THE PUBLIC HEALTHCARE SYSTEM IN THE TRANSITION COUNTRIES THE CASE STUDY OF SERBIA

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Abstract

The public healthcare system of Serbia, from the beginning of the past century, when more or less the unperceivable demolition of socialism, was faced with great problems. During the time, they became almost unsolvable due to servitude to old ideas and approaches to goals, organization and managing the state and public sector, political work and everday public and business managing. The application of ruling ideology, performed during the nineties of the last century and the restoration of capitalism expressed itself as unproductive, because everything else remained the same – methods of work, approach, values and standpoint. Its basic feature is institutional non-regulation being the consequence of unclear, foggy and manipulated transition. There are multiple reflexion to the public healtcare system. First the space for the wild privatisation of one part of the public healthcare system was open as well as for the development of irregular partnership between the public and private sector in the production of public goods and services. Second, the creation of a complex, to distribution oriented coalition was initiated that, within the framework of historical heritage, very skillfully using its political and any other influence intended to retain such a situation and stop necessary structural changes in the public healthcare system and the regular development of the private sector as well. Third, within of the framework of foggy and damped transition, arose the miracuous mixture of quasi-public, quasi-market and administrative mechanisms of regulation that nonsensenses necessity for the existence of the public healthcare system. Conseqently, Serbia needs the total reingeneering as a radical, qualitative and on inovations based methodology which, on the basis of development vision, should determine the direction of institutional changes and various reformatory operations in order to construct a radically new public healthcare system – oriented to prevention and preservation of health capacity (of the whole national population) on the basis of development of the relevant system of life and work while the medical treatmant of the mayor part of maladies, especially of those needing sofisticated and costly technologies, should be awarded to the private sector on the basis of personal participation. The key of implementation is in the new definition of the contents of paradigm “equity”. Paradigm that the public health insurance should provide the best healthcare for everybody is false and financially untenable even for much more wealtheir societies. On the other side, equity means necessity to provide the health care in the framework of public, transparent and precise minimum standards for everbody (meaning that nobody will die because he is not insured, because he has not money for cure or, simply, as often happens in Serbia, because he do not know relevant people).

JEL classification: H51, H61, I12, I18

Keywords: Public healthcare system, Unclear, foggy and manipulated transition, Institutional non-regulated environment, Total reingeenering, “Equity”

1. INTRODUCTION

This paper explores the problem of management of a public healthcare system in the transition countries, through case study of Serbia. The fundamental motive for this research is a difficult situation in the healthcare system in Serbia, and at the same time it is an attempt to explore a realistic model for improvement of its performances in the sense of providing necessary (health) services of adequate quality without financial barriers for the entire population in very limited (general) public institutional and material limits. Majority of politicians, researchers and experts, including the foreign factor, too, see a solution for improvement of performances of public healthcare system, on one hand in revitalization of existing capacities on basis of reconstruction of the existing premises, supply of new equipment, sale or rental of surplus space and rationalization of the staff, and defining a new model of payment to the providers of the services of healthcare, on the other hand [14].

The basic characteristics of the official strategy are: (1) An attempt to, following certain models of reform of the system of public healthcare realized in other (post) socialist countries, members of the European Union, open a space for reduction of public expenditure for health protection in the gross social product (from 6.6% in 2006 to 5% in 2009) and (2) Exclusion of the private sector from the public program for providing healthcare. Belief in a quick and efficient realization of this reform results from the fact that within the preparatory work for European integration in those countries a radical reconstruction and rationalization of public healthcare system has been made on basis of formal implementation of so-called European norms. However, on the other hand, there is no information how much those reforms really influenced the quality of public health services and fulfilled expectations of beneficiaries (the sick, users who are deprived of super specialized services and the most vulnerable segments of the society – the elderly, persons with disabilities, Gypsy population). No doubt those so-called European public healthcare norms have real and scientific foundations and that the reforms in the public healthcare system in Serbia are necessary, however there is no guarantee that its implementation will radically improve the performances in a short term period. In fact, the process of the social and economic development of Serbia so far have indicate that much better (scientifically determined and empirically confirmed) models of management of production (of public goods – author's remark) have not been accepted by (national) practice, in other words, there is a question “Why the practice does not use much bigger possibilities that have been offered?”. Before a more detailed elaboration, a short review of the situation in the healthcare system in Serbia and open questions in theirs work.

2. ESSENCE AND CAUSES OF CRISIS OF THE HEALTHCARE SYSTEM IN SERBIA

Serbia entered in the transition with a developed model of a "welfare state", which, in the limits of existing material possibilities, provided a high level of social and healthcare to the entire population. The national version of the "welfare state" was marked by socialist character of political and economy system, but its foundations reach back far in the past and are linked with the results of the revolution that took place at the beginning of the 19th century. Within the national liberation from the Ottoman rule, a social revolution took place by which a feudal system was repealed and foundation institutions of so-called "peasant economy" were established. In order to maintain and advance the national independence, the political elite gradually developed institutional and physical infrastructure, which, even in the environment of general poverty due to underdeveloped economic basis, managed to provide a minimum of healthcare for the majority of Serbia's population[1]. Very early Serbia accepted the so-called "Bismarck's model", too. In the period after the Second World War, the system of healthcare went through several phases in its development[2], so that in 1970, an equal scope of healthcare for all citizens with very wide range of rights and under general conditions guaranteed by the state by compensation of lacking funds from the budget.

Deterioration of the healthcare system began at the beginning of the eighties of the last century, in the process of more or less invisible deterioration of socialist started. Due to the ways, in which public expenditure was financed, the healthcare continued with illusionary development, but as soon as the end of

[1] In Serbia for a long time there was no explicitly defined healthcare policy with clearly and precisely defined obligations of individual, state and healthcare services (the first explicit healthcare policy was formulated as late as 1968!). The development of public healthcare service went an elemental manner, and in most cases above real economic possibilities (mostly because of dominant culture of egalitarism and incapability of the social – economic elite to replace it by a culture of economic freedoms in a propulsive developmental environment, and also very strong individual and group initiatives for advancement of public healthcare, because many of the key actors of the political stage of Serbia until 1914 were medical doctors by profession). It often resulted in development of too big and inefficient infrastructure, neglect of primary and overstressed secondary and tertiary healthcare, irrational usage of capacities, hyper production of cadre, etc. On the other hand, frequent changes of normative regulation were made causing from time to time confusion and acceptance of temporary solutions. Thus, seen as a whole, until the beginning of the eighties of the twentieth century, the development of the healthcare was moving, except in war periods, along a rising path and the population believed in a continual growth of its efficiency and rise in quality, following models of much more developed countries.

[2] In former Yugoslavia in forty years (from 1950 to 1990) there were 8 reforms of the healthcare system and healthcare insurance.

that period a gap between normed rights to healthcare and capability of their financing from public sources became visible[3].

Political and economic fall of socialism in the beginning of the nineties of the twentieth century brought about the falling apart of Yugoslavia, civil wars, various international political and economic sanctions, NATO aggression and restoration of capitalism, causing: (1) Aggravation of health state of the population due to living under great stress, expansion of economic and social hopelessness, a tide of risky behavior and generally social and personal carelessness about health and (2) Decline of scope and quality of public health services due to the lack of resources in the health insurance funds and devastation of curative and preventive infrastructure. Personal participation in financing costs of healthcare increased and a significant part of health services production was privatized. In order to improve their material position, employees in the public sector looked for additional sources of income by working illegally ("black market") in private offices and hospitals or they illegally privatized public resources. A widespread opinion of corruption in the public system of healthcare exists in general public; however it has never been proved.

In essence, in period of the (post) socialism transition, a threefold healthcare system was created. The first, private, financed directly by the users, in which, after seventeen years, a high quality of health services is provided; the second, in which users provide health services on irregular basis within the public curative infrastructure (for example: by purchasing medicines, medical care, hygiene and other materials and by paying privately to the medical staff) and the third, the public one, coping with periodical breaks in supply of necessary medicines, medical care and other materials and inability of timely performing complex diagnostically examinations and urgent operations.

The paralysis of the public healthcare system hit the socially most vulnerable segments of population in particular: children, the old, and persons with disabilities, women, and the Gypsy population being absolutely excluded from it. In the circumstances of mass unemployment and poverty, expansions of contagious and noncontiguous diseases occur, especially in children. Those diseases were believed to be extinct, but recur as consequence of bad quality and structure of food, personal hygiene, housing, water supply, improper drinking water quality and, of course, worsened conditions of medical treatment.

In the period after 2000 a number of documents were imposed and numerous proposals and drafts of documents formulated as an attempt to define a health policy and development strategy of public healthcare system. Among other

[3] In the period from 1980 to 1990 in Serbia (without territory of Kosovo and Metohija) gross social product was reduced for -3%, while participation of expenses of healthcare in the gross social product increased from 4,2 to 6,4% or really for 47,8%, i.e. around 352 US$ per capita according to the current value domestic purchasing power of the national currency.

things, in 2002 the Law on Healthcare of 1992, passed within institutional reform for demontage of institutions of the social system, was thoroughly innovated, and in 2005 a totally new law was passed, for which it has been claimed that it has been mostly adjusted to the currently valid instructions and positive practice in the European Union. However, little has been done in their implementation, even less on improving the situation, and almost nothing has been achieved in reaching the European standards of health services. All the time, it has been pointed out that the main reason for poor functioning of the healthcare system is the lack of financial resources[4].

The presented research shows that institutional reforms and partial privatization and commercialization in the last 17 years have not resulted in revitalization of the healthcare system. It means that great expert zeal and scientific thorough approach should be devoted to a deeper analysis of the structural disorders and problems related with the role of the public sector in managing the system of healthcare. Otherwise, sooner or later a question will impose itself: "What is the use of institutional reforms, privatization and deregulation in production of healthcare services according to the European Union, if they do not result in advanced health of the entire population and their education to face the problems and stresses of restoring capitalism, accepting individual responsibility for creation of decent conditions for life and work and challenges of the integration to Europe?". In that way three key problems of the historical heritage and vague, nontransparent and manipulative transition have been introduced and placed in the center of healthcare system reforms. The first is a consequence of socialization of economic risks of illnesses at work. In spite of nominally high ethical standards of protection of life and health, a large number of work posts and the micro-environment in which work processes took place, were created in such a way that they did not in the least contribute to maintaining health at work place. In fact, the system of health and social care did not contain realistic economic motives and administrative force, which would force economic subjects and employers to reduce healthcare risks at work places into socially acceptable limits by application of technically advanced equipment and specialized education, especially according to the very exact standards and norms from the relevant environment from which ideals

[4] Regression of the healthcare system in Serbia is result of a disproportionate increase of participation of expenses for those purposes in gross-social product. According to official data, expenditures for healthcare in Serbia have been significantly increased after 2000. In 2004 they were around 300 US$ (209 US$ in public and 91 US$ in private sector) per capita according to actual foreign currency rate and participated with around 10% in gross-social product of Serbia. Preliminary research shows that those relations have remained in 2005 and 2006. According to estimation, gross-social product in 2006 reached 65% of the scope realized in 1990, and the number of population has somewhat reduced, so a conclusion can be drawn that in 2006 the level of expenditure for healthcare per capita is bigger than the one in 1990. Therefore there is a justified doubt that the basic reason of (ill) functioning of the national health system is only of financial nature.

were taken for designing the healthcare system (Scandinavian countries in particular, which often were, explicitly and implicitly, pointed out as a model to be followed in the process of creating the national version of the "welfare state"!)

Analyzing the current reforms of the healthcare system, this problem should be dealt with in three contexts.

The first one is the moral and institutional obligation of a modern state to protect the right of each individual to work under the conditions which will not ruin their health and life in the environment of great disbalance of power between the employer and employee at the labor market. The second, integration into the European Union implies, among other things, implementation of very rigorous standards of protection of employees' right to a healthy and safe work place, as well as the right of users to receive a healthy safe product. The third and the most essential one is the existence of needs that demand creation of adequate work conditions in industry, construction industry and agriculture (where the work conditions are the hardest) for engaging workers from fifty to seventy years of age. Due to demographic regression, young labor power will not be interested in sufficient measure, nor will the system of individual life preferences and labor movement freedoms offered by the European model of market economy direct them to seek their prospects in those work fields within Serbia.

The second has come as a result of development of super specialized secondary and tertiary (meaning very expensive) infrastructure for healthcare in the public sector[5]. The division into sectors shows in practice a whole range of defects: (1) Fragmentation of the healthcare service and too wide introduction of clinical specialty, (2) Nonexistence of continuity of production of healthcare services (3) Very no equalized quality of services, (4) Overuse of higher levels of healthcare (5) Formal approach to health promotion and illness prevention, especially alcoholism, suicide, food related illnesses, smoking related illnesses, drug abuse and AIDS, (6) Neglecting family as a significant factor in health prevention, (7) Extremely low level of doctors working in primary healthcare from the aspect of internal and external reputation of the medical profession and so on.

The third is a consequence of an unclear, foggy and manipulated transition, that is to say, lack of state support to the public healthcare privatization. The growth of private practice in Serbia is going on in the environment of the so-called "passive privatization", demanded by the needs for higher quality of services

[5] Hospital and stationary healthcare in the public sector in Serbia is provided by 42 general hospitals, 15 specialized hospitals, 23 independent clinics and institutes, 5 clinic-hospital centers and three clinical centers and 59 institutes. Those stationary institutions had at disposal in 2002 46,547 beds or 6.2 beds per 1,000 inhabitants. Less than 40% beds are in general hospitals and almost as many (38%) in highly specialized institutions – clinics and clinic-hospital centers.

than the ones provided by the public sector. Strengthening of the private practice has been induced, first of all, by budget limitations in providing services defined by law. A wish to make a fortune quickly and poor control of work and income of the private sector has resulted in rise of number of private out patient clinics, dental and pharmaceutical institutions and super specialized clinics. There is very little relevant information about their effects on the healthcare, but it is undoubtedly clear that accessibility and equality in healthcare have been endangered by that situation, especially because of the mass phenomenon that medical doctors and other medical staff, while working within the system of obligatory insurance, identify and redirect patients into their own private practice, although it is evident that they could be served equally well and with lower expenses in the official working hours.

On the whole, a conclusion can be made that the change of the currently present ideology that took place in the beginning of the nineties years of the last century as well as the restoration of capitalism in case of overcoming the crisis of the healthcare system in Serbia has proven themselves as nonproductive, as everything else has remained the same – working methods, approach, values and attitudes. Its main feature is institutional non-regulated environment – consequence of unclear, foggy and manipulated transition. Reflections onto the public healthcare system are multifold. First, a space has been opened for a wild privatization of a part of the public healthcare system and development of an irregular system of partnership between the public and private sector in production. Second, a favorable milieu has been created for forming a distribution-oriented coalitions[6], which, by skillfully using their political and any other influence, in the limits of the historical heritage, tends to have this situation maintained, thus blocking the necessary structural changes in the public healthcare system and regular development of the private sector. Third, within of the framework of foggy and damped transition, arose the miracuous mixture of quasi-public, quasi-market and administrative mechanisms of regulation that nonsensenses necessity for the existence of the public healthcare system. However, prior to a detailed interpretation of the essence of the

[6] This term means a group of special interest – which, by means of joint activities, ensure their better position in the distribution of gross-social product and wealth without adequate their personal contribution to its maintenance and enlargement. The elementary social – economic features of distribution – oriented coalitions are: (1) a tendency towards creation of monopolistic political, social and economic structures, (2) weakening of interest in adapting to social, economic, and cultural changes in the environment, (3) inclination towards (ab)use of administrative- hierarchy evaluation and allocation mechanisms, instead of implementing market oriented ones, (4) inclination towards stimulating development of distribution-oriented coalitions on lower levels of social-economic organization, in order to cover up in that way real intentions of actors of key special interest groups. Basic causes of existence and development of distribution-oriented coalitions in Serbia and their role in blocking social reforms have been discussed in detail in: Adžić, S. and Popović, D. (2005). Fiscal system and fiscal policy – their contribution to advancement of competitiveness in economy: Case study Serbia**.** *Ekonomija/Economics*, br 1/2005, 173 – 200.

institutional non-regulated environment in Serbia, an attempt will be made to put more light on some crucial aspects in relation to the management of production of public goods, which have not been accepted nor implemented in national practice, because the public infrastructure for providing healthcare services, formally and de facto belongs to the regime of public administration, and not the public service, as it should be in the light of globalization and introducing market mechanisms in the management of public goods production.

3. BASIC ELEMENTS OF MANAGEMENT OF THE HEALTHCARE SYSTEM AS A PUBLIC SERVICE

Management of the healthcare system as a public service, like in any other human organization, is based on knowledge and beliefs about its way of functioning and what and how should be done in order to get from it the very thing that is the reason of its existence, in this case those are concrete healthcare services, in whose reproduction system, parallel with a system of economic criteria, exist also some wider, human and social and political factors which determine scope, quality, prices and production costs as well as dynamics of investment. Therefore, an institution producing (public) healthcare services is characterized by a specific in relation with the alternative production in the private sector. The problem of visioning and making a strategy as an essential statement about the future and the consequences of that choice has been dislocated out of the healthcare system, as in the modern society the decision whether a healthcare service is a public goods or not is in the first place a result of political fight among interest groups, not a result of an optimal process of social decision making. However, independent from this fact whose meaning has been neglected both in theory and practice, for efficient management of production of healthcare services in a regime of a public service, there must be a clear social vision, which explicitly defines: (1) Basic values (leading principles and rules, culture of life and work), which are unchangeable and are expression of the basic beliefs set through a consensus of all relevant options, (2) Purpose expressing clearly the basic reasons of existence of a certain socio-economic system and (3) Mission which is a statement of a clear and motivating goal the majority of the population tries to achieve. Naturally, it must be accepted that the science, at least in the dominating perception of its substance, cannot successfully develop methods and mechanisms for solving problems in the sphere of determining a social vision. Thereby, in fact, in the last consequence, some essential existential issues of production of healthcare services in a regime of the public service, no matter if we want it or not, have been left to voluntarism of politicians. That voluntarism is far from something that could be called the best achievable result (“best practice” principle) even in societies with a developed democratic decision-making in the sense of ensuring righteousness in approaching concrete healthcare services and high level of

political competence. On the other hand, possession and utilization of: (1) Specific knowledge and skills, (2) Ability of genuine understanding of problems and coping with complex and unstable circumstances and in particular (3) Specific abilities of producing solutions and persistence in their realization, can lead to a successful solution of this problem. That is the reason two facts must be stated. The first one is that there is neither direct nor final answer to the question: "How to management of the production of healthcare services in a regime of the public service?". And the second one is that the failure of the public healthcare system is, above all, result of incompetent (political) management.

When seeking an answer to the above stated question, one should understand the essence of the purpose of managing production of healthcare services in regime of the public service, such as: (1) Achievement of the outer mission (not only providing healthcare services in a certain structure, scope and price, but also a great number of other phenomena, such as: employment, reduction of public expenditure, technological development, protection and advancement of the environment, etc.) and (2) Own survival and development (which are not in linear connection, but are based on interaction between (healthcare) institutions, as organizations formed by the people bringing in their individual contributions and needs on one hand, and social preferences which determine, through a process of political competition, if a healthcare service has a status of public goods on the other hand). One of the solutions is that management, besides actions on solving problems, should create an adequate ambiance for achieving the purpose of management. In accordance with the above, the author's believes that a well structures management of production of healthcare goods in regime of the public service should contain the following elements: (1) Efficient planning and decision making, (2) Good organization, (3) Good motivation of employees, (4) Efficient control of the work process and (5) Development of positive culture and image in public. Let us see what should be scientifically recommended contents of those elements in structuring a public healthcare system as a public service.

Planning means matching the resources (material, financial, human, time and so on) which ensures: (1) Desired (optimal) efficiency which is in our case measured by realization of the scope and quality of healthcare services within the demanded dynamics and (2) Effectiveness in using limited resources, and they are in the first place, prices of healthcare services and the degree of engagement of public finances for participation in expenditures of their production and expended reproduction. Planning is in its essence an attempt to introduce determinism in a development process (healthcare system in this case – author's remark). However, as it is never possible to have access to all data which can influence the realization of the set plan, its realization has elements of a chaos. In this context, decision making can be observed in two ways. According to the classical approach, decision making is a choice between in

advance known and rival planned projected alternatives, and at that point an issue is opened, of course, who makes the decision on which of the alternatives is going to be selected. However, today in the practice of management of healthcare services production, another approach should have priority, and that priority should be analysis of decision making as a process of creation of solution to the problem. According to this concept, planning is seen above all as an attempt to set a goal to which our efforts will be directed, and which has both the past and the present as a starting point. However, interpretation of the past and present is burdened by subjectivity and can be interpreted in different ways, that is to say, it is relative. In that sense, planned setting of each goal must be taken as fluid, and the path towards its realization as a process subject to corrections in which determinism and stochastic are interwoven.

Organization of production of healthcare services in regime of the public service is analyzed in this paper, first of all, in a context of a phenomenon that the organizational structure which is formed with an intention to serve in realization of a strategy of healthcare, always stays away more or less from a normative regulation and starts producing its own strategy. This phenomenon is a result of the fact that in production of all public goods, including healthcare services, only two generic organizations are used: (1) Voluntarism bureaucratic organization and (2) Professional bureaucratic organization. Both these organizational structures are marked by hierarchy as result of work division and the need for their coordination, but also behavior in accordance with the axioms of so-called bureaucracy of economy, according to which it acts as organizational structure, which: (1) Obtains income from sources which are in no way connected with the sale of results of their activity, (2) Acts as a maximize of the state budget and (3) Tends to make money by using its position and role in the process of realization of functions of production healthcare services. In this context it is essential to keep in mind that it is impossible to imagine and realize perfect health institutions. Therefore it is necessary to reduce the number of hierarchy levels in order to minimize those phenomena, but also develop a new configuration of organizations for production of healthcare services, founded on so-called missionary organizational structure, whose main point is, in the first place, in the phenomena of culture development and adequate image.

Good motivation of employees in process of public goods production is connected by various authors, first of all, for its management. In accordance with mostly noncommercial features of public goods production, a concept “new public management” has been developed, meaning a mixture made from theoretical achievements of constitutional economy and usage of theory and practice of creating conditions for rise of motivation. Its basic characteristics are: (1) Introduction of a principle of contract management in practice of management, (2) Application of marketing mechanism in public sector and (3) Making a relation between employees' salaries with results of their work and

business. However, in case of healthcare services production, the issue of employees' motivation, medical staff in particular, must be brought onto the same level, if realistic advancement of their efficiency is desired. There are no ready-made recipes for solving this problem, but it is in relying of the environment that each healthcare institution should look for answers to the following questions: (1) "What is the main purpose of management of production of healthcare services in regime of the public service?" and (2) "What does success in actual contents of managing production of healthcare services depend on in order to advance efficiency?".

Control should ensure that achievement of aims, tasks, decisions etc are measured. The purpose of control is to find out what stimulates and what limits realization of set norms in order to make corrections in case it is needed – so that they would be realized, or, if it is necessary and acceptable, changes in their contents made. By that we come to one of the most controversy topics in management of production of healthcare services in regime of the public service. Norms for evaluation of success of their production depend, above all, on the relation of power among the leading socio-economic groups. According to that, assessing of success in healthcare services production is most of all a subjective and comparative procedure. Subjectivity of assessment comes from the fact that any of the marks can be rejected, if the norm it is based on is given up. The norms can be posted also in form of an ideal standard (based on an optimal theoretical calculation) or on the basis of a fixed empirically established alternative. On the other hand, application of the concept of total quality and orientation towards meeting the needs of patients and other users, in case of adequate implementation, they provide a more objective and active way for turning the control results into a required managerial or other action.

Culture of an organization is connected, first of all, for the contents of the strategy and policy of structuring of organization of healthcare services production. These figures can be in various relations – from agreement to antagonism, when functions of production of healthcare services are organized with the help of corruption, threats, and other socially unacceptable instruments. That is why forming of the culture of an organization must be the basic infrastructure of management of production of healthcare services in regime of the public service. In accordance with that, the culture of an organization should include: (1) A way of communication with the outer environment, especially patients and other users, (2) Ways of communication with the center or commanding body, (3) Level of knowledge and expertise of the employees and the attitude towards patients and other users, (4) The main symbols. The measure of success of the communication with the environment and the center or the commanding body is the image, that is the picture or perception the public has about the concrete organization for production of healthcare services.

At the end, it is important to present the circumstances in which it is very difficult to ensure in wider scope conditions for satisfactory management in production of healthcare services in regime of the public service. From the point of the goal of this paper, the following factors should be taken out: (1) Social-economic environment in which the following elements dominate: subjectively discount rates of makers of central managerial decisions, a short time horizon of decision making and the evaluation system of success which stimulates deceit or fraud, (2) Absence of altruism and antagonistic relation between the cultural values and ethical norms of the economic-political elite and the real social-economic reality in which the majority of population live and (3) Domination of interest of the distribution – oriented coalitions in formation of the structure of public income and expenses. Thereby we enter in the domain of the problem of institutional non-regularity, as the key factor for (in) efficiency of the healthcare system.

4. WHAT IS ESSENCE OF THE INSTITUTIONALLY NON-REGULATED ENVIRONMENT IN SERBIA?

In order to precisely assess the influence of the (current) institutional non-regulated environment on the structural adjustment of the healthcare system, it is necessary to understand the basic social – economic challenges which its functioning in Serbia has to cope with. They are: (1) Changes in demographic structure of population, which have caused certain movements in the structure and scope of individual and public expenditure and demand. A stressed tendency of aging of the population has as consequence a dynamic increase of demand for specific goods in the health and social care, which cannot be distinctly and precisely distinguished between those two sectors; (2) Changes in the pattern of living and consuming, a bigger stress is put on the issue of quality and contents of healthcare services in accordance with specific needs of individuals and their possibilities of individual participation, so the communication, in the sense of recognizing the real needs and possibilities of an individual and specific social-economic groups has become one of the key factors for efficient production of heath services; (3) Deregulation has removed administrative barriers for entrance of the private sector into the system of healthcare and opened space for partnership of the public and private sector, as well as for increase of personal participation in financing the costs of production and extended reproduction; (4) Rising innovational and software contents, as well as the problem of complex connection between causes of bad healthcare condition due to no synchronicity between new healthcare needs and challenges and public and market regulation of healthcare, educational and social sphere are in great extent narrowed the possibility to provide healthcare services on the principle “equal rights for all”; (5) Strict functional and territorial division of work in production of healthcare services is replaced by

their integration and specific forms of horizontal and vertical decentralization; (6) Great social-economic changes, chaos and absence of ethical norms have opened space for expansion of "shadow" economy, corruption and various misuses and deceits; (7) In order to respond to the challenges from (1) to (6), organization and management of the institutions of public care, modeled for long ruling economy and uniform contents of corresponding healthcare service, should be replaced by organization and management for the economy of flexibility, scope, time and innovation. Because of that, the barriers between certain functions of strongly structured organizations of healthcare have become less and less sharp and clear, so that creative way of performing work and introduction of multidisciplinary connections with educational and social sphere become basic criteria for measuring efficiency, and development of strategic, technological and other alliances on local, sub-regional and regional level on foundations of cooperation of public and private sector has become a necessity.

Since a reform creates something new, (in this case a change of the healthcare system with the aim to adjust itself to the demands stated earlier), a certain wider social-economic and technical ideal should be established as a system we aim at and which should represent a focal point of the goals, On the other hand, achievable reform activities should be performed by competent expert services on a principle of projecting technically feasible alternatives. From the point of view of other participants in the healthcare system, their initiatives become object of expert study and evaluation only after they have been totally defined. However, it is not the case with ideally established goals of a reform. First, each ideal goal is defined neither entirely precisely, nor clearly. Second, each decision maker defines for himself ideal definition of contents of goals of a reform, meaning that they contain many meanings. In fact, by this we come to the essence of the decision making issue. Reforms are the problem with more criteria, so the choice (decision making) is comparison of real alternatives and the ideal, that is, between something that is achievable at present and possibilities which are only vaguely achievable, but are very much desirable for decision makers. Although it is probable that, due to a specific situation in Serbia, not a single existing model of a healthcare system can be fully realized, we believe that some of the existing models from the European territory should be accepted as an ideal and as such taken as a starting point (of reforms). At the same time we must be aware that the goals established in that way will be realized only partially, never in total extent, and that there is a permanent threat of cosmetic actions, which do not touch actual essence of functioning of the system of healthcare.

In this context it is possible to make a comparison between ideally structural models of regulation of institutional infrastructure necessary for efficient functioning of the system of healthcare and real current situation in Serbia (TABLE 1). The presented taxonomy resulting from an analysis of the official

concept of Serbia's preparations for European integration [13, 14] shows that the problem of the reform of the healthcare system is possible to be solved only within a total social – economic reform in the sense of building democratic society in which citizens are free, competent and responsible. In the presented context a question is asked: "What should be a starting point in determining the role of the state in the sphere of healthcare in Serbia?".

Table 1 Ideal versus real institutional non-regulated environment

Ideal model of regularity of institutional infrastructure:	**Existing state of regularity of institutional infrastructure in Serbia:**
Legal state based on respect of human, social and economic freedoms	Undeveloped legal state
Clear political and economic concept of development of modern market economy based on the concept of economic freedoms and creation of real conditions for everyone who wishes and can work to get a job with income sufficient for at least physical reproduction	Unclear political and economic concept loaded by interest of broker-oriented entrepreneurship elite and numerous distribution-oriented coalitions
Clear political, economic, social and administrative concept of the role of the state in the sphere of production of public goods based on the general consensus of all relevant social, economic and political options and confirmed through all-inclusive citizens' opinion on its contents, and goals, on basis of precise, clear and transparent standards, defined on basis of the concept: "minimal rights for all, the rest according to the needs and abilities of an individual to finance them"	Great gap between by norms regulated and existing rights to usage of public goods Irregular relations between public and private sector in production of public goods Significant presence of "shadow" economy element, corruption, misuse and fraud in public sector Domination of monopoly interest and distribution- oriented coalitions on the bidders' side
Clear political and administrative concept of horizontal and vertical decentralization of resources for production of public goods in state (public) ownership regime, adapted to specific regional, sub regional, and local healthcare, social, cultural and ethnical characteristics	Unevenly distributed production of public goods in the regions, sub regional and local units
Efficient and professional public administration system and services management, oriented to users (individuals, their families and specific social – economic groups)	Politics driven, inefficient and bureaucratic system of public administration and services management

[1] In the presented methodological approach – the notion of institutional infrastructure is defined as a collection of active elements of the outer environment in which subjects of the healthcare system act.

5. TOTAL REINGENEERING OF THE PUBLIC HEALTHCARE SYSTEM IN SERBIA

5.1. To define a new contens of the paradigm "equity" as the key for decided of problem of the institutional non-regularity in Serbia

In the presented contents of the institutional non-regularity shows that in order to increase effectiveness of the healthcare system it is necessary to make relatively radical changes in the power structure and society without delay. The key of those changes is establishing a consensus between the political and economic elite and the majority of population of Serbia about the role of the state in the sphere of healthcare. Potential interest of the political and economic elite is, by increase of efficiency of healthcare, to ensure political and economic stability needed for their legal stratification. On the other hand, interest of the majority of the population of Serbia is, in the given material context, to ensure the best possible conditions for healthcare. However, the real situation shows that within the economic and political elite, those who do not see their interest in establishing a precise and transparent concept of reform of the healthcare system in Serbia prevail. Without going deeper at this point in the structure of interest standing behind this constellation, a hypothesis can be made that for realization of a successful reform of the healthcare system in Serbia, a total reengineering - an ambitious, radical, quality and innovation based methodology is necessary, which would, on the basis of a development vision, determine the direction of institutional changes and various reformatory actions with an aim to set up a radically new public healthcare system – oriented towards prevention and maintenance of healthcare capabilities (of the total national population) based on the development of adequate life and work, while treatment of diseases asking for sophisticated and expensive technologies should be left to the private sector with personal participation. The key of the implementation is in a new definition of contents of the paradigm "Equity". A paradigm that public healthcare insurance should provide the best healthcare is false and financially unsustainable even for societies much wealthier than Serbia. On the other hand, righteousness means a need to provide healthcare in the framework of public, transparent and precise minimal standards for all (meaning that nobody will die because he is not insured, because he has not money for cure or, simply, as often happens in Serbia, because he do not know relevant people) In this sense, according to the opinion of the author's, in order to create conditions for liberal structure of the contents of division of expenses of production of healthcare services between the public and private sector, and which would be accepted by the population as a legal replacement for their existence according to the concept of the state of prosperity, it is necessary to substitute the factor of institutional non-regularity – by a more intelligent

action of the public factor in function of advancement of micro efficiency in their production.
At first sight, the idea of total reengineering of the healthcare system in Serbia and the policy for its operationalization may seem pretentious. However, the (cruel) reality shows that the problems in the healthcare system are consequences of the slave like following the old ideas and attitudes in the public sector and society in general, in the managing the state, political work and everyday public and business management. In that sense, lessons can be learned from the past. In the last two centuries in Serbia, radical changes of the actors in the political power, that were nor followed by freedom of individual creativity, has already several time proved to be nonproductive, because everything else stayed the same – work methods, attitudes, values and beliefs. On the contrary, each liberation in the field of creativity and initiative, even with no big political changes, yielded a dynamic modernization. That is why Serbia needs a total reengineering as an ambitious, radical, quality and innovations based methodology, which will on the basis of a vision of development as well as the increase of the degree of creative freedom determine the direction of the institutional changes, and a more productive concept of goals and actions of the adequate policy, which would wake up the healthcare system from the dead, on the basis of a platform of a macro environment that guarantees equal chances for all as well as consistent strategy of integration of Serbia in the desired European environment. In that sense, we are going to define more closely what of the reengineering techniques should be used in the reform of the healthcare system in Serbia. In this context, he needs contents of the basic elements of the reengineering.

5.2. Reengineering – some basic concepts

Generally speaking, the term reengineering stands for such actions in the organization and design of the system (in our case in the healthcare system in Serbia, and in the policy for its operationalization) which result in essential and quality changes in its functioning. In that sense, reengineering should consist of actions towards improvement of the basic processes, as well as an attempt to adequately define real needs for engaging leading staff and other employees in realization of the process on basis of the criteria of maximal satisfaction of the users of a certain healthcare service. So, the basic elements of reengineering are the processes and the employees who are required to identify easily and quickly introduced changes that will enable them and the entire service or function to be more efficient. Three basic factors are essential for a successful reengineering: staff, planning and results.
Success of each reform depends on cadre potential. Systems, tools, techniques and standards of organization of a system of healthcare, that is, forming contents of goals and actions of a healthcare policy, for example according to

the criteria of the European Union, can be very useful, but only actors of public regulation and management are capable of their implementation and form an adequate institution, that is to say, carry out efficient realization of the set goals (of healthcare policy). Thereby the importance of two factors is put forth.

The first one is that processes in a public institution are as good as their actors (implementers) with the least enthusiasm in them. Well, let us see what potentials are at our disposal in this sphere. For realization of changes a fresh motivation is necessary. The radical change of the economy system and two essential changes of actors on the political scene of Serbia in the last seventeen years have created excellent predispositions for development of new and more efficient methods of public regulation, and thereby opening of space for reengineering of the system of healthcare and policy for its operationalization. However, it seems that those predispositions had been used up before essential changes in the model of functioning of national capitalism were made, so others should bee looked for. One of potential areas for development of fresh motivation for changes is, indeed, the program of integration of Serbia in the European integration flows. But, certain precaution is needed here also. Optimism about quick integration has been, partially though and influenced by a foreign factor, replaced by (more realistic) views about a long and hard way which the society and economy of Serbia must pass in order to be integrated into the European Union. In accordance with that, what Serbia really needs is a clear, public and precise determination for integration into European flows that should be the foundation for creation and implementation of exact, transparent, precise, public norms for measuring the effectiveness of certain political options, institutional adjustment and public regulation, and only after their promotion and establishing a social consensus for their implementation, the dynamics of realization and deadlines can be taken into consideration.

Another, a more important factor is the fact that for opening a space for changes, there must be a wish for learning, meaning a positive attitude to adequate implementation of other people's experiences, interest in foreign languages and cultures of life and work, as well as a wish to learn from the best foreign examples, all accompanied by a good information flow. Activation of a wish for learning depends on two factors – systems of continual education and a wide spread culture of management. As a matter of fact, current situation in these two areas suggests being cautious when determining a real wish for learning in function of radical social–economic changes. It is certain that Serbia has a quantum of cadres with adequate of education and certain managerial abilities, however, their number is insufficient to initiate a mass wish for learning in accordance with the above stated motto – saying that success of each reform change depends on those who have least enthusiasm.

In the beginning of the eighties of the last century macro and micro-planning in Serbia became a ritual with no substance, and practically it was forgotten at the beginning of restoration of capitalism. It is clear that modern planning has

nothing in common with total or self management style of planning from an earlier period. The character of this paper requires us to interpret only two models of planning that should find their place in the system of healthcare in Serbia. Since the beginning of 2001, a program of revitalization of the public healthcare system in Serbia has been going on partially financed by donations from abroad and long term credits. However, six year later its expenditures and results are not clear to the users and population. It is evident that the whole program was approached without public, precise and transparent concept and without planning by which key health, social, personnel and technical problems and time frame dynamics for its implementation would be analyzed. Looking from a time distance it is clear that those actions should not have been undertaken without adequate plans. On the other hand, planning of the reforms of the healthcare system and the healthcare policy demands certain space in which institutional foundation, practice of public regulation and behavior of subjects in the healthcare system could develop, change and adjust both to each other and to changeable circumstances. It was the talent for improvisation, as majority of actors learned to use the moment and employ creative improvisation in the chronically undeveloped infrastructure and poor normative and organizational institutional frame of life and work, and those are the key values of reengineering.

In order to decide in favor of radical reforms of the healthcare system, some results must be achieved as soon as possible. Actors of the political and economic changes of 2000 were aware of that, so some results soon became visible – material situation of the staff in the public system of healthcare improved, supply of medicines, sanitary and other materials also became better, also hygiene, and food in hospitals, waiting time for operations became shorter, and revitalization of the existing equipment and procurement of the new one have improved the conditions for timely diagnostics of complex illnesses. However, it soon became cleat that it was not enough to keep the reform enthusiasm up neither in the staff nor in users. A rational explanation for quick lessening of (the total) enthusiasm for reform should be sought in a fact that the majority of population of Serbia very soon found out that they had lost much more than they gained by the reform actions that had taken place. In fact, the increase of unemployment and social instability and thereby automatic limitation of access to healthcare services as well as absence of activates aimed at elimination of corruption and illegal mixture of public and private factor in the healthcare system influenced the change of the attitude towards reforms.

5.3. What is essence of total reengineering in this case?

In the presented taxonomy, reengineering should be treated as a technique whose aim is to improve the processes with bad outcome by the principle step by step, in order to make the advancement and results visible almost on daily

basis. No doubt that reengineering must rely on radical visions and be a component of big, long term projects, but its application should ensure that continual improvements of smaller scope are achieved. Thereby we come to the very essence of reengineering – it is not the technique that ensures radical changes in a long term, but a technique that seeks radically new solutions in a short term, which cannot be solved by application of some of the known techniques. The main idea is to direct the whole system to the inner restructuring by initiating macro projects for verification of the public healthcare system according to the standard of quality management according to ISO 9000:2000. This idea is based on the standpoint that restructuring of the public healthcare system must be initiated from "bottom to the top" and not from "top to the bottom" as it has been in the current reform. In this context the project of reengineering is divided into four levels:
The first, initial and the lowest level is, of course, ***business reengineering*****,** whose activities are located on the micro level and oriented towards rationalization and redesigning of business and similar processes.
The second level is ***managerial reengineering*** which means introduction of new approaches in management of business and other processes.
The third level is ***mental*** or ***educational reengineering*** whose basic function is education and change of attitudes of participants in any business or similar process.
On the fourth, the highest level is the ***total reengineering***, as a synthesis of all previous ones, which enables functioning of the whole, (in our case it is the system of healthcare and policy for its operationalization)
In order to realize this project, it is necessary to define a vision, what is desired to be achieved by reengineering in form of a clear, precise and public list of wishes and goals for whose realization the majority of participants do their best, as much as they can.

5.4. Reengineering and vision of development of the healtcare system in Serbia

The vision naturally must be based on solutions of the problems of development of the healthcare system in Serbia copes with. Here are the most important ones: (1) How to create conditions to stop the process of deterioration of healthcare status of the population? (2) How to ensure the balance in public income and expenditure for healthcare within so-called "Bismarck model" and make redistribution of the public expenditure funds for the benefit of healthcare in the environment with strong interior and exterior pressures for lesser participation of the state in redistribution of the gross social product? (3) How to continue the process of revitalization and modernization of the healthcare system in a more effective way? (4) How to start up and realize a process of partial privatization and transformation of ownership in order to use up one part

of the existing resources? (5) How to improve management and rational functioning of the public system of healthcare? (6) How to include personal funds of the population into the public healthcare system in a regular way? (7) How to realize the partnership between the public and private sector in the framework of the system of primary, secondary and tertiary healthcare? (8) How to attract fresh capital and know how for a partial privatization of the development of the healthcare system in the domain of high technologies? (9) How to get and use international help? (10) How to make a rationalization and improvement of the cadre education system (for example, Serbian's system of high education is too big in relation to its needs) – those are only a few of the urgent issues of the current (Serbian) reality.

If there was a clear and precise (developmental) vision of the healthcare system in Serbia, then determining the structure of actions in reengineering on each of the said levels would be only a matter of technique. In that case, for example, partial transformation of ownership would not be a goal per se, but a means of revitalization, modernization and development of a corresponding component of the healthcare system. At the same time we must be aware that a privatization, carried out in various ways, automatically leads to a concrete goal (for example, although privatization of the healthcare system in Serbia in the previous period was not clearly, precisely and transparently defined in social and economic sense, in practice it was going on in a form of a wild privatization of public resources, work on a "black market", corruption, irregular public – private partnership, so that the final result it had the consequence that the basic capacities and employment in the public sector formally more or less preserved, of course, the price being (real) perception of users that this kind of system is unnecessary , but also a negative perception about existence of private sector). The situation with other mentioned problems is similar. The structure of actions in reengineering for overcoming each of them can be labeled as good, bad, desirable, and unacceptable, only if it is measured in relation with contribution to the realization of the goals contained in the (development) vision. Well, what is really the goal of the transition of the healthcare system in Serbia?

This question has been waiting for an answer for the last seventeen years. In the meantime the initial premises about transition as a way towards an "ideal" vision of capitalism adapted to poor circumstances (illustrated by the initial paradigm "Serbia as Sweden") has been transformed into a new one "Serbia in the European Union". However, this one, like the initial one, in its essence was fruitless and idle. European integration for Serbia is, above all, a goal, not the means for its realization. What Serbia really needs is finding the answers to the questions in what kind of society, in respect of economic and social issues, shall we live in ten or twenty years and how shall we survive a year after a year until the minimal economic and social conditions are created before we reach the goal. As the (development) vision is missing, many elements of political, economy and social reality seem elemental, poorly designed, wrong, premature.

Means are proclaimed goals, and the goals means. Only that which in a certain moment suits the dominant political and/or economic option, but not the entire nation – is good. It seems that we are not able to determine (development) vision, because too much energy is being used for maintaining or conquering pure power and the tantieme coming from it. And its basic result is general fall of motivation, apathy, fatalism, a dynamic "brain drainage" and young population, demographic regression, and turning Serbia in to a country of hopeless old people. In this context another question can be asked - if the healthcare system is actor or victim of the current state. However, in harmony with ahead to lead contents of paradigm "Equity", to attempt to explain of the methodolgy of theirs implementation.

5.5. As one should a technique of the reengineering in to exceed of crisis of the healthcare system in Serbia?

However, in accordance with the above stated contents of the paradigm "Equity", we are going to try to explain methodology of its application. The presented methodology is not only an attempt of implementation of its technology, but it also relies on comprehensive analysis of historical experience, where explicit application of this technique, like in the developed European environment, on the basis of individual initiative and self learning, radical reforms of the system of healthcare have been realized even without a precise social vision. Actors of reengineering are divided into three basic groups according to their functions:

1. ***Management Committee*** - which should define the contents of the reengineering strategy and ensure supervision in realization. The main tasks of the Management Committee are: defining concrete processes which should be radically redesigned, starting the initiative for redesigning and provide support for redesigning.

2. ***Reengineering team*** which should consist of at least five, maximum ten persons with a mandate to realize reengineering of a certain process. The main task of the team is to define the meanings of the managing rules that will lead the process in a desired way. In order to avoid subjectivity in defining the rules, its output should be placed in the center of the process by defining concrete user (for example, procure preventive healthcare for children up to 6 years of age) and a degree of adequacy and the quality level of the health services that should be provided with detailed procedures about what activities should be undertaken further on, with corresponding pricelist and dynamics of settling public obligations. Adequacy of the contents and the quality level should be determined on the basis of good practice in the world and attempts to build own standards of functioning adapted to the economic abilities of users. In any case,

the process which is to be redesigned must be observed through the eyes of a user of a certain healthcare service. That is why members of the team for realization of the reengineering should be selected on the criterion: two to three members from within (from the process which is subject of redesigning) on one exterior member - in order to ensure objectivity and different views on the process which is being redesigned. The team for reengineering should manage itself and have independence in its work, while its work should be based on free communication, consensus and stimulation of innovative ways. In any case, the leader of the reengineering team should behave like the first among equals in accordance with premises that policy must be in slave of expertise and knowledge and not vice versa, as our current practice is.

3. ***Leader of reengineering*** is coordinator of the process being redesigned. Leader of the reengineering team can be but need not be leader of the reengineering of the concrete process. In fact, practice has proved that it is best to select natural leaders for leaders of reengineering who have already proved their qualities within the reengineering team because they are usually able to motivate other actors to act for change.

In this sense, according to the author's opinion, there are three elementary directions of the reform of functions of public factor in strategic management of the business and development of healthcare: (1) decentralization and deconcentration of functions of public administration in charge of realization of regulation of behavior of public and commercial organizations for production of healthcare services trying to get closer to users and ensure flexibility in work. The main challenge is how to organize central coordination and work control without violating work freedom of lower organization levels of power; (2) Introducing a system of continual advancement of quality of healthcare services in function of satisfying differentiated needs of users – taking over business techniques and orientation towards individual expectations and additional resources for their realization; (3) Advancement of regulative mechanisms – improvement of quality of legal regulation of the public and private sector, reduction of expenses of implementation and advancement of the monitoring and control system – by taking over adequate business techniques.

The following instruments should be used for realization: (1) Human resources management (based on scientifically established programs of cadre selection, introducing them to work, education, development of the cadres and improvement of motivation; (2) Modern information and telecommunication technologies – in order to provide better quality, faster access to (public) healthcare services as well as control of process of their reproduction; (3) Market mechanism – characteristic examples: (a) formation of internal markets (for example operationalization of the right of users to choose doctor, a group of doctors and healthcare organizations for certain services – which would introduce a direct competition among doctors and hospitals financed from

public funds, (b) existence of partnership between the public and private sector in providing healthcare services and (c) total privatization of providing some healthcare services.

5.7. Critical retrospective of the applied methodology for reingeneering of the public healthcare system in Serbia

The methodology for reingeneering of the public healthcare system in Serbia to base an application of the three paradigms: "Equity", "Learning" and "The intelligent and creative macro and micro-management as substitution for the institutionally non-regulated environment?", an one hand, and on of the multi-criterion compromise between of (science) concept for macro and micromanagement of the public healthcare system and the real goals and mechanisms of public policy, an other hand. The greates advantages of possible application of suggested methodology are indirect because of the variety of corrective actions and a wide circle of participiants, with their partial wiews and truths, is incorporated into the system oriented observation of "What is the best solution of the observed problematic situation". The real world in presented observation is problematic and process and methodology for improve the performances of public healthcare system is systematic. That approach is based on appropriate type of political and social culture and the principle of partitipation and proffesional management, and wider partitipation of all those involved in the problem. Applied methodology can be defined as mostly idealistic because it inputs the main initiative force to the ideas and coordination. This is the area in which we should search for the greatest limitations in this methodology. Altrough, the presented model for public regulation, to base on certain type of the partitipation culture and European norms for cooperation, healthcare and public regulation. Due to neglecting of the different subcultures and the difficulty of their integration, system of consultation and compact as a system for future macro and micro-menagement was soon replaced with the system of force. In this context, the issue of efficiency improvement in the production of public healthcare goods in Serbia remains open, and primarily depends on changes in the perception of the political elite and medical profession and the progress in the creation of concept of their social responsibility.

6. CONCLUSIONS

The public healthcare system of Serbia since the beginning of the eighties of the last century, when more or less unnoticed decline of socialism started, has been coping with great problems. They became almost impossible to solve as the time went on, due to slave like clinging to the old ideas and approaches to the goals, organization and management of state and public sector, political work

and everyday public and business management. The change of existing ideology, that took place at the beginning of the nineties of the last century, and restoration of capitalism has proved itself to be nonproductive, because everything else stayed the same – work methods, approaches, values and attitudes. Its essential characteristic is institutional non-regularity – as consequence of unclear, foggy and manipulated transition. Reflections on the public healthcare system are multifold. First, space was opened for wild privatization of a certain part of public healthcare system and development of irregular system of partnership between the public and private sector in production of healthcare services. Second, favorable conditions were created for complex distribution – oriented coalition, which, in the framework of historical heritage, very skillfully using its political and any other influence, tries to maintain such situation and stop necessary structural changes in the public system of healthcare and regular development of the private sector. Third, in the limits of misty and nontransparent transition a strange mixture of quasi public, quasi market and administrative regulation mechanism has occurred– which has made the need for existence of a public healthcare system practically purposeless. That is why solving the problem of the healthcare system crisis in Serbia is, above all, a matter of genuine understanding of the problem, and only after that creation of certain solution.

In this paper tends to show that a deterministic concept, in which the issue of financing the system of healthcare is the elementary focus of public action, cannot be a key foundation for reforms. Functioning of the healthcare system as a big social-economic system is at the same time predictable and unpredictable, stochastic and determinable. In this context, the existential and development problems of the healthcare system can be dealt with only by all-inclusive analysis of all available solutions and a careful choice of the optimal one. In that sense, Serbia needs a total reengineering – an ambitious, radical, quality and on innovations based methodology, which would, on basis of a development vision, determine the direction of institutional changes and various reform actions in order to build a radically new public healthcare system – oriented towards prevention and maintenance of healthcare capability (of the entire national population) on basis of development of adequate system of life and work, while treatment of majority of illnesses, especially those for which sophisticated and expensive technologies are used, should be left to the private sector on basis of personal participation. The key of implementation is, in the author's opinion, in a new definition of contents of the paradigm “Equity”.

A paradigm that public healthcare insurance should provide best healthcare is false and financially no sustainable even for societies much wealthier than Serbia. On the other hand, righteousness means a need to provide healthcare in the framework of public, transparent and precise minimal norms for all (meaning that nobody will die because he is not insured, because he has not money for cure or, simply, as often happens in Serbia, because he do not know

relevant people). In accordance with that, the presented concept of a total reengineering of the healthcare system in circumstances of institutional irregulation, is based on active approach in which the public factor, in accordance with basic division of responsibilities in administrative, hierarchical environment, should find out the right solutions for: (1) improvement of the external and internal system of management and control, (2) restructuring of the inner organizational structure, (3) improvement of quality of labor, (4) withdrawing those activities which can be organized on commercial basis and (5) formation of a needed capital base for revitalization and modernization – so that business will be rationalized, and the quality of healthcare services risen on a socially acceptable level. This gives a high level of subjectivity to the whole process of increasing the efficiency of the healthcare system. In this context, the problem of improvement of efficiency of public healthcare system in Serbia stays open and will depend, above all, on changes in perception of the political elite and medical profession and advancement in creating a concept of their social responsibility to the (minimal) European norms for cooperation, healthcare and public regulation.

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