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HEALTH POLICY PARALYSIS IN FORMER SOCIALIST COUNTRIES - CASE OF BOSNIA AND HERZEGOVINA

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Abstract
The inabilty of Former Socialist Countries (FCS) to improve the performance of their National Health Care Systems (NHCS), even 15 years after the collapse of communist regimes, is in this paper called the paralysis of health policy. The author distinguishes two different explanations of the deterioration of the health status and the health care after the transition to market economy. One ascribes the responsibility for current defficiences to economic policy imposed by international financial organizations, and expects the improvement from economic recovery. The other sees the defficiences as the effect of poor macro-management, absence of clear concepts (road maps) for the „transition'' of socialist health system to something better, and to the lack of qualified managemet advisers. The paper uses the case of Bosnia and Herzegovina to ilustrate the disasterous effects of poor management, and decribes the failed strategy of a nongovernmental organization (NGO) to motivate decision-makers and health bureaucracy to agree about essentials of a common health policy useful for all the population of this country.
Key words: health policy, national health care systems, interest groups, Eastern Europe, Bosnia and Herzegovina

Introduction

The NHCS of Former Socialist Countries, before the collapse of communist regimes, were the subjects of admiration or benign criticism by many western visitors and scientists, ie H.E.Sigerist (1947), M.G.Field (1967), E.R.Weinerman (1967), G.Hyde (1974), M.Kaser (1976), V.Navarro (1977), M.Ryan (1978), W.A.Knaus (1981), C. Davis (1988), D.E.Parmelee (1989), and M.I.Roemer (1993). The common features of NHCS in FSC were summarised by Roemer (1993) as follows: everyone was entitled to receive comprehensive health services as his social right without personal charges; the provision of health services was the responsibility of the government at its various levels; the delivery of preventive and therapeutic services was essentially integrated, with emphasis laid on prevention; health resouces and services were centrally planned as part of the entirely planned economic and social order; all components of the health system were integrated under the direction of one major authority, the Ministry of Health and its subdivisions; although local groups of citizens had the possibility of contributing to health policy formulation, all final decisions on the core system's structures and functions were made by central political authorities; in case of

resouce shortages, priority was accorded to the health care of industrial workers and children; private medical practice (and related activities) were not prohibited but were subject to strict regulations; all health work had to be based on principles of scientific medicine, non-scientific and cultist practices were not permitted.

After the collapse of communist regimes in FSC, their NHCS lost most of their former ethical and structural advantages. In nearly all of FSC citizens lost entitlements to free medical care paid from tax-generated funds. The governments introduced health insurance schemes financed predominantly by contributions of emploees. Large sections of the population were left without health care. Sickness insurance funds became unsolvent due to insufficient contributions of collapsed socialist economies and large unemployment.The socialist ideals of equity, solidarity and the priority of vulnerable groups were tacitly abandoned. The health planning became ineffective or impossible. Three of FSC (USSR, Yugoslavia, and Czechoslovakia) desintegrated into 25 independent countries, each with its specific health problems, resources, political structures and ideologies, and with an increased number of interest groups and decision-makers. The collapse of health care systems in FSC caused the deterioration of the health status of populations. Main causes of the deterioration were: the lack of programmes needed to keep the population healthy, reduced social health rights, increased costs of medical services, and reduced access to quality medical care.

Such outcome amazed those who expected from the transition to market economy the improvement and not the deterioration of the performance of health services. Among the explanation of causes of deterioration, and concepts of future improvement of FSC health systems, three different views can distinguished. The pessimistic, which interprets the collapse of socialist NHSC as the effects of neoliberal policy of international financial organizations, and particularly the International Monetary Fund (IMF) and the World Bank (WB), and does not expect in foreseeable time any serious improvement of the health sector. The pragmatic view also does not expect serious improvements in forseable time, but believes that some progress can be made with „reforms''consisting of small incremental changes.The optimistic view interprets the deterioration of the performance of health care (in those of FSC, who have already educated during the socialist days more than enough of heath workers, and developed high capacity health facilities), primarily as the effect of wrong management, and mistakes which could and should have been avoided, if the new decision-makers knew and wanted to do so, and had good advisers to tell them what to do.

The first concept is expressed by C.W. Afford (2003), in a report published by International Labour Office and Public Service International, as follows: „The

international community, its financial institutions, the IMF, World Bank and investors, must all bear considerable resposibility for advocating an approach to economic transformation which exposed the people of CEE to such extrems of dislocation''. The presumption underpinning the economic policy of international institutions was that the price liberation would create market relations, prompt the tightening of fiscal policy, depress demand and public spending, and - supported with the privatization - force the enterprizes to persue efficiency. This sequencing of reforms proved inappropriate (Standing, 1997). Price liberation led to spiralling inflation and indebtness of enterprizes, and was followed with a collapse in the production and labour markets. The main target of market reforms in FSC were manufactoring industries and utilities, but the public sector was also profoundly affected. Under the pressure to reduce budget deficits and to cope with dwindling tax revenues, the governments responded by cutting public expenditure and investment into the social infrastructure. For pessimists, the improvement of the performance of NHSC in FSC will depend predominantly on the speed of their economic development. With the existing slow rate of growth of FSC economies, the population of FS countries may wait half a century or longer to get the health care that it enjoyed fifty years ago.

The second concept is shared by most of health authorities and foreign advisers in FSC. It also connects the improvement of health care with the economic growth of particular FSC, but believes that in the meantime some improvement could be made with incremental reforms.

The third concept, advocated by a minority of authors, interprets the paralysis of health policy in FSC as the effect of poor macro-management of the transition from socialist to „capitalist'' health care system (if enything like that exists), and the lack of qualified (ie. ignorance of existing) managers capable to advise properly health policy-makers, and to manage appropriately health care systems. According to this view, all FSC could have saved what was good, and eliminate what was defficient in the equity, effectiveness, efficiency and patient/citizen power in FSC health systems. That approach was proposed by G. Zarkovic, A.Mielck, J.John and M.Beckmann (1994), and further developed with specified strategies and managerial methods by G. Žarković, W.Satzinger, A.Mielck, J. John (1998), and with coauthors in other FSC, such as in Russia with V.V.Grišin and B. Y. Semjonov (1998), in Romania with D.Enachescu (1998), in Serbia with M. Radovanović and Z. Jevtić (1998), in Bosnia and Herzegovina with B. Hrabač and B. Nakaš, (1999), and Žarković G.(2004). These publications were submitted to relevant local and international health policy makers, but were ignored, never discussed, never criticised and never rejected as inappropriate.

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The inability of the would-be-managers in FSC to change anything for better 15 years after the collapse of communist regimes, has caused a paralysis of health politics. That paralysis will probably last half a century or longer, unless long delayed changes become possible by another social revolution, or introduced by enlightened decision-makers advised by properly educated and dedicated health managers. Optimists believe that most FSC have already most of ingrediances for the improvement of the performance of health sector except good health policy and properly educated (and if possible) dedicated managers.

Unfortunately, in most of FSC there are no decision-makers blessed to have health ministries and managers capable to advise them properly and honestly how to plann and implement changes for the improvement of the performance of the health system. Unfortunately also, it is hard to break the paralysis of health policy in early stages of the transition in FSC societies when and where the change would result in changes of the power and position of various interest groups (Reich M.R. 1995, and Walt G.,1994). Those who would gain might eventually, but not necessarily, support the reform, while those who would loose would certainly opose it. Those who would like to change a health systems, unless they are already key decisio-makers, must be able, first to formulate and propose a clear vision of the goals, strategies and targets of the reform, second to obtain support of relevant interest groups, and third to manage consensus-building between the relevant interest groups. Without the support of relevant interest groups, even the best proposals would be domed to fail.

This paper explains the causes of the failed attempts of a group of dedicated optimists to cure the health policy paralysis in Bosnia and Herzegovina (B&H) during the period 1999-2004. It describes the goals, the strategies and the methods used by the Health Care Committee (HCC) of the Department of Medical Sciences of the Academy of Sciences and Arts of B&H, to mediate between relevant interest groups to discuss, formulate and agree about a common health policy useful for the population of the whole of B&H. The HCC is a NGO without any power or financial means, but with some prestige due to its former activities and to the authority of its memebers. HCC was founded in the year 1980 by the Council of Academies of Sciences and Arts of former Yugoslavia. Before the collapse of former Yugoslavia the HCC was advocating changes needed to improve the performance of the „self-managing" health system of former Yugoslavia, and was actively supporting the health policy based on the "Targets for Health for all" of the European Office of the World Health Organization (1986). Three years after the end of the war in B&H, the HC C coopted, alongside with permanent members of the Department of Medical Sciences

of the Academy, a number of health workers from both entities of B&H, and decided to tackle the issues of the paralysis of health policy in B&H.

The case of Bosnia and Herzegovina

The health care system in B&H, including its historical background, organizational structure, management, expenditure, the delivery system, the financial resources allocation and intended reforms are extensively decribed in a publication of the European Observatory on Health Care Systems (J.Cain and J. Jakubowski, 2002). This report is cautious with the evaluation and analysis of the performance of the health system in B&H, and rather pessimistic about its future. The strategy of the HCC was based on an evaluation which identified great inequity in the financing and the access to health care withe the following defficience : (a) poor health status and the lack of public health programmes needed for the prevention and control of noncommunicable diseases, such as obesity, cardio-vascular diseases, diabetes, cancer, accidents, alcoholism, smoking and drug addiction; (b) poor delivery of medical and profilactic services on all levels of the health care, and particularly in primary health services; (c) poor utilization of available personal, financial and capital resources, including physicians, nurses, health facilities and sickness insurance funds; (d) lack of freedom for patients to choose providers of health care services, (e) inappropriate remuneration of physicians and other providers of health services; (f) difficult access to health care, and unadequate referrals of patients between vertical and horizontal levels of the health care.

The causes of poor performance were numerous. Some are beyond the reach of domestic health policy-makers, such as the geopolitical situation and the division of B&H into two entities, and the Federation of B&H into cantons, political parties based on ethnic and religious differences, conflicting interests and influence of foreign powers, and the mandates of international organizations. However, the majority of causes are within the reach of domestic decision-makers and changeable, such as: (a) inapropriate organization and structure of the health care system and health insurance; (b) lack of organiyed pressure on governments and political parties to introduce necessary changes in the health system, (c) ignorant and expensive managing health bureaucracy, (d) inappropriate economic relations within the health system; (e) decentralized sickness insurance funds obliged to pay for equal rights to medical care from unequal (per capita) funds; (f) irresponsible attitude of governments and health authorities toward health research and development ; (g) absence of qualified managers in ministries of health, in institutes of public health and in health insurance funds;(h) poor postgraduate education in public health, and (i) complete lack of postgraduate education and training in health management.

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The authors of the European Observatory report on Health Care Systems Transition in B&H (2002) evaluated the health system in various chapters of the book, such as: „ Despite a number of reform proposals, a plethora of working groups, laws and draft laws health care delivery remains essentially unchanged when compared with the system that the country inherited when it became independent'' (p. 20). „The prewar health insitutions unready for change, remain functioning as in the prewar environment, while newly created facilities lack the capacity to operate efficiently''(p.22). B&H „inherited a particularly formal and rigid health facility and human resource planning method...Experience, however, shaws that in some areas the planning is more a fiction than planning''(p.31). „In FB&H, there is no serious prevention programme in place; instead there are two expensive high-technology cardio-surgery centers in Sarajevo and Tuzla, 120 km apart from each other''(p.32). „Physicians appointed to be directors of specialist institutions must be specialists in the same field of medicine. These positions do not require formal management training'' (p.33). „ ...legislated entitlements for the receipt of publicly-finaced health care in both entities are far above available resources that can be collected at present. This results in implicit rationing...''(p.44). „The health care sector became and continues to be burdened with specialists. So far, much of the primary care in B&H is in the hands of specialists due to the underdevelopment of community-based primary care, oversupply of specialists and lack of adequatly trained GPs. There are 1376 medical doctors in the primary health care of the B&H Federation, of which 713 are specialists; this is in contrast to 3176 nurses of which only 190, have higher education''(p.61). Und finally „ Western donors have contributed large amounts of funding to rebuilding system...This support, however, has not been free of contentious side effects...western aid seems to have triggered a „rent-seeking'' donor culture and a foreign aid dependency among politicians and professionals'' (p.88).

A World Bank Group for B&H (2000) in its report to the president of IDA found the health system in B&H complicated, expensive, ineffective and inefficient due to the administration which reflects the poor state of public administration in B&H as a whole. „Weak new institutions and political environment fragmented by ethnic divisions leaves space for corruption and rent-seeking''. According to a document of UNHCR (2001), the key problems of health system access and efficiency are a combination of complicated non-portable insurance schemes, a lack of adequtely equipped facilities and the general lack of funds to properly run the health system. According to an earlier survey of the World Bank (1999) „ Rural residents complain about the ...lack od access to health facilitis – basic health care is

available to only 28% of rural population surveyed". The survey also revealed that the „Health care is the leading priority for many participants of our survey''. An other WB document (2000) claims that „Over 73% of households perceive that fundamental change is required to improve the health sector.''

The trouble with health policy-makers and their would-be health managers in B&H is that they seem not to share the wishes of the 73% of the population for the „fundamental change''. Therefore the HCC decided to offer its help to decision - makers to meet the expectation of citizens for the fundamental change in sector. In the year 2000, the HCC published its first group of recommendations for the changes of the principles ad methods of the financing and organization of health care services in B&H. The most important proposed changes included: (a) equity in the financing and the delivery of essential health services for the whole of population in B&H; (b) planning and implementation of public health programmes capable to improve the health status of the whole population in B&H ; (c) freedom of choice of the providers of medical services, particularly in the primary health care; (d) per capita payment of providers of medical services in primary health services; (e) establishing market relations between the providers, users and payers of health services; (f) appropriate organization and management skills in ministries of health and their agencies; (g) discussion of health care issues in political parties and governments (h) pressuring political parties and governments to implement proposed changes. In adition to this document, the HCC formulated essencials for health policy programmes of political parties. In 2001 HCC published another document with similar but differntly formulated proposals.

Both documents were distributed to target groups consistng of registred political parties, governments, ministries of health, health care institutions, health insurance funds, media and international organizations. Methods used to reach the target groups were: published and unpublished documents, conferences for large audiences adressed by invited speakers, small conferences and working groups, visits to key persons, and individual contacts. Most of the HCC activities occured within the B&H Federation and particularly in towns Tuzla and Sarajevo (where the Academy of Sciences is located, and the majority of HCC members live). Lack of finances to pay for travel expences to other regions of B&H, and to obtain media support greatly reduced planned activities of the CHC.
Believing that the health authorities are familiar with, and do approve, the resolutions and other documents of the WHO European Region (of which they are members) the HCC followed strategies recommended in the chapter „Policies and

mechanisms for managing the change''of the WHO publication „Health 21 - The health for all policy framework'' (1999). Relevant for B&H in the „health policy framework for XXIst century'' are recommendations to: (a) strenghten the knowledge base for health (research and health information support); (b) mobilize partners for health (governments, politicians, professionals, nongovernmental organizations, private sector, individual citizens, bringing partners together for action); (c) the planning, implementing and evaluating (providing a clear map of the way forward, creating awareness, agreeing on the process, searching for consensus, setting targets, achieving transparency, legitimizing the process, creating new alliences, broadening the range of instruments for policy implementation, coordinating , monitoring and evaluating progress).
Guided by above strategy, the four years long activity of the HCC was a low intensity campaign of a weak penniless NGO against strong vested interests and ignorance. The HCC behaved as a NGO wishing primarely to supports ministries of health to formulate the, by the WHO recommended, clear map of the way forward of the B&H health sector, and to stimulate other health policy actors to demand from decision-makers to implement the long delayed changes.
The attempt of the HCC to make health policy issues a major political problem failed, probably because it was not suitable for interest of ruling political parties to keep the attention of the populations fixed on ethnic issues, but also due to the financial and logistic weaknesses of the HCC campaign. HCC only succeeded to send to registered political parties its documents, to offer them support in the formulation of their health policy programmes, and to ask a number of members of parliaments to discuss the health care isssues in their organizations. Out of 32 registred political parties in B&H, only six (not represented in parliaments) accepted the invitation.

The CHC also failed to turn the attention of entity governments on health policy issues. Entity governments never sent their members or observers to HCC meetings, and never discussed nor rejected the HCC proposals. The HCC failed also to get strong support from health care providers, nor help in establishing contacts with the patients. Relatively high proportion of health professionals approved HCC proposals, attended its meetings and several of them became its members, but the attempt to distribute HCC documents in physicians offices never materialized. Problem again was the lack of money to pay for travel expences of field organizers and the remuneration to the distributors of HCC pamflets.

The HCC failed to obtain support from media in either of B&H entities. When invited, media reporters attended the CHC meetings and registred the proceedings, but without supporting or commenting issuess discussed in meetings. The HCC

members did not succeed to find journalists sufficiently informed about health policy issues, nor to persuade the editors to report regularly about health policy issues and advocate changes of the health systems organization and management.

The HCC did not expect and did not get any support for its proposals from any international organization represented in B&H. These organizations were regularly supplied with HCC documents and invited to its conferences. They regularly sent their observers to meeting, but abstained from any written or oral official comments. Soon after the issue of the first HCC document, one World Bank oberver expressed opinion in unofficial conversation that the WB would not approve any increase of health expenditures in B&H, even not for investing into the public health programmes, because the health expenditures were already to high (around 7.7% of the B&H GDP in 1998). Since the per capita health expenditure in that year was in FB&H only 439 KM and in Republika Srpska three times less (136 KM), the HCC continued in its subsequent documents to recommend the financing of public health programes from tax generated government incomes. In the year 2003, when the B&H authorities decided to introduce indirect taxation beginning with the year 2005, the HCC proposed that a part of VAT should be used for the financing of public health projects profitable for the B&H as the whole. Considering that the necessary preparations should be made in 2004 by health ministries of entities, the HCC invited respective health ministers to take the initiative und preparations into their hands.

The World Bank in the meantime approved a US$12 million credit for programmes similar to HCC proposals. The Basic Health Project (BHP) has the following components: (a) primary health care, (b) public health and disease control, (c) accreditation and quality improvement, and (d) project management. The objectives of the project were expected to be achieved trough the : (a) training and deployment of family doctors, nurses and allied professionals, (b) development of an environment that is supportive of family medicine and nursing practices, (c) incentives and inovative techniques to increase productivity of health service managers, family doctors, nurses and allied professionals, (d) rehabilitation and equiping of primary care facilities, (e) development of regulations, institutions and competencies of accreditation and quality improvement, and (f) policies and interventions for the prevention of non-communicable diseases, accidents and injuries.

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12 million dolars is a lot of money, which in hands of able managers would be sufficient to achieve in the course of 3-5 years the folowing miracles (approximate calculation): (a) for 3 million dollars spent for primary health care (PHC): 2.000 general practitioners retrained and licenced to provide at least 70% of the health needs of patients; one edited and published texbook or code of practice for GPs; ten visits of GPs and nurses to countries with best PHC; 60 nurses trained to manage nursing services in PHC; all PHC facilities (Domovi zdravlja) equipped and organized to offer to citizens freedom of choice and per capita payment of providers of services; facilities organized and equipped with information technology, including data-bases about individual citizens and families; all health insurance funds prepared to pay providers per capita fees for medical services and remuneration for outcome based public health programmes; (b) for 2,5 million dollars: all existing epidemiologist in B&H, and equal number of economists and ecologists, additionaly trained to plann and manage the programmes for the reduction of lost productivity due to preventable illness, disabilities and premature deaths; one textbook or code of practice edited and published for assessing and reducing risks to health; one communal center of excellence in PHC practices established in each entity; (c) for 1 million dollars: one (if politically acceptable) or two sister-agencies trained and equipped for the accreditation and licencing of providers of PHC services, institutes of public health and health insurance funds; (d) for 3,5 milion dollars: 20 public health specialists additionaly trained for health management in best universities; departments of health management established in Public Health Institutes of entities; chairs for the management of health sector established in two unversities; one textbook about the management of health sector edited and published; programmes for the evaluation, analysis, planing and management of health programmes and organizations initiated as regular activities ; (e) for 2 million dollars: owerhead costs of running BHP programmes, travels of executives and visits of foreign consultants.

It is hard to predict what of the above – if anything - will entity health ministries implement and achieve. The acitivities and expenditures of ministries of health of entities are not transparent, and the outcomes of foreign sponsored programmes are never evaluated. The entity ministries of health and their agencies prefere for some reason to ignore the HCC proposals. Some recent events are illustrative of that strange behaviour.

First event. Two years after the publication of the first HCC recommendation, the ministries of health circulated the drafts of their longterm plans and strategies for the reform of the health sector in B&H. The ministry of health of

the FB&H even prepared two versions of its „Strategy and plan for the reform of the health care system and the health insurance in FB&H'', one for the perid 2002-2012, and the other for years 2oo2-2007. The former is a 73 pages long document rich of promises to make minor changes, and nonobliging declarations about the „global development goals'' and the „introduction of a modern, rational and efficient system of the allocation of financial resources which will sustain solidarity between groups and individuals, and strenghten to the end the efforts of the health system in favour of the improvement of the health status of the population''. The document promissed „universal, high quality, efficient and continuous primary health care based on the health of the family and the reorientation toward the health promotion and prevention''. No wonder that the draft of this document is still waiting to be disccued and approved by the FB&H parliament.

Second event. By the end of the 2003 year, the HCC invited members of a team of FB&H health ministry resposible for the management of the BHP project, to inform an audience in the Academy of Sciences and Arts about the progress of the project „Teaching and Capacity Building in Health management'', The group missed two dates for reporting and finally refused to appeart. In february 2004 in a solems ceremony presided by both entity ministers of health, a large group of individuals from both entities obtained certificates for attending traveling seminars for teaching managers and management teachers. When asked what text books students were using, one of organizers of that strange form of postgraduate education informed the author of this article that they used moduls developed by a foreign consultant, because, according to his best knowledge, there was no in the world a dependable texbook about health management. It seems as though the teachers of future B&H teachers of health management, did not consider worth of reading valuable books and reports deposed in their libraries, such as: G. Walt (1994) "Health Policy", WHO Regional Office (1997) "European Health Care Reform", R.B. Saltman, J.Figueras, and E. Sakellerides (1998) "Critical Challenges for Health Reform in Europe", G. Žarković, B.Hrabač, B. Nakaš (1999) "Health Policy and the Management of National Health Systems " (in bosnian), WHO Regional Office for Europe (1999) "Health 21 - the Health for All Policy Framework for the WHO European Region", WHO (2001)"Macroeconomics and Health: Investing in Health for Economic Development", WHO (2000) "World Health Report 2000, Health Systems:

Improving Performance" , WHO (2002) "The World Health Report 2000-Reducing Risks, Promoting Healthy Life", and the WHO (2003) "The World Health Report 2003 - Shaping the Future", and G. Žarković (2004) „Health Policy and the Management of Health Systems in Countries of Former Yugoslavia''(in bosnian).

The third event. After the HCC proposed, and nobody opposed in June 2003 that a part of indirect taxation should be allocated for the financing of profitable public health programmes, it expected from of health ministries to take the rest of activity into their hands. Since that expectation did not materialized till the end of the calendar year, the President of the HCC, assuming that the decision-makers were not informed about strange attitudes of their health ministers, sent a personal letter to 46 of top B&H political personalities. None of governments and various parliamentary bodies and political parties asked for further explanation or discussion about proposed changes of health policy. Instead, the letters of the HCC Presidents were sent for comment to health ministers . The government and political leaders in Republika Srpska did not find it necessary to inform the HCC about the answer of their health minister, while the President of B&H Federation kindly sent to the HCC the answer of his health minister. The minister rejected the changes recommenden in HCC documents stating that they reflect the absence of „ understanding of real causes of problems (and) functions of the health system, as well as of strategic directions and broadness of interventions of the ministry of health of the Federation to turn the developments in the direction of common good....We do not wish to polemize about the proposals of the Academy. Instead we wish to mention what the ministry has so far done, what it is currently doing and what will be done to consolidate the health system without major breakages.'' The letter ends as follows:„As you see, with series of stepwise but consistent changes we wish to change the health system down to its roots without causing with fast and unwary steps the collapse of a system which despite problems still functions''.

With that episode ended the efforts of the HCC to persuade the current decision-makers and their health ministers in B&H that with a better health policy they could substantially improve the performance of the health system in equity, effectiveness, efficiency and citizens health rights. The current leaders and senior executives in ministries of health turned out to be the least interested

group for optimal utilization of health resources for the improvement of the health status and the health care of all the three ethnic groups in B&H.

Conclusions

Wherever, like in B&H, the improvement of the performanceof a health system is inhibited by a paralysis of decision making about the health policy goals and strategies, there is a need and opportunity for NGOs to try to stimulate necessary changes.

To succeede in its efforts to introduce change in health policy, the optimistic NGOs need to be guided and suported by: (a) clear vision of goals and outcomes of intended changes; (b) dedicated and optimistic leadership guided by sound scientific, and aided by some economic and political support; (c) good relations with as many as possible interest groups; (d) diplomatic skills, patiency and, above everything else, a sense of humor to endure the defeats, und to truy again.

Apstrakt

PARALIZA ZDRAVSTVENE POLITIKE U BIVŠIM SOCIJALISTIČKIM ZEMLJAMA – SLUČAJ BOSNE i HERCEGOVINE

Slab napredak u poboljšavanju nacionalnih zdravstvenih sistema u bivšim socijalističkim zemljama, čak i 15 godina nakon raspada komunističkih režima naziva se u ovom članku paraliza zdravstvene politike. Autor razlikuje dva različita objašnjenja pogoršanja zdravstvenog stanja i zdravstvene zaštite nakon prelaza na tržišnu ekonomiju. Jedno objašnjenje čini odgovornom ekonomsku politikui nametnutu od strane međunarodnih financijskih organizacija, te očekuje da će poboljšanja ići u korak sa ekonomskim oporavkom. Drugo objašnjenje čini odgovornim loš makro menadžment i odsustvo jasne vizije (road map) za prelaz socijalističkog zdravstvenog sistema na nešto bolje, te na nedostatak kvalificiranih stručnjaka za makromenadžment. U članku se na primjeru Bosne i Hercegovine ilustriraju štetni efekti lošeg upravljanja i opisuje se neuspjeli pokušaj Odbora za zaštitu zdravlja da se pokrene donosioce odluka da se slože oko osnovnih elemenata zdravstvene politike korisne za cjelokupno stanovništvo zemlje

Ključne riječi: Zdravstvena politika, nacionalni zdravstveni sistemi, interesne grupe, Istočna Evropa, Bosna i Hercegovina

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