What is the State of our Health?

Indicator System for Social Dialogue on Health and Healthcare System of Serbia

Foreword

This research is the first step in the Centre for Advanced Economic Studies (CEVES) program aimed at strengthening the ability of Serbian society to decide on its goals and priorities and to call the authorities to account for concrete results. Central to this effort is the development of tools, a package of easily accessible, understandable and objectively measurable indicators, by which the society will be able to evaluate the results and quality of governance in public policy areas of strong and practical interest to citizens. Our intention is to encourage the production of a series of documents similar to this one. They should serve to foster a dialogue about the kind of society that we are, compared to what we want to be and can realistically achieve as well as an instrument in the societal dialogue and guidance of public policies.

We start from the health sector because the health of a society clearly and measurably reflects not only its actual health status, but also its general economic and social situation. Also, we believe that the strategic management of health policies and the self-awareness of Serbia's society regarding its health are at a surprisingly low level particularly given how interested are its citizens in health as a topic. Finally, health is particularly suitable for the development of the tools - a package of indisputable indicators, which we strive for in each field.

A democratic society cannot succeed without a vibrant dialogue about what its citizens need and what is really possible, without the freedom and opportunity for stakeholders to insert their issues in the public domain. Sometimes the issues relate to special interest groups, and often to the widest circles of public service users - even to all citizens. But there must be a way for all of them to participate, in mutual cooperation and rivalry, together with specific experts and the authorities, in seeking answers to how to achieve the desired results. The key actors and the language used in such a dialogue will differ depending on whether it is conducted in professional (policy analysis) circles, in the context of political (electoral) campaigns, with those competent in the state administration and government, or in the public / media domain. Nevertheless, all these domains must examine all the important topics, and the key actors in each domain ought to find ways to access and involve the public.

Without a dialogue oversight and societal pressure, the state structures and policies in Serbia today primarily focus on what public sector employees are able to do (legacy from the past) or what financial centres of power (public enterprises or larger businesses) succeed in pushing through. On the one hand, public service providers (trade unions, professional associations) are far better organized than public services users (e.g. parent, or general healthcare users). And large centres of economic power (public companies, the largest businesses) are far more influential than small and medium-sized enterprises and farmers (although the latter actually make up a significant part not only of the Serbian economy, but also of its population). On the other hand, public policies on practical day-to-day issues are almost completely absent from the public discourse. Populist media have neither the interest nor ability to deal with them. In the end, the international community appears as a more relevant counterweight to such pressures than the

Serbian public does. Finally, the research community is also more focused on that which it is prepared to study (again, a legacy from the past) than on the issues of highest relevance to the citizens of Serbia.

In this context, comprehensible, clearly communicated and easily accessible tools on vital topics can play an important role - this will make entering the public discourse easier. If the tools are based on undisputed facts - they can also help to build a consensus in a divided Serbian society. If the indicators are hierarchically well-organized and specific, they can directly serve as an instrument of government accountability. As to the obstacles to the achievement of social goals, we endeavour to keep to indicators that show "what is holding us back", "what is not working", and “which are the key factors”, so as to be able to monitor if they are being resolved. We want to encourage a dialogue on public policies, but in this document we do not deal with public policy issues – how to improve the situation / resolve the problem. The discussion of public policies has an ideological base and can be conflictive. In order for it to be productive, we first must establish a common ground, the criteria, develop the ability to reach consensus on whether something is able to produce results or not.

The colour of the cat matters less - we are now measuring how many mice it catches.

"Public health is the science and art of preventing disease, prolonging life and promoting, protecting and improving health through the organised efforts of society."

- Donald Acheson, 1988

1. Introduction and Summary

The aim of this research is **to develop a package of indicators on the quality of health** in Serbia, that will serve the public to monitor and roughly but reliably assess the results of public policy in this area. These indicators need to be based on readily available data, and to be easy to communicate and interpret. The term “health quality" here implies both the health status of citizens and the quality of the healthcare system (these and other definitions are given in the methodological considerations in the next chapter). Our aim is to raise awareness of the state of health and health priorities, that in Serbia it is possible to significantly improve it within the framework of existing funds, and to initiate a dialogue on public policies that can lead to this. Both the indicators and the dialogue are needed to tackle the relevant societal issues, to direct research towards the most acute difficulties, and to commit the government to bringing about the solutions. Also, each side in the dialogue must take its share of responsibility for the results. For citizens, this means they should understand the basic possibilities and constraints, and ask the authorities to be accountable. To this end, wherever we consider that we have sufficient material for it, in addition to the analysis of the indicators we also point to the issues that definitely arise.

That **such a tool is needed in Serbia** was made clear for example, when recent measurements of the *European Health Consumer Index (EHCI)*[1] caused perplexity that remained unresolved in public. The

[1] The *European Health Consumer Index (EHCI*) is an independent monitoring of the healthcare system in 35 countries, from the point of view of patients and service users. This research is conducted by *Health Consumer Powerhouse Ltd.* (HCP). The EHCI report is available at www.healthpowerhouse.com . EHCI only appears in the foreword as an illustration. The report itself does

index finds that the last three years showed such a significant progress in the quality of healthcare in Serbia - that its ranking moved from the 30th to 24th place on the list of 35 European countries. The subjective assessment of the quality of healthcare among citizens differs from one citizen to the next, but no healthcare user would quite agree that such progress has been made in any recent period.

What picture is the correct one? Is the image of the progress shown by the EHCI truthful, while the more negative subjective experience is only a consequence of, say, unwillingness to accept the necessary constraints imposed by the austerity measures? Or the EHCI index highlights topics that are less important for Serbia? Or is EHCI based on wrong assessments? In Chapter 3, we explain that the "measured" progress is the result of several assessments that are simply not accurate.

The citizens of Serbia must have a credible tool that will help them get a more objective picture of the quality of healthcare than their subjective experience. Every nation, like every individual, needs to know and follow the state of their health. The state of health is an important dimension of the general well-being of a society, as well as the consequence of its economic or social aspects. Just like people under stress or in social isolation get sick more easily than those more fortunate, the functioning of the healthcare system also reflects the wider "health" of public administration. Therefore, the dialogue concerns and must be contributed to by the representatives of the profession and the authorities, as well as the general public.

In healthcare, resources are **wasted**, **and much better results could be achieved** if it were better organized. This primarily requires objective information, but also making full use of parts of the system that exist (set up in the past) but are marginalized or ineffective. It is unacceptable that policy-makers and the public in Serbia are "in the dark" regarding the overall quality of Serbia's health - but unfortunately this so at the moment. There is no health-sector improvement strategy, nor is it possible to see-- simply and directly (without additional complicated calculations) --its progress (this is discussed in detail in Chapter 6). In this context, we find that **much data** on the quality of healthcare and data in the national health accounts **is of poor quality and hence of little use. This is telling.** We believe that the work of numerous staff engaged in their production is impaired by the way and conditions in which the Institute for Public Health of Serbia - Dr Milan Jovanovic Batut (hereafter Batut) collects the data, and we believe the change of these methods is ultimately under the authority of the Ministry of Health. However, fundamental methodological problems also reflect deeper rooted practices of the state administration in Serbia.

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Initial practical conclusions and opening the discussion do not necessitate a scientific analysis. This is an informed reflection and pointing out the indisputable facts and relations, primarily in comparison with other countries, but also relying on familiarity with the Serbian healthcare system (described in more detail in *Annex 1 - Healthcare System*). We focus on available internationally comparable **indicators**, and we assess them in comparison with the selected European countries. We start from the assumptions, explained in more detail in the methodological considerations in the next chapter, that two systems cannot

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not deal with this index as its target, i.e. in itself, but only within the framework of all indicator packages. The report before you is not a response to the EHCI report because the idea for the project was launched before the last report which highlighted Serbia as the system that made the most progress in 2016 and we use it only as an illustration of the doubt which remains when there are no clear societal objectives and benchmarks. The public cannot and should not take this kind of news for granted, but must have objectives as a society, i.e. clearly formulated expectations, and criteria for assessing whether Serbia fulfills them.

be compared only on the basis of their health outcomes (for example, the prevalence of certain diseases or the prevalence of early mortality caused by the diseases), as other systemic aspects which define objective possibilities and limitations must also be taken into account. Therefore, we make comparisons on the basis of what we expect to find, looking at the performance of "similar" countries, especially the former Yugoslav countries, or the EU28 average as something we strive for.

After presenting the data sources and the organizations that collect it in Chapter 3, we begin our consideration by analysing 5 umbrella **output indicators** as well as the 10 biggest causes of years of potential life lost (YPLL) and the 10 causes for which we are in the leading position in Chapter 4. The umbrella indicators, such as years of life expectancy (YLE) and years of life lost point to unexpectedly poor performance of Serbia. Some more specific indicators of maternal mortality (mortality related to motherhood) and infant mortality and mortality of children under 5, directly dependent on the quality of healthcare, confirm this relatively poor performance. The dynamics of YLE since 1990 to date, according to *Global Burden of Disease (GBD*), described in Chapter 3, indicates a relative deterioration of healthcare performance in Serbia during the 1990s. It has not fully recovered since then. After the first years of the 2000s, however, the increase of the YLE has generally kept pace with the observed European countries. The comparison of the YPLL based on the specific causes of mortality with the data for all comparer countries suggests that the structure of the disease prevalence in Serbia does not differ from that in other countries, but that the vast majority of illnesses contribute to the increased YPLL. The highest contributors to the number of YPLL are cerebrovascular disease and diabetes. Good performance is recorded with deaths related to alcoholism and drug abuse. It is interesting that Serbia and other former Yugoslav countries (except for Slovenia to some extent) are similar in terms of these relative characteristics, but that Serbia's performance is still inferior in each of the worst mortality causes.

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In Chapter 5, we contrast the available indicators for the group of countries for national characteristics that affect health and are not easily changed, the so-called **environment / risk factors**. In addition to those linked to socio-economic development (it is well known so we do not analyse it explicitly), these are the cultural and other habits for which we find 6 indicators. Serbia is distinguished by a low level of physical activity of its citizens, as well as by the share of active smokers in population. We, however, believe that these indicators do not provide an explanation for so consistently weaker performance of Serbia compared to other former Yugoslav countries.

In Chapter 6, we focus on the **process indicators** - the level of success and manner of prevention and treatment of diseases (by preventive actions) - as they directly indicate the quality of healthcare in the country. In this respect, the analysis is unfortunately limited due to a lack of reliable data, and focuses on indicators of mortality (except for vaccinations and infectious diseases within the competence of the WHO). The fact that data on quality of care - including prevention - is so poorly monitored, as well as that Serbia has extremely high rates of mortality from diseases such as cervical and breast cancer, indicates that there is a problem in the quality of healthcare that does not arise from limited resources. In this chapter, we are particularly concerned with the problems of collecting data on the quality of healthcare, because it is important in itself and as a case study on the functioning of the wider system.

In chapter 7 **on the available healthcare system resources**, we find indisputable evidence that they are inefficiently distributed and that the availability of healthcare in Serbia is far less equal than proclaimed

as a societal objective. We find that the resources in terms of equipment itself (e.g. density of physicians, number of hospital beds) and annual spending on healthcare from public and private funds (so-called "out of pocket" spending, as a percentage of GDP, or in dollars of purchasing power) are very significant and clearly above the comparative expectations, and therefore above the relative level of results. Whatever the objective challenges facing the Serbian healthcare system, there is no doubt that the resource allocation is not directed by some objective-oriented process that would maximize results, but habitually most likely complemented by short-term professional and political criteria. This is particularly reflected in the uneven geographic resource distribution. We analyse in more detail the number of gynaecologists and paediatricians according to the number of users - and we see that the public sector itself does not abide by its own criteria for their allocation. The analysis of the financing of the healthcare system shows clear evidence that the system is simply - unregulated. The public sector is managed as if the private sector does not exist. In fact, the private sector develops as an *ad hoc* supplement and compensates for public sector shortcomings. In this respect, the extremely high rate of "out of pocket" spending for healthcare is quite telling. We also believe that the high "out of pocket" spending is one of the key reasons for the high rate of unmet medical needs that citizens report, as well as for significant difference between those with the highest and lowest incomes.

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In the concluding considerations (Chapter 8), we present the possibility that the poor performance of Serbia's healthcare is to some degree a consequence of its demographic and developmental characteristics too. We are, however, of the opinion that the healthcare system of Serbia definitely suffers from general disorder and lack of management by objectives. We **therefore propose the package which consists of two levels of indicators. The three umbrella indicators** are the rate at which the YLE extends (compared to the EU28), the rise in public spending on healthcare - which should not be faster than the GDP growth, and the percentage of citizens reporting unmet medical needs in the income and living conditions survey (*SILC Survey*). The second level is comprised of **baskets of indicators that focus on risks, processes, and resource distribution**. The innovative aspect is the focus on dispersion / uneven geographic coverage of doctors in relation to the Serbian average. There are only a few indicators in this basket now, but more could be added and their targeting improved by engaging the professional community.

We believe that this is a package which would enable CEVES or anyone else to easily monitor the future progress of the Serbia's healthcare quality. We also offer our **recommendations** to the state authorities for improving the quality of data used in Serbia to officially monitor the healthcare quality. Some of these measures would easily and swiftly help the public and decision makers to become very well-informed. Furthermore, we call on the state officials to initiate a dialogue, as well as the expert community and the general public, and stakeholders to engage in a dialog on the strategy for improving health in Serbia, as well as on a specific package of measures to better regulate the system.

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Final Considerations and Selection of Indicator Packages

In this chapter we analyse the findings presented on the previous pages and identify the package of indicators that can directly serve the Serbian public to monitor the health quality in Serbia (health status and quality of the system operation) in a simple and easily interpretive way, customized to the needs of Serbia and based on the data available. We propose a series of improvements in the production system of healthcare quality indicators, both in shorter and longer term. This would significantly improve the informative value of the indicators that Batut produces. We invite the public to a dialogue on the improvement of the Serbian healthcare system.

Outcome indicators such as the YLE and YPLL, but also maternal and child mortality, point to the poorer health of the citizens of Serbia than expected from the level of socio-economic development, geographical position and inherited relatively developed healthcare system as well as advanced medical expertise in Serbia. It is unexpected for Serbia compared to all former Yugoslav countries to have the weakest performance in most indicators. Surprisingly so, especially in relation to BiH and Macedonia and Montenegro, the three countries that are undoubtedly behind Serbia in their socio-economic development, and in the development of medicine. [2] The lower level of socio-economic development having a negative impact on health may be supported by, for example, the relatively small advantage of the YLE for women compared to men in Macedonia and Montenegro, especially because their performance is better than Serbia's in terms of mortality inherent to women (maternal mortality, cervical and breast cancer).

Bad performance of Serbia is, at least to an extent, attributable to the role played by the slowly changing negative environmental factors. Directly measured risk factors, however, do not indicate such a significant difference in lifestyles between these countries and Serbia (except for the extremely low level of physical activity of the Serbian citizens). Interestingly, Serbia shares with these three countries a low alcohol consumption rate and an extremely sound performance in mortality from diseases associated with alcoholism and drug abuse. As the risk factors are difficult to measure, this issue can and should be subject to deeper research and dialogue.

It is hard to avoid the impression that two types of negative factors are blended in Serbia. On the one hand, Serbia is one of the demographically oldest nations in Europe. As such it not only suffers from diseases of aged societies - this effect is eliminated by normalization[3], but it is possible that the causes tied to aging are related also to the increased instances of cardiovascular diseases and cancer. Serbia is undoubtedly among the leading countries in the prevalence of these diseases.[4] On the other hand, the socio-economic development is not commensurate with this overaged society. There are also factors that accompany this lower development – such as less educated and less informed population and the like. The indicators of *correctable mortality* rates support the thesis on the particularly unfortunate set of circumstances. According to these indicators, the performance of Serbia is however in a much better position when the mortality data is focused on preventable causes (which, unfortunately, have not been calculated for BiH and Macedonia).

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[2] We do not rule out the possibility of problematic data in BiH and Macedonia behind this. For example, in Albania, the statistical duration of the YLE is surprisingly long; the WHO explains this by under-reporting of deaths - but we think this is unlikely.

[3] The direct effect of the difference in the age pyramid on mortality is eliminated when making comparisons, of course, but the question remains on the previous causes making Serbia so "aged" in the first place.

[4] According to the Euro Health Consumer Index 2016, and indicators of survival and mortality rates, cancer instances rate in BiH is the lowest in Europe, and although the survival rate is relatively low, this gives an overall lower mortality caused by all forms of cancer in BiH than in Serbia.

Nevertheless, there is undoubtedly a significant gap between the quality of care that Serbia's healthcare system is providing to its users and the quality that could be provided with the medical knowledge and resources currently invested. This is reflected in the high maternal and child mortality, as well as in high mortality rates caused by relatively easily preventable diseases - breast and cervical cancer, and diabetes. It is also a fact that Serbia particularly suffers from diseases pronounced in the other former Yugoslav countries too: cerebrovascular diseases and diabetes - two diseases where public policy measures can significantly impact the incidence and mortality.

Unfortunately, the available indicators of healthcare quality do not enable its direct and reliable evaluation. We essentially have to rely on the already mentioned mortality indicators, although there are a number of relatively easy-to-calculate indicators that could make the problems more reliably distinct.

We believe that this gap is primarily attributable to the inadequate overall healthcare system functioning capacity. In terms of outcomes, it has never fully recovered after the sudden disturbances in the 1990s.

This weakened capacity of system functioning can be seen at the level of healthcare system management, Targeted research would certainly show problems at the operational level too, in the functioning of individual institutions and in the actions of staff. After the collapse of the 1990s, healthcare has not been systematically adapted to the significant lowering of Serbia's budgetary capacity, nor to economic transition. There are no clearly defined rules for the functioning of the state and private sectors, separately, integrally and synergistically. The administrative mechanisms that ensure adherence to rules in practice are not established or are undermined. There is no systematic prioritization in the use of resources in the state sector. Their allocation does not consider the development of the private sector. Limited public funds are stretched thin to maintain the oversized system. Therefore, its parts together achieve lesser impacts than a smaller number of better equipped, more agile institutions with a clearer purpose would - with appropriate investments in them.

Such a system does not meet the commitment to provide universal healthcare to citizens. This is evident from the fact that as many as 7 percent of respondents report having unmet medical care needs due to lack of time, access or means to provide care. In this population, the percentage of those with the lowest incomes is 3 times higher than those with the highest incomes.

The healthcare system is not managed by objectives and comprehensively. This is clear from the fact that there are no practical strategic documents as guidance to the healthcare system management, and that data on the sector as a whole is not monitored. In addition, the informative content of healthcare quality data is also of limited usability for monitoring of the state sector separately. Besides the data commonly regarded as system quality indicators (on mortality from preventable diseases, and on the reduced and uneven vaccination coverage), we believe that the system management problems are indicated by the data on the high rate of out of pocket healthcare expense, the data on the uneven geographic distribution of resources (measured by the physician density relevant to population age), as well the unequal healthcare accessibility data.

With these assessments and the currently limited number of available indicators of sufficient quality, we opt for a package of indicators that will assess the overall system progress in a very simple way. It relies on only three intelligible umbrella indicators, and separately assesses the system aspects (risk factors, healthcare quality, and rational use of resources) through three additional composite quantitative indicators (See Table 7). We believe there is no need to reduce these 4 assessments to one value (by

evaluating different dimensions, weighting them, and calculating their total), as is done when comparing healthcare systems. Our goal is to provide to the public an instrument for monitoring of one system - Serbian, year over year, as well as provide an impetus for dialogue on its various aspects.

At the first level, there is a **general progress assessment of** health based on three umbrella indicators that assess the progress as good, satisfactory, or unsatisfactory. All three indicators must be satisfactory for the progress to be assessed as satisfactory. At least two must be good and the third at least satisfactory for the overall health to be assessed as good. The three umbrella indicators are:

(1) **The increase of YLE** year over year - must be higher than the increase for the EU28 countries (satisfactory), and if it is higher than the increase for the new EU member states average, the assessment is *good*. Such an assessment must also apply especially to the **YLE for women**. The assessment of the total indicator equals to the lower performance of the two.

(2) **Unmet healthcare needs** - the percentage of respondents reporting unmet healthcare needs must show a decreasing trend to assess the public policies as minimally satisfactory. If this decreasing trend develops faster than in the other European countries with improving performance in this respect, then the policies can be assessed as good;

(3) **Out of pocket healthcare spending**, the GDP share must not increase (satisfactory), and if the real payment value decreases, the policies can be considered good.

In the first two indicators the progress is compared to European countries, since Serbia is in the same environment. This indicator improvement can be expected due to the environment alone, even without subjective efforts and the Serbian policy enhancement.

In addition to the overall assessment of system progress derived from these three indicators, **progress should be separately assessed for its most problematic factors;** we do not include all the indicators discussed on the previous pages, to encourage the relevant discussion:

(1) The **risk indicator basket** includes the percentage of active smokers, physically inactive population, and those suffering from high blood pressure, as well as the percentage of air pollution reduction. The composite risk indicator is the average of these indicators, where we consider that air pollution affects 100% of the population.

(2) Two indicator subgroups are included in the **healthcare quality indicator basket**. One subgroup consists of an adjusted reduction in the YPLL due to maternal mortality, mortality of children under 5, stroke, diabetes, cervical cancer, and breast cancer. For each of these causes of death, the indicator is calculated as the difference of the current and the previous year YPLL number. The current year's YPLL number is adjusted so that the indicator is positive only if Serbia progressed faster than the EU28. This is a low standard given the significant room Serbia has for reducing mortality caused by these diseases[5]. The second subgroup consists of the share of children who have not received the DPT vaccine, the share of children who have not received MMR vaccine, and the share of late-diagnosed HIV in the total. The composite indicators for these two subgroups are calculated as the total of the indicator set and not accumulated into one.

[5] The current year is adjusted by reducing the current year YPLL by the percentage of the YLL reduction relative to that cause for the EU28 in the same year. Observing the difference in the YPLL instead of the level has the advantage in somewhat diminishing the disproportion in the effects of these mortality causes. That is why we opted for the YPLL instead of mortality - the YPLL mitigates the prevalence of mortality from cerebrovascular diseases over the others, as others cause mortality in the younger age.

(3) Finally, the **basket of the rational resource allocation indicators** consists of the hospital treatment duration and coefficients of variation in the number of paediatricians relative to the pre-school population, and the number of gynaecologists relative to the population of women over 15. A composite indicator is obtained by weighting the reduction of each of the indicators by the roughly estimated effect it can have on the costs in the system.

We consider this indicator package as an outline - a way to initiate health monitoring and a dialog about it.

Table 7 - Evaluation of general progress of the healthcare system of Serbia

Rating	**Umbrella indicators**					
	1. Increase in life expectancy		**2. Reduction of % of users with unmet medical needs**		**3. Real growth of out-of-pocket expense for citizens**	
	EU28	***NEU***	***0***	***Average for countries with decrease***	***Real GDP growth***	***0***
Good		>		>		≤
Satisfactory	>		>		≤	
Unsatisfactory	≤		≤		>	
OVERALL RATING:						
Unsatisfactory: one or more indicators unsatisfactory; Satisfactory: all indicators satisfactory, or more; Good: at least two indicators are good.						
Risk basket	**Process basket**				**Resource basket**	
Composite indicator *	Composite indicator *		Composite indicator *		Composite indicator *	
Share of population at risk	**Total years of life lost**		**Share of population**		**Savings in imputed costs**	

*% of active smokers; % of physically inactive population; % of patients with high blood pressure; % reduction of air pollution.

** YPLL maternal mortality; YPLL mortality rate of children under 5; YPLL mortality from stroke; YPLL mortality from cervical cancer and breast cancer.

***% DTP vaccination of children; % MMR vaccination of children; % late-diagnosed HIV.

**** Hospital treatment duration; Coefficient of variation in the number of paediatricians per 1,000 pre-school children; Coefficient of variation in the number of gynaecologists per 1,000 women

We recommend the following to the decision makers at the Ministry of Health and Batut:

- In the **short term,** enrich the selection of easily accessible indicators by starting to calculate and publish the following indicators:
    - Hospitalization rate at least for diabetes, and also for COPD and chronic heart failure.
    - Estimate of total antibiotics consumption or drug consumption in general
    - Number of Pap tests performed
    - Number of mammograms performed
    - Total number of MRI and CT scanners in the state and in the private sector, as well as the number of examinations performed in each sector.
    - Survival rate for certain diseases.
    - Number of doctors employed per specialist profile, and standards

- In a **slightly longer term**, significantly improve the Serbian health quality data by:
    - Expanding the scope to include the private sector;
    - Authorizing and enabling Batut to make corrections / assessments when the reported data clearly does not reflect the target dimension, as well as changing the way of cooperation / communication between the public health institutes and the healthcare institutions to motivate them and enable them to regularly provide better quality data;
    - Significantly narrowing the set of data requested, and simplifying their calculation.

We also **invite** experts and the general public, stakeholders and decision makers in Serbia to engage in a dialogue on:

- A practical strategy for improving the health quality of population, which must be concrete and prioritized based on appropriate financial assessments, and which would include
- A measures package ("a reform plan") to clearly separate the functions, purposes, and boundaries of the private and public healthcare system.