchical relationship between Strategic Objectives (SO), medium-term objectives (MO), functions, projects and activities: to achieve a SO, one or more MOs are required and one or more functions are required to achieve a MO, etc. This relationship can be illustrated by the relation-tree in figure 3.1.

It can be seen from the above-mentioned that FR deals with the levels from the SO to the functions but does not go into the level of projects and activities which is the subject for the Action Plan.

From the hierarchical relationship it is also possible to derive practical definitions of the different elements of the functional review that were applied by the team during the implementation of this FR.

[4] This chapter takes into account the approach to functional reviews described in "Rebuilding State Structures: Methods and Approaches. The Trials and Tribulations of Post-Communist Countries", Policy Advocacy Papers series, UNDP/RBEC, 2001.

Illustration 3.1: Relation-tree illustrating the relationship between objectives, functions, projects and activities



A function can be described as an inter-linked set of projects, which together are aimed at producing a specific outcome or result. Projects can either be temporary, repeated or continuous, but a function usually has a longer time horizon.

In principle, a functional approach focuses on functions and their contribution to objectives. A specific function can be attributed to several actors or agencies. For instance the function of data provision on health care utilisation can be held continuously by an Institute of Public Health or a National Statistical Office or a research centre or the function can be fulfilled

by a yearly tendering procedure whereby every time a new agent can be selected.

Explanation box - Main Definitions:

Definition of a strategic objective

Strategic objectives are the main, high level objectives of the organisation (i.e. the results that the organisation is trying to achieve within the next 5-7 years).

Examples of a strategic objective for a ministry could be: Improved accessibility and a uniform provision of health care services for the population.

Definition of a medium term objective

Medium term objectives are objectives that are due to be achieved in the next year or two. If possible they should be measurable so that one can know if they have been achieved.

Examples of a medium term objective could be: Universal coverage of health insurance introduced before 2005.

Definition of a function

A function is one or more projects that produce an outcome. Thus, the function of drafting laws is made up of a series of projects of drafting different specific laws.

Drafting laws itself is categorised as a policy function.

Examples of a function could be: Elaboration of draft laws and regulations for introduction of refunding for treatment of "out of region" patients before end of 2004.

Definition of a project

A project is one or more activities that produce an output. Thus, the project of drafting a specific law is made up of a series of activities (including for example, information gathering, consultation, brainstorming and drafting).

Examples of a project could be: Elaboration of draft agreement between all health insurance funds before the end of 2004 detailing universal coverage.

However, in practice, attribution of a function to a specific 'owner' or 'holder' increases the chance that the function will receive the proper amount of attention and resources. Therefore, in the recommendations and the State Action Plan, the Consultant does address the issue of institution and capacity building in order to be able to attribute functions to specific organisations. The Consultant also proposes projects and activities that are relevant for performing the recommended functions in an efficient and rational way.

3.2 The Methods used for the Functional Review of the BiH Health Sector

3.2.1 The Organisations Involved in the Functional Review

Each health care system can be divided into two main components:

1. A component providing health care services, such as diagnostics, medical treatment, nursing care, to the public. This component includes hospitals, Dom Zdravlja, family doctors, etc.[5]
2. A component that is 'governing' the provision of health care services by means of policy development, planning, legislation and regulation, financing etc. This component includes the Ministries of Health, health financing agencies, data provision and analysis bodies etc.

In general, the first component is called 'health care providers', the second 'health care administration' and where it is financed from public finances, 'public administration'.

During the Review the Project Team used, as a working definition of Public Administration, the following:

"The public administration part of the health sector encompasses institutions performing functions required for planning, financing and establishing policy for the provision of good quality health services to the population and that are financed by funds which the population is obliged to pay according to law."

The boundaries between the two components are not strict. Health care providers may use time and other resources to contribute to policy development, for example by providing data or by participating in planning activities whereas institutions within the Public Administration may use time and resources for activities directly aimed at the population, for instance Public Health Institutions that conduct prevention campaigns or organise immunisation.

This implies that in the Review, PHIs are considered to be part of the Public Administration.

The Consultant has focused the FR entirely on the PA of the health sector, for the following reasons:

1. The overall objective of the project as stipulated in the Terms of Reference:

   "The reform of the public administration sector in BiH results in an administration that is capable of effectively and efficiently performing its function as related to the needs of the country, within its financial means and in a way that is coherent with BiH's commitment to EU integration".

   refers clearly to the public administration as the focus of the activities;
2. The severe time limits of the project made it extremely necessary to focus the activities;
3. The health care provision component has been analysed by several ongoing and earlier projects, whereas the PA component has not been intensively assessed[6] so far.

[5] In general the health care provision component can be subdivided into Primary Health Care, where family doctors and nurses are providing the point of first general contact with the health system for a patient; Secondary Health Care where polyclinics and hospitals, after referral by PHC, provide specialised medical services, and Tertiary Care where specialised hospitals or departments provide treatment for complicated health problems.

The Consultant is convinced that a reformed PA component is a prerequisite for an improved performance of the health care provision component.

As reported above, the approach and focus of the Consultant were discussed with and approved by the main stakeholders and the Contracting Authority.

3.2.2 Implementation of the Functional Review by a Participative Approach

Participation, high level commitment and clear understanding by management and staff at all levels of what FR is and can be used for are the preconditions for a successful outcome. Therefore, the Consultant used a participative approach during the implementation of the Review.

The process started by consultative meetings with high level representatives from the institutions involved in the Review aiming at:

- sharing expectations;
- discussing methodology;
- appointing a Functional Review Contact Person within the organisation;
- supporting the management to "sell" the functional review to the organisation and to support the further process of FR in the cantons and municipalities;
- collecting key documents and preparing for data collection

The Consultant elaborated a Manual on Functional Review that can also be used by the organisations in the future to update and continue the strategic process (see the attached CD).

Three regional workshops with management and staff of the participating organisations were held to further explain objectives and methods for the Review.

Within each of the participating institutions, a Contact Person was appointed who acted as an intermediary between the Project Team and the institution. The Contact Persons proved to be very helpful to the Project Team for obtaining and clarifying information about functions and processes within the institutions.

Members of the Project Team were assigned to specific organisations to ensure continuity in the working relations. To obtain the required information, they visited the participating organisations, sometimes several times.

For obtaining the required information, a questionnaire had been elaborated as a part of the Functional Review Manual (see the attached CD). The visits also proved to be important to build good working relations

[6] A list of relevant projects has been presented in the Inception Report

and to obtain information about existing management processes and the organisational culture. This provided relevant background information to enable the Project Team to assess how and to which extent functions are actually performed by the organisations.

This approach also had as a result that 'hot spots' of skills and knowledge now exist within many of the participating institutions about the methodology of FR and its relevance for possible future organisational development processes and introduction of strategic management .

The Consultant would like to stress that a Functional Review project, by definition, has not the objective to implement intentional change within the client system. Nevertheless, the participative approach, the dissemination of recommendations and the exchange of information could lead to more openness within the client system towards future changes.

It is important to note that the project team has enjoyed full support from all the participating organisations which also have invested a lot of time and effort to assist the Project.

3.2.3 Consultation and co-ordination

Besides regular contacts with the participating organisations, the Project Team maintained contact with the main stakeholders by means of the Steering Committee. During the Project, three meetings with the Steering Committee were organised.

Regular meetings and other contacts with the national PAR co-ordinator, the other FR-projects and the EC Delegation enabled the Project Team to align its approaches and outcomes to the overall result of all the PAR reviews and to address cross sector issues.

3.2.4 Implementation of the Review

From the outset of the project, it was clear that the complexity of the health care system in BiH with two entities and one district, whereby one entity has devolved a significant part of the Public Administration to 10 Cantons, would imply that a high number of institutions would be eligible to participate in the Review.

A total of 56 institutions have been reviewed (see annex 7.7). Of these, 44 were reviewed via the detailed interview approach, 7 were reviewed by a general questionnaire focusing on their main functions, and the remaining institutions were reviewed together with the organisation of which they are part (e.g. regional offices of PHI RS as well as local and regional offices of HIF RS).

There were a number of reasons for this limitation:

The time constraints for the Functional Review Project, mentioned in the Inception Report, necessitated the Project Team to focus its activities on the most important and relevant institutions. For a number of institutions, especially those not directly related to health care, the relevance of participation was doubtful.

During the implementation of the Review, the Project Team found that both the PHI RS and HIF RS, that are centralised institutions with entity-level headquarters and regional branch offices, possess such a level of internal consistency that interviewing all regional offices would have provided the Project Team with no additional information.

With regards to the Cantonal PHIs of the FBiH, more or less the same applied. Although they are independent organisations, after having reviewed 4 of them, the Project Team found that their characteristics were common enough to allow for sending the remaining 7 a shorter questionnaire asking only for key data.

3.2.5 The Steps of the Functional Review of the health sector in BiH

In order to implement the Functional Review the following steps were taken:

Step 1: Collecting Baseline data

Based on the standard interview form, background data needed for conducting the FR were collected for each of the organisations.

These included: the legislation under which the institute operates, organisational set up (type and function of departments), staffing, budget, contacts with other institutions etc. (see the attached CD).

As part of the baseline data collection, an analysis was made of the Laws that govern the health sector, at state, entity, regional or Cantonal level, in order to assess which functions are attributed to which institutions. This analysis is presented in the Legal Toolbox (See attached CD).

For each participating organisation, the Project Team registered the Strategic Objectives officially approved by the organisations' governing body.

Step 2: Registering the already existing medium-term objectives (MO), if any

The same was done for the medium term objectives: the Project Team registered the approved Medium Term Objectives.

Step 3: Identifying the actually performed Functions at department level

On the basis of the assessment of legal documents, statutes, rule-books, organogrammes and interviews with the heads of departments and with other employees of the participating organisations, the Project Team identified the functions currently performed by each department or sub-department within the organisation.

At the end of this step, the results, mostly consisting of factual data, were presented to the leadership of each participating organisation to give an opportunity for comments and corrections. The comments were then included in the analysis.

Step 4: Estimating the actual use of financial and human resources for each Function

For each of the functions identified under step 3, the number of staff allocated to their execution was estimated. This estimation was also sent back to the organisation for comments. For each of the reviewed institutions, two feedback rounds were conducted.

After incorporating the feedback, the financial resources utilised by each function were calculated. For each institution an 'average cost per staff member' was calculated based on the recurrent budget with two main components:

1. variable unit costs: salaries, allowances and related taxes, administrative support, transport etc., directly linked to one full time equivalent
2. fixed costs: other recurrent costs, maintenance, energy, interest and insurance etc., indirectly linked to one full time equivalent

Based on the number of staff, allocated to each function, the costs per function per year could be calculated.

In the recommendations, when incremental changes are proposed such as transfer of functions within an organisation, the financial implications are calculated on the basis of variable unit costs. When more profound changes such as the establishment of a new institution were recommended, the total costs (variable and fixed) are used.

It should be noted that capital investment costs have not been taken into account.

Step 5: Analysing Functions

The next step in the Functional Review was the elaboration of recommendations for changes of functions in the organisation.

For this step, the Project Team used a number of principles, derived from both international management theory and practice and experience with developments in public administration in the region as well as in Europe.

The following guiding principles were used:

- Functions of the same type should be grouped together
- Policy and service delivery functions should be separated
- Support functions should be separated from other functions
- No duplication or overlap of functions
- Clear and short reporting lines
- Viable sizes of departments
- Optimum span of command for managers
- Equitable workload

- Responsibilities of senior staff should be equalised
- Decision making should be delegated to the lowest suitable level
- Gradual approach for restructuring

The Project Team also made an analysis of functions that traditionally are not part of a health system but that refer to important (national) strategies related to:

- EU integration
- Good Governance
- Macro-economic sustainability
- Existing and planned state and entity strategies

and that therefore need to be addressed in the health system.

The above-mentioned issues are described in detail in the Benchmark Toolbox (see the attached CD) which was used to assess the existence and the strength of functions.

Step 6: Recommending changes

Based on the previous analysis for each of the institutions recommendations were formulated for functions to be newly introduced, strengthened, rationalised, transferred to other departments, out-sourced to other institutions, abolished or kept unchanged.

A summary Recommendation Form that included the financial implications of the proposals was elaborated and sent to the organisations.

The time horizon applied when identifying the proposed changes is five years, as requested by the TOR.

Step 7 Translating the recommendations and the result of the FR into an Action Plan for the state level

In order to translate the recommendations into an Action Plan for the state level, a separate Review of Each of the Entities and the Brcko District was conducted as detailed below.

3.2.6 Review of the Entities and Brcko District

Given the particular characteristics of BiH, data collection and identification of functions were conducted separately for the Entities, Brcko District and the State Level. During this analysis, special attention was given to an assessment of internal consistency between functions within the organisation, between different organisations at the same level (horizontal consistency) and

between different levels of government and organisational 'pillars' (vertical consistency).

Based on this analysis, for each of the Entities and the Brcko District a Summary of Findings and Recommendations was compiled. Special attention was given to strengthen those functions and processes that enable integration and consistency and functions that are required for EU integration, good governance, macro-economic sustainability, existing entity strategies and national inter-sector strategies with implications for the health sector.

Based on aggregated data from the institutional review, the costs of entity level functions could be calculated and the financial consequences of the proposed changes could be forecasted.

The findings and recommendations were presented to and discussed with the key stakeholders of each entity and the Brcko District (see annexes 7.2 to 7.4).

3.2.7 State level

For the State Level, Findings and Recommendations were elaborated. Following the same method as at Entity Level, costs of functions and the financial implications of the recommended changes were calculated.

Based on these Findings and Recommendations, a State Level Action Plan has been elaborated (see attached CD). This Plan presents a number of functions that, according to the Consultant, are important to be introduced or strengthened at State Level. Institution and capacity building is recommended for these functions and projects are required to implement the recommendations.

The State Level Action Plan covers the period from 2005 to 2010 and contains short-term and mid-term recommendations.

The State Level Action Plan has been discussed with the relevant key stakeholders.

Implementation of the recommendations and proposals of this State Level Action Plan requires that donor support is available on the ground in 2005.

4. DESCRIPTION OF THE ORGANISATION AND THE SYSTEM

This section describes the health sector organisation in BiH and the way functions are distributed across organisations.

4.1 Overall Structure of the Health Sector in BiH

Organisation, financing and providing of health care in Bosnia and Herzegovina are the responsibilities of the two Entities, the ten autonomous Cantons in FBiH and District Brcko. Therefore, the health care system in BiH consists of 13 health 'subsystems' to cover approximately 3.9 million people.

At the BiH level, the Ministry of Civil Affairs (MoCA) is the only public administration body with responsibilities in respect to the health. The legal basis for MoCA is provided by the BiH Law on Ministries (March 2003) authorising MoCA to represent BiH at international level, to establish the basic principles for co-ordination and to co-ordinate plans of entities and other governmental bodies. The overall responsibilities of MoCA also include issues related to citizenship, citizen registration and records, personal data protection, residency, registration, identity documents, travel documents, vehicle registration process and de-mining issues.

The organisational structure of MoCA consists of the following nine departments: The Ministers Cabinet; the Cabinet of the Deputy Minister; the Department for Legal, Personnel, General and Financial Issues; the Department for Citizenship and Travel Documentation; the Department/Centre for Data Processing; the Department for Education, Science, Culture and Sport; the Department for Geodetic, Geological, Meteorological Issues; the Commission for de-mining in BiH and the Department for Labour, Employment, Health, Social Protection and Pension.

Within the Department for Labour, Employment, Health, Social Protection and Pension, health sector issues are under the responsibility of the Office for Health, Social Protection and Pension undertaking the following remits:

Drafting and reporting of bilateral agreements and contracts with respect to social insurance;

Co-ordination with entities and other bodies on provision of data and information on fulfilling international obligation in the field of health; and

Drafting and monitor regulations.

For these functions, the Office has the equivalent of 1,5 fulltime employees.

4.2 Federation of Bosnia and Herzegovina

FBiH occupies approximately 51% of the total territory of BiH and has a population of approximately 2.3 million. Administratively, it is divided into 10 cantons, each having its own Government and Assembly. The cantons are sub-divided into 79 municipalities.

The health care system in FBiH is decentralised with most competencies (functions and responsibilities) allocated to the cantons. However, the Ministry of Health FBiH (MoH) and the Health Insurance and Reinsurance Fund FBiH (HIF) have the function to define the health care network with a view to optimise its capacity for the provision of medical services. While the MoH FBiH has the functions of formulating health policy and drafting laws, these functions are doubled by the cantons. Determination of health service needs and functions related to provision of health care services (such as founding of institutions) are allocated to the cantons but, in principle, the co-ordination function lies within the Government of FBiH.

4.2.1 Organisation of the Health Sector in FBiH

The structure of the health sector in FBiH consists of 11 ministries of health (10 Cantonal and 1 Federal), 11 health insurance funds (10 Cantonal, and 1 Federal Health Insurance and Reinsurance Fund) and 11 Public Health Institutions (10 Cantonal PHI and 1 Federal).

The health care provider network consists of 280 public and 333 private institutions (including pharmacies)[7] employing altogether 23.477 persons, out of which 3.271 are medical doctors, 511 dentists, 260 pharmacists, 11.183 nurses, 286 health Consultants and 7.606 non medical staff.[8]

Figure: 4.2.1: Overview of the health sector organisations in FBiH

Ministry of Health FBiH

Cantonal Ministry of Health*

Health Insurance and Reinsurance Fund FBiH

Public Health Institute FBiH

Cantonal Public Health Institute

Cantonal Health Insurance Fund

Clinical Centre**

Hospital***

Dom zdravlja

Ambulanta

* The structure is the same for all cantons

** There are Cantons without clinical centre

*** There are Cantons without hospital

[7] Public Health Institute

[8] Health Statistics Annual FBiH, 2002

4.2.2 Distribution of functions

The **MoH FBiH** is responsible for functions that cannot be executed at the Cantonal level:

- sanitary inspections at borders;
- developing legislation at federal level;
- developing health policy for the FBiH;
- planning of the health care facilities network;
- capacity building;
- health inspections;
- developing and regulating of compulsory health insurance;
- monitoring and evaluating the health status of the population.

The Cantonal **Health Insurance Funds** are responsible for financing the health services at the cantonal level. The **Federal Health Insurance and Reinsurance Fund** was established in January 2002 to address some of the problems associated with a highly decentralised system related to an unequal economic basis and lack of cross-canton health insurance coverage. The Federal Health Insurance and Reinsurance Fund is entitled to receive 8% of all contributions collected by the cantonal HIFs.

The basic financial function of the health care system in FBiH is placed within the cantons. Each of the 10 cantons has its own Health Insurance Fund responsible for the overall financing of the health care services. The majority of income for the Cantonal HIF comes from health contributions. Health insurance contribution is based on gross salary and amounts to 17%. Cantons are authorised to define their own contribution rates within the upper ceiling of 17%.

The PHI of FBiH is the leading research and educational institution in the field of public health. Its functions also include health promotion and monitoring of the health status of the population. In the area of monitoring and research, especially in the field of health statistics and epidemiology research (also with respect to data collection for the 25 indicators needed for WHO reporting), there is collaboration between the federal PHI and the Cantonal PHIs.

Health ministries at the Cantonal level are in charge of Cantonal health legislation, advising on technical matters, implementing regulations, organising health care services and health policy planning mostly related to the Cantonal hospitals, the health centres (Dom Zdravlja - DZ), the ambulantas[9], pharmacies and other Cantonal health institutions.

[9] Ambulanta is a basic outpatient unit within Dom zdravlja.

Import, procurement, distribution and control of pharmaceutical products are under control of the **Department for Drugs within the MoH FBiH.** This department is also responsible for drug registration, control of drugs and herbal products, the issuing of work permits for pharmacies, controlling and issuing import permits for drugs and herbal products in FBiH.

4.3 Republika Srpska

The Republika Srpska (RS) with approximately 1.4 million inhabitants occupies approximately 49% of the total BiH territory. RS consists of four regions: Banja Luka (630.000 citizens), Doboj-Bijeljina (420.000 citizens), Sarajevo-Zvornik (230.000 citizens) and Trebinje/Foca/Srbinje (120.000 citizens)[10] and 64 municipalities.

The health care system in RS is centralised with the overall power concentrated within the Ministry of Health and Social Welfare (MoH), the Public Health Institute (PHI), and the Health Insurance Fund (HIF).

Recently, the Drug Agency of RS, and the Agency for Accreditation and Quality Improvement were established.

An overall strategic plan for development of the health care sector exists.

In 2003, the average per capita health care expenditure amounted to 147.2 KM.

4.3.1 Organisation of the Health Sector in RS

Health care services are provided by a network consisting of 63 Dom Zdravlja (DZ), (including spas and emergency centres), 16 secondary level health institutions (including psychiatry hospitals and rehabilitation centres) and 2 tertiary level clinical centres. Altogether, 11.211 people are employed in the health care sector out of which 7.177 are medical staff (1.783 medical doctors) and 4.034 non-medical staff[11].

4.3.2 Distribution of Functions

The MoH RS is responsible for the health sector in RS and has the following functions: policy making, strategy development, health care facilities, network planning, sanitary inspections, health inspections and co-ordinating health issues in RS.

PHI of RS is responsible for functions such as research and education in the field of public health, health promotion and monitoring of the health status of the population. PHI of RS also collects data for the 25 indicators needed for WHO reporting.

The Health Insurance Fund (HIF RS) has as main functions the collection of health insurance contribution (however this does not include contribution payment) and financing and contracting health care services. The

[10] Citizens' Guide to the Government of Republika Srpska, November 2003.

[11] WB BHP BiH Report, 2002.

organisational structure consists of eight regional offices and the head office of HIF in Banja Luka with four departments: Economy, Legal, Medical and Information Technology (IT) department. Health insurance contribution amounts to 15% of the net salary.

Figure: 4.3.2: Overview of the health sector organisations in RS

Ministry of Health and Social Welfare RS

Health Insurance Fund RS

HIF Regional Offices*

Clinical Centre

Hospital

Dom zdravlja

Ambulanta

Public Health Institute RS

PHI Regional Offices**

Drug Agency of RS

* There are eight regional offices

** There are five regional offices

4.4 Brcko District

Brcko District is located in Bosanska Posavina, it occupies approximately 1.5 % of the total territory of Bosnia and Herzegovina and has a total population of around 85.000. Brcko city has 41.406 inhabitants.

4.4.1 Organisation of the Health Sector in Brcko

Health care provision is undertaken by 4 health care institutions: Brcko Hospital, Health Center Brcko in the city, Health Center in Bijela and Health Center Maoča.

4.4.2 Distribution of Functions

The **Department of Health and Other Services** (with a total of 637 employees) has the overall responsibility for the provision and the management of primary health care, hospital health care and public health activities. Furthermore, the department is responsible for Centre for Social Work, health insurance and sport and culture.

The budget of the Department amounts to approximately 41 million KM (year 2004), which includes salary for the health workers. The average salary of a health worker in the Brcko District is 1,300 KM and physician's salary is around 2.000 KM. [12]

The **Health Insurance Fund** was established in 2003 under the Department of Health and Other Services. The Fund is at the moment establishing a Data Base covering all insured persons in Brcko. Before Brcko District gained its existing legal status, health care provision in the municipality had been funded from the three different health insurance funds in Tuzla, Mostar and Banja Luka.

Brcko has during the past three years implemented a number of reforms of its provider structure including the integration of three small health care centres into one larger. Those reforms contributed to improvements in the emergency medicine department (new ambulances), organisation of family health care services in small health care centres within the whole territory of Brcko District, improvements in medical equipment for all health centres and implementation of new hospital management principles based on continuous education and training.

[12] Unofficial data (internet; www.brcko.ba)

5. ANALYSIS OF THE PUBLIC ADMINISTRATION OF THE HEALTH SECTOR

This chapter presents the findings and the analysis conducted as part of the Functional Review of the public administration part of the health sector with respect to the human resources, the financial resources, the organizational set-up, the structures and main functions.

The chapter presents the findings at aggregated level for the entire BiH and also refers to peculiar features at the entity or institutional levels. The data on which this analysis is conducted is based on approximately 2.300 separate functions identified within the 56 institutions participating in the review (each has been identified, listed in terms of staff and resources and analysed). Due to the volume of the material for the individual institutions, the exact data are only presented on the attached CD, but aggregated data for the entities and for BiH are included as annex 7.1 to 7.4.

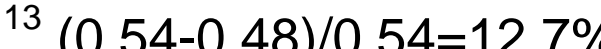
5.1 Analysis of the Human Resources in the Health Sector Administration

The Functional Review has identified that 2.205 employees are engaged in the public administration of the health sector in BiH equal to 5,7 employees per 10.000 inhabitants and amounting to 6% of the total health sector staff (See Table 5.1.2 below).

Data from different countries on the number of employees within the public administration of the health sector are difficult to obtain. Further, due to different organisational structures in different countries, data should be compared with precautions. Table 5.1.1 compares the number of employees in the ministries of health in BiH, Poland and in Denmark and shows that the number of staff is approximately 13%[13] higher in BiH than in Denmark. This finding is sustained by comparing the total number of employees within the public administration in Holland, Denmark and BiH (see table 5.1.2), Hence it is concluded that the public administration of the health sector in BiH is significantly overstaffed.

Table 5.1.1 Comparing the number of employees in Ministries of Health in Denmark, Poland and in BiH

	Poland	Denmark	BiH
Total number of staff in ministries of health	260	256	210,5
Population	38.626.349	5.383.507	3.863.735
Staff per 10.000 of population	0,07	0,48	0,54



13 (0,54-0,48)/0,54=12,7%

Table 5.1.2. Comparing the number of employees in the public administration in Holland, Denmark and in BiH

	Holland *	Denmark*	BiH
Total number of staff in ministries of health	7.916	2.726	2.205
Population	16.258.032	5.383.507	3.863.735
Staff per 10.000 of population	4,87	5,06	5,71
BiH overstaffing	14,6 %	11,3 %	-

*) 2003 data

Besides the size of the staff, the most striking finding relates to distribution of staff between levels of authority (see Chart 5.1.1). With less than 2 employees at the state level and the majority of staff at the entity level (19%) and cantonal/regional level (68%) it is the conclusion that almost no functional capacity exists at the state level able to handle EU integration, to implement national strategies and to act as change agent for overcoming the deficiencies existing within the health system.

Chart 5.1.1: Distribution of staff according to the level of authority

Distribution of staff according to the level of authority

9%
4%
0%
19%
68%

State Level
Entities and Brcko District
Cantons and Regional level
Local Authorities
Others

Taking into account the different organisation of the PA in the three entities it is an interesting finding of the Review that the amount of employees per citizen are almost identical for both entities and for Brcko. Therefore, it can be concluded that in terms of staffing, centralised and decentralised public administration systems do not necessarily need to be different.

Table 5.1.3: Distribution of staff according to administrative units in BiH

	RS	FBiH	Brcko	State level	Total BiH
No of employees	823	1332	48	2	2205
No of employees per 10.000 inhabitants	5,6	5,8	5,7	0	5,7

The following table shows the distribution of staff for the health sector in BiH across entities/Brcko in percent as well as in absolute terms.

Table 5.1.4: Public administration staff distribution for the health sector in BiH related to the entities as percent of total number of staff

	FBiH	%	RS	%	BD	%	Total	%
Ministry of Health	82	3,7	33	1,5	2	0,1	117	5,3
Cantonal level Ministries	92	4,1	na	na	na		92	4,1
Sub total Ministries	**174**	**7,8**	**33**	**1,5**	**2**	**0,1**	**209**	**9,5**
Entity or HQ Health Insurance Fund	26	1,2	56	2,5	na		82	3,7
Cantonal/Regional/Local level Health Insurance Funds	544	24,7	462	21	na		1006	45,7
Sub total HIFs	**570**	**25,9**	**518**	**23,5**	**21**	**0,95**	**1109**	50,4
Entity Institutions of Public Health	104	4,7	77	3,5	na		181	8,2
Cantonal/Regional level Institutions of Public Health	305	13,8	91	4,1	na		396	17,9
Sub total PHI	**409**	**18,5**	**168**	**7,6**	**19**	**0,9**	**596**	**27**
Local Authorities	**147**	**6,67**	**52**	**2,36**	**3**[14]	**0,13**	**202**	**9,16**
Drug Agency	**32**	**1,45**	**44**	**2**	**na**		**76**	**3,45**
Accreditation Agency	**0**	**0**	**8**	**0,36**	**na**		**8**	**0,36**
Department for public security[15]	**na**		**na**		**3**	**0,13**	**3**	**0,13**
GRAND TOTAL	**1.332**	**60,5**	**823**	**37,4**	**48**	**2,1**	**2205**	**100**

[14] Only posts related to health administration.
[15] Sanitary and health inspection.

From table 5.1.4 it can be seen that FBiH counts 60.5% of the total public administration staff in BiH, RS 37,4% and Brcko 2,1% which is fully correlated with population figures as illustrated in table 5.1.5.

	Total population	Population in %	PA health sector PA staff in %
FBiH	2.315.270	59,9	60,5
RS	1.463.465	37,9	37,4
Brcko	85.000	2,2	2,1
Total BiH	**3.863.735**	**100,0**	**100,0**

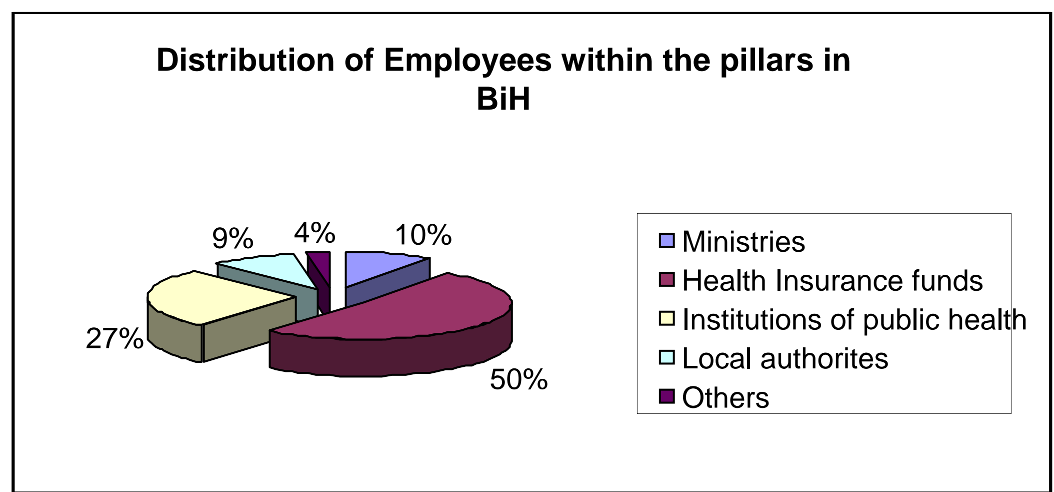
Table 5.1.5: The relation between the relative size of the population and the amount of employees

However, a more detailed analysis of the human resources used across main pillars (MoH, PHI, and HIF) reveals big differences between RS and FBiH. From table 5.1.6 it can be seen that while the majority of staff in RS is employed by the HIFs (63%), the same figure is almost 68% lower in FBiH (43%). The opposite situation is identified with respect to the human resources used in ministries and PHIs where these institutions in FBiH count for 13% and 30,7% respectively they amount to 4% and 20,4% in RS . With respect to distribution of employees on the main pillars within the entire BiH, the majority of staff (50%) is employed in the health insurance funds and 27% and 10% respectively are employed within the public health institute and ministries.

The above mentioned could indicate a general overstaffing within the HIF structures especially in RS, a lack of human and functional capacity at the ministry level in RS and overstaffing in FBiH. This conclusion is fully supported by the detailed review of the functions presented in section 5.4

Table 5.1.6: The comparison of staff number between FBiH and RS as percent of the total number of staff in each entity

	FBiH	%	RS	%
Ministry of Health	82	6,1	33	4
Cantonal level Ministries	92	6,9	na	na
Sub total Ministries	**174**	**13**	**33**	**4**
Entity or HQ Health Insurance Fund	26	1,95	56	6,8
Cantonal/Regional/Local level Health Insurance Funds	544	40,8	462	56,1
Sub total HIFs	**570**	**42,8**	**518**	**63**
Entity Institutions of Public Health	104	7,8	77	9,4
Cantonal/Regional level Institutions of Public Health	305	22,9	91	11
Sub total PHI	**409**	**30,7**	**168**	**20,4**
Local Authorities	**147**	**11**	**52**	**6,3**
Drug Agency	**32**	**2,4**	**44**	**5,3**
Accreditation Agency	**0**	**0**	**8**	**1**
GRAND TOTAL	**1.332**	**100**	**823**	**100**



The Review has identified that 30% (175 out of 596 employees) of all human resources in the PHIs are engaged in services provision related to standard laboratory analysis, a market activity for which the PHIs obtain income. Hence, service delivery on market conditions constitutes a sizable part of the total amount of functions performed by the PHIs. This implies that the core public health functions (for policy making, monitoring, and strategic planning) are mixed up with service provision - which is not good public administration practice. Further, as concluded in section 5.2, the mix of public related functions and "private business" makes financing of the PHIs none-transparent and provides a tendency that core public health functions are not performed to an extent needed.

However, it is realised that as only 60% of the expenditure of the PHIs is provided by budget transfer, the laboratory services are an important

income source and the PHIs partly compensate the lack of budget by market activities.

Further, the FR has identified that out of MoHs 209 employees 74,5, or 35%, are performing service delivery functions as sanitary inspection (65,5 employees) and drug inspection (9 employees). Inspectors at the level of Local Authorities have not been taken into account. The inspection function is not separately organized and belongs to the ministry level in both entities and in cantons although it is a general public administration principal that policy development should be separated from monitoring and controlling to avoid conflict of interest.

	Total population	Population in %	PA expenditure in %
FBiH	2.315.270	59,9	3,98
RS	1.463.465	37,9	7,00
Brcko	85.000	2,2	9,80
Total BiH	**3.863.735**	**100**	**4,74**

With respect to the function for accreditation and quality improvements 1 employee has been identified in RS and none in FBiH. At the moment the Law on the Accreditation and Quality Improvement in FBiH is being read by the Parliament.

5.2 Analysis of the Financial Resources in the Health Sector Administration

This section provides an overview of the findings and the analysis with respect to the financial resources for performing the functions within the public administration of the health sector.
The overall expenditure[16] of the health sector in BiH is 1.077,4 Mil. KM (budget for 2004) out of which, the Functional Review has identified the expenditure for the public administration part, to 51,2 mil. KM or 4,8% (for further details see annex 7.5)

Table 5.2.1: The relation between the relative size of the population and the public administration expenditure

[16] This figure encompasses resources for health services delivery and the costs of the public administration.

The relative size of the public administration expenditure, across entities, seems to be negatively related to the size of the population - a small population requires a relatively higher share for public administration - as illustrated in table 5.2.1 above. However, these differences could also be explained by various salary levels, as well as the overall amount of resources available for the health sector.

The overall amount of resources available for health care is closely linked to the scale of the economy in the entities, as well as to the amount of the population covered by health insurance. The percentage of insurance coverage is significantly lower in the RS (74%) in comparison to the FBiH (85%). Therefore, expanding the contribution base for insurance could significantly increase the revenues. Most likely, smart public relations campaigns would attract uninsured people, such as farmers, to join the insurance scheme which will increase the health sector expenditure and hereby lower the relative share of the public administration expenditure.

Mechanisms to achieve an overall financial sustainability of the health care system are deliberated in other project documents such as «Toolbox for Functional Review of the Health Sector». «Medium-term Expenditure Framework» could be applied as a useful tool for sustainability and cost containment development scheme.

The above-mentioned shows that economy of scale is an important factor when efforts are made to obtain cost containment within the public administration of the health sector. Further, the findings indicate that the function for health insurance contribution collection within the HIFs is too weak.

The table below presents the aggregated public administration expenditure for the entire BiH across main pillars (MoHs, HIF, PHIs). It is obvious that the highest expenditure absorber is the health insurance funds (46,4%), followed by the institutions of public health (27,1%) , the ministries of health (10,4%), the local authorities (10,3%) and by other types of institutions (5,8%). It is noteworthy that the total expenditure for the ministries is almost the same as for the municipalities. This could indicate the need to rationalise the functions of the municipality level and strengthen policy and planning functions at the ministry level.

However, lack of uniform accounting rules and practices make comparisons between institutions difficult. While this observation makes it necessary to use the above mentioned data with caution, it also highlights the need to strengthen the function for introduction of the uniform accounting ledger in FBiH and at the BiH level.

Table 5.2.2: The public administration expenditure – aggregated for the entire BiH

Existing budget	Budget 2004	Per cent 2004 *)
State level ministry functions	35.500	0,7
Entity/Brcko ministry functions	2.347.406	44,2
Cantonal ministries	2.932.000	55,2
Sub total Ministries	**5.314.906**	**10,4**
Entity/HQ/Brcko Health Insurance Funds	11.615.798	48,9
Cantonal Health Insurance Funds	12.149.151	51,1
Sub total HIFs	**23.764.949**	**46,4**
Entity and Brcko Public Health Institutions	6.385.321	46,0
Cantonal Public Health Institutions	7.494.624	54,0
Sub total PHIs	**13.879.945**	**27,1**
Sub total Local Authorities	**5.247.992**	**10,3**
Sub total Others	**2.985.806**	**5,8**
GRAND TOTAL	**51.193.598**	**100,0**

*) The per cent for sub totals are calculated based on the grand and the other are calculated based on the subtotals

The FR Project has determined the cost of performing functions for each of the institutions (see the CD). Although these were calculated on the basis of the average costs for each institution, they form a good basis for drafting the budget according to functions actually performed.

Ministries of Health

It is interesting that the resources available for the PA at the State level are scarce and entail only 0,7 % out of the total cost for the PA. This underlines the conclusion made with respect to the human resources that none of the required state functions are present.

With regard to ministerial structure within FBiH, the previous chapter identified an almost equal capacity in terms of human resources with 92 employees in the cantonal ministries and 82 in the federal ministry. It is therefore a surprising finding that the budget for the federal ministry (1,4 Mil. KM) is almost half the size of the financial resources used by the cantonal ministries totalling 2,8 mil. KM. This is also reflected in the recurrent unit cost per employee per year being 17.582 KM and 31.870 KM respectively.

As the salary level in the federal and in the cantonal ministries are almost identical it is the conclusion that economy of scale and higher fixed costs of having 10 separated premises, as well as lack of uniform accounting ledger[17], are the main reasons for the higher resource use in the cantonal ministries.

The total recurrent unit cost per employee per year in the ministry of health of RS is 25.231 KM, what is close to the average value for ministries at both levels in the FBiH being 25.136 KM. However, no significant difference was found between the FBiH and RS.

Health Insurance Funds

Total recurrent unit cost per employee per year within the HIFs in BiH is 21.429 KM. The cantonal average of 22.333 KM is a bit higher than the entity level offices, amounting to 20.559 KM. However, the recurrent unit cost per employee per year within the Federal Health Insurance Fund (50.462 KM) is more than double compared to the cantonal level. Those values for RS and Brcko are much lower, 18.340 KM and 36.536 KM respectively.

It is interesting that the percentage of HIFs overall administrative costs in the revenues being collected within the compulsory health insurance differs a lot. These values are as follows: 1,75% in F BiH, 4,33% in RS and 4,47 % in BD. This could indicate a potential for rationalisation of the functions of the HIF in Brcko and in RS.

Table 5.2.3: The percentage of HIFs recurrent costs within the overall revenues

	F BiH	RS	DB
Percentage of HIFs recurrent costs within the overall revenues	**1,75 %**	**4,33 %**	**4,47 %**

Public Health Institutions

Due to scarcity of budgetary resources, governments participate in PHIs financing by approximately 60% of their total expenditure. The rest is covered by providing laboratory services in the market. Cantonal PHI in Sarajevo has made a special arrangement with the Cantonal HIFs, and is financed by extra-budgetary funds provided by the compulsory health insurance, covering approximately 60% of total expenditure of the PHI.

Therefore, it can be concluded that the important PHI functions are not funded to sufficient extent.

[17] Accounting plan

5.3 Analysis of the Organisational Set-up

The section presents the findings of the Functional Review with respect to the organisations' structures to which the functions are attached and the process that binds functions together (e.g. budgeting process, HRM practices, etc).

The key findings concerning the organisational set-up of the public administration in the health sector in Bosnia and Herzegovina are summarised in table 5.3.1 below.

No structures exist at state level which could carry the change management function and no organisational structures have been identified performing the functions related to EU integration.

Only 7% of the public administration organisations in the health sector have a separate HRM department (9% in FBiH and none in RS) and only around 1/3 of all organisations have a separate budget for additional training and continuous education of employees.

The strategic planning organisation is very weak and insufficient to provide a safe ground for development of sustainable health care system in Bosnia and Herzegovina in the long-run. Only few reviewed institutions have a separate department for planning and performance monitoring, and only 15% of the reviewed institutions have undertaken strategic planning as well as adopted strategic plans. However, the average figure covers big differences between FBiH and RS. While only around 3% of the reviewed institutions in FBiH have undertaken medium-term planning and officially set-up medium-term objectives, 60 % of the organisations in RS have done so. Most of the institutions in RS have aligned their strategic and medium term objectives to the overall RS health policy.

On average, for the entire BiH, the legal organisation is strong and around 43% of reviewed institutions have a separate legal department. However, the organisational settings are different from RS where only around 20 % of the institutions have a separate legal department where 37% of reviewed institutions in FBiH possess one. This is not surprising taking into account that the federal health law gives the right to the cantons to draft their own legislation.

About 41% of reviewed institutions have a separate department for finance (similar figures for FBiH and RS) which, however, does not imply that the financial function is strong enough to provide good financial planning and to achieve financial sustainability in the long-run. 74% of the organisations responded that they do coordinate their draft budget with other institutions. The main shortage with respect to the financial function relates to the lack of MTEF in more than 83% of reviewed institutions.

Table 5.3.1: Organisational and structural findings – aggregated for the entire BiH

	Percentage of organisations with:				
Overview of result of analysis	**Separate legal department or unit**	**separate HRM department or unit**	**separate budget for training and education of the staff**	**performance based incentives beyond what is provided by the law**	**a separate department for finance/ budget**
Sub total Ministries	57	7	29	0	50
Sub total HIFs	77	8	38	0	54
Sub total PHI	8	8	17	0	17
Sub total Local Authorities	25	0	50	0	50
Sub total Others	0	0	0	0	33
GRAND TOTAL	43	7	28	0	41

Table 5.3.1: Continued

	Percentage of organisations:			
Overview of result of analysis	**coordinating their draft budget with other institutions**	**undertaking any medium-expenditure framework (MTEF)**	**with appropriately approved strategic objectives**	**with appropriately approved medium-term objectives**
Sub total Ministries	100	43	29	29
Sub total HIFs	69	0	0	0
Sub total PHI	67	8	8	8
Sub total Local Authorities	50	0	25	25
Sub total Others	33	33	33	67
GRAND TOTAL	74	17	15	17

The organisational set-up of a health care administration in Brcko District differs from those found in FBiH and in RS. It is a municipality structure, with a limited population (85.000 inhabitants) and with a centralised setting.

The Department for Health and Other Services performs all health care functions including delivery of health care services in BD.

Key findings for organisational set-up in DB reveal that there is no separate legal department or finance/budget department within the Department for Health and Other Services. Those functions are performed by the departments within the BD Government. However, all sub-departments and the Department itself coordinate their draft budgets.

No HRM department exists and no separate budget for training and education of staff was identified. Strategic and medium-term planning functions are weak and no MTEF is elaborated.

It is the overall conclusion that the organisational set-up of the public health administration is designed to administer the health system, but lacks almost completely organisational structures required for managing and changing the health care system.

5.4 Main Functions of the Public Health Sector Administration

This section presents the findings and analyses related to the major functions as identified by the Functional Review.

5.4.1 The State Administration of the Health Sector

One of the main findings in respect to the state level is that almost no state functions exist. The only body that deals with some health care related issues is the Department for Health, Social Care and Pensions within the MoCA allocating only 1,5 fulltime employees for these issues.

Thus, it is concluded that none of the functions that would enable a successful EU integration are present. This relates to the organisational structures that would not be able to provide a partner-link with EU institutions, to the competences that do not exist to an extent able to commit the entire health sector in BiH, as well as to the technical planning of the integration itself. The conclusion is also that the change management function/capacity required to bring the EU integration, the SAA and the national health strategy (PRSP) into being, is absent.

There are no functions for planning, monitoring and managing the heath care system in order to secure universal health insurance coverage, equal access and equity of health care.

Functions for coordinating, supporting and monitoring the implementation of the entity health sector strategies do not exist.

No functions that could ensure macroeconomic sustainability of the health sector in BiH have been identified.

Functions for coordination between the state level and the Entities are not present to a required degree and no permanent organisational structures for cooperation could be identified.

5.4.2 The Entity Administration and District Brcko

Entity Ministries of Health

Within the ministerial structures at entity level the project team expected to identify the below mentioned core functions:

- Policy development and policy coordination with cantonal level
- Drafting frame laws for health care system in the F BiH
- Identifying the health care network (capacity and speciality planning based on prognoses for demand for health care elaborated by PHI) including private provision of health care
- Setting standards and determining BBP and positive list for drugs
- Participate in establishing MTEF for the health sector at Federal level
- Planning, coordination and monitoring the distribution of funds on priority sectors (prevention/promotion, primary health care and secondary health care)
- Monitoring the performance of the health sector
- Monitoring the performance of the Federal HIF and other institutions and organisations within the health sector
- Coordinating curriculum development and conducting education planning
- International cooperation functions (bilateral cooperation with similar organisations)
- Inter-entity cooperation issues
- Inspections functions

However, the findings revealed that out of all the functions mentioned above, only the Federal and the RS ministries of Health perform the following functions to satisfactory level:

- Policy development
- Drafting frame laws on the entire health care system in the F BiH
- Establishing tertiary level institutions at the Federal level (university clinical centers)
- International cooperation functions
- Inspections functions

It is concluded that the coordination and cooperation between the main health pillars (PHI, MoH and HIF) is very weak.

It is also concluded that there is no planning cycle: (a) identification of health needs (PHI); (b) HR and health care planning (MoH); (c) contracting health services on the basis of actually identified health needs (HIF).

There are neither appropriate functions to support planning and monitoring, nor to plan approve capital investments.

No functions for evidence based closing or adjusting the capacity of health institutions have been identified.

The human resources management function, internally and with respect to skills and competences of professionals in the health care sector, does not exists.

Cooperation with Ministries of education and Universities is not proactive. MoHs are not involved in HR planning for medical educations. The Ministries are not involved in curriculum development.

Entity Health Insurance Funds
The core functions of the Health Insurance Funds were expected to be identified as follows:

- Improving collection of contributions especially broadening the contribution basis and enlarging the coverage of health insurance
- Contracting health institutions according to needs and with incentives for resolving problems prevailing in the health sector
- Monitoring the contract implementation
- Paying health care providers
- Performing National Health Accounts
- Preparing international agreements on health insurance
- Undertaking activities to obtain health care abroad
- Coordination with cantonal/regional/local health insurance funds
- Contributing to and participating in establishing of universal coverage of health insurance in BiH
- Strategic planning of health care service provision (only to a minor extent)
- Contribution verification
- Granting and validation of health insurance status
- Sick benefit and other cash benefit administration (RS)
- Uniform health information system

In summary, however, the Functional Review revealed that only the following core functions were performed to an expected extent:

- Contracting of health institutions
- Paying health care institutions
- Contribution verification
- Granting and validation of health insurance status
- Sick benefit and other cash benefit administration (RS)

During the last couple of years, the HIFs have undergone a number of reforms that have changed the system of financing health institutions system. However, contracting of health care providers is still input-related (e.g. number of beds and number of medical professionals) rather than output-

based although the PRSP and the Entity strategies highlight the introduction of Global Budgeting with performance elements as an objective.

Further, none of the HIFs has regular monitoring and reporting of measures for productivity, efficiency, and quality.

The planning function is partly conducted in isolation (not based on prognoses for demand for health care as well as no capacity and speciality planning) and is not based on patient preferences, prognoses for demand for health care (to be elaborated by PHI) and on capacity and speciality planning of the health care network (to be done by MoH).

Functions related to introduction of universal coverage of health insurance in BiH are not present to a required extent.
Receiving of health insurance contribution is conducted by the local tax-offices (MoF as part of the treasury) and not by HIF. However, the function for contribution collection is not performed to a sufficient extent. To this end it is important to note that while the contribution collection function includes receiving the monthly payment its most essential part consists of: broadening the contribution basis (including PR campaigns, special initiatives for farmers and self employed), ensure correspondence between what the insurees pay for and what they get as well as control and debt reconciliation.

No human resources management functions have been identified – only human resources administration. There is no budget for upgrading the competences and the skills of the staff.

The reforms of the HIF RS has brought about a centralisation of some of the major functions (e.g. contracting of health care providers is today performed by the HQ) and most of the functions previously performed by the regional offices have, alongside the centralisation, been transferred to the HQ leaving only few functions to the regional offices. Despite these changes, the organisation has not been changed accordingly.

Entity Public Health Institutions
The core functions expected to be performed by the Federal Public Health Institute were as follows:

- Monitoring the health status of the population
- Monitoring the performance of the health system
- Elaboration of prognoses for demand for heath care
- Elaborate prognoses and analyses for evidence based planning and decision making by MoH, HIF and other stakeholders (not performed today)
- Participate in drafting norms, standards, laws and regulation
- Health statistics including international reporting
- Participate in development and maintenance (especially with respect to data definitions and nomenclature) of the health information system

- Ad hoc scientific research and analyses in the field of public health
- Health promotion and disease prevention analyses, based on the highest impact on the health states per KM used
- Control of contagious diseases
- Prevention of spread of communicational diseases
- Environmental health
- Detection and reduction of NCD risk factors
- Sanitary control of potable water, air and food and sources of ionising radiation
- Reference laboratory and development of standards for accreditation according to EU legislation.

The functional review identified that the following functions were performed at a satisfactory level (which does not mean that functions are performed within the right body):

- Monitoring the health status of the population
- Participating in drafting norms, standards, laws and regulation
- Health statistics including international reporting
- Ad hoc scientific research and analyses in the field of public health (needs however to be strengthened further)
- Control of contagious diseases and prevention of spread of infectious diseases
- Sanitary control of potable water, air and food and sources of ionising radiation
- Laboratory analyses

Explanation box – EU integration requirements with respect to food safety:

The EU has an integrated approach to food safety that aims to assure a high level of food safety, animal health, animal welfare and plant health within the European Union through coherent farm-to-table measures and adequate monitoring while ensuring the effective functioning of the internal market.

The principles behind this approach can be summarised as follows:

- Trade in foodstuffs is one of the most important aspects of the common market;
- All the Member States must endeavour to protect the health and economic interests of their citizens;
- The protection of health must be given unconditional priority.

The implementation of this approach involves the development of legislative and other actions:

- To **assure effective control systems and evaluate compliance with EU standards** in the food safety and quality, animal health, animal welfare, animal nutrition and plants within the EU and in third countries in relation to their exports to the EU;
- To **manage international relations** with third countries and international organisations concerning food safety, animal health, animal welfare, animal nutrition and plant health;
- To **manage relations with the** European Food Safety Authority (EFSA) and ensure science-based risk management.

The basic principles related to responsibilities of the Member States authorities are laid down in the Regulation (EC) No 178/2002 which is based upon previous Council Directives No 89/397/EEC, No 93/99/EEC, No 89/662/EEC and No 97/178/EC.
This established set of rules for control system will continue to apply until 1 January 2005 when

the new Regulation (EC) No 882/2004 -29 April 2004- (on official control to ensure the verification of compliance with feed and food law, animal health and animal welfare) will become effective. It will be enforced completely as from 1 January 2006.

This Regulation stipulates that the official controls carried out by the Member States must enable them to verify and ensure compliance with national and Community rules on feed and food. To this end, official controls must be carried out at any stage of production, processing and distribution of feed and food. These controls are defined as a function of the identified risks, the experience and knowledge gained from previous controls, the reliability of the controls already carried out by the business operators concerned and a suspicion of possible non-compliance.

The Member States designate the competent national authority that must satisfy well defined operational criteria ensuring their effectiveness and their impartiality. It will be responsible for performing the official controls. They can delegate some of the controls to regional or local authorities, in which case effective cooperation between the central authority and these authorities must be ensured.

The competent authority may also delegate certain control tasks to non-governmental bodies provided these bodies meet the strictly defined conditions set out in the Regulation. Hence a procedure is therefore provided to define the tasks that can (or cannot) be delegated to such bodies. In fact control bodies must be accredited in accordance with European Standards EN 45004 "General criteria for the operation of various types of bodies performing inspections".
Each Member State shall communicate to the Commission the names of the competent authority or authorities and the extent of their territorial responsibility and functions.
Audits subject to independent scrutiny must be carried out to verify that the competent authorities fulfil the conditions mentioned above.

In general, the PHIs has, during the last two years, been introducing strategic management and has, as one of the few organisations in the public administration part of the health sector, a well defined hierarchy of strategic and medium-term objectives, functions and projects which are used as basis for budgeting, budget execution and management. However, PHI seems not to have anchored the function for technical update of the strategic management process to any organisational unit.

The federal PHI is also one of the few reviewed organisations, with a HRM function and with an explicitly stated budget for training and education of the staff.

It was observed that the activities of the RS PHI and its regional institutions are still orientated towards control of communicable diseases, environmental hygiene and lately moderated orientation towards the prevention and control of chronic non-communicable diseases and health promotion.

Although, the PHIs are conducting analyses and providing good health statistics (e.g. on the health status of the population) the PHIs do not elaborate prognoses for demand for health care or estimation of the need for medical professionals that could form a background for a cyclic process of evidence based planning. These prognoses should form the basis for MoH's capacity and speciality planning which HIF in turn should use as a background for contracting of the heath care providers.

Functions related to health promotion, based on analysis of which areas would have the highest impact on the health status of the population per KM spent, have not been identified. It was also observed that the PHIs do not perform analyses of health related socio-economic indicators or indicators related to the financing of the health system.

District Brcko

There is no explicit health ministerial structure in Brcko District but the Department for Health and Other Services that consists of six sub-departments covering various issues from health and social care to sport and culture.

Most of the functions were observed to be weak or undeveloped. In general, there is not enough capacity for strategic planning, drafting regulations, policy-making and for performing the coordinating function within the Department. Furthermore, there is no HRM function and the legal function is absent.

The main functions performed by the Sub-department for Health Insurance Fund are:

- Monitoring contribution collection,
- Verification of health insurance status,
- Monitoring health care expenditures,
- Allocation of resources,
- National Health Accounts for Brcko District,
- Medical board activities,
- Complaints and patients' requests (e.g. for medical treatment outside of BD, for orthopaedic and other appliances, etc.).

It was identified that the Sub-department for health insurance did not perform the contracting function, MTEF, cooperation with the Revenue Agency and Tax Authorities, HRM, coordination with Inspections Division (pharmaceutical, health, etc.), PR nor legal function.

The main functions of the Sub-department for public health are:

- Monitoring health status of the population,
- Reporting on morbidity,
- Assessing the health needs,
- Organising immunization of the population,
- Promotion,
- Education,
- Monitoring hygiene situation of potable water, food, common goods, and employees in production and distribution of food and beverages.

The functions for strategic planning, MTEF, coordination with entity PHIs, HRM, and the legal function were either not identified or found performed in a too low degree.

Part of the health administration is situated at the Inspections Division, which is an organizational unit within the Department for Public Safety performing mostly functions related to health care, sanitary and health inspection.

5.4.3 The Cantonal Health Sector Administration

Cantonal Ministries of Health
According to good PA practice the cantonal ministries of health were expected to perform the following functions:

- Design of health care system at the cantonal level
- Strategic planning
- Defining priorities within capital investments and patients entitlements
- Granting health insurance for disadvantaged groups and transfer of money to local authorities
- Monitor the performance of the primary health care institutions in the canton including monitoring of private health care institutions
- Monitoring the performance of the cantonal health insurance fund
- Monitoring the performance of PHI and other stakeholders in the canton
- Planning the provision of primary health care and adjusting the health care network to the need of the population in the canton
- Planning and monitoring of preventive and promotion activities in the canton
- Coordinate, implement and monitor the realisation of federal policy, laws and regulations
- Participate in development of standards, concept and legislation together with federal and national health authorities

In the majority of the cantonal ministries there are no appropriate functions to support planning, monitoring and approval of capital investments as well as to adjust the provider capacities, if necessary. The cantonal ministries are found to have a weak leadership role in respect to resource allocation for health service provision. Ministries usually do not develop detailed criteria for contracting and do not possess functions that could support implementation of entire policy/strategies.

The CMoHs are also charged with the functions of planning the future need for qualified medical professionals while the Cantonal MoEs are responsible for curriculum development. However, none of the ministries are performing these functions. Cantons are also fund to be too small units to have their own independent medical education system, even Sarajevo Canton, with its approximately 400.000 inhabitants would not be of a sufficient size. Further, with no overall standards covering the entire BiH medical education system, there is a risk of creating medical professionals with different qualifications

and in an amount that would result in over production (or under production) of medical professionals. EU membership would require BiH to ensure free movement of labour and mutual recognition of qualifications which would not be possible with the existing fragmented system.

It was also identified that Orasje, Travnik, and West-Hertzegovina CMoHs performed the function of drafting laws (the number of employees to undertake all functions within these cantonal ministries are 4,4; 12 and 8 respectively). Although, the principle of shared responsibilities between the federal and the cantonal level includes the principle for coordination (e.g. the federation can issue frame laws and legal coordination) it is concluded that the function of drafting laws at the cantonal level risk to fragment the health system and can not be performed satisfactory with the existing capacity of human resources. Taken into account the limit size of BiH, it would not be economically effective to build-up the required capacity for the law function at the cantonal level.

Cantonal Health Insurance Funds

The core functions of the cantonal HIFs were expected to be identified as follows:

- Improvement of collection of contributions especially broadening the contribution basis and enlarge the coverage of health insurance
- Contracting health institutions according to needs and with incentives for resolving problems prevailing in the health sector
- Monitoring of the contract implementation
- Payment of health care providers
- Performing parts of the National Health Accounts
- Contribute to and participate in establishing of universal coverage of health insurance in BiH
- Strategic planning of health care service provision (only to a minor extent)
- Contribution verification
- Granting and validation of health insurance status
- Uniform health information system

The following core functions were identified:

- Running compulsory health insurance at the territory of the Canton
- Monitoring of contribution collection
- Registration of insured persons
- Contracting services with health institutions
- Payment of health care providers

It is therefore the conclusion that the function for contribution coverage and for broadening the collection basis is not performed to a sufficient extent.

The function of verification of health insurance status of the insurees is performed in an administrative cumbersome way. A number of municipality offices are located in Dom Zdravlja buildings or in the vicinity. Therefore, the

function of registration of insured persons and certifying the validity of health cards is at the close disposal to the users / patients. Apart from that, retired persons are released from the obligation to certify the validity of their health cards because once being retired they are insured forever.

The function of contracting health care institutions is done to a satisfactory level only in 3 cantons (Zenica, Bihać, and Goražde). All other cantons allocate resources in accordance to the payroll list of health professionals in the health care institutions.

Cantonal Public Health Institutions
The core functions of the cantonal public health institutions are as follows:

- Monitoring of epidemiological situation and discovering epidemics of communicable diseases
- Reporting on morbidity data and assessing health needs
- Analysis of hygiene status of drinking water
- Health promotion and disease prevention
- Organizing of continuing medical education for health professionals

Public health institutions at federal and cantonal level employ in total 409 employees within 11 institutions. However, the geographical distribution of staff is not equitable as more than half are employed in Sarajevo (207). Due to lack of staff, equipment and financial resources, some of the core functions are still missing in the smallest cantons. There is a scarcity of highly specialized staff living in those cantons, and therefore it is a problem to attract staff.

5.4.4 The Municipal Health Sector Administration

A total of 144 municipalities exist in BiH (79 in FBiH, 64 in RS, and in Brcko District).

The functionality identified within the six municipalities, included in the Functional Review, shows big differences from municipality to municipality within FBiH. In general the following main functions related to the public administration of the health sector are performed by the municipalities:

- Sanitary inspection
- Organisation of coroner's services (stipulated by the law but not performed by all)
- Pest control
- Organising and financing the health care of social-aid-dependent cases, war-veterans, invalids, and disabled persons
- Appointment of directors and members of managing boards in above mentioned health institutions
- Co-financing of Emergency Service

- Establishing and closing of health institutions (mostly DZ, pharmacies, ambulanta but according to the law also hospitals could be established by municipalities in FBiH)

In RS the function for coordination and articulation of health needs at local level is conducted by the Health Boards, which are part of the local government. However, these functions are lacking an institutional foundation in FBiH.

Apart from the functions of coordination, determination of local preferences, and administration of the health insurance for social-aid-dependents it is the conclusion of the Consultant that municipalities can not, due to the limited population basis, perform functions related to the public administration of the health sector in a well coordinated and economically effective way. Consequently, all other functions should be abolished or transferred to other more relevant institutions as follows:

- Sanitary inspection (should be transferred to entity and state inspectorates)
- Pest control (should be transferred to PHI/agriculture sector)
- Directors and members of managing boards for the health institutions should not be appointed by the local authorities.
- Health Boards should be established throughout BiH and be represented in the board of the health institutions.
- Co-financing of Emergency Service (should be abolished)
- Establishing and closing of health institutions (should be abolished)

5.5 Conclusion of the Analysis of Functions

The findings of the functional review and the analysis presented above can be summarised as follows:

The overall public administration of the health sector in BiH is characterised by being too voluminous, focusing on functions that are outdated or could be rationalised. Too much attention is placed on isolated administration and service delivery functions with not link to policy formation/implementation, decision-making and establishment of incentives that could provide for cohesiveness of the health system. Duplication of functions across two or more levels is observed. Further, a lack of functions has been identified that could provide for a rational use of resources attuned to the need of the single patient or citizen. HRM, consistent planning, policy development and coordination as well as mechanisms for EU integration do almost not exist. Finally no function for change management, that could own and guide reforms within the sector exist.

With 1,5 employees to perform all functions at **state level** it is the conclusion that almost none of the functions required for planning, monitoring, for running a sustainable, coherent health care system with universal coverage, equal access, equity and able to guide the EU integration, exist.

With 823 employees to perform the public administration functions of the health sector in **RS** (equal to 5,6 employees per 10.000 inhabitants or 7% of the total health sector expenditures), a need exists for streamlining the existing functions. Especially separation of the policy functions and the service provision functions as well as rationalisation of functions to match recent years' reforms are necessary. Further, functions for planning, preference monitoring, rational use of resources and evidence based decision-making should be strengthened to prepare for a successful implementation of EU integration. The functions for successful implementation of RS health sector strategies and policies as well as the PRSP are too weak. Functions to ensure that a bigger proportion of the population is insured and therefore participates in carrying the burden of health insurance are found to be too weak. Furthermore, coordination, internally, between entities and with the state are found to be too weak.

The public administration of the health sector in **FBiH** involves 1.332 employees (equal to 5,8 employees per 10.000 inhabitants or 4% of the total health sector expenditures). The performance of the functions is characterised by a mixture of service delivery and policy functions (sanitary inspection, standard laboratory services). Functions related to planning, preference monitoring, rational use of resources and evidence based decision-making are performed to a too low extent. Further, functions that could provide for successful implementation of EU integration are almost not existing and functions for implementation of FBiH health sector strategies and the PRSP are too weak. Functions to ensure increasing of health insurance coverage, broadening the health insurance contribution basis, better

capacity utilisation are weak or not existing. Coordination, internally as well as with the state and between entities are weak.

The public administration of the health sector in **Brcko** employs 48 fulltime employees (equal to 5,7 employees per 10.000 inhabitants or approximately 10% of the total health sector expenditures). The functions for planning, HRM and coordination are weak.

The existing distribution of functions across levels, as identified in section 5 is summarised in table 5.5.1 below.

Table 5.5.1: Summary of existing distribution of functions across levels

Major function: Organising the provision of health care and improving the health status of the population			
Function groups	**Performance of functions with respect to levels**		
	State	**Entity / District**	**Canton or other levels**
Policy development and policy coordination		Drafting frame laws and strategies for the entity / district encompassing primary, secondary and tertiary health care	Drafting regulation and cantonal laws in some cantons
Setting standards for the provider network, BBP, quality etc.		Frame standards/ minimum standards for both primary, secondary and tertiary issues	Setting standards for pharmaceutical reimbursements, co-payments, etc.
Opening and closing health institutions		Tertiary health care (in F BiH) Secondary and tertiary health care (in RS) Secondary health care (in district)	Primary health care
Macroeconomic sustainability		-Drafting budget for Entity level -Entity MTEF -Health account for entities	-Drafting budget for local level
Capacity and speciality planning		Tertiary health care Secondary health care (in RS)	Primary health care Secondary health care (in F BiH)
HRM and Workforce planning		Tertiary and secondary health care and internally in the PA at Entity level	Primary and secondary health care and internally in the PA at cantonal level
Education/competence planning as well as coordination of curriculum development		For the entire health care system in cooperation with the other levels with respect to higher education (not performed to a sufficient extent)	For lower education not taking place at university level.
Accreditation and quality assurance			
Internal coordination		Within each institutions	Within each institution
Inter entity and inter section coordination	-contracts obligating the entities and cantons	-Participating in the inter entity health council -contracts obligating the entities and cantons	-Local health council -contracts obligating the entities and cantons
International relation and coordination		-Participating in international organisations and entering into obligations committing BiH, including convernance for treatment of patients	
EU integration			
Inspection		-setting standards for inspection of all kinds for BiH -handle complaints about inspection	-sanitary inspection -pharmaceuticals inspection -drug inspection

		-pharmaceuticals inspection -sanitary inspection -drug inspection -technical assessment of medico-technical equipment -reference laboratories -Radiation control	

Table 5.5.1: Summary of existing distribution of functions across levels – continued

Major function: Organising the availability of financial resources			
Functions	**Performance of functions with respect to levels**		
	State	**Entity**	**Canton or other levels**
Contribution collection		Entire revenues (RS) Solidarity revenues (F BiH)	92 % of revenues for cantonal HIFs (F BiH)
Verification of health insurance status		HIF of RS HIF of F BiH	Municipality HIF offices
Contracting of health institutions		HIF of RS HIF of F BiH (for solidarity benefit package)	Contracting of primary, secondary and, partly, tertiary health care (F BiH)
Payment of health institutions		Global prospective budget (RS) Fee-for-services (FBiH)	Global prospective budget (Zenica, Bihać, Goražde) Payroll list / salary system (the rest of the F BiH)
Universal coverage of health insurance		HIF of RS	Cantonal HIF (in F BiH)
EU integration			

Table 5.5.1: Summary of existing distribution of functions across levels – continued

Major function: Monitoring, information provision and control			
Functions	**Performance of functions with respect to levels**		
	State	**Entity**	**Canton or other levels**
Prognoses for demand for health care		Tertiary health care (F BiH) All levels of health care (RS)	Primary and secondary health care (F BiH)
Performance monitoring		Tertiary health care (F BiH) All levels of health care (RS)	Primary and secondary health care (F BiH)
Epidemiological monitoring		For entity institutions	For cantonal institutions
Ad hoc and scientific development and monitoring		For entity institutions	For cantonal institutions
Reporting (national, local and international		For entity issues	For cantonal issues

Health information system		-Standards, protocols, architecture and nomenclature for the entity system -running the system for all levels of health care	Data collection at the cantonal level – PHIs (F BiH)
Estimating preferences of the patients and the population		With respect to all health care levels (RS)	In respect to secondary and primary health care (F BiH)

6. RECOMMENDATIONS

The Functional Review has identified a need for restructuring, rationalising, abolishing, strengthening and introducing new functions as concluded in chapter 5.

The recommendations deriving from the findings and the methodology of the Functional Review are many and detailed i.e. for each of the reviewed institutions separate recommendations are provided (see the CD and annex 7.1 to 7.4).

Hence, this section summarises the recommendations relevant for the overall well functioning of the health system and functions that should be present within the public administration in order to ensure:

- Well functioning of the health system and realisation of its overall visions.
- Successful implementation of BiH or Entity strategies and policies
- Good governance
- EU integration
- Macroeconomic sustainability

The analysis of the existing functions and subsequently the recommendation for changes are based on a number of general principles deriving from good public administration and management practice. Those are:

- Functions of the same type should be grouped together
- Policy and service delivery functions should be separated
- Support functions should be separated from other functions
- No duplication or overlap of functions
- Clear and short reporting lines
- Viable sizes of departments
- Optimum spans of command for managers
- Equitable workload
- Responsibilities of senior staff should be equalised
- Decision making should be delegated to the lowest suitable level
- Gradual approach to restructuring

As the functional review deals with identifying functions actually performed by a given organisation and estimation of their magnitude, measured in terms of staff and financial resources, the recommendations can also be measured by those parameters as follows:

- Qualitative aspects of a function measuring the recommendations in terms of whether a function should be strengthened, reduced, rationalised, abolished, outsourced, transferred to other bodies, or whether there is a need for introduction of new functions or whether the existing functions should remain unchanged.

- Quantitative aspects of the recommendations measuring the changes in terms of resources (staff and budget).

It is important to note that the recommendations presented in this chapter are identified under the preconditions that they should be feasible to implement during the next half decade - before the end of 2010. This implies that the recommendations are not to be seen as a "big-bang" and not to be implemented overnight but represent a gradual change-approach. The proposed recommendations have both consequences with respect to distribution of functions between levels and between sectors within the levels as well as for the human and financial resources provided to perform them. Hence, a gradual implementation is required in order not to dismantle functions before new ones have been established at the recommended level.

The recommendations also constitute one comprehensive public administration package where none of the single components can stand alone or can be taken out.

Based on the above-mentioned the recommendations detailed in this chapter can be summarised under five major headings as follows:

- **Establish or strengthen functions at the state level** required to ensure a sustainable, coherent health care system with universal health insurance coverage, equal access, equity and readiness for EU integration. This includes recommendations for: establishing a separate department for health within Ministry of Civil Affairs, a BiH Accreditation and Quality Improvement Agency, a BiH Drug Agency, a BiH Health Insurance Agency, a BiH Public Health Agency, and a BiH Inspectorate.

- **Strengthen all functions related to policy formation**, evidence based planning, performance monitoring, functions related to strategic issues (PRSP and Entity strategies) as well as functions for successful EU integration. This group of recommendations also includes strengthening of functions related to public health functions, broadening the health insurance contribution basis, universal health insurance coverage throughout BiH and macroeconomic sustainability.

- **Rationalise functions within the entities/cantons/municipalities** that are outdated or not performed rationally or efficiently. This includes the recommendations for establishing Entity Inspectorates (sanitary inspections), proposal for outsourcing of standard laboratory analyses, rationalising of the health insurance functions in both RS and FBiH related to contracting health care providers, health institutions monthly invoices, verification of health insurance status. Therefore the functions of the regional offices of the HIF in RS and the PHIs within the FBiH would have to be significantly rationalised.

- **Reinforce all functions related to good governance** including strategic management, HRM, coordination, education/workforce planning curriculum coordination and a uniform health information system

- .**Provide donor support and establish change management capacity** that can own, facilitate and provide direction for the implementation of the recommendations.

The recommendations mentioned above will make a more efficient public administration of the health sector and can be implemented without increase in the financial and human resources as illustrated in table 6.1 and 6.2.

Table 6.1: Staff and budget consequences of the recommendations – aggregated for the entire BiH

	Staff	Budget in mil. KM
Existing Situation	2.205	51,2
Impact of recommendations	-225[18]	-4,3
Situation after implementation of the recommendations	1.980	46,9

For more details see annex 7.5

Table 6.2: Staff consequences of the recommendations – aggregated for the entities

	Staff	Budget in mil. KM
FBiH	-215	-5,3
RS	-178	-3,7
Brcko	-6	-0,2
Other changes	174	4,9
TOTAL	**-225**	**-4,3**

See also annex 7,5

With respect to distribution of the functions across levels, the recommendations encompass the formation of a number of state functions as well as recommendations aimed at avoiding duplications of functions. Hence, the recommendations would have an impact on the distribution of functions across levels and among institutions which can be summarised as follows (for more details, see table 6.3):

- The state level would undertake the functions of drafting frame laws, entities would draft laws (within the boundaries of the frame laws), and lower levels would draft regulations (within the boundaries of the frame laws and laws – see also example box below).
- The state level would perform the functions for setting minimum standards /frame norms for the entire health care system in BiH.

[18] Including 175 laboratory staff that are proposed to be considered outsourced.

- With respect to the functions for establishing, planning, monitoring of the provider network, the state would have the responsibility for the tertiary health care network, the entities for the secondary/primary and the Cantons for the primary health care network.
- The state level will undertake the function for elaboration of a MTEF for BiH based on entity MTEFs.
- The state level will perform the functions for education planning and coordination of curriculum development for the entire BiH.
- The state level will perform the functions related to the drug agency, pharmaceutical inspections and the Entities will perform the sanitary inspection based on standards elaborated at the state level.
- The state level will undertake the functions related to plan for and committing BiH with respect to EU integration and the Entities to enact the integration requirements.
- The state level takes care of establishing the function for universal coverage with health insurance throughout BiH.

Table 6.3: Distribution of functions across levels

Major function: Organising the provision of health care and improving the health status of the population			
Function groups	**Recommendations with respect to levels**		
	State	**Entity**	**Canton or other levels**
Policy development and policy coordination	Drafting frame laws and frame strategies for BiH and laws and strategies for tertiary health care and other state issues	Drafting laws for secondary and primary health care within the frame of the BiH laws and strategies	Drafting regulations
Setting standards for the provider network, BBP, quality etc.	Frame standards/ minimum standards for both primary, secondary and tertiary issues	Standards for secondary health care within the BiH frame standards or above the minimum standards. For RS also standards for primary health	Standards for primary health care within the BiH/Entity frame standards or above the minimum standards
Opening and closing health institutions	Tertiary health care	Secondary health care. For RS also Primary health care	Primary health care
Macroeconomic sustainability	-Drafting budget for state level -MTEF consolidating the Entity MTEFs -Health account for BiH	-Drafting budget for Entity level -Entity MTEF -Health account for entities	-Drafting budget for local level
Capacity and speciality planning	Tertiary health care[19]	Secondary health care For RS also standards for primary health	Primary health care
HRM and Workforce planning	Tertiary health care and internally in the PA at state level	Secondary health care and internally in the PA at Entity level For RS also standards for primary health	Primary health care and internally in the PA at cantonal level
Education/competence planning and coordination of curriculum development	For the entire health care system in cooperation with other levels in respect to higher education	For lower education levels not taking place at university level.	
Accreditation and quality assurance	Standards for accreditation and quality assurance Coordination with entity bodies	Accreditation and quality assurance according to BiH standards	
Internal coordination	Within each institution	Within each institution	Within each institution
Inter entity and inter section coordination	-Permanent inter entity health council -contracts obligating the	-Participate in the inter entity health council -contracts obligating the	-Local health council -contracts obligating the

[19] Could be provided by different hospitals throughout the country

	entities and cantons	entities and cantons	entities and cantons
International relations and coordination	-Participate in international organisations and - taking commitments obligating BiH including agreements for treatment of patients	-Bilateral cooperation with similar institutions abroad	-Bilateral cooperation with similar institutions abroad
EU integration	-Strategies, plans and participating in EU integration obligating BiH -monitoring EU integration -Export of benefits	-implementing and participating in EU integration	-implementing and participating in EU integration
Inspection	-setting standards for inspection of all kinds for BiH -handle complaints about inspection -pharmaceutical inspection -technical assessment of medico-technical equipment -reference laboratories -Radiation control	-Sanitary inspection	-standard laboratory tests should be handled by private and/or public accredited laboratories

Table 6.3: Distribution of functions across levels – continued

Major function: Organising the availability of financial resources			
Functions	**Recommendations with respect to levels**		
	State	**Entity**	**Canton or other levels**
Contribution collection		As today – No changes	As today – No changes
Verification of health insurance status		As today – No changes	As today – No changes
Contracting of health institutions		As today – No changes	As today – No changes
Payment of health institutions		As today – No changes	As today – No changes
Universal coverage of health insurance	For the entire BiH in cooperation with entities		
EU integration	-Export of benefits for the entire BiH		

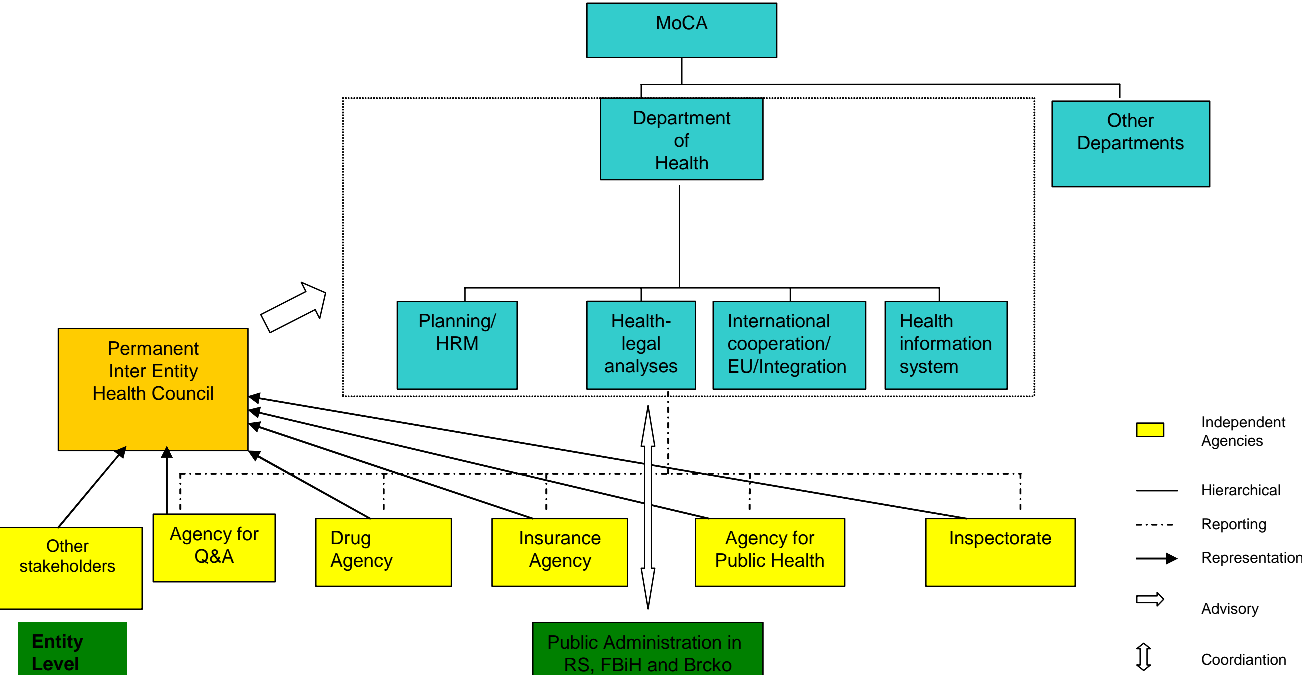
Table 6.3: Distribution of functions across levels – continued

Major function: Monitoring, information provision and control			
Functions	**Recommendations with respect to levels**		
	State	**Entity**	**Canton or other levels**
Prognoses for demand for health care	Tertiary health care and consolidating for BiH	Secondary health care For RS also Primary health care	Primary health care
Performance monitoring	Tertiary health care and consolidating for BiH and state level	Secondary health care and entity level	Primary health care and cantonal institutions

	institutions	institutions For RS also Primary health care	
Epidemiological monitoring	Consolidated for BiH	For entity institutions	For cantonal institutions
Ad hoc analyses, scientific research and monitoring	Consolidated for BiH	For entity institutions	For cantonal institutions
Reporting (local, national and international)	-For BiH issues with respect to national reporting -All international reporting	For entity issues	For cantonal issues
Health information system	-Standards, protocols, architecture and nomenclature for the BiH system -running the system for tertiary care -Running the BiH system	Running the system for secondary care For RS also Primary health care	Running the system for primary care
Estimating preferences of the patients and the population	-Consolidated preferences	With respect to secondary, tertiary care, promotion and prevention	In respect to secondary, primary health care, and promotion and prevention

In terms of organisation figure 6.4 below gives a schematic overview.

Figure 6.4 Organisation after implementation of the recommendations



6.1 Recommendation 1: Strengthen functions at BiH level

This section presents recommendations to strengthen/establish functions required to ensure a sustainable, coherent health care system with universal health insurance coverage, equal access, equity as well as formation, implementation/monitoring of BiH (PRSP) and entity policies/strategies

With 1,5 employees dealing with the public administration at **state level** the findings can be summarised as follows:

- None of the functions required for planning, monitoring and running a sustainable and coherent health care system with universal health insurance coverage, equal access and equity exist.
- No functions for coordinating, initiating and monitoring the implementation of BiH health sector objectives or for support to the Entities in implementation of more specific health sector strategies and changes exist.
- Functions related to EU integration are not present to an extent that will guaranty a timely and smooth integration. No functions have been identified which can provide a partner-link for EU institutions as well as to commit the entire BiH health sector with respect to EU integration. Further, none of the functions required for EU membership can be identified (e.g. policy coordination, free movement of goods, free movement of persons/patients and export of benefits).
- No function exists that can provide macroeconomic sustainability (establishing, coordinating and monitoring an overall economy frame for the health sector in BiH neither in the short nor in the medium term perspective).
- No functions for education planning and coordination of curriculum development exist.
- Functions for coordination between the state level and the Entities are not anchored to any permanent structures and are performed at a magnitude by which they are almost not existing.

In order to place these functions within an institutional context it is proposed to establish the following organisational structures:

- Department for Health within MoCA.
- BiH Accreditation and Quality Improvement Agency.
- BiH Drug Agency.
- BiH Health Insurance Agency.
- BiH Public Health Agency.
- BiH Inspectorate.

6.1.1 Recommendation 1.1: Establish a Separate Department for Health within MoCA

The following functions are recommended to be undertaken by the Department for Health:

- The function for elaboration of overall strategies for the entire health sector in BiH in cooperation with the Entities.
- The function for cross sectional and cross entity coordination.
- The function for drafting frame laws for the health sector in BiH.
- The function for drafting laws and regulations for state institutions.
- The function for policy planning, monitoring and coordination.
- The function for defining the network for provision of tertiary health care (capacity and speciality planning[20] based on prognoses for demand for health care elaborated by PHIs).
- The function for elaborating consolidated plans for the health care network in BiH (including private, primary, secondary and other types of health services) based on capacity and speciality plans elaborated by the Entities and Brcko (also based on prognoses for demand for health care elaborated by PHIs).
- The function for elaborating MTEF for the health sector at BiH-level, participating in planning and monitoring the distribution of funds for priority sectors (prevention/promotion, primary health care, secondary and tertiary health care) in BiH.
- The function for facilitating establishment of universal coverage of health insurance in BiH, including establishing of minimum standards for the health system in BiH, determining a minimum BBP and establishing an equitable price system for universal health insurance coverage.
- The function for developing and monitoring the implementation of the human resources management strategy for the BiH health sector also determining the future number of medical professionals and their competences.
- The function for coordinating and participating in curriculum development together with universities and schools involved in medical education and for education planning.
- The function for establishing minimum standards for a health information system for BiH.
- The function for monitoring the performance of the health sector (including the private sector) in BiH and the performance of institutions and organisations within the health sector at state level.
- The function for EU integration within the health sector in BiH, donor prioritisation and coordination.
- The function for concluding international agreements and cooperation within the health sector (also concerning treatment of patients abroad).
- The function for defining the rules for a national reference laboratory.
- The function for establishing standards for accreditation and quality certification of laboratories.
- The function for establishing tender procedures for common standard laboratory tests.

[20] Defining how many health institutions should provide which kind of health services and where.

Explanation Box - **The Head of the Department of Health of the MoCA**

In order to give the Department of Health the position that is in line with its responsibilities, the Head of the Department should be able to have direct contacts with the Government and other Departments or Ministries. This implies that the Head of the Department preferably should have the rank of Assistant Minister for Civil Affairs and would be invited to the Government's meetings where health or health-related issues are on the agenda.

Explanation Box - Legislation

There are several ways of looking at legislation:

1) the drafting of comprehensive and detailed laws that act as the start of new policies, where implementation is possible once the law has been approved;
2) a process of experimenting with new policies that will be reflected in new laws as the final stage of the policy development - where the new policies are deemed to be legalised.

Laws can be detailed and comprehensive, dealing with all relevant aspects, or they can have a more global set up, where a framework of principles and procedures are stipulated, but where detailed changes can be introduced via regulations issued by the minister, without need for approval by the parliament.

Too detailed legislation has a potential disadvantage that the Parliament enters into day-to-day management of the health care provision

For each of the above mentioned functions the project team has conducted a detailed calculation of the needed resources in terms of staffing and budget (for further details see the Functional Review of MoCA) which can be summarised as follows:

Table 6.1.1: Proposed change in staffing and budget for Department of Health

Department of Health	Change in staff	Total number of staff	Change in budget *)
Sub-Directorate and support staff	+2,5	4	+70.736
Sub-Department for Planning, Coordination and HRM:	+1	1	+28.295
-Unit for Performance Monitoring, Planning and coordination.	+13	13	+367.830
-Unit for Health Insurance	+8	8	+226.357
-Unit for HRM in the health sector	+8	8	+226.357
Sub-Department Legal Issues	+10	10	+282.950
Sub-Department for EU Integration and International Cooperation	+9,5	9,5	+268.799
Sub-Department for Informatics and Health Information System	+8	8	+226.357

TOTAL	+60	61,5	+1.697.681

*) As the change is cardinal the total unit cost of 28.295 KM per employee per year has been used to calculate the budget increase. The budget does not include investment costs and recurrent budget for training and education of staff.

A department of the proposed size, approximately equal to the minimum size of a well functioning health ministry, could at the first glance be seen as too voluminous. It could also be argued that the department does not perform the support functions (accounting, IT-support, cleaning, etc.) a ministry has, and therefore should not be of an equal size. However, a number of special issues prevailing in BiH have been taken into account.

First, the Department of Health would not only have to perform day-to-day administration as ministries in other countries. Apart from its administrative function, it has to act as a change management center for creation of all the needed state health functions. Therefore, the Department of Health needs to have additional capacity for doing so.

Second, given the fragmented nature of the health system(s) in BiH and the associated large amount of institutions, the Department of Health will need to have a bigger coordination capacity than what is found in ministries in other countries in the region.

Third, given the strategic importance of the EU integration for BiH, given the conclusion of this Functional Review that none of the functions/institutional structures required for integration exists and given the amount of tasks involved in enforcement of EU legislation, standards and procedures, the Department needs to have capacity simultaneously to kick-start the EU integration process and to establish its own organisation. To this end, it should be recalled that EU integration not only deals with the technical transposition of a few directives but would require enforcement including the single citizen's basic rights, the functioning of universal health insurance coverage, equal access to good health care services, a public sector responsive to the needs of the population and able to ensure transparent, efficient and sustainable financing of the health sector. This is a complicated process for which Department of Health will be the catalyst and therefore needs the capacity to act as such.

In summary, the impact of the recommendation is that a total of 60 fulltime employees is needed (before 2010) in addition to the 1,5 already engaged which will require an increase in the annual recurrent budget of 1,69 Mil. KM bringing the total budget up to 1,73 Mil. KM. Investment costs and resources for staff training and education are not included. For more details see the detailed functional review of MoCA, the Action plan on the CD and the State level Functional Review in annex 7.1.

6.1.2 Recommendation 1.2: Establish a BiH Accreditation and Quality Improvement Agency.

The following functions are recommended to be undertaken by the State Accreditation and Quality Assurance Agency:

- The function for collaboration center for evidence based medicine for BiH.
- The function for professional center of excellence for accreditation and quality assurance.
- The function for developing methodology for accreditation and quality assurance.
- The function for acting as a resource, support and coordination centre. To this end it is important that the Entity Agencies develop their activities based on the principles of complemetarity in order to avoid duplication of functions for which a strong coordination function is required.
- The function for cooperating with the Entity agencies for quality and accreditation.

To perform these functions a total of 5 fulltime employees is required equivalent to an annual recurrent budget of 0,141 mil. KM. Investment costs and resources for staff training and education are not included. For more details see the Action Plan for the state level included on the attached CD.

In this respect it is important to see the BiH Agency in relation to the two Entity Agencies that together will have 23 employees. Over time it would be natural that the BiH Agency and the Entity Agencies develop into one organisation. However, already in the short-run the Entity Agencies together with the BiH Agency could identify special fields of competences, for each of the Entity Agencies, in order to avoid duplication and ensure complementarity.

6.1.3 Recommendation 1.3: Establish a BiH Drug Agency.

The following functions are recommended to be undertaken by the State Drug Agency:

- The function for control and assessment of pharmaceuticals, herbal products and related medical substances for the entire BiH.
- The function for issuing export/import license for the entire BiH.
- The function for participating in drafting standards and procedures for testing drugs (including the reference laboratory function).
- The function for participating in drafting of norms, standards and procedures for pharmaceutical inspection.
- The function for participating in drafting norms and standards for good practices (producer, wholesaler and retailer).

- The function for providing technical advice with respect to rational use of drugs.

To perform these functions a total of 45 fulltime employees is required equivalent to an annual recurrent budget of 1,27 mil. KM. Investment costs and resources for staff training and education are not included. For more details see the Action Plan for the state level included on the attached CD.

6.1.4 Recommendation 1.4: Establish a BiH Health Insurance Agency.

The following functions are recommended to be undertaken by the State Health Insurance Agency:

- The function for negotiating, concluding and monitoring international agreements with respect to health insurance covering BiH, and agreements for treating patient abroad.
- The function for participating in drafting regulations for BiH with respect to free movement of patient and export of health insurance benefits.
- The function for elaborating health insurance statistics for BiH including national health account for BiH.
- The function for providing professional support for establishing of universal health insurance coverage in BiH.

It is important to note that the Insurance Agency is not supposed to undertake any functions related to contracting and financing of health care providers which will be undertaken by the existing HIFs.

To perform these functions a total of 15 fulltime employees is required equivalent to an annual recurrent budget of 0,42 mil. KM. Investment costs and resources for staff training and education are not included. For more details see the Action Plan for the state level included on the attached CD.

6.1.5 Recommendation 1.5: Establish a BiH Public Health Agency.

The following functions are recommended to be undertaken by the State Public Health Agency:

- The function for reference laboratory for BiH defining standards, procedures and technical guidelines for laboratory tests and for conducting special complicated laboratory analyses (if they can not otherwise be performed in the private or public sector).
- The function for supervising and monitoring tender procedures for standard laboratory services performed by Entity/Cantonal PHIs, with respect to technical issues.
- The function for processing and dissemination of health sector information and statistics related to international agreements and obligations e.g. WHO, Eurostat, etc.

- The function for processing, elaboration and dissemination of aggregated health sector information to all stakeholders across BiH.
- The function for acting as a center of excellence for public health, health promotion and disease prevention.
- The function for cooperating with public health organisation in the entities and in Brcko

To perform these functions a total of 15 fulltime employees is required equivalent to an annual recurrent budget of 0,42 mil. KM. Investment costs and resources for staff training and education are not included. For more details see the Action Plan for the state level included on the attached CD.

6.1.6 Recommendation 1.6: Establish a BiH Inspectorate.

The following functions are recommended to be undertaken by the State Inspectorate:

- The function for establishing standards and methods for inspection (sanitary and drug inspection).
- The function for handling complaints (appeals) with respect to inspection.
- The function for providing professional support and act as excellence center.
- The function for coordination with the entity inspectorates and the common inspection in Brcko.
- The function for technical approval for medico technical equipment including EC labelling
- The function for pharmaceutical inspections throughout BiH.
- The function for establishing standards and methods for radiation inspection.
- The function for organising the measuring of employees working with radiation substances.

Explanation Box - The State Inspectorate
In the current situation, inspections are divided over the Ministries of Health and local authorities, who employ health, pharmaceutical and sanitary inspectors and the Institutions of Public Health who also conduct inspections. As policy development and inspection should be kept separate, inspectors working within a Ministry of Health are not desirable. Inspecting pharmaceutical and sanitary issues is a profession with common characteristics, methods and competence requirements. Therefore, creating a joint Inspectorate seems justifiable. The main function of a state level Inspectorate would be to elaborate standards, methods and guidelines for health and sanitary inspections that can be carried out by entity and other Inspectorates, to ensure a nation-wide common approach and equal treatment of those inspected.

In line with emerging legislation, the Inspectorate would conduct nation wide pharmaceutical inspections.

The state Inspectorate also acts as an instance for appeal against entity inspectors' decisions. For this function, a dedicated Appeal Commission should be established within the Inspectorate.

To perform these functions a total of 34 fulltime employees is required equivalent to an annual recurrent budget of 0,97 mil. KM. Investment costs and resources for staff training and education are not included. For more details see the Action Plan for the state level included on the attached CD.

6.2 Recommendation 2: Rationalise functions that are outdated or not performed rationally

This section provides recommendations for rationalisation of functions within the entities/cantons/municipalities that are outdated or not performed rationally, and how to separate policy functions and service delivery functions.

6.2.1 Recommendation 2.1 (MoHs): Transfer functions related to inspection to two new Entity Inspectorates

Functions related to sanitary inspection are in both entities performed by the ministries and by the municipalities. An exception to confirm the general rule is Brcko which conducts sanitary inspection from a common inspectorate within the Department for Public Safety.

Good administration practice stipulates that policy functions and service delivery functions should be separated for the benefit of both. Sanitary inspection is a service delivery function and ministries are predominantly concerned with policy formation. Therefore, the sanitary inspection function should be moved to an independent body outside the ministries.

Sanitary inspection provides the guarantee to the population that standards and norms established by the Ministries are fulfilled by private/public providers. Thus we can eat the bread from the bakery, drink the water from the tap, etc. without damaging our health. Hence, it is not good public administration practice to have the same body for establishing the rules and for judging whether they are obeyed.

For the ministry a mix of the functions would mean that a technical issue as e.g. problems with contaminated water in a school would emerge as a political problem and a Ministry would have no neutral technical body to advice on the issue.

From the point of view of the producer - the bakery, the restaurant, or the water supplier - it is of utmost importance to know that the standards for sanitary inspection reflect technical requirements (technical function) and the level of hygiene preferred by the population for which the population is willing to pay (the policy function). To that end, the inspectors would have the roles of technical partners for the producer helping ensuring correspondence between e.g. level of hygiene demanded by consumers and the actual level of hygiene provided. But mixing up the functions would give the sanitary inspection the flavour of policy inspection.

Good governance means that all citizens are equal for the law or that the same laws apply to all. Therefore, good governance with respect to inspection means that sanitary inspection should be performed according to

the same rules and regulations no matter if it is done in Brcko, Banja Luka or in Mostar.

It is therefore recommended to transfer the sanitary inspection function to two new entity inspectorates (Brcko already has a separate inspectorate) which will conduct the inspection based on rules and standards drafted by State Inspectorate, endorsed and processed by the Department of Health and approved by the BiH Parliament.
The functions for pharmaceutical inspection are proposed to be transferred to the BiH inspectorate.

In terms of human and recurrent financial resources this recommendation is neutral. However, resources for investment and training/education of staff are not included.

6.2.2 Recommendation 2.2 (PHIs): Functions related to common standard laboratory tests should be considered outsourced

Common laboratory tests related to e.g. sanitary inspection are today performed by the different PHIs and provide extra budgetary income equal to approximately 40 % of their expenditures. Today, the laboratory business is necessary for financing the important public health functions: prevention, promotion, monitoring, ad hoc analyses, reporting and assessment of future demand for health care vital for all planning of the health care provider network. Unfortunately, the functional review has disclosed that these core public health functions are either not performed at all or not performed to a required extent. It is worrying that the possibility for performing important public health functions depends on risk associated with market activities. Further, the mixture of market related income makes financing of the PHI non-transparent and financial authorities do not have a clear picture of what public budget resources are used for. It is important to note that the function related to reference laboratories and setting standards for common laboratory services belong to the public part of the PHI's functions.

Therefore, it is recommended that standard laboratory tests should be considered outsourced when competitive, open, equal and transparent tender procedures can be conducted with the participation of a sufficient amount of accredited laboratories and when the public health functions of the PHIs are fully financed by the budget.

The Consultant is fully aware that today very few accredited private or public laboratories exist, that common standards for lab analyses are not developed to a required extent and that no system for accreditation of laboratories exists. Therefore, the recommendation provided above clearly uses the notion "should be considered outsourced" and not "should be outsourced" and points at the preconditions that should be established before outsourcing can take place. However, a start could be taken by a clear separation of the common laboratory functions within the PHIs and the public health functions.

Fully implemented, the impact of the recommendation is that functions performed by 175 laboratory staff throughout BiH would be transferred to be performed outside the public administration part of the health sector

Explanation box – outsourcing:

Outsourcing does not mean that only private laboratories can participate in a tender procedure, also public accredited laboratories should take part in it. By separation of the existing laboratory functions from other functions performed by the PHIs, the PHI's labs could also participate in the tender procedure.

Example box – **Arrangement for laboratory tests in different countries:**

UK and France :

- Laboratories, both for food safety and environment protection, are public and mainly belonging to local (community) authorities.
- Laboratories are regularly accredited.
- Relevant national authorities periodically audit them.
- They work in collaboration with national reference laboratories

Italy, Belgium, Spain and Germany

- Laboratories, both for food safety and environment protection, may be either public (belonging to local authorities) or private (contracted by local authorities).
- Both types are regularly accredited for the purpose of their assignments.
- Relevant national authorities periodically audit them.
- They work in collaboration with national reference laboratories

Explanation Box - EU integration and laboratory sampling and analysis

The methods of sampling and analysis used within the context of official control must be fully validated in accordance with Community legislation or with internationally accepted protocols. These analyses must take into account a set of defined criteria and must be implemented by laboratories (either public or private) approved to this end in compliance with the standards laid down by the European Committee for Standardisation (CEN) that includes regulation for:

Control Operations:

- inspection;
- sampling and analysis;
- inspection of staff hygiene;
- examination of written and documentary material;
- examination of any verification systems set up by the undertaking

Subject to inspection:

- the state and use which is made at the different stages of the site, premises;
- offices, plant surroundings, means of transport, machinery and

equipment;
- raw materials, ingredients, technological aids and other products used for the preparation and production of foodstuffs;
- semi-finished products;
- finished products;
- materials and articles intended to come into contact with foodstuffs;
- cleaning and maintenance products and processes and pesticides;
- processes used for the manufacture or processing of foodstuffs;
- labelling and presentation of foodstuffs;
- preserving methods.

Type of laboratories involved:
- Community Reference Laboratories;
- National Reference Laboratories;
- Local laboratories (private or public).

EU Accreditation standards for laboratories:
- EN ISO/IEC 17025;
- EN 45002;
- N 45003.

6.2.3 Recommendation 2.3 (HIFs): Rationalise the function for contracting of health care providers

The function for contracting health care providers is one of the core functions of the HIFs. Today, the cantonal HIFs in Zenica, Bihać and Goražde contract health care providers based on the principle of output/capitation and with performance elements (see example box below. All other HIFs in FBiH, in RS and Brcko still have a contracting function based on inputs (e.g. number of physicians, number of beds, etc.) that is only relevant in a fee-for-service system (see explanation box in section 6.3.4).

As the previous fee-for-service system has been replaced by budget financing, there is a need to change the contracting function towards a more output oriented, performance related concept linked to evidence based planning. In this way contracting could provide incentives for resolving some of the major problems in the health care provider network such as a too high ALOS[21], too low occupational rate[22], too low quality, etc.

Therefore, it is recommended to rationalise the function for contracting of health care providers by changing the existing input based contracts to be output oriented and to include performance elements monitored on a regular basis.

[21] Average length of stay – measuring how many days a patient stays in a hospital
[22] The occupational rate measures how many fulltime beds are used during a period – normally a year

Example box – output based hospital contract with performance elements within a global budget system:
The notion "Global budget" refers to the process of realistic forecast of the income of the HIF and to the allocation of these resources on reserve and main expenditure priorities as e.g.: expenditure for primary, secondary tertiary health care, health promotion, disease prevention, etc.
Within these ceiling HIF elaborates and concludes contracts with the health care providers.
Good practice with respect to contracting of primary health care providers shows that per capita based contracts (paying a fixed amount of money per registered insured in the physician's catchment area) eventually combined with payment for some services, give the right incentives and are administratively simple.
For hospitals, good contracting practice can be obtained from the ongoing reform of the Macedonian system. Here the new contracts for hospitals and specialised consultative institutions are made based on the total amount of discharges (specified for main diagnoses – ICD-10) foreseen to be provided to the insured population in the hospitals' catchment area. The global budget for hospital treatment is allocated on the total number of discharges and the budget for the single hospital identified. This budget is paid to the hospital in 12 instalments by HIF. The contract includes a transitional arrangement whereby the historical based budget step by step is replaced by need based elements and performance.
Article 4 in the Macedonian contract states: For performing of the amount and the quality of health services stipulated in this contract the Health Institution will receive budget allocation (hereinafter the payment). The payment is in general calculated on the basis of the expenditure index for year 2000 adjusted to the fund's budget ceiling for 2002 for purchase of secondary or higher health care services but deducted for an anticipated annual productivity increase of 5%. In addition the Health Institution will receive encouragement payment upon justification of increased quality of services and increased efficiency. The Health Institution can freely dispose the budget for payment and the encouragement payment according to good management practice except for the limitations stipulated in article 8. The Health Institution carries the full responsibility for staying within the budget ceiling. The Health Institution is responsible for budgeting of resources allocated by the Fund. All reallocation within the agreed budget according to this contract has to be endorsed by the Fund except for reallocations within the limits stated in article 8 in this.

The encouragement payment equals 5% of the total contract and is linked to measurable indicators as follows: 5% reduction of the average length of stay; 5% reduction in the number of readmitted patients; 5% reduction in the number of re-operations; 5% reduction in the number of patient complaints; 5% reduction in the number of patients referred to other Health Institutions; Occupational rate above 70%

The impact of this recommendation does not relate to change of the amount of staff or financial resources but would require a change in the focus of these resources for which training would be required.

6.2.4 Recommendation 2.4 (HIFs): Abolish monthly invoicing and strengthen performance monitoring

Only relevant for a fee-for-service system are the monthly invoices, issued by the health care providers to the HIFs, detailing the services provided for each patient. In RS and in the majority of the cantons, health institutions today are typing invoicing data into the electronic based invoicing system. A hardcopy is send to the HIF that controls them, and enters the main data into their computer system. And then, despite the actual amount of resources claimed by the health institutions, the fixed monthly budget is transferred to the HI by the fund. Altogether 13 fulltime employees in the HIFs are involved in receiving, controlling and entering data related to the monthly invoices.

Therefore, it is recommended to replace the existing invoicing function with a function for regular performance monitoring of the health care providers by well defined indicators that also should relate to the performance indicators stipulated in the contract.

Example box - the role of the invoice in a fee for service versus a budget based system

Fee-for-service financing is based on a set of well defined services (injection, therapy, suture, appendix operation, etc) and a price-list attaching a price to each of the services. Under a fee-for-service system, hospitals are paid according to the amount and the type of services they perform. In a fee-for-service system the invoice is the background for the Fund to pay the health care providers for the services provided in accordance with the price list (the blue-book). In such a financial approach (that has a tendency to enlarge the service provision – induced supply) the invoice is a key instrument to monitor and control that health institutions only provide services within the BBP, to an extent that is professionally likely and only to insured patients. For the health institutions, the invoices are the legal claim for payment from the Fund related to the amount of services provided.

In a system based on budget as applied in BiH (which has a tendency to decrease the amount of services – lower supply) health institutions do not receive financial resources according to the single service provided but receive a total budget for the total amount of patients they, according to the contract with HIF, are obliged to provide. Hence, in a budget system no need for invoices exists but a well defined set of monitoring parameters for regular performance monitoring and information feed-back to the institutions.

The impact of this recommendation is estimated to 13 fulltime employees. However, strengthening the function for performance monitoring would require an equal amount. Therefore, seen as an integrating part of the other recommendations this proposal is neutral.

6.2.5 Recommendation 2.5 (HIFs): Rationalise the function for verification of health insurance status

Today all HIFs, based on information of contribution payment (whether the collection is done by the Funds or by the tax office) verify the health insurance status of the insurees by stamping the health card. This means in principle that each of the 3,1 mil. insured citizens in BiH monthly has to show up at a health insurance fund, which has to verify 3,1 mil. contribution payments and to stamp 3,1 mil. health cards. In practise some of the funds are stamping the health cards for a three months period. But even if this was applied as a general practice it would not provide a safe link between

payment of health insurance contribution and entitlement (as a person has evidence for being insured for two months without payment). It is the conclusion of the Consultant that this practice is administratively too cumbersome and does not provide a good enough link between payment and insurance status. Altogether, 75 employees are performing this function.

Therefore, it is recommended that the function for verification of health insurance status is rationalised, e.g. by introducing a simple health insurance card (could be made of paper wrapped in plastic folio, only changed when major information for the insured changes and with no stamps). The verification of the health insurance status could be done by the registration counter in the health institutions based on regular data transfer from the HIF on which cards are no longer valid.

Explanation box – verification of health insurance status

Currently, social security contributions are collected from the employer and transferred to a dedicated bank account. The HIFs are informed that the contribution has been paid. If the employer has not paid the full amount, although the employees have paid their part to the employer, the employees are deemed to be uninsured. This information is then via IT forwarded to the local branch office of the HIF. Insured citizens need to validate their insurance status by visiting the local office of the health insurance and have their health insurance card stamped. In principle this has to be done on a monthly basis (except for pensioners, whose contribution is paid by the Pension Fund and whose cards have to be stamped each quarter.) In practice this means that before visiting a health care facility, patients have to visit the local branch office to get their stamp.

There are at least two problems with this procedure:

1. a *principle* problem: insured individuals are held responsible and are 'punished' for the payment discipline of their employer over which they have no control;
2. A *practical* problem for insured patients: as they, in case of illness, first need to go the HIF to validate their health insurance card and then go to the health institution. Two visits are required where one could be avoided.

An underlying assumption of the current procedure seems to be that the insured persons are regarded as 'not insured' unless their card has been stamped (negative verification of status).

The principal problem has to be resolved via more strict procedures for collecting social contributions and accountability of employers with regards to their payments of social contributions.

The practical problem is solvable by placing the computer of the local branch office of the Fund in the reception of the health care providers (as is done in Slovenia) where upon entrance the provider can check if the patient is currently insured. If so, the treatment is covered by the health insurance fund (or the patient has to pay the mandatory co-payment). If the patient is not insured, he will receive an invoice for the services delivered, to be based on real costs.

By issuing a more enduring, laminated insurance card on a yearly basis (or when key data on the existing card are outdated), the HIF also expresses the assumption that the patient is insured, unless during a visit to a health facility, it is proven to be otherwise (positive verification of status).

Also in other countries (Croatia, Netherlands, Denmark) the insurance status of the patient is assessed by health care providers based on positive verification.

The advantage for the patient is that unnecessary visits are avoided.

The advantage for the HIF is that the local branch office could be transformed into a PR agency for health care issues.

The impact of this recommendation is estimated to 75 fulltime employees. However, strengthening other functions included in this proposal is neutral.

6.2.6 Recommendation 2.6 (HIF): Abolish the regional offices of the health insurance funds in RS and transfer the remaining functions to the HQ and to the local offices

The HIF in RS has during the last couple of years, been through a number of reforms that have centralised some of its major functions. For example the contracting function (contracting of health care providers) that previously was partly performed by the regional offices is today predominantly conducted by the HQ. The main function performed by the regional offices is mostly related to collection, control and processing of the monthly invoices from the health institutions - a function that is proposed to be rationalised (see recommendation 2.4). Simultaneously, a number of functions in the HQ are not performed due to lack of capacity. The local offices provide a very good window for promotion and broadening the health insurance coverage among the population and could be used as a front-end counter to resolve issues for the insurees and to obtain a good impression of their preferences. However, none of these functions are performed by the local offices due to the lack of capacity.

Therefore, it is recommended to abolish the regional health insurance fund structure in RS and to transfer the remaining functions to the HQ and the local offices.

Although, 207 employees are working in the 8 regional offices (with an annual recurrent budget of 3,45 mil. KM) the net impact of this recommendation (including strengthening of HQ and the Local Offices is estimated to -134 fulltime employees and an annual budget saving of 2,2 mil.

6.3 Recommendation 3: Strengthen functions related to policy formation and EU integration

This section includes recommendations for strengthening all functions related to policy formation; evidence based planning; performance monitoring; functions related to strategic issues (PRSP and Entity strategies) as well as functions needed for successful EU integration.

6.3.1 Recommendation 3.1 (all): Strengthen functions necessary for a coherent system of evidence based planning and decision-making

The prerequisite for a sustainable, effective health care system providing high quality services, matching the need of the population is decision making and good planning based on reliable data and prognoses.

It is the finding of the Consultant that PHIs do not perform the function of elaboration of prognoses for the future demand for health care. Therefore, MoHs do not have a basis for perform the function of capacity and speciality planning. And hence, HIFs do not have any overall guidelines or data that can facilitate the contracting process. This, together with the finding that no function for need assessment of the preferences of the population exists, leaves decision makers with no evidence based background for making decisions.

Therefore, it is proposed to strengthen the functions necessary to establish a coherent system of evidence based planning and decision making by introduction of a planning cycle. This should include a process where the PHIs (based on morbidity, population data, etc.) elaborate reports on the existing and the future demand for health care, based on which MoHs elaborate capacity and specialty plans, and based on which HIFs conclude contracts with health care providers.
Further, the proposed planning cycle should be used also for other planning functions as: workforce planning, education planning, elaboration of strategies and policies.

It is also recommended to introduce the function for providing regular feedback to the health institutions about the health situation in their regions and on the result of the performance monitoring in order to enable comparison between health institutions and facilitate decision-making at the institutional level.

6.3.2 Recommendation 3.2 (all): Strengthen/establish all functions required for EU integration

The health sector is not part of the core acquis but belongs to the so-called social aquis which is tightly linked to the fundamental freedom of free movement of workers and persons (including free movement of patients and export of benefits). Free movement of goods related to the health sector (including drugs and medical equipment) is part of the acquis. Hence, EU membership, with respect to the health sector, is requesting the existence of an administrative capacity able to handle these issues. A detailed list of functions required for EU membership is provided in the Benchmark Toolbox attached on the CD.

The main findings are that most of the functions required for EU integration could not be identified and that the functions needed for planning, implementation and monitoring of the EU integration are absent.

While a number of these functions are required at state level e.g. establishing a roadmap for integration based on the SAA, legal transposition, general rules for participating in EU policy coordination, functions related to enforcement/ implementation are required throughout the system. Recommendations related to the overall functions essential for EU integration are mentioned in section 6.1 and only the enforcement part will be detailed in this section.

For the health insurance funds it is recommended to introduce/strengthen the following functions with respect to administration of:

- Handle export of benefits (sickness, maternity benefits health insurance, death grants, occupational diseases and accident related benefits)
- Setting transparent health service tariffs,
- Adjustment of medical cost structures taking into account differences in tariffs, for which the function for cost accounting needs to be established.
- A system for transfer of payment between member states including E-forms[23],
- Elaboration of administrative manuals describing the procedures

For the public health institutions it is recommended to introduce/strengthen the following functions related to administration of:

- Exchange of statistical data according to Eurostat procedures;
- Ability to document the impact of health promotion and disease prevention;
- Occupational health;
- Cross sector coordination related e.g. to environmental and agricultural issues.

[23] Special procedures and forms used for export of benefits between the EU memberstates.

For the entity and cantonal MoHs it is recommended to introduce/strengthen the following functions related to administration of:

- Coordination of health issues related to complementary cross boarder labour market.

The impact of this recommendation constitutes an integrated part of all the recommendations and can therefore not be calculated separately.

6.3.3 *Recommendation 3.3 (PHIs): Strengthen all core public health functions that should be fully financed by the budget.*

It is a general finding that the PHIs are focusing too much on service delivery and too little on provision of good background materials for evidence based decision making, planning of the health care network and optimal utilisation of the resources.

> Therefore, it is recommended to strengthen the functions, within the PHIs, related to analyses and elaboration of prognoses for the demand for health care as the starting point for the proposed planning cycle (where prognoses elaborated by PHIs provide the background for capacity and speciality planning in MoHs, which provides the background for contracting of health care providers by HIFs). Further all public health functions should be financed by the budget.

It is concluded that economy of scale could provide possibility for some of the cantonal PHIs to perform core functions that are not undertaken to a satisfactory degree today.

> Therefore, it is recommended to consider and further investigate the possibilities to merge the cantonal institutions of public health. It should especially be considered to merge Gorazde and Sarajevo CPHI, Orasje and Tuzla, as well as Grude and Mostar.

It has been observed that the functions for health promotion and disease prevention are performed without clear priorities and without a clear knowledge about the relation between the cost of promotion and prevention and the impact on the health status of the population.

> Therefore, it is recommended to strengthen the functions for

health promotion and disease prevention and base them on clear analyses of cost and impact on the health status of the population and only implement those with the highest impact on the health status per KM.

The impact of this recommendation is estimated to additional 45 fulltime staff or 1,1 Mil. KM.

6.3.4 Recommendation 3.4 (HIFs): Strengthen functions required for broadening the contribution collection basis.

It is observed that the function for collection of health insurance contribution is too weak and not focused on broadening the contribution collection basis. In consequence the major burden is carried by the approximately 20-30% of the population that are regular contribution payers. Any increase in the contribution rate would tend to give dis-incentives for working and to lower the revenue for the fund. The existing practice that not-insured, in case of illness, can enjoy the same rights as the insured by paying 6 months of minimum insurance (around 40 KM per month in both FBiH and RS) gives no incentives for the population to be insured.

Further, this practice is in conflict with the principles of solidarity over age. It leaves few contribution payers in the active age with low treatment expenditure and many in the very low and very high age (who are not contributing at all) but with high treatment costs. Hence, in the long run, the Funds tend not to be financially sustainable.

Therefore, it is recommended to strengthen the contribution collection function encompassing cost effective campaigns for increasing the collection from uninsured groups, registration of contribution on a individual basis, changing the right for being insured from when the insurance is paid to the employer, abolishing the existing practice that uninsured can have covered treatment costs by paying 6 months of health insurance.

The impact of this recommendation is estimated to 42 fulltime staff equalling 0,6 Mil. KM. This does not include required resources for training and investment.

6.3.5 Recommendation 3.5 (HIFs): Strengthen functions required for universal health insurance coverage within BiH

The review has identified that the function for export of benefits is performed to a higher extent than universal coverage between entities and between cantons within the same entity. Consequently, insurees have a better and more transparent coverage when treated abroad than in their own country.

Therefore, it is recommended to strengthen all functions related to establishment of universal health insurance coverage throughout BiH including establishing minimum health care standards, a minimum basic benefit package and a simple, transparent price system for inter-Entity insurance able to handle differences in level of economy and income.

Explanation box - Marginal pricing of health care services:
Most systems for costing/pricing health care services are based on the total running cost for a health institution. This implies that differences in income, economic development and salary of medical professionals would be reflected in the price. Thus, regions with high income and high salary would have higher price for the same service than regions with lower income.

Marginal cost is defined as the additional cost related to treatment of one additional patient. Given that a health institution is not operating near its capacity limit the marginal cost includes only variable costs directly related to the particular treatment. As a hospital is already established its total investment cost would not be influenced by treating one additional patient. No additional nurses or physicians or other staff would be required as they are already employed and paid by the normal contract with the HIF. Hence, only the variable cost directly related to the treatment of the additional discharge would be part of the marginal cost e.g.: the cost of medications, prostheses, drugs, gases, laundry, cleaning, etc. -cost elements that for the biggest part follow the international price level.

Therefore, the marginal cost could be used as the basis for establishing a price system for universal coverage between regions with different economy and salary levels.

The marginal cost per discharge is normally established by the so-called Cost Accounting practice applied by most hospitals in the EU member states. By Cost Accounting all costs within a hospital are allocated on cost centres (e.g. departments) by which the cost for one unit (e.g. one discharge) provided by the cost centres can be identified. By defining the cost elements included in the marginal cost, Cost Accounting can be used also to calculate the marginal cost per discharge.

The impact of this recommendation is partly included in the recommendations related to the state functions and requires refocusing of already existing resources.

6.3.6 Recommendation 3.6 (HIFs): Strengthen functions required for macroeconomic sustainability

All countries need the ability to prioritise limited resources between sectors, and among main elements within the sectors. No function has been observed enabling resources allocation on sectors or on main priorities within the health sector (e.g. prevention/promotion, primary, secondary and tertiary health care) and further no function exists for monitoring the implementation of such allocation.

> Therefore, it is the recommendation to initiate a system of MTEF elaborated at the BiH level, encompassing MTEFs for the entities and combined with an agreement stipulating maximum and minimum measures for economy behaviour as well as sanctions in case the framework is not kept.

The impact of this recommendation requires refocusing of already existing resources.

6.4 Recommendation 4: Strengthen functions needed for improving good governance

This section includes recommendation required for strengthen all functions at entity/canton/local level needed for improving good governance

6.4.1 Recommendation 4.1 (all): Strengthen functions related to vertical and horizontal coordination

Although it is the impression, based on field interviews, that inter-entity coordination has improved over recent years it is also the finding that the coordination function (also between MoHs, HIFs and PHIs) is mostly performed on an informal and irregular basis. However, establishing BiH standards, universal health insurance coverage, etc. are not possible without a formal function for coordination. This should enable all parties concerned to participate in developing solutions and commit them on their implementation.

> Therefore, in order to strengthen the coordination function, it is recommended to establish a permanent Inter-Entity Health Council and Municipal Health Boards.

Explanation Box - The inter-entity Health Council.
As the Council is the first and only regularly debate forum for health policy development at

state level, the Council should be composed of representatives of the main stakeholders in the health system :

- Professional bodies (such as the medical chamber, nursing chamber)
- Health Insurance Funds
- Public Health Institutions
- Municipal Health Boards
- Representatives of patients/consumers
- Entity level Ministries of Health
- Other

The chair of the Council should be independent. The Council should be consulted on all relevant issues related to health policy, for instance:

- New legislation
- The Basic Benefit Package
- Human Resources Management
- Regulations with regard to universal health insurance coverage
- Etc.

The Council should meet on a regular, pre-scheduled basis (for instance 8 times per year) and work on the basis of an annual work programme that has to be approved by the Head of the Health Department.

This programme should be strict in the sense that continuity of activities would be ensured, and flexible enough to be adapted to newly emerging issues. The work programme should identify a number of issues on which the Council has been asked to advise the Health Department of the MoCA. The Council can also decide to provide advice without being asked.
The Council works under a legal framework that ensures its independent advisory role to the Health Department and has its own regulations with regards to decision making procedures, reporting etc. The activities of the Council would be supported by a secretariat, that reports to the chair of the Council, with the following as its main tasks:

- Preparation of the agenda and the minutes of the meetings
- Preparation of the annual work programme and report
- Special activities (such as research) required to support the advisory role of the Council

6.4.2 Recommendation 4.2 (all): Strengthen/establish functions required for strategic management

The functional review concludes that only 15% of the organisations have officially adopted strategic and medium term objectives. Only two (FBiH and Sarajevo municipality) have a formalised system linking strategic development, budgeting and monitoring that can be used for day-to-day management and avoiding “fire-fighting” management.

Therefore, it is recommended to introduce strategic management at all levels.

6.4.3 Recommendation 4.3 (all): Strengthen/introduce functions related to human resources management

Only 3% of the organisations have a separate organisational unit performing the HRM function. Only 28% of the organisations have a separate budget for training and education of their staff and none of the included organisations is conducting workforces planning and training needs assessments as well as education planning for medical professionals. Further, none of the institutions included in the review performs the function for assessment and coordination of curriculum for the medical educations.

> Therefore, it is proposed to strengthen/introduce all functions related to human resources management (internal in the institutions as well as for the entire health care network) encompassing work force planning, continuous education/training of staff, education planning and coordination of curriculum development.

The recommendation on HRM is further detailed by the horizontal review (one of the altogether nine functional reviews which are part of the PAR.

6.4.4 Recommendation 4.4 (all): Establish the functions needed for a uniform health information system in BiH

Good planning and evidence based decision-making depends on the availability of electronic, accurate, well defined and comparable data for the health system. Further, electronic data transfer between the provider network and the public administration would enable rationalisation and a higher degree of accuracy. Hence, it is worrying that the functions for establishment of a health information system for BiH, able to interact with entity level HIS as well as the functions for developing entity HIS is either absent or performed at a magnitude not expected to lead to the intended results.

> Therefore, it is recommended to strengthen the functions for developing a health information system at entity and state level able to ensure electronic transfer of data and provision of information on the health system. This should include definition of system architecture, nomenclature, protocols for data exchange, data definitions, data ownership and data protection.

Explanation box - health information system:
A modern health information system is not characterised by the same software running on the same type of computers.

Modern information systems apply the so-called open standards enabling different kinds of software used on different types of hardware to communicate with each

other. To establish a health information system it is required that the involved parties agree on the following:

The system architecture: detailing which general IT principles should be applied.
The data protocol: determining which technical standards should be applied for exchange of data.
The data nomenclature: defining which standard data should be collected and who should maintain the nomenclature.
The data definition: defining what is to be understood by each of the data collected (e.g. defining what a bed day is).
Data ownership and data protection: giving the rules for who is the owner of the data and which practice should be applied for protection of sensitive information.

When this has been agreed between all parties involved everyone is free to use whatever software and hardware that can operate and meet the above mentioned standards.

6.4.5 Recommendation 4.5 (all): Strengthen functions required to establish a uniform accounting ledger

It is also the finding that the accounting function in FBiH is not based on common standards (common ledger) and governed by legislation that enables application of uniform accounting practice and principles. No function for accumulating accounting data for the entire BiH exists.

Therefore, it is recommended to strengthen the functions for establishing a uniform accounting practice and principles for BiH and an overall national accounting ledger.

6.5 Recommendation 5: Donor support

Changes do not implement themselves. Therefore, in order to elevate the recommendations from thoughts and ideas on paper to tangible improvements to be experienced by the population, change management capacity is required. There is a need for capacity that can transform the recommendations into decision-making, legal and institutional changes which will impact the way functions are performed on day-to-day basis. Although, the recommendations provided in this Report are detailed and give a good background for further discussions, they would only remain ideas if sufficient change management is not established.

This section details what donors and international partners should do in order to assist the counterparts in the public administration to build the change management capacity and to establish the required drivers that would lead to a self sustainable ability to implement the public administration reform and prepare it for EU integration.

6.5.1 Support establishing the Department for Health

This component should provide TA and investment over a period of 5 years for the implementation of the State Action Plan (see CD).

6.5.2 Support introducing strategic management at all levels

This component should provide mainly TA for establishing an office in MoHs, HIFs and PHIs that can facilitate the development of long and short term goals for the organisations, adjust their functions accordingly, elaborate action plans, monitor the implementation of the action plans and keep the entire organisation informed and involved.

6.5.3 Support introducing evidence based decision-making

This component should provide TA and investment for HIFs, MoHs and PHIs with respect to the following issues:

- Management and leadership training.
- Support establishing the proposed planning departments in HIFs and MoHs and training of the staff.
- Support establishing a coherent approach for performance monitoring and elaboration of prognoses (PHIs); for capacity, speciality and education planning (MoH) and for contracting of health care providers based on output and performance in accordance with the plan (HIFs).

- Support rationalising of the organizations of HIFs, MoHs and PHIs including the required investment support.
- Support the introduction of performance monitoring of the health provider network and information dissemination to the providers.
- Support for elaboration of an accounting ledger for BiH.
- Support establishing a health information system for BiH including defining the architecture, nomenclature, data protocol, data definitions and the relevant legal provisions.

6.5.4 Support introducing HRM at all levels

This component should provide mostly TA to MoHs for introduction of HRM practice and principles within the entire health system. However, support should also be provided to the HRM units within HIFs and PHIs. The support should include:

- Support establishing and building the capacity of the HRM units.
- Support conducting work force planning for the entire health system (assess demand, supply and skill gap).
- Support elaborating of training and education plans and implementation of these.
- Support elaborating retainment and recruitment strategies.
- Support elaborating flexible job descriptions.
- Support enacting the practices for management by objectives.
- Support to perform medical education curriculum assessment and to participate in curriculum development and coordination.

6.5.5 Strengthening the universal health insurance system in BiH

This component should provide TA and investment support for strengthening the major functions of the state, of the entities and of the cantonal health insurance funds with the aim of introduction of universal coverage of health insurance in BiH. The assistance should include:

- Support for broadening the health insurance collection basis,and for increasing the number of population covered by health insurance and for enabling verification of contribution collection for each single individual.
- Support for elaboration of a minimum BBP for BiH
- Support for introducing Global Budgeting and introduction of a participative and simple contracting practice of health care providers based on outputs and with performance elements.
- Support for introduction of more updated procedures and practices for verification of the health insurance status of the patients.
- Support for establishing simple and transparent mechanisms for universal health insurance coverage in BiH including consideration of

utilising marginal pricing of discharges based on cost accounting principles.

6.5.6 *Strengthening the sanitary and the pharmaceutical inspection*

This component should provide TA and investment support for establishing of the new system for sanitary and pharmaceutical inspection in BiH and in the entities. The component should include the following elements:

- Support defining the activities of the different parts of the inspection system, the size in terms of manpower, budget, investment, etc.
- Support elaborating the law governing the BiH inspectorate
- Support establishing the new organisation
- Support updating the practice and the procedures for sanitary and pharmaceutical inspection
- Support establishing good practices and procedures for medico technical assessments and EC-labelling.

6.6 Legal impacts

Although, the above mentioned recommendations include a separate recommendation 3.2 related to EU integration, it is important to underline that all recommendations, directly or indirectly will provide for progress towards EU integration.

The methodology of the functional review deals only with functions and not with competences that are a legal term stipulating the rights and obligations of different pubic bodies as stipulated in the law. Hence, the legal impact of recommendation related to e.g. moving a function from one organisation to another is to a certain extent outside the scope of the functional review. The functional review does not provide any explicit guidelines of whatever the implementation of a recommendation would require change of regulations, of a law, of the constitution or could be implemented by a memorandum of understanding. However, the project team has during the process of establishing the recommendations considered the legal implication.

It is evident that the recommendations detailed in this Report would result in changes of competences, introduction of new and abolishing of old ones.

It is important to note that the Constitution stipulates (article III 3a) that "All governmental functions and powers not explicitly assigned in this Constitution to the institutions of Bosnia and Herzegovina shall be those of the Entities." Further Article III, 1 assigns the following responsibilities to the institutions of BiH: Foreign policy, foreign trade policy, customs policy, monitory policy, finance of institutions and for international obligations, policy/regulation related to immigration/refugee/asylum, international and inter-Entity criminal law issues, communication, transportation and air control.

Although health issues are not explicitly mentioned as a BiH responsibility it is clear that those functions within the health sector that relate to EU integration (international obligations – see also III,2b) are largely under the responsibility of BiH.

The rest of the functions allocated to the BiH level, related to this report and within the health sector, are to be transferred by agreement between the Entities (article III, 5a) and District of Brcko or through formal amendment of the Constitution.

The proposed state institutions can then be established and relevant laws and regulations be adopted.

7. ANNEXES

7.1 Summary of Functional Review and Recommendations - State

This note summarises the data for the two Entities and Brcko and the general findings for the BiH state level. Further it highlights the recommendations for the state level.

The population in BiH:

Total population	Estimated population	Number of insured	Per cent of population insured
FBiH	2.315.270	1.981.186	86 %
RS	1.463.465	1.081.356	74 %
Brcko	85.000	69.945	82 %
Total BiH	**3.863.735**	**3.132.487**	**81 %**

Total health sector expenditures - aggregated for the entire BiH:

Health sector expenditure	2002	2003	2004
Public	948.432.721	966.406.084	1.003.519.035
Private *)	41.208.200	71.041.196	73.894.477
Total	989.640.921	1.037.447.280	1.077.413.512

The public administration part for the health sector – aggregated for the entire BiH:

Existing staff	**No of staff 2004**	**Per cent within each level**	**Per cent between the levels**
State level ministry functions	1,5	0,7	
Entity/Brcko ministry functions	117,0	55,6	
Cantonal ministries	92,0	43,7	
Sub total Ministries	**210,5**	**100**	**9,5**
Entity/HQ/Brcko Health Insurance Funds	565,0	50,9	
Cantonal Health Insurance Funds	544,0	49,1	
Sub total HIFs	**1.109,0**	**100**	**50,4**
Entity and Brcko Institutions of Public Health	291,0	48,8	
Cantonal Institutions of Public Health	305,0	51,2	
Sub total PHI	**596,0**	**100**	**27,0**
Sub total Authorities	202,0		**9,2**
Sub total Others	87,0		**3,9**
GRAND TOTAL	**2.204,5**		**100,0**

Number of Laboratory staff: 175, number of sanitary inspectors: 65,5 and number of Drug Inspectors: 9

The public administration expenditure – aggregated for the entire BiH:

Existing budget	Budget 2002	Budget 2003	Budget 2004	Per cent 2004 *)
State level ministry functions		**35.149**	35.500	0,7
Entity/Brcko ministry functions	2.660.866	2.304.171	2.347.406	44,2
Cantonal ministries	2.003.905	2.787.988	2.932.000	55,2
Sub total Ministries	**4.664.771**	**5.127.308**	**5.314.906**	**10,4**
Entity/HQ/Brcko Health Insurance Funds	11.327.926	10.435.505	11.615.798	48,9
Cantonal Health Insurance Funds	8.320.596	11.911.973	12.149.151	51,1
Sub total HIFs	**19.648.522**	**22.347.478**	**23.764.949**	**46,4**
Entity and Brcko Institutions of Public Health	4.949.295	5.767.516	6.385.321	46,0
Cantonal Institutions of Public Health	6.754.423	7.944.988	7.494.624	54,0
Sub total I PHI	**11.703.718**	**13.712.504**	**13.879.945**	**27,1**
Sub total Local Authorities	**4.663.324**	**4.988.245**	**5.247.992**	**10,3**
Sub total Others	**1.772.071**	**2.156.931**	**2.985.806**	**5,8**
GRAND TOTAL	**42.452.406**	**48.332.466**	**51.193.598**	**100,0**

*) The per cent for sub totals are calculated based on the grand and the other are calculated based on the subtotals

The present situation with respect to functions at the state level:

Altogether 1,5 fulltime employees undertake all functions at the state level related to the health care sector in the Sector for Labour, Employment, Health, Social Protection and Pension within Ministry of Civil Affairs as the only state institution dealing among other things with health care issues.

Therefore, it is evident that almost none of the functions required for planning, monitoring and running a sustainable and coherent heath care system with universal coverage, equal access and equity exist.

No functions to coordinate, initiate and monitor the implementation of BiH health sector objectives or to support the Entities in implementation of more specific health sector strategies and changes can be performed.

Functions related to EU integration are not present to an extent that will guaranty a timely and smooth integration and no organisations has been identified which can

be a partner for EU institutions committing the BiH health sector. Further, none of the functions required for EU membership can be identified (e.g. policy coordination, free movement of goods, patients and export of benefits).

Organisational issues – aggregated for the entire BiH:

Overview of result of analysis	No of organisations with separate legal department or unit	Per cent	No of organisations with separate HRM department or unit	Per cent	No of organisations with separate budget for training and education of the staff	Per cent	No of organisations with performance based incentives beyond what is provided by the law	Per cent	No of organisations with a separate department for finance/ budget	Per cent
State level ministry functions	0	0	0	0	0	0	0	0	0	0
Entity/Brcko ministry functions	0	0	0	0	0	0	0	0	1	33
Cantonal ministries	8	80	1	10	4	40	0	0	6	60
Sub total Ministries	8	57	1	7	4	29	0	0	7	50
Entity/HQ/Brcko Health Insurance Funds	2	67	0	0	1	33	0	0	1	33
Cantonal Health Insurance Funds	8	80	1	10	4	40	0	0	6	60
Sub total HIFs	10	77	1	8	5	38	0	0	7	54
Entity and Brcko Institutions of Public Health	0	0	1	33	2	67	0	0	1	33
Cantonal Institutions of Public Health	1	11	0	0	0	0	0	0	1	11
Sub total PHI	1	8	1	8	2	17	0	0	2	17
Sub total Local Authorities	1	25	0	0	2	50	0	0	2	50
Sub total Others	0	0	0	0	0	0	0	0	1	33
GRAND TOTAL	20	43	3	7	13	28	0	0	19	41

Overview of result of analysis	**No of organisations coordinating their draft budget with other institutions**	**Per cent**	**No of organisations undertaking any medium-term expenditure framework (MTEF)**	**Per cent**	**No of organisations with appropriately approved strategic objectives**	**Per cent**	**No of organisation s with appropriatel y approved medium-term objectives**	**Per cent**
State level ministry functions	1	100	1	100	1	100	1	100
Entity/Brcko ministry functions	3	100	3	100	3	100	3	100
Cantonal ministries	10	100	2	20	0	0	0	0
Sub total Ministries	14	100	6	43	4	29	4	29
Entity/HQ/Brcko Health Insurance Funds	3	100	0	0	0	0	0	0
Cantonal Health Insurance Funds	6	60	0	0	0	0	0	0
Sub total HIFs	9	69	0	0	0	0	0	0
Entity and Brcko Institutions of Public Health	3	100	0	0	1	33	1	33
Cantonal Institutions of Public Health	5	56	1	11	0	0	0	0
Sub total PHI	8	67	1	8	1	8	1	8
Sub total Local Authorities	2	50	0	0	1	25	1	25
Sub total Others	1	33	1	33	1	33	2	67

GRAND TOTAL	34	74	8	17	7	15	8	17

Key indicators for staff and budget – aggregated for the entire BiH:

Key indicators for staff and budget use 2004	Total recurrent unit cost per employee per year	No of staff per 1.000 inhabitants	KM per inhabitants
Department for Health	23.667	0,00	0,01
Entity/Brcko ministry functions	20.063	0,03	0,61
Cantonal ministries	31.870	0,02	0,76
Sub total Ministries	25.249	0,05	1,38
Entity/HQ/Brcko Health Insurance Fund	20.559	0,15	3,01
Cantonal Health Insurance Funds	22.333	0,14	3,14
Sub total HIFs	21.429	0,29	6,15
Entity/Brcko Institutions of Public Health	21.943	0,08	1,65
Cantonal Institutions of Public Health	24.573	0,08	1,94
Sub total PHI	23.288	0,15	3,59
Sub total Local Authorities	25.980	0,05	1,36
Entity/Brcko Inspectorates	35.258	0,00	0,03
Entity Accreditation and Quality Agencies	15.932	0,00	0,03
Drug Agencies/Quality	36.218	0,02	0,71
Sub total Other	34.320	0,02	0,77
GRAND TOTAL	23.222	0,57	13,25

Overall recommendations related to the state-level:

The following functions are recommended to be established or strengthened considerably:

1) State ministry functions:

- The function for elaborate overall strategies for the entire health sector in BiH in cooperation with the Entities and Brcko.
- The function for cross sectional and cross entity coordination.
- The function for drafting frame laws for the health sector in BiH.
- The function for drafting laws and regulations for state institutions.
- The function for policy planning, monitoring and coordination.
- The function for defining the network for provision of tertiary health care (capacity and speciality planning based on prognoses for demand for health care elaborated by PHIs).
- The function for elaborating consolidated plans for the health care network in BiH (including private, primary, secondary and other type of health services) based on capacity and speciality plans elaborated by the Entities and Brcko (also based on prognoses for demand for health care elaborated by PHIs).

- The function for elaborating MTEF for the health sector at BiH-level, participate in planning and monitoring the distribution of funds for priority sectors (prevention/promotion, primary health care, secondary and tertiary health care) in BiH

- The function for facilitating establishing of universal coverage of health insurance in BiH, including establishing of minimum standards for the health system in BiH, determining a minimum BBP and establishing an equitable price system for universal coverage.
- The function for developing and monitoring the implementation of the human resources management strategy for the BiH health sector also determining the future number of medial professions and their competences.
- The function for coordinating and participating in curriculum development together with universities and schools involved in medical educations.
- The function for establishing minimum standards for a health information system for BiH.
- The function for monitoring the performance of the health sector (incl. the private sector) in BiH and the performance of institutions and organisations within the health sector at state level.
- The function for EU integration within the health sector in BiH, donor prioritisation and coordination.
- The function for concluding international agreements and cooperation within the health sector (also concerning treatment of patients abroad).
- The function for define the rules for separation of public from "private" standard laboratory tests and for public reference laboratories.
- The function for establishing rules/system for accreditation and quality check of laboratories.
- The function for establishing tender procedures for tendering of common standard laboratory tests.

2. State accreditation and quality assurance functions:

- The function for collaboration center for evidence based medicine for BiH.
- The function for professional center of excellences for accreditation and quality assurance.
- The function for developing methodology for accreditation and quality assurance and disseminating these.
- The function as resource and support centre.
- The function for cooperating with the Entity agencies for quality and accreditation.

3. State drug agency functions:

- The function for control and assessment of pharmaceuticals, herbal products and related medical substances for the entire BiH.
- The function for issuing export/import license for the entire BiH.

- The function for elaborating of standards and procedures for test of drugs (incl. the reference laboratory function).
- The function for elaborating norms, standards and procedures for pharmaceutical inspection.
- The function for elaborating of norms and standards for good practices (producer, wholesaler and retailer).
- The function for providing technical advice with respect to rational use of drugs.

4. State health insurance functions:

- The function for negotiating, concluding and monitoring international agreements with respect to health insurance covering BiH including follow-up on the compliance covernants with other countries (where citizens of BIH are working) and enter new once when required.
- The function for participating in drafting regulations for BiH with respect to free movement of patient and export of health insurance benefits.
- The function for elaborating health insurance statistics for BiH including national health account for BiH.
- The function for providing professional support for establishing of universal health insurance coverage in BiH.

5. State public health functions:

- The function for as reference laboratory for BiH defining standards, procedures and technical guidelines for laboratory tests and to conduct special complicated laboratory analyses (if they can not otherwise be performed in the private or pubic sector).
- The function for medico technical assessment and approval according to EU standards (e.g. EC-labelling).
- The function for supervising and monitoring tendering procedures for standard laboratory services performed by Entity/Cantons' PHIs, with respect to technical issues.
- The function for processing and dissemination of health sector information and statistics related to international agreements and obligations e.g. WHO, Eurostat, etc.
- The function for acting as center of excellence for public health, promotion and prevention.
- The function for cooperating with public health organisation in the entities and in Brcko

6. State inspection functions:

- The function for establishing standards and methods for inspection (sanitary and drug inspection).
- The function for handling complaints (appeal) with respect to inspection.

- The function for providing professional support and act as excellence center.
- The function for coordination with the entity inspectorates and the common inspection in Brcko.
- The function for pharmaceutical inspections throughout BiH

7. State radiation protection functions:

- The function for establishing of standards and methods for radiation inspection.
- The function for organising the measuring of employees working with radiation substances.

As a consequence of the abovementioned it is recommended to establish the following organisational structures:

- A separate Department for Health within MoCA
- A BiH Accreditation and Quality Agency
- A BiH State Drug Agency
- A BiH Health Insurance Agency
- A BiH Public Health Agency
- A BiH Inspectorate(s)

Key indicators for staff and budget after implementation of recommendations – aggregated for the entire BiH:

Key indicators for staff and budget after implementation of recommendations	Total recurrent unit cost per employee per year	No of staff per 1.000 inhabitants	KM per inhabitants
Department for Health	28.182	0,02	0,45
Entity/Brcko ministry functions	20.670	0,03	0,54
Cantonal ministries	33.397	0,02	0,66
Sub total Ministries	**26.689**	**0,06**	**1,65**
BiH Health Insurance Agency new	28.295	0,00	0,11
Entity/HQ/Brcko Health Insurance Fund	21.464	0,12	2,50
Cantonal Health Insurance Funds	22.627	0,14	3,12
Sub total HIFs	**22.187**	**0,26**	**5,73**
BiH Public Health Agency new	28.295	0,00	0,11
Entity/Brcko Institutions of Public Health	22.039	0,06	1,32
Cantonal Institutions of Public Health	24.155	0,05	1,17
Sub total PHI	**23.168**	**0,11**	**2,60**
Sub total Local Authorities	**29.016**	**0,04**	**1,18**
BiH Inspectorate new	28.295	0,01	0,18

Entity/Brcko Inspectorates new	21.601	0,01	0,29
BiH Accreditation and Quality Agency new	28.295	0,00	0,04
Entity Accreditation and Quality Agencies	16.888	0,00	0,08
BiH Institute for Radiation Protection new	28.295	0,00	0,07
BiH State Drug Agency new	28.295	0,01	0,33
Entity Drug Agency	0	0,00	0,00
Sub total Other	**24.722**	**0,04**	**0,98**
GRAND TOTAL*	**23.682**	**0,51**	**12,13**

7.2 Summary of Functional Review and Recommendations – FBiH

The population:

Total population	Estimated population*)	Number of insured	Per cent of population insured
FBiH	2.315.270	1.981.186	85,43 %

Source and year: FBiH Institute for Statistics, 2002

The health sector expenditures:

Health sector expenditure	2002	2003	2004*)
Public	726.080.718	726.905.475	766.461.009
Private	24.918.900	53.501.173	56.176.232
Total	750.999.618	780.406.648	822.637.241

Source: National Health Resources Account for FBiH, added the public administration expenditure and subtracted HIF expenditure.
*) Based on estimation of increase of 5 %

The public administration part for the health sector:

Human resources

Existing staff	**No of staff 2004**
Federal Ministry of Health	82
Cantonal level Ministries	92
Sub total Ministries	**174**
Entity or HQ Health Insurance Fund	26
Local or other level Health Insurance Funds	544
Sub total HIFs	**570**
Entity Institutions of Public Health	104
Local or other level Institutions of Public Health	305
Sub total PHI	**409**
Local Authorities	**147**
Drug Agency	32
Accreditation Agency	0
Sub total other	**32**
GRAND TOTAL	**1.332**

Existing budget	**Budget 2002**	**Budget 2003**	**Budget 2004**
Entity level Ministry	1.471.148*)	1.496.590	1.441.700
Cantonal ministries	2.003.905	2.787.988	2.932.000
Sub total Ministries	3.475.053	4.284.578	4.373.700
Entity Health Insurance Fund	680.000	870.000	1.312.000
Cantonal Health Insurance Funds	8.320.596	11.911.973	12.149.151
Sub total HIFs	9.000.596	12.781.973	13.461.151
Entity Institutions of Public Health	2.406.118	2.567.381	2.592.304
Cantonal Institutions of Public Health	6.754.423	7.944.988	7.494.624
Sub Total PHI	9.160.541	10.512.369	10.086.928
Local Authorities **)	3.336.181*)	3.393.877*)	3.463.140
Drug Agency	1.087.832	1.128.330	1.373.340
Accreditation Agency	0	0	0
Sub total Other	**1.087.832**	**1.128.330**	1.373.340
GRAND TOTAL	**26.060.203**	**32.101.127**	**32.758.259**

*) Calculated based on previous year adjusted by the increase in the consumer prices
**) Extrapolate based on a representative sample of institutions

The present situation (separate for each of the 3-big):

In accordance to the F BiH Constitution, health care is considered as a segment of divided jurisdictions between the federal and cantonal authorities. The health care is organized at cantonal level but coordinated at the federal level. The Federal Ministry of Health can not prescribe orders to cantonal ministries, but can provide a legislative framework dealing with basic issues of health care system design. The major laws i.e. Law on Health Care and Law on Health Insurance provide the legal frame for the health system. It is agreed that decision-making powers would not be decentralized in the following areas: decisions on the basic health system framework; strategic decisions on health resources development; regulation of public security related to communicable diseases; and monitoring, assessment and analysis of population health and health care delivery.

Key findings for MoH:

In accordance with political-administrative organization of the F BiH, functions in the field of health system management are performed by the Federal Ministry of Health and the 10 cantonal ministries of health. The overall staff of 10 cantonal ministries

amounts to 92 in comparison to 82 in the Federal MoH. Only three cantons have passed their own laws on health care and laws on health insurance.

- Ministries of health do some planning in the area of resident physicians training, although insufficient. However, planning of undergraduate education is the responsibility of the Ministry of Education and Science, but without appropriate coordination with the Ministry of Health. In addition educational curricula are not coordinated enough with the ministries in order to enhance the reform process with new skills and knowledge.
- There is a mixture of service delivery functions and policy functions (e.g. sanitary inspection).

Key findings for HIF:

- The health insurance system is based on the principles of non-competitive, regionally-based, compulsory social health insurance. Besides the Federal Health Insurance and Reinsurance Fund, there are 10 cantonal funds. Universal coverage of the population by health insurance has been stipulated by legislation. The percentage of insurance coverage for the entire Federation is above 85 %. "Risk pooling scheme" at the federal level has been established and is managed by the Federal Health Insurance Fund, being financed by 8 % of the overall health revenues. The total figure of employees in the 11 funds is 570.
- Total figure of employees of 570 within health insurance funds provide services for the F BiH population of 2.315.270. An average value of number of staff per 1.000 population and total recurrent unit costs per employee per year are 0,25 and 23.616 KM, respectively. However, total recurrent unit costs per employee per year within Federal Health Insurance Fund (50.462 KM) are more than double in comparison to the average value at the cantonal level (22.333 KM). There is a need to find out the reasons behind such an inefficiency
- The function of verification of health insurance statues of the insurees is performed in an administrative cumbersome way.
- The function for contribution coverage and for broadening the collection basis is not performed to the sufficient extent.

Key findings for PHI:

- Public health institutions have been established at federal and cantonal level. In total there are 409 employees within the 11 institutions. However, geographical distribution of staff is not equitable; from more than half of the employed, 104 are in Sarajevo within the Federal and within the Cantonal PHI employing 103. The rest of the 9 cantonal PHIs have 202 employees.

- The Institutions were established to provide the core public health function for the territory of the cantons (i.e. monitoring of epidemiological situation and discovering epidemics of communicable diseases; reporting on morbidity data and assessing health needs; analysis of hygiene status of drinking water).

- There is a mixture of service delivery functions and policy functions (e.g. laboratory services).

General remarks:

- In general, the function for informed decision-making process in the ministries is very weak and not supported appropriately by the institutions of public health and health insurance fund. The key role of a PHI is to do evaluation of health care needs for the population in the catchment area, as well as planning of health care measures based on morbidity data and evaluated needs. On the other hand, HIF should provide data on a supply side (i.e. inputs such as number of hospital beds, hospitals, health professionals, etc.). Allocation of resources is usually done on the basis of the supply side, but not on the population needs.

- It is common almost for each institution to have missing or insufficient the following functions: public relations, human resources management and strategic planning.
- There are no appropriate functions to support planning, monitoring and approval of capital investments, as well as cutting of capacities, if necessary. This gap deals with civil works and purchasing of high technology equipment.
- No common accounting ledger exists.
- No common architecture, nomenclature, protocol, exists for enabling electronic data exchange within FBiH and within BiH.

Organisational and structural findings:

Overview of result of analysis	No of organisations with separate legal department or unit	Per cent	No of organisations with separate HRM department or unit	Per cent	No of organisations with separate budget for training and education of the staff	Per cent	No of organisations with performance based incentives beyond what is provided by the law	Per cent	No of organisations with a separate department for finance/ budget	Per cent
Entity level Ministry	0	0	0	0	0	0	0	0	1	100
Canton Ministries	2	20	1	10	1	10	0	0	3	30
Sub total Ministries	**2**	18	**1**	9	**1**	9	**0**	0	**4**	36
Entity Health Insurance Fund	1	100	0	0	0	0	0	0	0	0
Cantonal Health Insurance Funds	8	80	1	10	4	40	0	0	6	60
Sub total HIFs	**9**	82	**1**	9	**4**	36	**0**	0	**6**	55
Entity Institutions of Public Health	0	0	1	100	1	100	0	0	1	100
Cantonal Institutions of Public Health	1	11	0	0	0	0	0	0	1	11
Sub total PHI	**1**	10	**1**	10	**1**	10	**0**	0	**2**	20
Local Authorities	1	33	0	0	2	67	0	0	2	67
Sub total other	0	0	0	0	0	0	0	0	0	0
TOTAL	**13**	**37**	**3**	**9**	**8**	**23**	**0**	**0**	**14**	**40**

Overview of result of analysis	**No of organisations coordinating their draft budget with other institutions**	**Per cent**	**No of organisations undertaking any medium-expenditure framework (MTEF)**	**Per cent**	**No of organisations with appropriately approved strategic objectives**	**Per cent**	**No of organisations with appropriately approved medium-term objectives**	**Per cent**
Entity level Ministry	0	0	0	0	0	0	0	0
Canton Ministries	10	100	2	20	0	0	0	0
Sub total Ministries	10	91	2	18	0	0	0	0
Entity Health Insurance Fund	1	100	0	0	0	0	0	0
Cantonal Health Insurance Funds	6	60	0	0	0	0	0	0
Sub total HIFs	7	64	0	0	0	0	0	0
Entity Institutions of Public Health	1	100	0	0	0	0	0	0
Cantonal Institutions of Public Health	5	56	1	11	0	0	0	0
Sub total PHI	6	60	1	10	0	0	0	0
Local Authorities	1	33	0	0	1	33	1	33
Subtotal Other	0	0	0	0	0	0	0	0
TOTAL	24	69	3	9	1	3	1	3

Key indicators – existing situation:

Key indicators for staff and budget – existing situation	Total recurrent unit cost per employee per year	No of staff per 1.000 inhabitants	KM per inhabitants
Entity level Ministry	17.582	0,04	0,62
Cantonal ministries	31.870	0,04	1,27
Sub total Ministries	25.136	0,08	1,89
Entity Health Insurance Fund	50.462	0,01	0,57
Cantonal Health Insurance Funds	22.333	0,23	5,25
Sub total HIFs	23.616	0,25	5,81
Entity Institutions of Public Health	24.926	0,04	1,12
Cantonal Public Health	24.573	0,13	3,24
Sub total PHI	24.662	0,18	4,36
Local Authorities *)	23.559	0,06	1,50
Entity Sanitary Inspection	0	0,00	0,00
Drug agency	42.917	0,01	0,59
Accreditation Agency	0	0,00	0,00
Sub total other	42.917	0,01	0,59
GRAND TOTAL	24.593	0,58	14,15

Overall recommendations related to transfer of functions between levels within the Entity and between the main pillars (MoH, PHI, and HIF):

- There is a need to enact legislation in the F BiH concerning accounting system in order to have a national ledger system. Therefore, comparisons of institutional efficiency could be much easier.

Recommendations related to MoH

- Due to consistency, cantonal ministries of health should not perform the function of drafting laws on health care in their parliaments (i.e. Law on Health Care and Law on Health Insurance). Cantonal ministries should deal with regulations with regard to regional issues, but not about the fundamental issues of health care policy. The framework of health care system should be designed at the national / higher level (i.e. federal or state level).
- The function for planning should be strengthened considerably.

Recommendations related to HIF

- The function of contracting between HIFs and health care institutions are done to the satisfactory level only in 3 cantons (Zenica, Bihać, Goražde). All other cantons allocate resources based on input indicators and the payroll list of health professionals in the health care institutions.
- The function for checking health insurance status should be rationalized (e.g. by sending to health institutions a monthly update on health insurance status which are not valid and leave it to the registration counter in health institutions to conduct the check).
- The function for contribution collection should be strengthened, encompassing cost effective campaigns for increasing the contribution collection basis and broadening insurance coverage from uninsured groups, registration of contribution on individuals, changing the right for being insured from when the insurance is paid to the employer, abolish the existing practice that uninsured can have covered treatment costs by paying 6 months of health insurance, and access should be given to HIF in auditing companies.

Recommendations related to PHI

- Benefit of scale and rational resource utilisation could be obtained by merging two cantonal public health institutions into one that would cover two cantons. Therefore, the overall costs could be lower and all functions could be accomplished, especially with regard to highly skilled professionals and high tech-equipment. For instance, problems in Goražde could easily be solved by merging with Sarajevo CPHI. PHI in Orašje could merge with the one in Tuzla, as well as the PHI in Grude and Mostar. Therefore, 6 cantons could be easily covered by 3 PHIs, being sufficiently skilled to performed core public health functions.

- Services provision function within laboratory units of PHI should be considered outsourced during the next five years. It could be performed by a private sector undertaking a proper tender procedure. Having in mind that a remarkable share of total PHI income is generated in the market dealing with laboratory services, there are prerequisites for that outsourcing functions, such as: PHIs should be fully financed by the government budget in order to perform their core functions without competition in the market. "New public health" emphasises functions like policy development, monitoring, planning, health promotion, etc., but not simple laboratory tests that could be done elsewhere. Laboratory knowledge and skills in the PHIs could be engaged to licence and supervise the work of other laboratories, and to create laboratory standards
- Federal Public Health Institute (FPHI) is located in Sarajevo and Mostar, employing in total 104 persons. Within the premises in Mostar there are more than 30 employees. Apart from FPHI employees in Mostar, there is 58 staff within Cantonal PHI. Obviously, there is surplus of public health staff and

overlapping functions between two PHIs in the same city. Official site for the FPHI is Mostar, not Sarajevo. Therefore, current concept of organization is not sustainable in the long-run.

Staff and budget consequences of recommendations:

Entity institutions	Existing situation		Proposed changes		Situation after changes	
	Staff 2004	Budget 2004	Change in staff	Change in budget	No of staff after implementation	Budget after implementation
Entity level Ministry	82	1.441.700	-16	-256.527	67	1.185.173
Cantonal Ministries	92	2.932.000	-16	-377.150	77	2.554.850
Sub total Ministries	**174**	**4.373.700**	**-31**	**-633.677**	**143**	**3.740.023**
Entity Health Insurance Fund	26	1.312.000	7	353.220	33	1.665.220
Cantonal Health Insurance Funds	544	12.149.151	-12	-100.489	533	12.048.662
Sub total HIFs	**570**	**13.461.151**	**-5**	**252.731**	**566**	**13.713.882**
Entity Institutions of Public Health	104	2.592.304	-24	-571.270	81	2.021.034
Cantonal Institutions of Public Health	305	7.494.624	-118	-2.977.662	187	4.516.962
Sub total PHI	**409**	**10.086.928**	**-142**	**-3.548.932**	**268**	**6.537.996**
Local Authorities	**147**	**3.463.140**	**-44**	**-660.000**	103	2.803.140
Entity Sanitary Inspection (New) *)	**0**	**0**	**29**	**509.878**	29	509.878
Drug Agency**)	**32**	**1.373.340**	**-32**	**-1.373.340**	0	0
Accreditation Agency	0	0	9	**160.600**	9	160.600
Sub total other	**32**	**1.373.340**	**6**	**-702.862**	**38**	**670.478**
TOTAL*)**	**1.332**	**32.758.259**	**-215**	**-5.292.740**	**1.117**	**27.465.519**

*) Altogether 65 sanitary inspectors have been identified in BiH. Using size of the population size as a proxy 29 of these should be engaged in the proposed new Entity Sanitary Inspectorate of RS. Today RS has 11 sanitary inspectors in the institutions reviewed.

**) Is proposed moved to the new State Drug Agency, and with respect to the pharmaceutical inspectorate it should be moved to the new State Inspectorate.

***) Includes 119 laboratory staff to be considered outsourced.

Key indicators for staff and budget after implementation of recommendations:

Key indicators for staff and budget after implementation of recommendations - 2004	Total recurrent unit cost per employee per year	No of staff per 1.000 inhabitants	KM per inhabitants
Entity level Ministry	17.822	0,03	0,51
Cantonal ministries	33.397	0,03	1,10
Sub total Ministries	**26.154**	**0,06**	**1,62**
Entity Health Insurance Fund	50.461	0,01	0,72
Cantonal Health Insurance Funds	22.627	0,23	5,20
Sub total HIFs	**24.251**	**0,24**	**5,92**
Entity Institutions of Public Health	25.106	0,03	0,87
Cantonal Public Health	24.155	0,08	1,95
Sub total PHI	**24.441**	**0,12**	**2,82**
Local Authorities	**27.215**	**0,04**	**1,21**
Entity Sanitary Inspection (new)	17.582	0,01	0,22
Drug agency	0	0,00	0,00
Accreditation Agency (new)	17.844	0,00	0,07
Sub total others	**17.644**	**0,02**	**0,29**
GRAND TOTAL	**24.589**	**0,48**	**11,86**

7.3 Summary of Functional Review and Recommendations – RS

The population:

Total population	Estimated population*)	Number of insured persons	Percentage of insured persons
RS	1.463.465	1.081.356	74 %

Source and year: RS Institute for Statistics, 2003

The health sector expenditures (in KM):

Health sector expenditure	2002	2003	2004
Public *)	201.419.615	215.422.048	219.084.223
Private **)	14.824.741	15.855.338	16.124.879
Total	216.246.358	231.279.389	235.211.106

*) Calculated based on 147,2 KM per capita for 2003 and an increase from 2002 to 2003 of 6,5% and from 2003 to 2004 of 1,7%
**) Calculated as 7,6% as the public expenditure for health care.

The public administration part for the health sector:

Existing staff	No of staff 2004
Ministry of Health and Social Welfare	33
Health Insurance Fund	518
Institute of Public Health	168
Local Authorities *)	**52**
Drug Agency	44
Accreditation Agency	8
TOTAL	**823**

*) Extrapolated on the basis of data from staff number in two municipalities (Banja Luka and Zvornik)

Expenditure of the public administration

Existing budget	Budget 2002	Budget 2003	Budget 2004
Ministry of Health and Social Welfare	661.080	721.716	832.633
Health Insurance Fund	10.482.000	9.100.000	9.500.000
Institutions of Public Health	2.543.177	2.889.490	2.960.982
Local Authorities *)	1.263.252	153.0421	1.681.233
Drug Agency	573.696	918.672	1.379.240
Accreditation Agency			127.452
TOTAL	**15.523.205**	**15.160.299**	**16.481.540**

*) Extrapolated on the basis of data from 2004 total budget in two municipalities (Banja Luka and Zvornik)

The present situation:

The Republika Srpska (RS) consists of 64 municipalities and four regions: Banja Luka, Doboj-Bijeljina, Sarajevo-Zvornik and Trebinje-Srbinje.

The health care system is rather centralised with the main power concentrated within the Ministry of Health and Welfare (MOH), the Public Health Institute (PHI) and the Health Insurance Fund (HIF). Recent reforms have further centralised some of the major functions of the HIF (e.g. contracting of health care providers is today performed by the HQ).

The average per capita health care expenditure amounted to 147,2 KM in 2003 and the total budget for 2004 provisions around 200 million KM for health care.

Health care services are delivered by a network of 63 Dom Zdravlja (DZ), 16 secondary level health care institutions and 2 tertiary level clinical centres.

Out of 11.211 people employed in the health sector 7.177 are health professionals (out of which 1.783 are medical doctors) and 4.034 are non-medical staff. Out of 11.211 employees in health sector 823 are part of public administration (7,3%).

Previous projects in domain of health have concluded that the health system is characterised by inequity in accessibility to health care, with over-provision of some services and under-utilisation of health care facilities. The provision of health care seems inefficient, with duplication of resources, inappropriate use of medical technology and a relatively long average length of stay.

Health insurance contribution collection seems not to be effective especially related to farmers and self employed. A large proportion of the population in RS is involved in activities related to agricultural production, and their health insurance contribution amounts only to 1%.

There is a weak coordination among the three pillars (MoH, PHI, and HIF) and there is no cohesive role of a single major stakeholder when outputs from one institution are to be used by the other one.

Health Information System (HIS) is not sufficiently supported by modern information technology tools (hardware and software). And there is no integrated HIS.

Key findings for MOH:

- The overall planning function is insufficient. There is no dedicated unit for policy making, strategic planning, financial planning and capacity planning.
- There is no function for performance monitoring of the health care system and of HIF.
- Cooperation with Ministry of education and University is not proactive. MoH is not involved in process of HRM and educational planning for high school and higher education. The MoH is not involved in curriculum development.

- There is no human resources management (HRM) function at MoH level and within overall health sector.
- Coordination with Labour Market in respect to health insurance payment for unemployed persons is not at satisfactory level.
- There is no motivational mechanisms/system of incentives.

Coordination and cooperation between main health pillars – PHI, MoH, and HIF is very weak. There is no health planning life-cycle: (A) identification of health needs (PHI), (B) HR and health care planning (MoH), (C) contracting health workers and health services on basis of actually identified health needs (HIF).

Key findings for PHI:

- PHI of RS is composed of the main office in Banja Luka and 5 regional offices which are positioned throughout RS. It has 168 employees.
- Income for the Institute is coming from three sources: government budget, HIF and services (mainly laboratory tests) provided both to population, private and state companies. Due to insufficient funds from government budget the public health functions are partly self financed through services provided on the market.
- The main functions performed consist mainly of: prevention of spread of infectious diseases, monitoring of health and nutrition status of the population, preparation of annual reports on health status of the population for the MOH, health promotion activities, monitoring and evaluation of preventive programmes, sanitary control of water, air, food, control of sources of radiation and supply of health institutions with vaccines.
- Furthermore, the PHI delivers services such as different kinds of laboratory tests (microbiology, sanitary microbiology, serology, bacteriology, parazitology and immunology analysis) and that makes a major source of income for PHI.
- It was observed that the activities of the RS Institute of Public Health and its regional institutions still are orientated towards control of communicable diseases, environmental hygiene, and lately with moderate orientation toward the prevention and control of chronic non-communicable diseases and health promotion.
- Communication between the regional institutions and between the regional institutions and the HQ is poor.
- Functions related to research, collection, analysis and dissemination of health data and elaboration of prognosis for demand and trends in health care service delivery are being neglected as well as functions related to health promotion.
- It was also observed that PHI does not perform analyses of health related socio-economic indicators or indicators related to the financing of the health system.

Key findings for HIF:

- The HIF-RS organisation consists of the HQ in Banja Luka (56 employees), 8 regional offices (207 employees) and 64 local offices (255 employees).
- Health insurance contribution is collected by the local tax-offices (MoF as part of the treasury) and not by HIF. HIF does not have the possibility to participate

in audit of companies and does not have a function for enlarging the contribution basis.

- Approximately 70% of the population is insured out of which only 40% (or 30% of the total population) are regular contribution payers.
- Most of the functions previously performed by the regional offices have, alongside the centralising process, been transferred to the HQ leaving a small role to the regional offices.
- Functions related to introduction of universal coverage of health insurance in BiH are not present to a required extent.
- The planning function is partly conducted in isolation and is not relying on evidence based inputs such as patient preferences, relation of supply and demand for health care (to be elaborated by PHI) and on human resources planning within the health care network (to be done by MoH).
- No human resources management functions have been identified – only human administration and no budget for upgrading the competences of staff exists.
- Contracting of health care providers is based on input (e.g. number of beds and number of medical professionals) rather than on output. Further, regular monitoring, reporting on measures for productivity, efficiency, and quality have not been observed.
- The function for issuing monthly invoices, by the health institutions, for each patient detailing the provision of services has been maintained, despite the shift from fee for service to budget financing.
- The function for validation of health insurance status is based on procedures obligating the insuree, once per month and in person, to go to HIF to obtain the stamp on the health insurance card that documents the insurance right.

Organisational and structural findings:

Overview of result of analysis	No of organisations with separate legal department or unit	Per cent	No of organisations with separate HRM department or unit	Per cent	No of organisations with separate budget for training and education of the staff	Per cent	No of organisations with performance based incentives beyond what is provided by the law	Per cent	No of organisation s with a separate department for finance/ budget	Per cent
Entity level Ministry	0		0		0		0		0	
Entity or HQ Health Insurance Fund	1		0		0		0		1	
Entity Institutions of Public Health	0		0		1		0		0	
Drug Agency	0		0		0		0		1	
Accreditation Agency	0		0		0		0		0	
TOTAL	**1**	**20%**	**0**	**0%**	**1**	**20%**	**0**	**0%**	**2**	**40%**

Overview of result of analysis	No of organisations coordinating their draft budget with other institutions	Per cent	No of organisations undertaking any medium-expenditure framework (MTEF)	Per cent	No of organisations with appropriately approved strategic objectives	Per cent	No of organisations with appropriately approved medium-term objectives	Per cen t
Ministry of Health and Social Welfare	1	100	0	0	1	100	1	100
Health Insurance Fund	1	100	0	0	0	0	0	0
Institute of Public Health	1	100	0	0	1	100	1	100
Drug Agency	0	0	1	100	0	0	1	100
Accreditation Agency	0	0	0	0	1	100	1	100

TOTAL	3	60	1	20	3	60	4	80

Key indicators – existing situation:

Key indicators for staff and budget	Total recurrent unit cost per employee per year	No of staff per 1.000 inhabitants	KM per inhabitants
Ministry of Health and Social Welfare	25.231	0,02	0,57
Health Insurance Fund	18.340	0,35	6,49
Entity Institute of Public Health	17.625	0,11	2,02
Local Authorities	32.331	0,04	1,15
Drug Agency	31.346	0,03	0,94
Accreditation Agency	15.932	0,01	0,09
TOTAL	**20.026**	**0,56**	**11,26**

Overall recommendations related to transfer of functions between levels within the Entity and between the main pillars (MoH, PHI, and HIF):

- Establish inspectorate for sanitary inspection.
- Establish universal health insurance coverage including establishing minimum health care standards in RS.
- The functions for elaboration of a simple, transparent pricing system for inter-Entity insurance coverage should be strengthened
- Drafting laws at entity level.
- Elaborate MTEF for the health sector in RS.
- Plan capacities for primary and secondary health care network based on prognoses for demand for health care.
- Improvement of cooperation and coordination of activities among the main pillars.
- Establish minimum standards for health information system at entity level.
- Establish Health Boards in municipalities making sure that local communities will have a proactive participation in health care issues.

MOH

- Sanitary inspection should be transferred from the Ministry to a new independent organization – Inspectorate together with other inspections.
- The Sector for policy making, strategy planning and development of health care system should be established.
- The performance monitoring function (of health institutions and internally) should be strengthen.
- Initiate cooperation with Ministry of education and coordination on curriculum development.
- A new function should be introduced for conducting analysis of educational needs related to health staff, research and consultancy functions.

- The function for monitoring of patients' preferences and for transforming these into measurable performance incentives should be strengthened.
- Improve coordination with Labour Market.
- Development and introduction of HRM function and PR (public relations) function.
- Development of motivational mechanisms/system of incentives.
- Improvement of capabilities for international cooperation that is not performed at state level.

PHI

- It is recommended to consider outsourcing of common standard laboratory tests_(microbiology and sanitary chemistry departments) to the private sector, provided that functions for monitoring of health status, analysis of data, reporting, prognosis of health trends are sufficiently funded from the Governmental budget, as income for implementation of these activities is for the time being coming from the service delivery functions.
- Strengthening the functions for health promotion, diseases prevention and control of non communicable diseases, analysis of socio-economic indicators and for provision of technical support to Ministry of Health for planning and decision making.
- The function for providing regular feedback towards health institutions about health situation in their regions should be introduced.
- Functions related to conducting population surveys and health system research should be strengthened and should be performed at the School of Public Health.
- Coordination between regional institutions and central office should be strengthened.

HIF

- The functions for coordination between different insurance funds within BiH should be strengthened
- The contracting function should be strengthened - using the capacity and speciality planning (elaborated by MoH) and the prognoses for demand for health care elaborated by (PHI) and by basing the contracts on output, performance and quality of care with incentives for improving results.
- The invoicing-function should be rationalised (e.g. changed into obtaining regular data useful for planning and management on e.g. demographic, morbidity, capacity, productivity, efficiency, quality, referrals, prescriptions, economic status, etc.).
- The function for checking health insurance status should be rationalised (e.g. by sending the health institutions a monthly update of which health insurance cards - permanent health insurance cards should be issued - are not valid and leave it to the registration counter in the HIs to conduct the check).
- The function for defining protocols, data definition and format for simple electronic transfer of data between the health institutions and HIF should be strengthened.
- The function for contribution collection should be strengthened, encompassing cost effective campaigns for increasing the contribution

collection from uninsured groups, registration of contribution on individuals, changing the right for being insured from when the insurance is paid to the employer, abolish the existing practice that uninsured can have covered treatment costs by paying 6 month of health insurance, and access should be given to HIF in auditing companies.

- The remaining required functions at the regional office should be rationalised and transferred partly to the local offices and partly to the HQ.

Staff and budget consequences of recommendations:

Entity institutions	Existing situation		Proposed changes		Situation after changes	
	Staff 2004	Budget 2004	Change in staff	Change in budget	No of staff after implementation	Budget after implementation
Ministry of Health and Social Welfare	33	832.633	-2	-50.082	31	782.551
Health Insurance Fund	518	9.500.000	-118	-2.164.120	400	7.335.880
Institute of Public Health	168	2.960.982	-32	-536.968	136	2.424.014
Local Authorities	52	1.681.233	-1	-32.519	51	1.648.714
Drug Agency**)	44	1.379.240	-44	-1.379.240	0	0
Accreditation Agency	8	127.452	1	15.932	9	143.384
Entity Sanitary inspectorate (new) *)	0		18	450.738	18	450.738
TOTAL*)**	**823**	**16.481.540**	**-178**	**-3.696.259**	**645**	**12.785.281**

*) Altogether 65 sanitary inspectors have been identified in BiH. Using the population size as proxy 18 of these should be engaged in the proposed new Entity Sanitary Inspectorate of RS. Today RS has 11 sanitary inspectors in the institutions reviewed.

**) Is proposed moved to the new State Drug Agency, and with respect to the pharmaceutical inspectorate it should be moved to the new State Inspectorate.

***) Includes 56 laboratory staff to be considered outsourced.

Key indicators for staff and budget after implementation of recommendations:

Key indicators for staff and budget after implementation of recommendations	Total recurrent unit cost per employee per year	No of staff per 1.000 inhabitants	KM per inhabitants
Ministry of Health and Social	25.244	0,02	0,53

Welfare			
Health Insurance Fund	18.340	0,27	5,01
Entity Institute of Public Health	17.824	0,09	1,66
Local Authorities	32.328	0,03	1,13
Drug Agency	0	0,00	0,00
Accreditation Agency	15.932	0,01	0,10
Sanitary inspectorate	25.041	0,01	0,31
TOTAL	**19.822**	**0,44**	**8,74**

7.4 Summary of Functional Review and Recommendations – Brcko

The population:

Total population	Estimated population[24]	Number of insured persons[25]	Percentage of insured persons
Brcko	85.000	69.945	82 %

The health sector expenditures (in KM):*

Health sector expenditure	2002	2003	2004**
Public	20.932.388	24.078.561	17.973.803
Private[26] *)**	1.464.559	1.684.685	1.593.366
Total	22.396.947	25.763.246	19.567.169

*Department for health and other services, October 2004.
**Planned
***) Private expenditure for 2002 is calculated based on the same increase as for public expenditure between 2002 and 2003

The public administration part for the health sector:

Existing staff / man-years	No of staff 2004
Ministry/Department for Health and other services[27]	2
Total Ministry	**2**
HIF/Sub-Department Health Insurance Fund[28]	21
Total HIF	**21**
PHI/Sub-department for public health	19
Total PHI	**19**
Sub-department for social welfare[29]	**3**
Department for public security[30]	**3**

[24] „The Future has begun", Brcko, February 2004.
[25] "Annual report", Sub-department HIF BD, October 2004.
[26] Data for institutions that have signed a contract with Sub-department HIF.
[27] Those 2 posts are on a payoll of the Sub-department health insurance fund.
[28] Without above mentioned 2 posts from the ministerial structure.
[29] Only posts related to health administration.
[30] Sanitary and health inspection.

TOTAL	**48**

Existing budget – recurrent costs (in KM)	**Planned Budget 2002**	**Planned Budget 2003**	**Planned Budget 2004**
Ministry/Department for Health and other services	528.638	85.865	73.073
Total Ministry	**528.638**[31]	**85.865**[32]	**73.073**[33]
HIF/Sub-Department Health Insurance Fund	165.926	465.505	803.798
Total HIF	**165.926**	**465.505**	**803.798**[34]
PHI/Sub-department for public health[35]	0	310.645	832.035
Total PHI	**0**	**310.645**[36]	**832.035**
Sub-department for social welfare[37]	**63.891**	**63.947**	**103.619**
Department for public security[38]	**110.543**	**109.929**	**105.774**
TOTAL	**868.998**	**1.035.891**	**1.918.299**

The present situation:

The health care system in Brcko District has specific organisational structure. The Department for health and other services is established in 2000 as a supreme health authority in Brcko District. Currently, the Department consists of six divisions with 637 employees. The Department includes the following sub-departments/divisions: Public health, Social welfare, Health insurance fund, Sport and culture, Primary health care, and Hospital health care.

The part of health administration is situated at the Inspections Division, which is an organizational unit within the Department for public safety. There are two sanitary inspectors, and one health inspector.

The primary health care with its 211 employees is organized in 3 health centres (Brcko, Maoča, Bijela), 8 outpatient clinics (Gornji Rahić, Omerbegovača, Brezovo Polje, Ražljevo, Ulice, Boće i Zovik), Consultative and Specialist Service, Emergency Unit, Public Health Service, and Centre for Mental Health. The hospital health care is organized in Brcko hospital with 280 beds and 321 employees. It provides services not only for the citizens of Brcko District, but also for citizens from FBiH and RS.

[31] It was the Administration at the time including ministerial structure and employees from public health service.
[32] Those 2 posts were on a payoll of the Sub-department Public Health Institute in 2003.
[33] Those 2 posts are on a payoll of the Sub-department Health Insurance Fund in 2004.
[34] Without above mentioned 2 posts from the ministerial structure.
[35] The Sub-department is established in October 2003.
[36] Without above mentioned 2 posts from the ministerial structure.
[37] Only posts related to health administration.
[38] Sanitary and health inspection.

The private health care sector has a significant role in health care system of Brcko District. There are 10 private pharmacies – all of them have contract with HIF Division. There are 8 private outpatient clinics (2 of them have contract with HIF Division), 3 dental clinics, 2 outpatient eye surgery clinics – both under contract with HIF Division, and 3 orthopaedic workshops (all under contract with HIF Division).

The Health Insurance Fund Division is established in November 2002. The main activities of the Health Insurance Fund are: monitoring contribution collection, verification of health insurance status, monitoring health care expenditures, allocation of resources, National Health Accounts for Brcko District, participation in medical board, dealing with patients' requests (e.g. for medical treatment outside of BD, for orthopaedic and other appliances, etc.).

The Sub-department for public health is established in October 2003. The main functions are: monitoring health status of the population, reporting on morbidity data and assessing the health needs, organizing immunization of the population, promotion and education, monitoring hygiene situation of portable water, food, common goods, and employees in production and distribution of food and beverages.

The primary activity of the Social Welfare Division is the application of the legal regulations for the protection of children, children's rights, implementation of social welfare, protection of marriage and families. It deals with application of the legal regulations aimed at protecting adult persons with special needs and it is responsible for the disabled, invalids, and geriatric services.

Key findings for the Department for Health and Other Services:

- There is no explicit health ministerial structure, but there is the Department for Health and Other Services that is accountable for health care in Brcko District.
- There is not enough capacity for planning, drafting laws and regulation, policymaking, and coordination functions within the Department.
- The Sub-department for Sport and Culture is organisational unit within the Department.
- Lack of capacity for strategic planning and absolute lack of MTEF.
- There is no HRM function.
- There are no motivational mechanisms or system of incentives.
- There is no exclusively appointed legal expert within the Legal Team/Services of BD to provide services for the Department for health and other services.

Key findings for Sub-department HIF:

- The Sub-department HIF is not a legal entity.
- There is no contracting function within the Sub-department HIF. All contracts must be signed by the Mayor of BD.
- Lack of strategic planning and MTEF.
- A number of core functions are performed by staff under temporary contracts.

- There is no HRM function.
- There are no motivational mechanisms or system of incentives.
- There is no appointed legal expert within the Legal Team/Services of BD for the sub-department's issues.

Some functions at the operational level could be rationalised (e.g. issuing of health cards, verification of health status, etc.)

Key findings for Sub-department for public health:

- The Sub-department for public health is not a legal entity.
- Lack of strategic planning and MTEF.
- There is no HRM function.
- There are no motivational mechanisms or system of incentives.
- There is no appointed legal expert within the Legal Team/Service of BD for the sub-department's issues.
- Coordination and cooperation with entity PHIs could be improved.
- A number of functions at the Sub-department could be rationalized (e.g. immunisation, keeping records on contagious diseases, monitoring disposal of waste, etc.)

Key findings for Sub-department for Social Care:

- Lack of strategic planning.
- There is no HRM function.
- Low technical level of data management.
- There are no motivational mechanisms or system of incentives
- There is no appointed and dedicated legal expert within the Legal Team/Service of BD for social issues.
- Additional training is needed for staff in domain of counselling.

In addition to findings it has been observed that despite the available funds to establish Counselling office for marriage and family, and Counselling office for youth, there is no good will to reach the agreement on location of premises.

Overview of result of analysis	No of organisations with separate legal department or unit	Per cent	No of organisations with separate HRM department or unit	Per cent	No of organisations with separate budget for training and education of the staff	Per cent	No of organisations with performance based incentives beyond what is provided by the law	Per cent	No of organisations with a separate department for finance/ budget	Per cent
Ministry/Department for Health and other services[39]	0	0	0	0	0	0	0	0	0	0
Total Ministry	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
HIF/Sub-Department Health Insurance Fund[40]	0	0	0	0	1	100	0	0	0	0
Total HIF	**0**	**0**	**0**	**0**	**1**	**100**	**0**	**0**	**0**	**0**
PHI/Sub-department for public health	0	0	0	0	0	0	0	0	0	0
Total PHI	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Sub-department for social welfare[41]	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Department for public security[42]	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
TOTAL	**0**	**0**	**0**	**0**	**1**	**25**	**0**	**0**	**0**	**0**

[39] Those 2 posts are on a payoll of the Sub-department health insurance fund.
[40] Without above mentioned 2 posts from the ministerial structure.
[41] Only posts related to health administration.
[42] Sanitary and health inspection.

Overview of result of analysis	**No of organisations coordinating their draft budget with other institutions**	**Per cent**	**No of organisations undertaking any medium-expenditure framework (MTEF)**	**Per cent**	**No of organisations with appropriately approved strategic objectives**	**Per cent**	**No of organisations with appropriately approved medium-term objectives**	**Per cen t**
Ministry/Department for Health and other services[43]	1	100	0	0	1	100	1	100
Total Ministry	**1**	**100**	**0**	**0**	**1**	**100**	**1**	**100**
HIF/Sub-Department Health Insurance Fund[44]	1	100	0	0	0	0	0	0
Total HIF	**1**	**100**	**0**	**0**	**0**	**0**	**0**	**0**
PHI/Sub-department for public health	1	100	0	0	0	0	0	0
Total PHI	**1**	**100**	**0**	**0**	**0**	**0**	**0**	**0**
Sub-department for social welfare[45]	**1**	**100**	**0**	**0**	**0**	**0**	**0**	**0**
Department for public security[46]	**1**	**100**	**0**	**0**	**0**	**0**	**0**	**0**
TOTAL	**4**	**100**	**0**	**0**	**1**	**25**	**1**	**25**

[43] Those 2 posts are on a payoll of the Sub-department health insurance fund.
[44] Without above mentioned 2 posts from the ministerial structure.
[45] Only posts related to health administration.
[46] Sanitary and health inspection.

Key indicators for staff and budget use 2004	Total recurrent unit cost per employee per year	No of staff per 1.000 inhabitants	KM per inhabitant
Ministry/Department for Health and other services[47]	36.536	0,024	0,86
Total Ministry	**36.536**	**0,024**	**0,86**
HIF/Sub-Department Health Insurance Fund[48]	36.536	0,25	9,46
Total HIF	**36.536**	**0,25**	**9,46**
PHI/Sub-department for public health	43.791	0,22	9,79
Total PHI	**43.791**	**0,22**	**9,79**
Sub-department for social welfare[49]	**33.973**	**0,036**	**1,22**
Department for public security[50]	**35.258**	**0,035**	**1,24**
TOTAL	**39.964**	**0,57**	**22,57**

Overall recommendations related to transfer of functions within the health administration structure in Brcko District:

- Update the Act on systematisation and job descriptions.
- The exclusive legal function for health issues should be established at the Legal Team/Service of BD. It means that the barristers should be appointed to provide legal services exclusively for the Department for health and other services and its sub-departments.
- One pharmaceutical inspector should be selected and employed at the Public Safety Department within the Inspections Division.
- The hiring procedure at the Brcko District should be simplified, more participative from the stakeholders' part, and less time-consuming.
- In order to secure proactive involvement of local communities in domain of health care a Health Board should be established
- Motivational mechanisms and system of incentives should be developed.
- Strategic planning function should be strengthened.
- Implementation of MTEF should be considered.
- Human Resources Management function should be introduced.
- Mid-term planning should be further developed.
- To consider harmonisation of health contribution base and health contribution rates at the BiH level.
- Define basic health package.

[47] Those 2 posts are on a payoll of the Sub-department health insurance fund.
[48] Without above mentioned 2 posts from the ministerial structure.
[49] Only posts related to health administration.
[50] Sanitary and health inspection.

- Improve cooperation with Revenue Agency, and Tax Authorities in BD.
- Improve coordination and cooperation with Inspections Division (health, sanitary, etc.).
- The municipality codes should be unified at the BiH level. The redundancy in the codes causes a lot of confusion in payments between entities and BD.

Further to the findings it would be advisable to consider the following:

- The Sub-department for sport and culture should be excluded from the existing organisational structure of the Department for health and other services.
- A separate budget line for training and education of staff should be included in annual budget.
- To consider harmonisation of account codes at the BiH level.
- To consider changes/simplification of procurement procedures.

Recommendations Sub-department HIF:

- Introduce contracting function.
- Accelerate hiring procedure for advertised posts at the Sub-department HIF.
- Transfer most of the legal tasks to the Legal Team/Service of BD and appoint a legal expert within the Legal Team/Service of BD that will deal only with legal issues related to the health care.
- Planning, monitoring and PR functions should be strengthened.
- Update the Act on systematisation and job descriptions.
- Resolve status of employees under temporary contracts.
- Develop motivational mechanisms and system of incentives.
- Human Resources Management function should be introduced and developed. Thus, the budget line devoted for training and education of staff should be included in annual budget.
- Improve strategic and mid-term planning and introduce MTEF.

Recommendations Sub-department for public health:

- Transfer most of the legal tasks to the Legal Team/Service of BD and appoint a legal expert within the Legal Team/Service of BD that will deal only with legal issues related to health care.
- Within the Service for general issues rationalisation is needed for the following functions: administrative services, preparation of tenders and reporting.
- Rationalisation at the Service for public health should be done for the following functions: immunisation, monitoring and keeping records of contagious diseases, and monitoring disposal of waste.
- Update the Act on systematisation and job descriptions.
- Human Resources Management function should be introduced and developed. Thus, the budget line devoted for training and education of staff should be included in annual budget.
- Develop motivational mechanisms and system of incentives.
- Improve strategic and mid-term planning and introduce MTEF.

Recommendations Sub-department for Social Care:

- Appoint a legal expert within the Legal Team/Service of BD that will deal only with social care issues.
- Improve technical level of data management. Additional IT equipment and training is needed.
- Human Resources Management function should be introduced and developed. Thus, the budget line devoted for training and education of staff should be included in annual budget.
- Develop motivational mechanisms and system of incentives.
- Find an acceptable solution for Counselling offices premises.
- Improve professional skills and knowledge in domain of counselling.

Staff and budget consequences of recommendations:

Staff and budget consequences of recommendations	**Change in staff**	**Change in budget**
Ministry/Department for Health and other services[51]	+1	+36.536
Total Ministry	**+1**	**+36.536**
HIF/Sub-Department Health Insurance Fund[52]	-4	-146.145
Total HIF	**-4**	**-146.145**
PHI/Sub-department for public health	-4	-175.165
Total PHI	**-4**	**-175.165**
Sub-department for social welfare[53]	**0**	**0**
Department for public security[54]	**+1**	**+35.258**
TOTAL	**-6**	**-249.516**

Number of Laboratory staff to be considered outsourced: 0

Number of sanitary inspectors to be transferred to the new Inspectorate: 0
This is not applicable to Brcko District, because the Inspections Division has been already set up within the Department for Public Safety.

[51] Those 2 posts are on a payoll of the Sub-department health insurance fund.
[52] Without above mentioned 2 posts from the ministerial structure.
[53] Only posts related to health administration.
[54] Sanitary and health inspection.

Number of Drug Inspectors to be transferred to the new Inspectorate: 0.
A pharmaceutical inspector should be employed at the Inspections Division within the Department for Public Safety.

Key indicators for staff and budget after implementation of recommendations:

Brcko District institutions	Staff 2004	Budget 2004	Change in staff	Change in budget	No of staff after implementation	Budget after implementation
Ministry/Department for Health and other services[55]	2	73.073	+1	36.536	3	109.609
HIF/Sub-Department Health Insurance Fund[56]	21	803.798	-4	-146.145	17	657.653
PHI/Sub-department for public health	19	832.035	-4	-175.165	15	656.870
Sub-department for social welfare[57]	3	103.619	0	0	3	103.619
Department for public security[58]	3	105.774	+1	35.258	4	141.032
TOTAL	**48**	1.918.299	**-6**	-249.516	**42**	**1.668.783**

Key indicators for staff and budget after implementation of recommendations	Total recurrent unit cost per employee per year	No of staff per 1.000 inhabitants	KM per inhabitants
Ministry/Department for Health and other services[59]	36.536	0,035	1,29
HIF/Sub-Department Health Insurance Fund[60]	38.639	0,2	7,74
PHI/Sub-department for public health	43.791	0,18	7,73
Sub-department for social welfare[61]	34.540	0,35	1,22

[55] Those 2 posts are on a payoll of the Sub-department health insurance fund.
[56] Without above mentioned 2 posts from the ministerial structure.
[57] Only posts related to health administration.
[58] Posts related to health care sector.
[59] Those 2 posts are on a payoll of the Sub-department health insurance fund.
[60] Without above mentioned 2 posts from the ministerial structure.
[61] Only posts related to health administration.

Department for public security[62]	35.258	0,047	1,66
TOTAL	**39.733**	**0,49**	**19,63**

7.5 Overview of the impact (staffing and recurrent budget) of the recommendations

Staff and budget consequences of recommendations – aggregated for the entire BiH:

Institutions	Existing situation		Proposed changes		Situation after changes	
	Staff 2004	Budget 2004	Change in staff	Change in budget	No of staff after impleme ntation	Budget after implement ation
Department for Health	2	35.500	60	1.697.681	62	1.733.181
Entity/Brcko ministry functions	117	2.347.406	-17	-270.073	101	2.077.333
Cantonal ministries	92	2.932.000	-16	-377.150	77	2.554.850
Sub total Ministries	**211**	**5.314.906**	**28**	**1.050.458**	**239**	**6.365.364**
BiH Health Insurance Agency new	0	0	15	424.425	15	424.425
Entity/HQ/Brcko Health Insurance Fund	565	11.615.798	-115	-1.957.045	450	9.658.753
Cantonal Health Insurance Funds	544	12.149.151	-12	-100.489	533	12.048.662
Sub total HIFs	**1.109**	**23.764.949**	**-112**	**-1.633.109**	**998**	**22.131.840**
BiH Public Health Agency new			15	424.425	15	424.425
Entity/Brcko Public Health Institutions	291	6.385.321	-60	-1.283.403	232	5.101.918
Cantonal Public Health Institutions	305	7.494.624	-118	-2.977.662	187	4.516.962
Sub total PHI	**596**	**13.879.945**	**-163**	**-3.836.640**	**434**	**10.043.305**
Sub total Local Authorities	**202**	**5.247.992**	**-45**	**-692.519**	157	4.555.473
BiH Inspectorate new			34	962.030	34	962.030
Entity/Brcko Inspectorates new	3	105.774	48	995.874	51	1.101.648
BiH Accreditation and Quality Imp. Agency new			5	141.475	5	141.475

[62] Posts related to health care sector.

Entity Accreditation and Quality Agencies	8	127.452	10	176.532	18	303.984
BiH State Drug Agency new			45	1.273.275	45	1.273.275
Entity Drug Agency	76	2.752.580	-76	-2.752.580	0	0
Sub total Other	**87**	**2.985.806**	**66**	**796.606**	**153**	**3.782.412**
GRAND TOTAL*	**2.205**	**51.193.598**	**-225**	**-4.315.204**	**1.980**	**46.878.394**

*) Out of which 175 employees are laboratory staffs which are recommended to be considered outsourced. This does not include resources for the needed investment and recurrent cost for training and education of staff.

7.6 List of Reviewed Institutions

Number of institutions reviewed by the detailed approach:	44
Number of institutions reviewed by the detailed approach but included as part of the organisation to which they belong (e.g. branch office of PHI in RS)	5
Number of institutions review by general approach:	7
Total number of institutions reviewed:	56

State level (BiH)

Ministry of Civil Affairs-Department for Health, Social Welfare, and Pensions

Federation of Bosnia and Herzegovina

Ministry of Health (FBiH)

Public Health Institute (FBiH)

Department for Drugs within MoH (FBiH)

Institute for Transfusion Medicine (FBiH)

Health Insurance and Reinsurance Fund (FBiH)

Canton Sarajevo-Ministry of Health

Canton Sarajevo-Health Insurance Fund

Canton Sarajevo-Public Health Institute

Canton Una-Sana-Ministry of Health

Canton Una-Sana-Health Insurance Fund

Canton Una-Sana -Public Health Institute

Canton Posavina-Ministry of Health

Canton Posavina-Health Insurance Fund

Canton Posavina – Public Health Institute

Canton Tuzla-Ministry of Health

Canton Tuzla-Health Insurance Fund

Canton Tuzla- Public Health Institute

Canton Zenica-Doboj-Ministry of Health

Canton Zenica-Doboj-Health Insurance Fund

Canton Zenica-Doboj - Public Health Institute

Canton Bosnian Podrinje-Ministry of Health

Canton Bosnian Podrinje-Health Insurance Fund

Canton Bosnian Podrinje – Public Health Institute

Canton Central Bosnia-Ministry of Health

Canton Central Bosnia-Health Insurance Fund

Canton Bosnian Podrinje – Public Health Institute

Canton Herzegovina-Neretva-Ministry of Health

Canton Herzegovina-Neretva-Health Insurance Fund

Canton Herzegovina-Neretva-Public Health Institute

Canton West Herzegovina-Ministry of Health

Canton West Herzegovina-Health Insurance Fund

Canton West Herzegovina-Public Health Institute

Canton 10-Ministry of Health

Canton 10-Health Insurance Fund

Canton 10 – Public Health Institute

Faculty of Medicine (FBiH)

Municipality Center Sarajevo *)

Municipality Mostar *)

Municipality Ljubuski *)

*as a sample of the existing 79 municipalities

Republika Srpska

Ministry of Health and Social Welfare of Republika Srpska

Public Health Institute (RS)

PHI Regional Office in Trebinje**

PHI Regional Office in Zvornik**

Health Insurance Fund (RS)

HIF Regional Office in Trebinje***

HIF Regional Office in Bijelina***

Drug Agency (RS)

Faculty of Medicine (RS)

Municipality Banja Luka *)

Municipality Zvornik *)

*) as a sample of the existing 64 municipalities

**as a sample of the existing five PHI regional offices

***as a sample of the existing eight HIF regional offices/fifty-four branch offices

District Brcko

Department of Health and Other Services (BD)

Department for budget and finance (BD)

Administrative department (BD)

Department for Public Safety (DB)

7.7 Overview of content of CD

The CD includes 215 documents created by the project team, and laws considered during the process.

All the documents are filed in folders, under the main folder called ***FINAL DOCUMENTS,*** that has two branches, according to the language the documents are written in:

1. ***ENGLISH***
2. ***LOCAL***

Both ***ENGLISH*** and ***LOCAL*** folders have the same structure:

1. STATE LEVEL
*1.1 INSTITUTIONAL REVIEW**
1.2 STATE REVIEW
1.3 ACTION PLAN (containing a document of the same name; only in English)

2. FEDERATION BiH
*2.1 INSTITUTIONAL REVIEW**
2.2 ENTITY REVIEW

3. REPUBLIKA SRPSKA
*3.1 INSTITUTIONAL REVIEW**
3.2 ENTITY REVIEW

4. BRCKO DISTRICT
*4.1 INSTITUTIONAL REVIEW**
4.2 DISTRICT REVIEW

5. OTHER DOCUMENTS
5.1 INCEPTION REPORT
5.2 LEGAL TOOLBOX
5.3 BENCHMARKS TOOLBOX
5.4 CONSIDERED LEGISLATION
5.5 FINAL REPORT

*The subfolder ***INSTITUTIONAL REVIEW*** includes sub-subfolders named after each reviewed institution containing the following documents:

- Front page
- Introduction
- Functional review questionnaire
- Recommendations

Thus, in order to reach one's final destination one has to follow this step by step procedure.