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Natalija Perišić[1]
Faculty of Political Sciences, Belgrade

Health Care System Between the State and the Market – the Case of Serbia

Abstract

Serbia's health care sector passed a long way from embracing state to market oriented values. During the first transition phase of the 1990s, health care reforms were rather provisional and forced by unfavorable trends in the society, while in the second transition decade more comprehensive, yet incomplete reforms, have been designed. The trajectory of main developments in the sectoral reforms clearly reveals a transformation of the national health care system from the state through quasi-state and finally mixed state-market health care schemes. Straightforward comparisons of access, quality and sustainability of health care in the past and in the present are hard to be made. However, the current reform outcomes reveal compromised accessibility, quality and sustainability of health care services. Those unresolved challenges have created room for widespread corrupt practices. Currently their main source seem to be unclear relations between the public and the private health care sectors.

Key words: health care, reform, access, quality, sustainability, corruption.

Introduction

Health care reforms are generally subject to many important factors, other than only economic. The Governments frequently show hesistance to introducing (radical) changes into their health care systems and the population are highly sensitive to health care issues. The underlying reason is that the „health care is a unique commodity" (Pestieau 2006: 116). This paper focuses on health care reforms on the basis of the case study of Serbia from the social policy perspective. The first Chapter explores the welfare sectors providing health care, generally the public

1 Assistant Professor
natalija.perisic@fpn.bg.ac.rs

and the private sectors, trying to draw lines between their competencies in the national context. A complex, nation-wide evaluation of implemented reforms in Serbia as of the 2000s is absent and the preferred evaluation method of the paper is structured around access, quality and sustainability of health care, as analyzed in Chapter 2. This approach can be partially justified by the absence of many indicators and data necessary for an in-depth evaluation. The shortages of the health care system in terms of access and coverage, quality and performance, as well as sustainability are reflected on corrupt practices. However of modified forms during the different phases in the development of the society (socialism, transition, capitalism), they seem to be equally vivid and hard to eradicate. Corrupt practices are presented in Chapter 3 in a qualitative and documentary manner, through examples from the practice illustrative of the ways in which the health care system and individuals have been coping with the changes and challenges. Extrapolation of deeper and generalized insights would need appropriate theoretical background information, which is out of the scope of this paper. Finally, a stronger emphasis in the paper is on the characteristics of the present health care system.

Health Care System in the Past and in the Present

The oldest heritage of the national health care system is in the Yugoslav self-management socialist concept which adopted the Bismarckian principles of health care insurance and adapted it to the principles of solidarity, egalitarism and universalism in health care. Consequently with the overall state ownership, the public sector was the only provider of health care services. It was not until the 1980s when the legal changes of 1986 and 1989 enabled the introduction of private dental and private medical practices respectively. However, numbers of private health care facilities were very low, while the state sector remained absolutely dominant.

The achievements of the socialist health care model were mainly in the spheres of eradication of many pre-war diseases and promotion of public health, as well as in improvement of a series of health indicators, such as life expectancy, mortality rates in general and especially in infants, etc. A significant progress was made in terms of developing previ-

ously underdeveloped network of health care facilities, using the then modern medical equipment, raising the number of medical staff, etc. Despite the positive developments, the challenges faced by the health care system in the late 1980s, primarily regarding the improvement of the health situation, have become increasingly complex and „the health care needs of the population that were not followed by adequate state measures have increased" (Lakićević 1991: 351).

In the transition period during the 1990s, the Serbian health care system experienced its most severe crisis. Overall political and economic circumstances in the society[2] have coincided with the total collapse of the health care sector.[3] Almost all reported health care indicators were aggravated during this period.

An enactment of health care system related laws of 1992[4] created a paradoxal situation. On the one hand, many rules from the Laws were not clear or were at least ambiguous – the definition of health care, the competencies of certain agencies in charge of health care activities, the founders of health care facilities, etc. and created a wide „grey" zone eventually susceptible to many corrupt practices. On the other hand, some rules were not or could not be implemented – for example, the voluntary health insurance, albeit they were provided for by the Law (Pražić 1998: 169).

Despite actual impossibility to effectuate legally prescribed rights to many health care benefits and services, the Government did not make any legal changes. Therefore, a parallel health system was created, in the shadow of the public sector. The private health care facilities were

2 The reforms of the 1990s were implemented in the context of extremely adverse trends: 1) in the political sphere: disintegration of Yugoslavia, civil war, sanctions of the United Nations, bombing; 2) in the economic sphere: macroeconomic instability, sharp drop in GDP, high foreign trade deficit and public debt, extremely low employment and activity rates, high unemployment rates, enormously huge grey market, hyperinflation; 3) in the social sphere: increased inequalities, drop in the living standard and widespread poverty, major inflow of refugees and internally displaced persons, etc

3 It was manifested in numerious ways, with some of the following: „the state health institutions did not provide even basic hygienic conditions, and there were no prerequisities for medical check-ups and hospital treatments. At one time, almost a complete interruption in the supply of medicines and medical materials occurred and obsolete technology disabled medical procedures and surgeries" (Vuković, Perišić 2011: 234).

4 The subjected Laws are the Law on Health Care and the Law on Health Insurance, both of 1992.

flourishing in the first transition years. By part-time engaging the medical staff (employed in the public sector for extremely small wages), they were offering value for money.

The first strategic paper was enacted two years after the political changes of October 5, 2000 and later in comparison with reforms in other welfare programs. Only in 2005, the new Laws regulating health care and health insurance were adopted. The dominant health care services provider is still the state and the organization of public health care facilities has been characterized by insufficiently clear division of levels of care (Simić, Marinković, Boulton 2012: 105-107). Compared to the period of socialism, the most striking changes were made with the introduction of mandatory health insurance and the widening of the scope of work and types of private health care services. Benefits' package and the rights in the public health system in the Law of 2005 have become significantly reduced compared to the previous Laws regulating this area. From the point of view of those in favour of savings in the health care system, that reduction is not sufficient and the rights (as well as the claims) should be scrutinized furthermore. There were many cuts in the number of beds and also in the number of both medical and administrative staff in the sector, frequently with unexpected and negative consequences.

Along with the dominance of the public sector, the activities of the private health care sector have been steadily increasing. They are mainly offered at the level of primary health care, but also at the level of highly profitable specialized health care services. However, any of the so far implemented reforms did not prevent the parallel existence of the two sectors. The functioning of the private sector is still lacking completely clear regulations, resulting in unfavorable consequences for the population. Some of the consequences relate to paying significant funds to private health care facilities, despite paid contributions to the public Health Insurance Fund. Along with the lack of consistence with the reform objectives, a part of the agenda from the beginning of the 2000s which was not implemented, was actually the problem of relation between the public and private health care sectors and the functioning of the latter. The only drastic changes compared to the socialism and the 1990s have been made in dental care: Only children and preventive dental care have remained within the state sector. A progress was made in the sphere of obligatory licencing of staff employed both in the public and the private health care sector, but the accreditation of facilities is voluntary so far.

Private health insurance has a short history – it is regulated by a Regulation of 2008,[5] which disables reliable estimations of its impact. Ten insurance companies are active in the field. The role of the state is reduced to giving licences to the insurance companies to deal with the activity of private health insurance. Private health insurance is designed as a form of substitution for those without a public insurance and for those opting for higher standards, i.e. other benefits and services compared to the existent in the public insurance.

Indicators of Health Care Provision and Organization

Coverage and Access to Health Care Services

The socialist state incorporated in its Constitution and laws the right to health care for all. The practice evidenced that the mentioned right had a different scope for different groups in the society. Probably due to high centralization in the health care sector characteristic of socialism, health care facilities and medical professionals were not equally distributed throughout the country. Consequently the population in certain areas (especially those underdeveloped) was facing factual geographical inaccessibility of health care services (Lakićević 1991: 351), especially of specialist care.

The most striking gap between the proclaimed rights and their actual implementation existed in the period that followed, i.e. in the 1990s. The exit strategy of the Government was to keep the status quo in the laws. "This created a superficial impression of the functioning of the (public) health care sector and prevented the problem to come out of the shadow" (Dimitrijević 1999: 284-285). Also, by-laws were frequently de facto narrowing the rights proclaimed in the laws. Geographical inaccessibility continued to be present, but not in all parts of the country: For example, the best developed network of health care facilities was characteristic of Vojvodina, contrary to the Central Serbia, while on Kosovo and Metohija there was no even enough medical staff (Pražić 1998: 176-177). In the 1990s, the challenge of inaccessibility additionally translated into the challenge of affordability: already impoverished population was forced to pay for health care, either under-the-table to

5 The Law on Health Insurance of 2005 introduced the voluntary health insurance, and the Regulation on Voluntary Health Insurance in Serbia was enacted in 2008.

the public sector or legally to the private sector. There are empirical evidence that the effects of health care costs in either of the two ways were devastating to households' budgets (Vuković, Perišić 2011: 234).

According to the official statistical data, the current coverage rate with health care services accounts for app. 95-96% of the population (RFZO 2013: 11). Albeit almost universal coverage reported from public sources, researches into social exclusion bring different data: a research by Cvejić, Babović, Petrović, Bogdanov and Vuković of 2010 points to inadequate coverage of elderly in rural areas of the country, even with primary health care. According to the statements made during the research, 12.6% of the respondents did not have health insurance, while 20%, 8% and 17% due to lack of money could not buy necessary medicines, medical appliances and pay for specialist check-ups respectively (Cvejić, Babović, Petrović, Bogdanov, Vuković 2010: 84-86). The coverage rate is the lowest in Roma population: Even 24.7% of them could not effectuate the right to health care (Vlada RS 2011: 177).

A study by Idzerda, Adams, Patrick, Schrecker and Tugwell of 2011 suggests that availability of health services is not an issue that disproportionately affects the Roma, but the geographical accessibility and affordability (both of services and medications) (Idzerda, Adams, Patrick, Schrecker, Tugwell 2011: 10). The issue of geographical inaccessibility is connected with the secondary and tertiary health care. The World Health Organization applied Primary Care Evaluation Tool to find out that 2/3 of respondents could reach their physician or pharmacist in less than 20 minutes, but not the dentist. Contrary to that, only 20% of respondents could reach the hospital in the mentioned 20 minute time (WHO 2010: 10-12).

There are strong differences between the average population and 20% of the poor regarding the indicators of "inability to access health care due to financial reasons" and "inability to provide medications, medical treatment and orthopedic appliances due to financial reasons" (Vlada RS 2012: 41). These findings are supported by the recent survey data that every tenth respondent reported that he/she did not visit a physician, at least once during the year, because of the lack of money (IJZ 2013a: 46). A comparative survey of health care systems in 34 European countries of 2012 (European Health Consumer Index) positions

Serbia at the bottom of table of European countries[6] primarily regarding the accessibility to surgeries and diagnostic treatments.

The number of the population contributing to private health insurance schemes is low – in 2010, there were less than 100,000 payers (NBS 2011). Furthermore, private health care facilities are not equally distributed in the country. Due to higher demand, the majority of them (almost 80%) are in the capital city.

Quality of Health Care

From the perspective of health indicators of the population, quality of the socialist health care was undisputedly advanced compared to the pre-war period. From 1948 to 1989, life expectancy increased from 50 to 72 years of life. Even though this and other health indicators were lower compared to highly industrialized countries, they were still above the average values in the countries of Central and Eastern Europe (Čekerevac 2007: 34). Also the causes of deaths were rather similar to those in developed, and not the developing countries. The number and qualifications of medical staff were in the trend of raising and improving. However, increasing inconsistency between the benefit package and available funds for health care with consequent continuous inflow of more and more beneficiaries, along with the ageing of the population, their increased expectations, etc., finally resulted in decreased quality of the services.

Thus, already at the beginning of the transition, quality of health care services was compromised and the situation was continuously aggravating to result in „a complete breakdown of supplying medicines to health care facilities, outdating of technology and inability of performing even urgent surgeries [...] aggravated hospital treatments, extremely bad hygienic conditions in health care facilities, etc." (Vuković 2009: 132). Unsurprisingly, health indicators of the population become highly unfavorable. The internal supervision of work and of quality of provided services was done only sporadically, while the regular and extraordinary supervision by external organization was not done at all (Pražić 1998: 187). The quality of private health care services was significantly better in many ways, even though only anecdotal evidence can be found in

6 With 451 points out of 1,000, Serbia is on the 34th position out of 34 European countries, based on 42 indicators classified into five categories (HCP 2012: 15).

support to this: experiences of the citizens visiting private doctors are that [...] the quality of their services is, generally speaking, on significantly higher level in the majority of private facilities. The owners of private health care facilities bought new and state-of-the-art equipment and engaged the best professionals from the public facilities to work as their consultants (Dimitrijević 1999: 298).

Currently, the basic methods of measuring quality of health services are two health indicators (life expectancy at birth and infant mortality rate) and surveys on the satisfaction of patients with the public health facilities and staff employed in them. The mentioned health indicators show improving results, but still huge differences for certain groups in the society have remained. Life expectancy for the Roma is 10 years shorter, while mortality rate of Roma children is two times higher than the national average, and 20% of Roma children are ill conditioned (compared to 7% of children from general population) (Vlada RS 2011: 187). Self-perceived health status is different depending on the income of households: It is bad and very bad in 32% of the lowest quintile, contrary to 12% of the highest quintile (Vlada RS 2012: 28). A survey on the satisfaction of patients with the public health facilities of 2012, reveals surprisingly high, although decreasing satisfaction (3.96 out of 5). The satisfaction in staff employed in the public sector is also decreasing (IJZ 2013b: 3).

The assessment of the World Bank of 2009 on improved situation in the public health care sector in Serbia was based actually on achievements in the system management, and especially: reconstruction of several health centers, as well as some hospitals and clinics, improvement of medical equipment and capacities for the national production of vaccines, establishment of professional chambers, foundation of the National Agency for Quality and Accreditation (Svetska banka 2009: 22).

It seems that there are significant regional disparities in practice, in terms of quality of provided services. As a rule, better quality of services is provided in major medical centres, especially in bigger cities and at secondary and tertiary levels of care.

The data about the quality of services offered in the private sector have been mising to a large extent. An efforts to include the private sector into the program of a continuous quality improvement failed, but the reporting on the use of private health care services (as as well the

registered morbidity) has been improved. For a couple of last years, the private health sector has been subjected to a regular auditing.

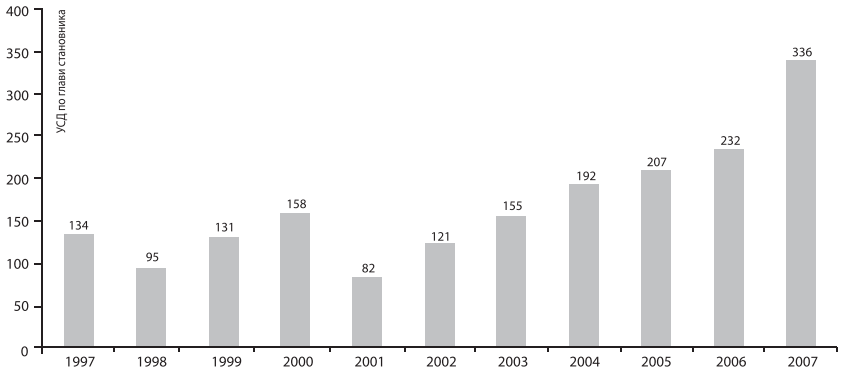
Sustainability of Health System

There are indications that the first signs of the crisis in health care financing coincided with the economic crisis in the Yugoslav society at the beginning of the 1980s, which reflected in slight decrease of health care expenditures as a GDP percentage (from 5.76% in 1980 to 5.14% in 1982). In 1989, they were 5.6% – almost at the same level as a decade ago. However, the GDP was shrinking and the actual funds devoted to health care were decreased, along with increased number of the population.

During the 1990s, the health care system was openly unsustainable. The amount of contribution collected funds was insufficient, as a consequence of nominally low salaries, depreciated by hyperinflation. Furthemore, the collection of health care contributions was extremely low – the practice of employers to avoid paying social contributions was wideapread and yet tolerated by the Government. After that, from 1997 to 2001, health care expenditures per capita were significnatly oscillating (graph 1), with constantly increasing trend from 2001 onward. In 2009, the trend was interrupted for the first time after the beginning of the 2000s, as a consequence of reduced economic activities.

However, the share of expenditures for the public health care system in GDP is higher compared to the health expenditures in the countries in the region while the results or outcomes of the health system are average (FREN 2010: 167). The reason for that is significantly lower productivity of health services (Svetska banka 2009: 28).

Another big challenge are high private expenditures for health care: the so-called out-of-pocket payments are made mainly, but not exclusively, for those medicines which are not on the positive list. These expenditures amount to about 25% of total expenditures on health care, which ranks Serbia high compared to many other European countries. Even worse, data from the National Health Account in Serbia suggest that more than 35% of costs of health care are financed by households. Thus, private expenditures for private health care services significantly increase household expenses.



Graph 1: Health care expenditures per capita, in US$, from 1997-2007. Source: IJZ, 2008.

Pending financing reforms have been reported to present the key challenge to the health care system in many studies.[7] The secondary and tertiary levels of care are over-dimensioned, even though the primary level was conceived as a gate keeper in strategic documents. It has clearly led to irrational usage of available (deficit) resources. The relief was expected to come after the introduction of new payment mechanisms – capitation at the primary health care and diagnosis-related groups at the secondary and tertiary levels of care. While the capitation system was finalized in October 2012, the diagnosis-related groups system has been piloted. The first findings point that the new payment methods did not generate expected results (RFZO 2013: 12). Despite the developments, the sustainability of health funds remains at further risk, partially due to underdeveloped mechanisms of enforcement and control (European Commission 2013: 36).

Corrupt Practices in Health Care Sector

Available scientific papers and books from the socialist period approached the problem of corruption in health care primarily from the

7 Some of them are: Social Protection and Social Inclusion in the Republic of Serbia by the European Commission of 2008; Reforme u Srbiji: dostignuća i izazovi by Mijatović of 2008; Socijalna sigurnost by Vuković of 2009; Srbija: kako sa manje uraditi više - suočavanje sa fiskalnom krizom putem povećanja produktivnosti javnog sektora by the World Bank of 2009, etc.

perspective of its devastating effects on solidarity and equality in the socialist regime, highly immoral behavior, the so-called "residues" of capitalist past which will be overcome with the development of the socialist society, etc. Broadly, the corrupt practices from that period were most frequently referred to as "abuse of a position" and "deriving personal benefits from being on a privileged position" (Kočović 1997: 165). Those could be taken as to refer at least to providing the medical staff with gifts in kind, and probably even cash payments. It could be that the first mentioned was relaxed by those taking them as widespread cultural norms of kindness in the Serbian society and by those offering them as a gratitude and/or an expectation of obtaining better care and treatment. Efforts to evaluate the dimensions of health related corruption were taken rarely, probably partially due to absence of evidence from the practice, i.e. researches in support of theoretical statements.

The changed nature of the health care system in the practice, despite minor legal changes, resulted in dramatically changed corrupt practices, which became a common norm in the 1990s. The corruption has become built-in in the health system of that time. One of the sources of corruption was derived from the characteristic of the Serbian political system and monopolistic position of the governing party during the whole 1990s. Its impact on all spheres of the society (and among other things on the health care system) was decisive. Functioning of the Republic Health Insurance Fund during the period was characterized by widespread practices of using money allocated for one purpose for another. Because of close connections between the Managers of the Fund and the political party in power which was appointing them, collected funds were used for paying political campaigns for elections, but also for paying pensions and other benefits. Even though insufficient for the health care of the population, the collected funds were high, and the turnover was high for that time. „The astonishing facts that the audit of the Health Insurance Fund has not been done for more than 10 years during the nineties, or that 10 out of 12 HIF Managers were at one point put in prison, speak for themselves!" (Arandarenko, Golicin 2006: 270). Not only at the level of the Health Insurance Fund, but also at the level of public health care facilities, a huge space for corruption was offered by the procedure of the so called public purchases.

Another massive corruption path was connected with a narrow circle of medical doctors on high positions in the political hierarchy. Health care facilities that were managed by them had an access to top quality

equipment and top educated personnel. Furthermore, there were indications that employed in those facilities were receiving higher salaries compared to others (Dimitrijević 1999: 285). Not only that they benefited in terms of that, but also not all patients could approach to those facilities. Because of the restrictive policy of service provision, those facilities benefited from those for whom the only option for admission was to bribe someone. The latter stem from another feature of the health care system of the time: On the one hand, there were too many by-laws, and on the other hand, their implementation was very selective, resulting in extreme inequalities in access to health care, despite formally equal rights.

That irreversibly led to widespread giving under-the-table payments, most frequently in the form of cash payments. In general, there were several corrupt practices on the individual level during the 1990s in the public facilities: Asking cash payments from patients in order to obtain a necessary treatment or to obtain it without waiting; Asking from patients to buy necessary supplies (there were no basic supplies in certain health care facilities); Directing patients to private health care facilities in which the same doctor employed with the public facility provides a service or vice verse, asking cash payments even when the private practicing doctor provides a service in the public facility; Asking cash payments for signing documents enabling a patient to effectuate the right to disability pension. A survey conducted by the Centre for Liberal-Democratic Studies reported that every second respondent had a personal experience in corruption practices related to health care (Begović, Mjatović 2001: 123). These findings could point that under-the-table payments were actually the surviving strategy for many who needed health care services.

In its Health Policy of Serbia of 2003 transparency was listed as one of the development objectives of the national health care system. Ten years after that, in its Progress Report for 2013, the European Commission finds that the health care sector in Serbia is particularly vulnerable to the corruption. While "in theory all agree that the corruption must stop, in practice it is not the case" (Dickov 2012: _). Stabilization of the situation in the health care sector after 2000 did not end the corruption. Now it mainly stems from unclear relation between the public and the private sector, and could be that it is supported by the situation in which the medical staff in the public health care facilities is overloaded but underpaid.

The private health care sector and "increasing the participation of the private, profit and non-profit sector in rendering health care financed by the Republic Health Insurance Fund" (MZ 2003: 5) as regulated by the fifth principle of the Vision of Health Care System in Serbia starts from the need to offer more diversified health care services, but also to monitor the quality of private services. Since it means the inclusion of the private sector into offering services (and even some specific services of public health) through contracting with the public Fund, it could be reasonably expected that the (better) integration of the two sectors would decrease opportunities for corruption. However, the current legislation on sub-contracting services, for which the Republic Health Insurance Fund would pay to private physicians, has not affected the change in the public-private mix, since this model has not been used in practice. Reasons for that are partially a result of "overlapping public and private health sectors, widespread corruption and inability of the state to introduce control systems" (Vuković 2010: 215). The practice has shown that the so-called temporary engagement in the private sector of physicians employed in the public sector is not a realistic solution for legal connection of the public and private health sectors in Serbia.

Estimated data of the United Nations Development Program for the health sector show that an average amount of bribe in 2009, 2010 and 2011 was EUR 169, 225 and 178 respectively (Doktori protiv korupcije 2014). The decreasing trend could be possibly interpreted in terms of a severe hit of the world economic and financial crisis on household incomes in Serbia. Unsurprisingly, in most cases (70%), this payment had an impact on personal budget to a great or moderate extent (UNDP Serbia 2011: 9). The reasons for that could be easily found by comparing the average and minimal salaries in Serbia with under-the-table payments. However, there have been significant difference of the amount and frequency of these payments, depending on the type of specialist care. Informal payments are higher and more widespread in gynecological and surgical facilities, while they are generally less frequent in outpatient services.

The results from the last, seventh research cycle of CESID and UNDP of 2016 show that the highest number of corruption cases is reported within the health care system with 47% of direct corruption experiences in the past three months related to physicians (UNDP Serbia 2013: 8). Accordingly, the population is accustomed to corruption – 88% agree that corruption is common place in Serbia (UNDP Serbia 2009: 12).

There are differences in the perception of corruption based on the living standard: the better-off perceived the corruption as a lower priority problem, contrary to the population with average and especially above the average income. Citizens seem to underestimate their possible role in the fight against corruption. Slightly more than half of respondents (52%) think that there is less corruption thanks to citizens themselves, while 57% think that a person giving a bribe is as responsible as the one accepting it. The reasons for that are numerous: (relative) tolerance of the Governments towards the corrupt practices, rare and slow judicial processes related with the corruption in health care, etc.

Conclusion

The process of the national health care system transformation followed the trajectory of reduced state responsibilities and activities in many ways. Faced with ever increasing demand for health care services and decreasing capacities to meet the (un)justified demand, the Government has been using different rationalizing paths. However, the health care reforms have been characterized to a large extent by unclear and sometimes ambiguous objectives. Legal changes have been directed toward the market logic, but the clear relations between the public and the private sectors have not been delineated and implemented. An absence of a dialogue between the decision makers and the public contributed to such a situation. An excessive impact of political parties in the reforms (i.e. the political power of levying own agenda has been frequently the main argument for reforms), has been delaying the necessary steps and making the situation harder. National decision makers were the most hesitant to reform the health care system and therefore many measures were taken on an ad hoc basis. Due to that, their maneuver space has become significantly reduced and currently weaknesses of the system seem rather more pronounced than its strengths.

Straightforward comparisons of access, quality and sustainability of health care in the past and in the present are hard to be made not only due to nonexistent and different indicators, but also due to higher expectations and aspirations of the citizens. Currently, the health care system faces fundamental challenges to access (low access in practice, especially of certain groups, aggravated affordability and unequal geographical accessibility) to quality (lowering satisfaction of patients and professionals,

lagging behind the EU regarding health indicators) and to sustainability (low health care expenditures which yet jeopardize the GDP). These obvious weaknesses are additionally potentiated with those indirect: e.g. limitation of health care "basket" covered by the public insurance system, rather low quality standards, very low (and decreasing) GDP, etc. It seems that the future changes to the system will be made within the framework of financial constraints in the system and the period of the current crisis will not present a favorable moment for the creation of a sustainable system. That brings into arena concerns about even higher levels of corruption, then currently. High vulnerability of the national health care system to corrupt practices will remain in case of persistence of current model of relation between the public and the private sectors. The concept of the private sector development should take into account that it will not solve the health problems of the most vulnerable and that the purchasing power of the population is comparatively very low. Therefore, obstacles referring more specifically to the public sector should be eliminated: Reviving the discourse on solidarity and mutuality in the society and in health care sector especially; Eliminating discretionary interpretation of rules and shortages in equal treatment for all; Improving the management with waiting lists and usage of technology; Creating shared responsibilities for outcomes, etc.

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