Private sector engagement for noncommunicable disease control in Republika Srpska and the Federation of Bosnia and Herzegovina

current scope and policy options

MARCH 2023
Private sector engagement for noncommunicable disease control in Republika Srpska and the Federation of Bosnia and Herzegovina

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current scope and policy options
# Contents

Abbreviations ................................................................. v
Acknowledgments ......................................................... vi
Executive Summary ..................................................... vii
1. Introduction ............................................................ 1
   1.1 Purpose of the report ...................................... 1
   1.2 Methodology ................................................ 2
2. Country Context ....................................................... 4
3. Governance for NCD Prevention and Control ...................... 8
   3.1 Governance of health systems .............................. 9
   3.2 NCD-related policy documents and legislative framework ... 10
   3.3 Strategic and policy documents on private health care providers ... 15
   3.4 Legislative frameworks for establishment of private health care facilities ........................................... 17
   3.5 Public-private partnerships ................................ 21
4. Financing of NCD Prevention and Control .......................... 23
   4.1 Health care financing in health systems in BiH .......... 24
   4.2 Financing of NCD prevention and control services ...... 27
   4.3 Contracting of private health care providers .......... 28
   4.4 Pricing of the private health care providers’ services ... 32
5. NCD Prevention and Control Service Delivery ..................... 34
   5.1 Provision of NCD prevention and control services in primary health care ................................................. 35
   5.2 Impact of COVID-19 pandemic on health service delivery ... 37
   5.3 Overview of existing private health care providers .... 40
   5.4 Health workforce and provision of NCD prevention and control services .............................................. 45
   5.5 Private health care providers and quality of NCD prevention and control services ................................. 48
6. Policy Recommendations ............................................. 55
   6.1 Recommendations for policy makers in Republika Srpska ... 56
   6.2 Recommendations for policy makers in the Federation of BiH .... 58
Annex A: Interview guide for ASKVA and AKAZ ..................... 60
Annex B: Interview guide for health insurance funds .................. 62
Annex C: Interview guide for medical chambers ..................... 65
Annex D: Interview guide for ministries of health .................... 68
Annex E: Interview guide for public health institutes .................. 71
Annex F: Interview guide for private health care providers .......... 73
Annex G: Interview guide for public private partnerships .......... 76
Annex H: Questions for focus group session .......................... 78
References ........................................................................ 79
## Abbreviations

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<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>AKAZ</td>
<td>Agency for Health Care Quality and Accreditation in Federation of BiH</td>
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<tr>
<td>ASKVA</td>
<td>Agency for Certification, Accreditation and Improvement of Health Care Quality of Republika Srpska</td>
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<tr>
<td>BiH</td>
<td>Bosnia and Herzegovina</td>
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<tr>
<td>COPD</td>
<td>chronic obstructive pulmonary disease</td>
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<tr>
<td>COVID-19</td>
<td>Coronavirus disease 2019</td>
</tr>
<tr>
<td>DALY</td>
<td>disability-adjusted life year</td>
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<tr>
<td>DRG</td>
<td>diagnostic-related group</td>
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<tr>
<td>GDP</td>
<td>gross domestic product</td>
</tr>
<tr>
<td>NCD</td>
<td>noncommunicable disease</td>
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<tr>
<td>OECD</td>
<td>Organization for Economic Co-operation and Development</td>
</tr>
<tr>
<td>PPP</td>
<td>public-private partnership</td>
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<tr>
<td>SDC</td>
<td>Swiss Agency for Development and Cooperation</td>
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<td>WHO</td>
<td>World Health Organization</td>
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</table>
This report was supervised by Rialda Kovacevic, Jaime Nicolas Bayona Garcia, Tania Dmytraczenko, and Christopher G. Sheldon. It was authored by Severin Rakic, Sinisa Stevic, Barbara O’Hanlon, Ian Forde, Senad Huseinagic, Aida Pilav, Charles Birungi, and Adanna Chukwuma. The work was funded by the World Bank Group’s Tackling Non-Communicable Diseases Challenges in Low and Middle Income Countries Trust Fund, supported by the Access Accelerated Partnership.

The analysis benefited from close engagement with the Republika Srpska Ministry of Health and Social Welfare and the Federal Ministry of Health. The authors are grateful to Mirja Channa Sjoblom and Elisha Kipkemoi Ngetich for their helpful comments on an earlier version of the draft. Furthermore, the exceptional editorial support from Richard A. B. Crabbe and operational assistance from Dijana Jurkovic is appreciated. All errors and omissions are the author’s responsibility.
Noncommunicable diseases (NCDs) are the leading causes of death and disability in Bosnia and Herzegovina (BiH). Tobacco consumption, high fasting plasma glucose, high blood pressure, and high body-mass index are the top four risk factors contributing to the development of these illnesses. The high NCD burden, coupled with aging and other unfavorable demographic trends, has increased the vulnerability of the population to COVID-19. NCDs need to be addressed in the complex governance system of BiH, in which policy making and reform activities in the health sector are the responsibility of the Government in Republika Srpska and Government in the Federation of BiH as well as the cantonal governments in the Federation of BiH.

Integrated programs are key for the prevention and control of NCDs. These programs combine resources and approaches in ways that align activities for prevention and disease control and health promotion in the entire community. They may involve an assessment of population health needs, development of guidelines, and use of managerial acumen to drive the system towards responding to the needs. Integrated management is especially recommended in countries with limited resources and is relevant in countries with mixed systems where both private and public providers play a role in the supply of care. However, in many health systems, while the role of public provider is understood, the private sector is far less explored or well-coordinated.

Hence, this assessment of private sector provision gives authorities and development partners a better understanding of options for improving NCD prevention and control. It recommends actions that the health authorities in Republika Srpska and the Federation of BiH can undertake to better engage private providers in tackling NCDs. The assessment was informed by tools developed by the United States Agency for International Development (USAID) and the World Health Organization (WHO). The study framework encompasses three interrelated elements critical to understanding the role of the private health sector and scope for improvement: the policy environment and related regulatory issues (governance arrangements); health financing opportunities and constraints (financing arrangements); and private provision of health services (service delivery arrangements). The main findings and recommendations for each framework element are reviewed below.
Governance Arrangements

The legal framework for the provision of health care in Republika Srpska was recently revised, which provides a window of opportunity to improve the governance arrangements. The Ministry of Health and Social Welfare in Republika Srpska has set the strategic directions and the priority interventions in the “Action Plan for the Prevention and Control of NCDs in the Republika Srpska 2019–2026.” Though the action plan envisaged the engagement of private sector partners, the role of private health care providers in the implementation is not explicitly defined. Also, private health care providers are insufficiently aware of the action plan. Furthermore, institutional capacities for engaging with, contracting, and monitoring private health care providers need strengthening. Mechanisms have yet to be devised on how to specifically involve private facilities when embarking on the development of the new Program for the Prevention of NCD. Registries of the number and structure of private health facilities, and the services they provide are often not updated or publicly available. Existing regulations to enable more effective provision of NCD prevention and control services by private health facilities and through public–private partnerships are not sufficiently elaborated and updated.

The Federal Ministry of Health coordinates cantonal health administrations for health system planning and regulation in the Federation of BiH, including NCD-related services. The Action Plan for the Prevention and Control of Chronic NCDs 2019–2025 sets the strategic directions for the prevention and control of NCDs in the Federation of BiH. The Action Plan did not explicitly envisage the engagement of the private sector partners in its implementation. This implies that institutional capacity for engaging private providers may need to be strengthened. Application of the legislation defining requirements for the establishment of health facilities varies across the cantons. Separate cantonal health information systems further weaken efforts toward an integrated and coordinated approach to NCD prevention and control in the Federation of BiH.

### Main recommendations on governance

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<thead>
<tr>
<th>Republika Srpska</th>
<th>Federation of BiH</th>
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<td>Revise existing regulations to identify the roles of private providers in effective provision of NCD prevention and control services.</td>
<td>Ensure consistent monitoring of the application of legislation in the cantons in connection with the establishment of private health institutions.</td>
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<tr>
<td>Strengthen institutional capacities for engaging with, contracting, and monitoring private health care providers.</td>
<td>Strengthen the institutional capacities for contract preparation, monitoring, and reporting, with engagement of private sector providers.</td>
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<tr>
<td>Ensure updated public registry and more detailed information on the number and structure of private health facilities, and the services they provide.</td>
<td>Integrate the existing health information systems at the cantonal level to enable centralized access to the electronic medical record of each patient.</td>
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<tr>
<td></td>
<td>Enable the active participation of members of the medical chamber and professional associations of private health care providers in strengthening the health system and in NCD prevention and control activities.</td>
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</tbody>
</table>
Financing Arrangements

Contracting and payment mechanisms selectively incentivize the prevention and control of NCDs in Republika Srpska. Despite central pooling, a narrow revenue base limits funding for health care, including prevention and control of NCDs. Still, the Health Insurance Fund of Republika Srpska allocates funds for the provision of a limited number of prevention services by public providers. The Fund contracts a significant number of private health care providers for primary and hospital care. Although the private health facilities can choose whether to enter contractual arrangements with the Fund or not, uncertainties related to contracting conditions make it difficult to invest in expansion of services. The prices of health care services are the same for public and private health care providers contracted by the Fund. Furthermore, the criteria used in price-setting process and transparency of the process need to be improved.

Legislation in the Federation of BiH allows for contracting of services from private health care providers. Most of the revenue in the Federation of BiH is pooled at the cantonal level, limiting opportunities for cross-subsidization across risk levels in different cantons, including for NCDs. Approximately 10 percent of revenues are pooled into the Solidarity Fund managed by the Institute for Health Insurance and Reinsurance of the Federation of BiH, which finances certain preventive programs, but not those related to NCDs. There are differences in contracting regulations and practices between the cantons. Privately-owned pharmacies are usually contracted by the cantonal health insurance funds to dispense prescription medicines. Some cantons contract public and private providers for the provision of family medicine services, paying them through capitation. In the majority of cantons, there are no incentives for the provision of NCD prevention and control services.

The prices of health care services for contracting are determined by the Institute for Health Insurance and Reinsurance of the Federation of BiH, while the cantonal health insurance funds determine the prices of health care programs. The maximum price of health services for a private health care provider without a health insurance fund contract is set by the relevant health chamber.

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<th>Main recommendations on financing</th>
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<td><strong>Republika Srpska</strong></td>
<td><strong>Federation of BiH</strong></td>
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<tr>
<td>Allocate specific funds for financing of NCD prevention and control services in the Health Insurance Fund’s budget for all primary health care (PHC) providers.</td>
<td>Introduce incentive payments for better NCD prevention and control.</td>
</tr>
<tr>
<td>Define and adopt payment methods that incentivize the provision of NCD-related services by private and public health care facilities, including results-based payments.</td>
<td>Develop operational and financial plans which define the budgetary allocation for implementation, in line with the Action Plan for NCD control.</td>
</tr>
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<td>Engage with private and public health care providers regarding the refinement/development of nomenclature of services on primary secondary and tertiary level of care, setting capitation rates, and setting service prices.</td>
<td>Engage with private health care providers in refining health insurance funds’ contracting practices, payment for performance systems, capitation rates, and prices.</td>
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</table>
Service Delivery Arrangements

**Executive Summary**

A variety of private health care providers deliver NCD prevention and control services. Private practices and polyclinics in the Federation of BiH and specialist practices and specialist centers in Republika Srpska provide NCD prevention and control services. These are mostly small and medium-sized providers, due to the high cost of establishing larger facilities. The lack of a health network plan and unclear referral paths from private to public providers contribute to the uncertainties related to the establishment of private health care facilities. There are plans to develop comprehensive NCD prevention programs in both Republika Srpska and the Federation of BiH. But although there are up-to-date clinical guidelines on the reduction of the most frequent NCD risk factors, the private sector had limited input in their development. Clinical guidelines on case management of the most frequent NCDs are outdated, and there are no care pathways to inform coordination of care for patients with NCDs across service delivery levels. Limited data are available from electronic health records for monitoring and evaluation of NCD prevention and control activities.

<table>
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<tr>
<th>Republika Srpska</th>
<th>Federation of BiH</th>
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<tr>
<td>Engage with private health care providers in the</td>
<td>Engage with private health care providers</td>
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<tr>
<td>development of the comprehensive NCD prevention</td>
<td>in the development of the comprehensive NCD prevention and</td>
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<tr>
<td>program, revision of referral system, and defining a</td>
<td>control program, and responsibilities for its implementation</td>
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<tr>
<td>network of health facilities.</td>
<td>based on the Action Plan for NCD prevention and control</td>
</tr>
<tr>
<td>Engage with private health care providers in the</td>
<td>Stimulate the utilization of electronic health records in public</td>
</tr>
<tr>
<td>development of care pathways and revision of</td>
<td>and private facilities providing NCD-related services.</td>
</tr>
<tr>
<td>existing clinical guidelines for NCDs.</td>
<td>Stimulate use of updated clinical guidelines for NCDs in public</td>
</tr>
<tr>
<td>Stimulate use of existing clinical guidelines and</td>
<td>and private facilities providing NCD-related services.</td>
</tr>
<tr>
<td>utilization of the electronic health records in</td>
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<tr>
<td>facilities providing NCD-related services, including</td>
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<td>private facilities.</td>
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1. Introduction

1.1 Purpose of the report

This report aims to assess the current role and scope of private health care provision for non-communicable diseases (NCDs) in Republika Srpska and Federation of Bosnia and Herzegovina (Federation of BiH). Over the last decade, the Ministry of Health and Social Welfare in the Republika Srpska and the Federal Ministry of Health have implemented municipal initiatives to reduce NCD risk factor exposure and formulate an action plan for NCD control. These efforts have been supported by development partners, including the Swiss Agency for Development and Cooperation (SDC), the World Bank, and the World Health Organization (WHO). The assessment recommends actions that the health authorities in Republika Srpska and the Federation of BiH can take to better engage private providers in tackling NCDs. In mixed health systems, improving NCD prevention and control requires effective partnerships between the public and private sector and establishing an effective regulatory and financial context to contribute to progress towards Universal Health Coverage.

Health sector reform is a priority in Bosnia and Herzegovina (BiH), as recognized by the recent Joint Economic Reform Program. This program has been adopted by each of the governments in BiH and informs development partners’ activity in the health sector. Under the recently approved Health Systems Improvement Project (HSIP), the World Bank will provide support to reforms of health systems in Bosnia and Herzegovina, including in service delivery. An important component of the HSIP will be to strengthen the primary care management of NCDs, with expansion of the private provision of the services. However, critical evidence gaps exist around the role of private healthcare providers. An analysis of the scope of private sector provision for addressing NCDs will give authorities in BiH and development partners a better
understanding of options for improving NCD prevention and management. Better understanding of the role of the private sector in BiH can also inform other countries’ strategies.

1.2 Methodology

The assessment methodology was based on the United States Agency for International Development’s Private Sector Assessment Tool, “Assessment to Action.” Elements of the methodology were also drawn from the WHO assessment guide for NCDs. The Assessment to Action approach typically encompasses five interrelated elements critical to understanding the wider role of the private health sector: assessing the policy environment and related regulatory issues (governance); identifying health financing opportunities and constraints (financing); documenting the private provision of health services (service delivery); mapping the supply of health products in the private sector; and analyzing demand for priority health services and products. Given the NCD focus, the supply of health products was not included in the assessment. The timeline for the assessment did not allow for the collection of data from service users that would enable an analysis of existing and potential demand for NCD prevention and control services from the private sector.

The study draws on primary data, collected via interviews, and secondary data, obtained via a literature review. Initial data collection was conducted through a desk review of relevant policy documents, legislation, analytical reports, and statistical data on the private sector and NCDs prevention and control in BiH. This information was supplemented and validated through 26 in-depth interviews held with key respondents from 16 health institutions and 10 private health care facilities from Republika Srpska and three cantons of the Federation of BiH. Interviews were conducted using interview guides (see Annexes A-G) that were informed by the assessment methodology and customized to the context of health systems in BiH. In addition to interviews, a focus group with 10 representatives of health authorities and private and public health care providers was held in the Federation of BiH to supplement the data collection (see Annex H).

Interview guides were tailored to the key informant’s type of organization. Following a mapping of key stakeholders, seven interview guides were tailored to different stakeholder groups including private providers, ministries of health, health insurance funds, accreditation agencies, medical chambers, and public health institutes. The interview guides covered the assessment of the policy environment and related issues (context, policy making, regulation, and public-private partnership arrangements); identification of health financing opportunities and constraints (financing of NCD services, market conditions, and contracting of private sectors); and documentation of the private provision of the NCD prevention and control services (establishment of private facilities, structure and number of private facilities, human resources, provision of NCD prevention and control services, and quality of care). In larger health facilities, where separate departments deal with the NCDs and private providers, more than one person was interviewed. The interviews lasted on average 60-90 minutes.

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1 SHOPS Assessment to Action, 2021.
2 WHO Regional Office for Europe, 2014.
The sample purposively selected different types of private health care providers that provide NCD prevention and control services: private specialist practices, private specialist centers, private health facilities, and public-private partnerships for hemodialysis and radiotherapy. In addition, four interviews were conducted with representatives of the health authorities that regulate, contract, and monitor services provided by private health facilities. Themes arising from the desk review were extracted and triangulated with themes from the experts’ assessments elicited during interviews. Preliminary findings and policy recommendations were presented to the representatives of health authorities and, in line with the feedback provided, those were adjusted for the final report.

The rest of the report is structured as follows. Chapter 2 provides background information about the burden of NCDs in BiH, and their risk factors. Chapter 3 provides an overview of the governance arrangements in the health systems of BiH, relevant for the provision of NCD prevention and control services by private health care providers. Chapter 4 discusses financing arrangements relevant for the provision of NCD prevention and control services by private health care providers. Chapter 5 describes the current delivery of NCD prevention and control services, focusing on the role of private health care providers. Chapter 6 proposes policy recommendations for the engagement of private providers in tackling NCDs in Republika Srpska and the Federation of BiH.
2. Country Context

Key takeaways

• Health policy making, including for NCDs, is the responsibility of the Government in Republika Srpska and the cantonal governments in the Federation of BiH.

• While life expectancy has increased over the past decades, NCDs have emerged as an important public health priority due to aging and social and behavioral risk factors.

• COVID-19 has posed a serious social, health, and economic challenge to BiH, the burden of which is driven in part by high NCDs and aging.
2. Country Context

BiH has a complex governance system. According to the Constitution of BiH, which is an integral part of the General Framework Agreement for Peace in BiH, the country consists of two entities—Republika Srpska and the Federation of BiH. All state functions and powers belong to the entities, except those which, according to the Constitution of BiH, have been placed within the exclusive competence of specific institutions of BiH. Federation of BiH, Republika Srpska, and Brcko District of BiH independently exercise their constitutional, legislative, executive, and judicial functions. The Federation of BiH has 10 autonomous cantons with 79 municipalities and cities; Republika Srpska has nine cities and 55 municipalities. Health policy making and reform activities, including those related to NCDs, are the responsibility of the Government in Republika Srpska and the cantonal governments in the Federation of BiH.

BiH is an upper middle-income country, with a gross domestic product (GDP) per capita of US$ 6,080 in 2020 (Table 1). The country has faced unfavorable demographic trends in recent years, including an aging and shrinking population, which significantly declined from 4.7 million people in 1990 to 3.3 million in 2020. Between 2008 and 2019, the percentage of the population aged 65 and above has increased from 13.8 to 17.2 percent and the total fertility rate has declined from 1.69 in 1996 to 1.25 in 2019. Emigration has been a significant feature of BiH’s demography in recent years. In 2017 net migration was -107,926, with mostly working-age adults choosing to leave.

Life expectancy in BiH has been improving over the past few decades. In 2018, life expectancy at birth for women and men stood at 79.7 and 74.7 years respectively, having risen steadily from 76 and 70 years, respectively, since 1996. This rise in life expectancy has been accompanied by a decline in infant mortality rate from 14 per 1,000 live births in BiH (14.9 in Republika Srpska) in 1996 to 6.7 per 1,000 live births in BiH (1.6 in Republika Srpska) in 2019. Under-5 mortality for children has fallen from 12.2 per 1,000 live births in 1996 to 5.9 per 1,000 live births in 2019.

Table 2.1. Key demographic and economic indicators in BiH and comparator countries, latest year available

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<tbody>
<tr>
<td>BiH</td>
<td>6,080</td>
<td>3,281,000</td>
<td>1.25</td>
<td>-107,926</td>
<td>77.40</td>
</tr>
<tr>
<td>Croatia</td>
<td>14,134</td>
<td>4,047,000</td>
<td>1.47</td>
<td>-40,000</td>
<td>78.42</td>
</tr>
<tr>
<td>Hungary</td>
<td>15,981</td>
<td>9,750,000</td>
<td>1.49</td>
<td>29,999</td>
<td>76.02</td>
</tr>
<tr>
<td>Serbia</td>
<td>7,721</td>
<td>6,908,000</td>
<td>1.52</td>
<td>20,000</td>
<td>75.69</td>
</tr>
<tr>
<td>Slovenia</td>
<td>25,517</td>
<td>2,100,000</td>
<td>1.61</td>
<td>9,999</td>
<td>81.28</td>
</tr>
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</table>

Source: Original table for this publication based on data from World Bank, 2022.

NCDs are the leading causes of death and disability in BiH. Since 2005, ischemic heart disease, cerebrovascular disease, diabetes, lung and colorectal cancer, and chronic obstructive pulmonary disease (COPD) have consistently been the top causes of death (Table 2.2). However, the mortality rate from NCDs between ages 30 and 70 years has fallen from 24.4 percent in 2000 to 17.8 percent in 2016. NCDs are also the dominant causes of disability and absenteeism, including conditions such as back pain, sensory organ disease, and migraines.

Table 2.2. Age-standardized death rates 0-64 years, per 100,000 population

<table>
<thead>
<tr>
<th>Country</th>
<th>Malignant neoplasms</th>
<th>Diseases of the circulatory system</th>
<th>Ischemic heart disease</th>
<th>Cerebrovascular disease</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Croatia</td>
<td>84.1</td>
<td>53.3</td>
<td>27.2</td>
<td>11.3</td>
<td>2016</td>
</tr>
<tr>
<td>Hungary</td>
<td>109.8</td>
<td>86.3</td>
<td>41.5</td>
<td>14.8</td>
<td>2016</td>
</tr>
<tr>
<td>Slovenia</td>
<td>72.2</td>
<td>28.0</td>
<td>16.1</td>
<td>5.6</td>
<td>2015</td>
</tr>
<tr>
<td>BiH</td>
<td>74.7</td>
<td>69.9</td>
<td>24.0</td>
<td>12.0</td>
<td>2014</td>
</tr>
<tr>
<td>Serbia</td>
<td>99.8</td>
<td>82.0</td>
<td>24.0</td>
<td>17.0</td>
<td>2015</td>
</tr>
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</table>

Source: Original table for this publication based on data from WHO Regional Office for Europe 2021.

The main risk factors behind NCDs are metabolic and behavioral risks. Between 2006 and 2019, tobacco consumption, high fasting plasma glucose, high blood pressure, and high body-mass index were consistently the top four risk factors for death and disability in BiH. Environmental risks, such as air pollution, are also among the top ten risk factors – see Figure 2.1 below.

Figure 2.1. Risk factors for the development of NCDs in BiH, both genders, all ages, 2019

Note: DALYs = disability-adjusted life years.
Source: Original figure for this publication based on data from IHME, 2021.
NCDs are the biggest public health priority in BiH. Health officials and private providers in Federation of BiH and Republika Srpska acknowledge that the country has a high burden of NCDs driven by behavioral and metabolic risk factors (Figure 2.2). They are aware that the epidemiological situation is like what pertains in other countries in the region where unhealthy diets, tobacco use, sedentary lifestyles, and an elderly population contribute to high mortality and morbidity due to NCDs. Interviewees agreed that work needs to be done to reduce NCD risk factors, increase early detection of these diseases, and implement comprehensive prevention programs.

Figure 2.2. Prevalence of selected NCDs in Republika Srpska and Federation of BiH, both genders, all ages, 2018-2020

The high NCD burden and aging increase the vulnerability of the population to COVID-19. BiH has a lower level of cumulative COVID-19 cases per million people than comparator countries. However, the COVID-19 pandemic has posed serious social and economic challenges to BiH, resulting in a slowdown in key productive sectors, lower demand for BiH exports, and a spike in unemployment. The sectors most affected by the pandemic are health, tourism, transport and agriculture. The number of registered unemployed people increased by 4.7 percent during 2020; this did not account for informal jobs, which represent a third of economic activity. The pandemic compounded long-standing structural challenges undermining BiH’s development potential, including a large and inefficient public sector, a private sector stifled by difficulties in the business environment, limited export competitiveness, and a rapid loss of human capital to emigration.
3. Governance for NCD Prevention and Control

Key takeaways

• Responsibility for organizing the health care systems and providing health care services, including NCD prevention and control services, is constitutionally devolved to the Republika Srpska and the Federation of BiH.

• Implementation of entity action plans for the prevention and control of NCDs is delayed due to a lack of financial resources and the COVID-19 pandemic.

• Private providers are not recognized as stakeholders responsible for implementing the action plans for the prevention and control of NCDs. Thus, the relationship between the health authorities and the private health sector in BiH could be more collaborative and inclusive.

• Comprehensive involvement of the private sector in the implementation of the action plans for the prevention and control of NCDs requires refinement of existing legislation and a cooperative approach between interested parties.
This chapter describes governance arrangements in the health systems of BiH relevant for the provision of NCD prevention and control services by private health care providers. After an overview of the health systems’ organization, the chapter reflects on the policy and legislative framework regarding the establishment of private health care facilities, provision of NCD prevention and control services, and public-private partnerships (PPP) in Republika Srpska and the Federation of BiH.

3.1 Governance of health systems

Responsibility for organizing mandatory health insurance and providing health care services, including the NCD prevention and control services, is constitutionally devolved to the entity-, district-, and canton-level governments – the latter in the Federation of BiH only. The health systems in BiH include the health system of Republika Srpska, a health system in each of the ten cantons in the Federation of BiH, and the health system of Brcko District (Table 3.1). The Law on Ministries and Other Bodies of Administration of BiH stipulates responsibilities of the Ministry of Civil Affairs of BiH. In practice, however, the ministry’s involvement in the health care domain is weak and limited to aspects of international engagement, including reporting to international organizations. Legislation in both health systems defines private health care institutions and providers as an integral part of each healthcare system.

Table 3.1. Overview of the organization of health systems in BiH

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<thead>
<tr>
<th>Institutions and Facilities</th>
<th>Federation of BiH</th>
<th>Republika Srpska</th>
<th>Brcko District</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ministry of health</td>
<td>1 federal ministry</td>
<td>1 (department)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>10 cantonal ministries</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health insurance fund</td>
<td>1 federal fund/institute</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>10 cantonal funds</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Public health institute</td>
<td>1 federal institute</td>
<td></td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>10 cantonal institutes</td>
<td></td>
<td>-</td>
</tr>
<tr>
<td>Quality and accreditation agency</td>
<td>1</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Public hospital</td>
<td>18</td>
<td>10</td>
<td>1</td>
</tr>
<tr>
<td>Public special hospital</td>
<td>3</td>
<td>3</td>
<td>-</td>
</tr>
<tr>
<td>Public special institute</td>
<td>12</td>
<td>6</td>
<td>-</td>
</tr>
<tr>
<td>Public primary health care centers</td>
<td>79</td>
<td>55</td>
<td>1</td>
</tr>
</tbody>
</table>

Source: Original table for this publication.

3. Governance for NCD Prevention and Control

Republika Srpska

The health system in Republika Srpska is centralized. The health system planning, regulation, and governance functions are held by the Ministry of Health and Social Welfare in Republika Srpska. While the Government of Republika Srpska is the founder of the Public Health Institute of Republika Srpska, the Health Insurance Fund of Republika Srpska, the Agency for Certification, Accreditation, and Improvement of Health Care Quality of Republika Srpska, and public hospitals and institutes, the primary health care centers (dom zdravlja) are owned and to some extent managed by local self-governance units—municipalities and cities. The Health Insurance Fund of Republika Srpska administers the compulsory health insurance scheme in support of the provision of health care service by the public and private facilities.

Federation of BiH

In contrast, in the Federation of BiH, the Federal Ministry of Health, located in Sarajevo, coordinates cantonal health administrations for planning and regulation functions. Each of the ten cantonal administrations is responsible for governing the provision of primary and secondary health care as well as tertiary health care, including for NCDs, through its ministry. Cantonal health insurance funds finance health care for insured persons through contracting with health care institution(s) founded by the cantons or municipalities. Cantons also manage their public health institutes, which among other duties, are responsible for performing health promotion and disease prevention functions. Capital investments in the hospital sector are approved by the Ministry of Health (at the cantonal or Federation of BiH level) and included in the annual government budget or the budget of the health insurance fund. The Federal Institute for Health Insurance and Reinsurance, through the Federal Solidarity Fund, finances the provision of complex health services in specialized facilities for insured people from all cantons, and funds for priority vertical health care programs including some prevention programs.

3.2 NCD-related policy documents and legislative framework

Action plans for prevention and control of NCDs in Republika Srpska and the Federation of BiH are based on the action plan for the WHO European Region. The documents were developed under the SDC-supported project, “Reducing Health Risk Factors in BiH – Developing and Advancing Modern and Sustainable Public Health Strategies, Capacities and Services to Improve Population Health in BiH.” The strategic framework for prevention and control of NCDs also covers mental health, sexual and reproductive health, diabetes, and cancer.

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8 WHO Regional Office for Europe, 2016.
The Action Plan for the Prevention and Control of NCDs in the Republika Srpska 2019–2026 sets the strategic directions for the prevention and control of NCDs. The action plan was developed with the support of the WHO and SDC. It sets the goal of taking integrated action on risk factors in all sectors and strengthening the health system for improved prevention and control of NCDs. It calls for a comprehensive approach that systematically integrates policy and action to reduce inequalities in health and tackles NCDs, with simultaneous actions on: (1) carrying out population-level health promotion and disease prevention programs; (2) actively targeting groups and individuals at high risk; and (3) maximizing population coverage with effective treatment and care.

The action plan envisaged the engagement of private sector partners in the implementation of the priority interventions. It outlines partnership areas with the private sector in: (1) promoting, protecting, and supporting breastfeeding; (2) reducing alcohol consumption; (3) promoting healthy lifestyles and reducing discrimination against people with chronic diseases in the workplace; (4) preparing and conducting comprehensive social marketing campaigns; (5) enabling and promoting active lifestyles and mobility; (6) reducing air pollution; and (7) advancing the implementation of the WHO Framework Convention on Tobacco Control. Private health care providers could potentially play a role in the implementation of all the listed activities. However, the action plan does not directly specify private health care providers, but the role of the private health care providers is implied whenever the generic term “health facilities” is used.

Representatives of health authorities in Republika Srpska acknowledged that private partners are needed to successfully implement the Action Plan. They clarified that although private facilities are not specifically mentioned in the Action Plan, it was expected that all health care facilities – public and private – that had a contract with the Health Insurance Fund of Republika Srpska would work on implementation once the Public Health Institute of Republika Srpska develops a new Program for the Prevention of Non-Communicable Diseases. But mechanisms have yet to be devised on how to specifically involve private facilities – primarily private family medicine and gynecology practices – when embarking on this new program.

Private sector providers in Republika Srpska stated there is a lack of clear vision on the private sector’s role in the Action Plan. Private sector respondents had mixed awareness of the Action Plan – some were aware of it, while many were not. Those who were aware of the plan believed there was no special or specific role for the private sector. Others were not optimistic that the health authorities would implement the plan at all or involve the private sector in its implementation.

The outbreak of the COVID-19 pandemic and lack of financial resources delayed progress on implementation of the planned activities. The Action Plan was adopted by the Government of Republika Srpska in December 2018, and preparation for its implementation commenced in 2019 with the definition of specific institutional level plans and required financing. However, due to the outbreak of the COVID-19 pandemic, there was a delay in the advancement of the

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planned activities. Several key informants stated that the government was experiencing difficulties in implementing the Action Plan even before COVID-19. Key among the challenges was the lack of financial resources, which have not been clearly allocated for the implementation. It is not possible, therefore, to assess progress on the actual engagement of the private sector partners in the implementation of the Action Plan for Republika Srpska or actual use of the engagement mechanisms.

**Measures to reduce morbidity and premature deaths from reproductive cancers are primarily to be implemented by public health care providers.** One of the general goals of the Strategy for Improving Sexual and Reproductive Health in Republika Srpska (2021–2029) is to reduce the burden of reproductive diseases—malignancies, sexually transmitted diseases, and development abnormalities of the reproductive tract.\(^{10}\) The strategy outlined several measures to reduce morbidity and premature deaths from reproductive cancers, such as the continuous implementation of health education; the introduction of the human papillomavirus vaccination program; the introduction of organized breast cancer and cervical cancer screening programs; ensuring coverage of women by the screening programs; and establishment of psychological support services for persons suffering from reproductive organ cancers and their families. Responsibility for the implementation of all the measures lies with the public health care providers. At the same time, the strategy recognizes that private laboratories should play a role in accurately and rapidly detecting sexually transmitted diseases.

**The legal framework for the provision of healthcare services including prevention and control of NCDs was recently updated.** The most important regulations relevant to the prevention and control of NCDs in Republika Srpska are the Law on Health Care, the Law on Mandatory Health Insurance, and the bylaws enacted based on the laws. The Law on Health Care regulates the establishment of the health facilities, type and jurisdiction of health facilities, responsibilities of Republika Srpska and municipalities in the health care provision, and quality standards and indicators.\(^{11}\) The Law on Mandatory Health Insurance regulates the system of mandatory health insurance, insurance entitlements, copayments, and purchasing of health services.\(^{12}\) It is expected that all the relevant bylaws will be revised and enacted. This provides a window of opportunity to consider the recommendations provided in this report, reflect on their impact on the private delivery of healthcare, and influence the recommended policy options in the legal framework in Republika Srpska.

**Federation of BiH**

**The Action Plan for the Prevention and Control of Chronic NCDs 2019–2025 was also developed with the support of WHO and SDC.**\(^{13}\) It sets the strategic directions for the prevention and control of NCDs in the Federation of BiH, based on a set of leading principles (Box 3.1). The action plan defines the following goals: (1) strengthen leadership, capacities, multisectoral actions and partnership to facilitate response in the prevention and control of NCDs; (2) reduce risk factors for the development of chronic NCDs; (3) strengthen/orient all health care

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levels toward the prevention and control of NCDs by improving the management of biological risk factors (raised blood pressure, obesity, dyslipidemia); and (4) monitoring trends of chronic NCDs.

The Action Plan did not envisage the engagement of the private sector partners in its implementation. It defined activities in four priority action areas – governance, health promotion and disease protection, health care, and research, monitoring and evaluation. It also envisaged engagement of various implementing bodies and stakeholders, including health authorities and governmental agencies at the Federation of BiH and cantonal level, and national and international nongovernmental organizations. The Action Plan did not, however, specifically recognize the need to involve private health care providers to implement the planned activities.

According to Article 4 of the Law on Health Care of the FBiH, health care institutions, private practices, health insurance institutes, and the Agency for Quality and Accreditation in Health Care participate in the provision and implementation of health care. Therefore, private healthcare institutions and service providers are recognized as an integral part of the healthcare system. However, it is necessary to define the roles more clearly, especially in the implementation of systematic and comprehensive program activities, which implies clear tasks, methods of monitoring and evaluation, and achievement of set goals.

The strategic framework for the prevention and control of NCDs in the Federation of BiH extends to mental health and sexual and reproductive health. The Policy and Strategy for the Protection and Improvement of Mental Health in the Federation of BiH 2012–2020 outlines a set of specific objectives to improve and protect the mental health of the population.14 The policy and strategy advocate for partnership with other sectors in promoting mental health.

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14 Federal Ministry of Health, 2011.
health. The Strategy for the Improvement of Sexual and Reproductive Health and Rights in the Federation of BiH2010–2019 prioritized the promotion of sexual and reproductive health through the implementation of cancer prevention programs and specifically called for the introduction and implementation of a comprehensive cervical cancer screening program.\textsuperscript{15}

The engagement of private health care providers in implementation is not foreseen in the two aforementioned strategic documents on mental health and sexual and reproductive health. Both documents define a wide range of implementing partners including the Federal Ministry of Health, cantonal ministries of health, health care facilities, local communities, Center for Health Management, Agency for Quality and Accreditation in Health of the Federation of BiH, cantonal health insurance funds, nongovernmental organizations, and health professionals. However, neither of these strategies calls for the involvement of the private sector or private health care providers to implement the envisaged activities.

Private health care providers have not been recognized as implementing partners in the strategies on diabetes and cancers. Specific strategies for diabetes and cancer contribute to the strategic framework for the prevention and control of NCDs in the Federation of BiH. The Strategy for Combating Diabetes in the Federation of BiH 2014–2024 has the objectives to (1) reduce the incidence of Type 2 diabetes; (2) improve detection of diabetes; (3) ensure equally accessible, effective, safe and quality treatment of people with diabetes; and (4) ensure comprehensive and continuous collection of data on diabetes and functioning of monitoring and evaluation system.\textsuperscript{16} The Strategy for Prevention, Treatment, and Control of Malignant Neoplasms in Federation of BiH 2012–2020 calls for (1) improvement of the process of cancer early detection, so that the diagnosis is timely and the treatment is successful; and (2) introduction and improvement of organized population screenings for three localizations—breast cancer, cervical cancer, and colon cancer.\textsuperscript{17} Both strategies outline health care authorities and governmental agencies at the Federation of BiH and cantonal level as well as nongovernmental organizations as implementing partners, but neither mentions the engagement of private health care providers in meeting the objectives of the strategies.

A comprehensive NCD prevention and control program needs to be developed for the implementation of the Action Plan on Prevention and Control of NCDs. Representatives of health authorities from the Federation of BiH have emphasized that a prerequisite for the implementation of the Action Plan on Prevention and Control of NCDs is the development and adoption of a comprehensive and systematic NCD prevention program for the federal and cantonal levels. The need for the development of an adequate reporting system to facilitate effective monitoring of the implementation process was also expressed.

The Law on Health Care and the Law on Health Insurance in the Federation of BiH provide a legislative framework for the prevention and control of NCDs. The Law on Health Care defines that detection and control of risk factors for mass NCDs is provided on primary health care level and that activities on prevention and control of chronic diseases are funded from

\textsuperscript{15} Federal Ministry of Health, 2010.
\textsuperscript{16} Federal Ministry of Health, 2014
\textsuperscript{17} Federal Ministry of Health, 2012d.
the Federal budget.\textsuperscript{18} The Law on Health Insurance outlines the framework for the set of bylaws that specify the rights derived from mandatory health insurance that include health promotion, prevention and early detection of diseases, diagnostics, treatment, and rehabilitation.\textsuperscript{19} Other regulations relevant for the prevention and control of NCDs in the Federation of BiH are the bylaws enacted based on the laws. Apart from this, family medicine teams should provide the NCD prevention services as defined by the “The order on standards and normative on health services derived from compulsory health insurance in FBiH,” which includes nomenclature of services to be provided at different levels of care.\textsuperscript{20}

**Relevant legislation should be amended to enable the comprehensive involvement of the private sector in the implementation of the Action Plan.** Representatives of health authorities are aware that there are no defined policies or programs that explicitly involve the private health sector in its implementation. They also recognize that activities defined in the Action Plan are focused on public health care providers and that the private sector has not been envisaged to participate in the implementation. The option of developing a specific health sector program defining the type and scope of promotion and prevention services to be delivered by private providers was suggested. Other health officials pointed out that it would be necessary to change the Law on Health Insurance to enable contracting of private providers for the provision of NCD prevention and control services defined in the Action Plan.

**The same rules should apply to public and private providers related to the provision of NCD prevention and control services.** Private providers commented that there should be no division between public and private providers in legislation regulating the provision of NCD prevention and control services. They also pointed out that it was necessary to adopt legislation that would create an obligation for healthcare facilities and the population to perform regular preventive examinations and that sanctions for noncompliance should be introduced in the law. Further, the respondents remarked that adjustment of legislation between cantons was required if effective involvement of the private sector in the provision of NCD preventive and control services was expected.

### 3.3 Strategic and policy documents on private health care providers

There are no specific policies or strategies in the health systems in BiH on the role and scope of private health care providers in the provision of health care services to the population. No strategic document clearly defines the private sector’s role in health generally, or in specific health areas. Existing strategic documents provide limited direction for the engagement of private health care providers in service provision in general, and the prevention and control of NCDs. There is no framework to guide private sector engagement or regulations governing market entry, quality, or pricing for the services provided by private health care providers.

\textsuperscript{18} Parliament of Federation of BiH, 2010a.
\textsuperscript{19} Parliament of Federation of BiH, 1997.
\textsuperscript{20} Federal Ministry of Health, 2014.
Republika Srpska

The Action Plan for Ensuring Republika Srpska’s Health System Sustainability calls for better regulation of private health care providers. This plan envisages granting concessions for the establishment of new family medicine practices under private ownership, advocates for the strengthening of the inspection process of the private health care providers, and calls for revision of the current contracting practice between the Health Insurance Funds of Republika Srpska and the private health care providers to level the playing field between public and private facilities. Given the COVID-19 outbreak, it is unclear which of the measures from the plan have been implemented.

The key informant interviews revealed several policy reforms needed for the private sector to play a larger role. Several private sector informants noted that the Law on Health Care includes some problematic clauses that could present barriers to a private sector role in NCD prevention and control, such as the consent of local self-government to the establishment of the new private facilities and preparation of studies on the justification of investment in new facilities. An intention of the regulator was to improve planning and management of the network of health facilities, based on changing needs of the population. Public and private key informants agreed that it is important to define in the NCD guidelines which prevention examinations should be provided, to whom, by whom, and how often.

The relationship between the health authorities and the private health sector in Republika Srpska could be more inclusive or collaborative. According to health officials, representatives of private facilities and their associations can provide their comments on strategic documents submitted for public discussion, same as the representatives of public health facilities, patient associations and all other stakeholders. In the process leading to adoption of the latest health legislation, private providers made important contributions. On the other hand, private providers who were interviewed stated that the private sector is often not included, and they do not participate in drafting these documents, which gives the impression that private sector representatives are marginalized. Private sector providers have therefore formed a new association of private health facilities to protect their interests and to influence policy development in the health care system.

Federation of BiH

The Strategic Plan for the Development of the Health System for the period 2008–2018 recommended greater engagement of the private health care providers in the Federation of BiH. Although focused on the public health sector reforms, the strategic plan recognized the growing importance of the private sector and called for better coordination between the private and public sector at all levels of health care and the development of the public-private partnerships in the healthcare system.

Most health officials and private providers understand that private providers should be systematically involved in health policy making. They agree that is necessary to work on the development and adoption of publicly funded programs and action plans based on established
priorities and the need to involve the private sector in their implementation. They also agree that the private sector is now a recognized factor in health and has become a serious competitor to the public sector in health service provision. On the other hand, health officials stated that private facilities should not be financed by public funds. A private provider explained that the current insufficient participation of private health service providers in the policy-making process is a consequence of their general lack of interest in public health affairs.

There are opposing views regarding the involvement of private providers in the policy making process. Some health officials believe that private providers are adequately involved in policy development through public hearings in the process of adopting certain laws or have the option to influence policy through political groups according to their interests. On the other hand, other officials are of opinion that the representation of the private sector in the policy-making process is not adequate and there should be more systematic involvement of their representatives in the policy development process. A key informant said that any improvement in the functioning of the health system would have to consider the systematic involvement of the private sector. Similar views are held by the group of private providers, saying that they were not invited to participate in policy development and that they feel excluded from such processes. One of the respondents stated that private providers can be involved in the policy development through the process of public consultations and that their current insufficient participation in the policy-making process is a consequence of the private sector’s lack of interest in greater public engagement.

3.4 Legislative frameworks for establishment of private health care facilities

The legislative framework for the establishment of private health care providers differs between health systems in BiH. The separate laws in Republika Srpska and the Federation of BiH provide for different types of private health care providers in their health systems. Registration procedures and conditions for establishment also differ, as does legislation on public-private partnership in health care.

Republika Srpska

The legal framework was recently updated in Republika Srpska, but no major changes involved already established private health facilities. The new Law on Health Care still allows private entities—either companies or private persons—to establish various types of health facilities (table 3.2).23 It has also preserved the existing types of health facilities and allowed for two additional types of private health facilities to be established. The law provides for PPP arrangements to establish biological materials, reproductive tissues and stem cells banks; and continues to recognize specific services that cannot be provided in private health facilities, including organ transplantation, immunization, and emergency treatments. The scope of services in private health facilities has been more precisely regulated in the law, to discourage the facilities from providing services for which they are not registered. The establishment of pharmacies remains separately regulated.24

23 National Assembly of Republika Srpska, 2022a.
24 National Assembly of Republika Srpska, 2008.
### Table 3.2. Types of health care facilities and their establishment in Republika Srpska

<table>
<thead>
<tr>
<th>No.</th>
<th>Type of health facility</th>
<th>WHO CAN ESTABLISH THE FACILITY</th>
<th>Government of Republika Srpska</th>
<th>Municipality or City</th>
<th>Private entities</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Previous Law on Health Care</td>
<td>New Law on Health Care</td>
<td>Previous Law on Health Care</td>
<td>New Law on Health Care</td>
</tr>
<tr>
<td>1.</td>
<td>Nursing and rehabilitation practice</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>2.</td>
<td>Therapy, nursing, and rehabilitation practice</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>3.</td>
<td>Nursing home</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>4.</td>
<td>Family medicine practice</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>5.</td>
<td>Specialist practice</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>6.</td>
<td>Specialist center</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>7.</td>
<td>Dental practice</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>8.</td>
<td>Radiological dental practice</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>9.</td>
<td>Pharmacy</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>10.</td>
<td>Laboratory</td>
<td></td>
<td></td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>11.</td>
<td>Primary health care center</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.</td>
<td>Hospital</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>13.</td>
<td>Special hospital</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>14.</td>
<td>Clinical center</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.</td>
<td>Institute</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16.</td>
<td>Bank (biological material, stem cells, reproductive tissues/cells, and embryos)</td>
<td>✓</td>
<td>PPP</td>
<td>PPP</td>
<td></td>
</tr>
</tbody>
</table>

Note: Types of health care facilities were regulated by the previous Law on Health Care (National Assembly of Republika Srpska 2009); they are now included in the new Law on Health Care (National Assembly of Republika Srpska 2022). PPP = public-private partnership.

Source: Original table for this publication.

Private and public health facilities in Republika Srpska are established under the same conditions. A bylaw provides requirements regarding premises, equipment, and staffing that private and public health facilities need to meet to begin delivering health care services.\(^\text{25}\) Confirmation of compliance with the requirement is part of a health facility registration with the Ministry of Health and Social Welfare in Republika Srpska. Both private and public health...

facilities undergo the same registration process. The new Law on Health Care introduces additional requirements for registration of new private health facilities, which do not apply to the existing facilities. It empowers a municipality or a city to formally recognize the need for a nursing and rehabilitation practice, pharmacy, laboratory, dental practice, radiological dental practice, specialist practice (including family medicine practice and occupational medicine practice), specialist center, and therapy, nursing and rehabilitation practice in its network of health facilities plan. The Government of Republika Srpska will have to formally recognize the need for the existence of a special hospital in its five-year plan of health facilities network.

The establishment of public and private health facilities is financially demanding. Health officials in Republika Srpska do not consider the regulations for opening a health private health facility to be a barrier to market entry. However, health officials and private providers share the opinion that meeting requirements for establishment of health facilities, such as space, staff, and equipment are financially demanding. Access to capital and terms of credit present barriers to market entry which was shared by many private key informants. Also, private providers repeatedly emphasized that the Rulebook on the Conditions for the Establishment of Health Care Facilities is outdated and includes too many conditions related to unnecessary equipment that are not medically required.

Specific obstacles are mentioned related to the establishment of family medicine private practices. Private providers pointed out that the requirement for a doctor to have a family medicine specialization or additional education in family medicine is too demanding given the context that there are not enough family medicine specialists, declining interest in family medicine and additional education teaching programs have been terminated. Also, the requirement to have two nurses with additional education in family medicine is difficult to meet. The private providers also commented on the discriminatory practice where public primary health centers can have physicians working in family medicine departments without specializations or additional education in family medicine as well as nurses without additional education.

**Federation of BiH**

Provision of health service in the private sector of the Federation of BiH takes two different legal forms—private practices and private health facilities. The establishment of private health care providers is regulated by federal and cantonal level legislation. At the federal level, the Law on Health Care defines the main types of public and private health facilities in the Federation of BiH (Table 3.3), leaving an opportunity for cantonal level legislation to regulate the establishment of primary care level facilities. The law also allows for the establishment of private practices by health professionals who can both own the practice and provide the services. The law allows forming of private group practices, which is defined by separate bylaw. The establishment of public and private pharmacies is also regulated by the Law on Pharmaceutical Activities and corresponding bylaws. Although the legislations stipulate that public health activities like social medicine, epidemiology, and hygiene is to be performed by

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the public health care system, the law allows private provision of care and does not restrict the scope of NCD prevention and control services that could be provided in the private sector of the Federation of BiH.29

Table 3.3. Types of health care providers and their establishment in the Federation of BiH

<table>
<thead>
<tr>
<th>No.</th>
<th>Provider types</th>
<th>Who can establish the health care provider</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Federation and/or Cantons</td>
</tr>
<tr>
<td>1</td>
<td>Family medicine practice</td>
<td>✓</td>
</tr>
<tr>
<td>2</td>
<td>Specialist practice</td>
<td>✓</td>
</tr>
<tr>
<td>3</td>
<td>Nursing practice</td>
<td>✓</td>
</tr>
<tr>
<td>4</td>
<td>Dental practice</td>
<td>✓</td>
</tr>
<tr>
<td>5</td>
<td>Dental technician practice</td>
<td>✓</td>
</tr>
<tr>
<td>6</td>
<td>Radiological dental practice</td>
<td>✓</td>
</tr>
<tr>
<td>7</td>
<td>Physiotherapy practice</td>
<td>✓</td>
</tr>
<tr>
<td>8</td>
<td>Laboratory</td>
<td>✓</td>
</tr>
<tr>
<td>9</td>
<td>Polyclinic</td>
<td>✓</td>
</tr>
<tr>
<td>10</td>
<td>Dialysis center</td>
<td>✓</td>
</tr>
<tr>
<td>11</td>
<td>Specialized institute</td>
<td>✓</td>
</tr>
<tr>
<td>12</td>
<td>Palliative care facility</td>
<td>✓</td>
</tr>
<tr>
<td>13</td>
<td>Community nursing facility</td>
<td>✓</td>
</tr>
<tr>
<td>14</td>
<td>Pharmacy</td>
<td>✓</td>
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<tr>
<td>15</td>
<td>Spa</td>
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<tr>
<td>16</td>
<td>General hospital</td>
<td>✓</td>
</tr>
<tr>
<td>17</td>
<td>Special hospital</td>
<td>✓</td>
</tr>
<tr>
<td>18</td>
<td>Cantonal hospital</td>
<td>✓</td>
</tr>
<tr>
<td>19</td>
<td>University clinical hospital</td>
<td>✓</td>
</tr>
<tr>
<td>20</td>
<td>Primary health care center</td>
<td>✓</td>
</tr>
<tr>
<td>21</td>
<td>Emergency care facility</td>
<td>✓</td>
</tr>
<tr>
<td>22</td>
<td>Institute</td>
<td>✓</td>
</tr>
</tbody>
</table>

Source: Original table for this publication.

Conditions for the establishment of private health facilities and private practices differ in the Federation of BiH. Two separate bylaws set the conditions in the Federation of BiH.30 The bylaws are complemented by the rulebook on conditions for performing additional work by health professionals employed by health facilities.31 The regulations also outline rules for creating a private-public partnership (PPP) between existing public health facilities and private practice. Private practices are established by an individual health professional, while health

29 Federal Ministry of Health, 2012b.
facilities can be established by domestic or foreign individuals or legal entities that are not necessarily healthcare professionals. Private practices and private health facilities must obtain the certificate of need from the health chamber(s), while health facilities additionally need to obtain the opinion of the responsible public health institute. An individual can form only one private practice but can establish several health facilities.

**Regulations for the establishment of health facilities in the Federation of BiH are well designed and detailed, but there is room for improvement regarding their implementation.** According to the health authorities, existing bylaws that regulate the establishment of public and private health care facilities are well defined with clear requirements describing needed space, equipment, and health staff for each type of facility. However, representatives of the health officials pointed out that, in some cantons, authorities apply federal rules partially and selectively, making regulations meaningless. Private providers agreed that the legal framework was very clear and comprehensive, but emphasized that entering the market was financially demanding. They added that the procedure to establish a facility should be simplified and more applicant-friendly.

### 3.5 Public-private partnerships

The legislation that regulates public-private partnership (PPP) in health care systems is decentralized in BiH. In Republika Srpska, the Law on Public-Private Partnership states that a health infrastructure and/or service can be a PPP and that public need for the establishment of the PPPs can be expressed by the health care institutions. The Ministry of Health and Social Welfare in Republika Srpska manages two private-public partnership contracts for the provision of radiotherapy and hemodialysis services. In the Federation of BiH, there is no umbrella law on health PPPs, but the cantons have recognized the potential of the PPPs and passed laws on it.

**Republika Srpska**

Hemodialysis and radiotherapy services in Republika Srpska are provided by health facilities operating under PPP arrangements. Health officials from Republika Srpska expressed satisfaction with the existing PPP arrangements. They understand that private partners have an interest in entering PPPs for complicated, infrequent, and expensive services, but felt that the interest of private partners in establishing PPPs in relatively inexpensive NCD prevention and control should not be expected. On the other hand, some health officials stated that if additional funds for NCD prevention and control would be provided – from additional taxes for environmental protection and excise taxes – it would be possible to motivate private sector investors to enter the PPP for NCDs.

Private providers feel that positive experiences can be drawn from the PPP model in Republika Srpska. They emphasized that there was insufficient understanding and knowledge in the public and among some health authorities about the PPP model of health care delivery. They suggest that it would be useful to further promote positive experiences from

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32 National Assembly of Republika Srpska, 2009b.
the PPP model to attract other investors to establish facilities under the PPP arrangements. Promoting the benefits of this model of health care delivery would also help to change the negative perception of facilities operating under the PPP model as purely private for-profit facilities.

**Regulation outlining the establishment of the health facilities under PPP arrangements needs refinement.** A representative of private partners under the existing PPP arrangements expressed shortcomings related to an insufficiently clear framework to establish a PPP in the health care system, and that health PPPs are established on basis of the Public Procurement Law, which is not specific to health. Also, there is a legal constraint with obtaining a license to continue PPP operations after 10 years, and authorities are actively seeking solutions. On the other hand, other representatives from the private sector stated that the Law on Concessions and Public-Private Partnerships allows for establishing public-private enterprises in health care.

**Federation of BiH**

Public-private partnership arrangements are yet to be introduced in the health system of the Federation of BiH. Representatives of health authorities in the Federation of BiH stated that they were not aware of the possible benefits of the PPP model as they did not have experience with such types of projects. An example of the PPP project in Zenica Doboj Canton was mentioned where private investment in the building of the department of interventional cardiology in Zenica Hospital was stopped due to unresolved property issues. Private providers expressed the opinion that PPP arrangements could be a successful mechanism for the effective provision of NCD prevention and control services. Both groups of respondents believed more external investments in the health sector were needed, including investments in the provision of NCD prevention and control services.
4. Financing of NCD Prevention and Control

**Key takeaways**

- Total health expenditure per capita in BiH is the lowest in the region. As a percentage of GDP, the country’s spending on health is higher than in neighboring countries.
- About 70 percent of total health expenditures is publicly financed, however, budget allocations for NCD prevention and control are highly limited.
- Legislation in health systems in BiH allows for the contracting of private health care providers. Most private health care providers in Republika Srpska are contracted by the Health Insurance Fund. In the Federation of BiH, the contracting of private providers varies between cantons.
- Contracting and payment mechanisms selectively incentivize the prevention and control of NCDs in Republika Srpska, while in the Federation of BiH, several cantons have introduced incentives for NCD prevention and control.
- Capitation rates and prices of health care services for contracted facilities are determined by the health insurance funds with limited or no input from the service providers.
- The prices of non-contracted services provided by private facilities in Republika Srpska are set without restrictions, while in the Federation of BiH maximum prices are determined by medical chambers.
This chapter describes financing arrangements in the health systems of BiH that are relevant for the provision of NCD prevention and control services by private health care providers. After an overview of health care financing in BiH, the chapter discusses allocations for NCD prevention and control services, contracting of private health care providers, and pricing of the private health care providers’ services in Republika Srpska and Federation of BiH.

4.1 Health care financing in health systems in BiH

Total health expenditure per capita in BiH is the lowest in the region. However, as a percentage of GDP, the country’s spending on health is higher than in neighboring countries. Expenditure on health as a percentage of GDP reached 8.9 percent in 2018 (Figure 4.1). According to the Agency for Statistics of BiH, expenditure on health as a percentage of GDP reached 9.0 percent in 2019.33 In 2019, Republika Srpska spent more than the Federation of BiH (Figures 4.2 and 4.3), both in absolute (1009 BAM/515 EUR versus 896 BAM/458 EUR per capita) and in relative terms (11.3 percent versus 8.5 percent of GDP).

Figure 4.1. Current health expenditure in BiH and countries in the region, 2018

Source: Original figure for this publication based on data from World Bank, 2021b.

About 70 percent of total health expenditures is publicly financed. According to aggregated National Health Accounts, total health expenditures in BiH in 2019 amounted to 3,194 million BAM (approximately USD 1.85 million or EUR 1.63 million), of which about 70 percent was financed by public funds and about 30 percent came from private expenditures. Medicines and medical devices for outpatients are largely financed from direct household (private) expenditure (Figure 4.4), which raises equity and access concerns. Long-term care, preventive health care, and health administration are primarily financed by public expenditure.
Repulika Srpska

In Republika Srpska, despite central pooling, a narrow revenue base limits funding for health care, including NCDs. Revenues are pooled through a single health insurance fund. Salary contributions are pooled from across Republika Srpska. Financial sustainability is also limited by the insufficient cross-subsidization and wider demographic and macroeconomic constraints that affect resource allocation for efficient prevention and control of NCDs. Earmarked taxation of alcohol and tobacco was proposed as an additional revenue stream to fit this purpose, although reaching a political agreement regarding such earmarking has proved to be difficult. Introduction of a new model for covering costs of patients injured in traffic accidents was also considered, whereas insurance companies would contribute by allocating a percentage of the premiums paid under auto insurance policies to treatment of these patients, as it is done in Croatia and Serbia.

Federation of BiH

Health financing in the Federation of BiH is largely fragmented. Revenues are pooled at the cantonal level, limiting opportunities for cross-subsidization across risk levels in different cantons, including for NCD. Approximately 10 percent of revenues are pooled into the Solidarity Fund managed by the Institute for Health Insurance and Reinsurance of the Federation of BiH. This fund primarily finances complex or high-cost clinical services and medicines – for example in cancer care – as well as provision of health care abroad, if treatment cannot be provided in BiH.
4.2 Financing of NCD prevention and control services

Budgetary allocations for NCD prevention services differ between Federation of BiH and Republika Srpska, as shown below in Figure 4.5. The Health Insurance Fund of Republika Srpska has recently started allocating funds specifically for the provision of prevention services in the publicly-owned PHC centers. Also, a limited number of preventive services are included in the scope of services for family medicine teams.\textsuperscript{35,36} The Federal Institute for Health Insurance and Reinsurance finances certain preventive programs for insured people through the Solidarity Fund in all cantons of the Federation of BiH. However, these programs are not related to the prevention of NCDs.\textsuperscript{37}

**Figure 4.5.** Expenditure for prevention in Republika Srpska and Federation of BiH, percentage of total annual expenditures, 2017-2019

Sources: Original figure for this publication based on data from Institute for Statistics of Federation of BiH (2020a, b and 2021) and Republika Srpska Institute of Statistics (2020 and 2021a). Note: The reported data about expenditures on prevention programs in the Federation of BiH might not be reliable, as, Zenica-Doboj, Tuzla and Herzegovina-Neretva cantons implement specific prevention programs, such as breast cancer early detection program (Ministry of Health, Labour and Social Welfare of Herzegovina-Neretva Canton, 2018).

Republika Srpska

The health officials from Republika Srpska confirmed that there is a specific allocation for the provision of NCD prevention and control services in the Health Insurance Fund’s budget exclusively for the publicly owned PHC centers. Also, health officials and private providers feel that specific incentives for the provision of NCD prevention and control services should be designed and implemented.

\textsuperscript{35} Republika Srpska Health Insurance Fund, 2022.
\textsuperscript{36} Republika Srpska Health Insurance Fund, 2023.
\textsuperscript{37} Federal Health Insurance and Reinsurance Fund, 2020.
Federation of BiH

Respondents from the Federation of BiH presented a similar view regarding financing for the provision of NCD prevention and control services. Health officials stated that the government should play a more prominent role in the financing of NCD programs. It was suggested that supplementary and extended health insurance could be introduced to secure financing of health services including NCD prevention and control programs. Focus group participants pointed out that public and private providers at the PHC level prefer payment by service, while payment by program – the dominant payment model in the public sector – is acceptable to private providers. Respondents emphasized the need to develop financial incentives for the PHC level, specifically for family medicine teams, which should include the provision of health promotion and NCD prevention and control services. The model of remuneration for family medicine teams that provide NCD prevention and control services in Herzegovina-Neretva, Tuzla, and Zenica-Doboj cantons was mentioned as a good practice example.

4.3 Contracting of private health care providers

Though legislation in the health systems of BiH generally allows for the contracting of private health care providers, only some types of facilities have been contracted. Health insurance funds in BiH usually contract private pharmacies for dispensing medication. Other types of private providers could be contracted in some of the health systems. The pricing of medical services is differently regulated across the health systems. Out-of-pocket payments by users may be more significant in the cantons of the Federation of BiH, where the health insurance funds do not contract the services of private health care providers.

Republika Srpska

The Health Insurance Fund of Republika Srpska contracts a significant number of private health care providers. The Law on Health Insurance stipulates that both public and private health care providers can be contracted for the provision of health services. The Fund’s rulebook on contracting permits contracts to be concluded with private pharmacies, special hospitals, specialist practices, and specialist centers. Contracting follows the annual public invitation for submission of proposals by providers. Private health facilities can choose whether to enter contracting arrangements with the Fund. Virtually all the private pharmacies are contracted by the Fund for dispensing medicines and medicinal products to insured population. The Fund does not contract dental care services with private dental practices. Private health care facilities registered for family medicine, specialist practices, and specialist centers are, inter alia, contracted for services in the field of family medicine, laboratory diagnostics, radiology and ultrasound diagnostics, and prescribing medicines.

The Health Insurance Fund of Republika Srpska contracts diagnostic services and hospital care from private and public providers. The special hospitals, specialist practices, and specialist centers can be contracted for the ambulatory services in several medical fields: internal medicine, pediatrics, cardiology, neurology, pulmonology, urology, orthopedics,
4. Financing of NCD Prevention and Control

ophthalmology, otolaryngology, dermatovenerology, oncology, and general surgery – see Figure 4.6 below. The Health Insurance Fund of Republika Srpska has integrated private hospitals in the diagnosis-related group (DRG) payment system for the provision of acute hospital care. For the provision of ambulatory care, special hospitals are contracted by the Fund for some of their services, and they continue to charge users directly for the non-contracted services.

Figure 4.6. Private specialist practices contracted by the Health Insurance Fund of Republika Srpska, 2021

Public and private respondents in Republika Srpska consider contracting an important tool for encouraging private investments in the health sector, though several issues need to be addressed. Although health authorities believe that the increasing number of private facilities contracted by the Health Insurance Fund of Republika Srpska suggests that there are no major problems with the financing of their services, private providers feel that the way the Fund’s contracts are implemented creates uncertainty in the marketplace. Private sector informants stated that the rulebook on contracting allowed the Fund wide discretion in deciding whether to award a contract or not. They also stated that they could not rely on the revenue from the contract with the Fund, due to this uncertainty, making it difficult to invest in expanding services. They also noted that the public sector was favored in contracting because all specialties in health centers were contracted regardless of the needs of the population, while in the private sector the Fund made selective contracts for the required services. Health authorities believe that the current contracting approach is aligned with duties and obligations of the public sector, which could not be simply compared to those of the private sector, and that private health facilities selectively choose areas of service provision, led only by profitability principles. They also noted that contracting conditions are equal for the public and private health facilities, although the scope of service provided by the public facilities is much wider than the scope of private facilities’ services, allowing the insured population to get all the required services in a simpler manner, less costly and at one place.

Contracting and payment mechanisms selectively incentivize the prevention and control of
NCDs in Republika Srpska. Contracts for public- or privately-owned health care facilities providing family medicine services are based on the number of registered family medicine teams in the facility and weighted capitation, which should incentivize prevention to encourage cost containment. However, the contracts for publicly-owned PHC centers have funds specifically allocated for NCD prevention and control while the contracts for the private providers do not specifically mention the provision of such services. Contracts for both types of providers do not include any additional incentives for the efficient management of chronic diseases or provision of preventive services. Low capitation rates for financing of health facilities, relatively low salary payments for health workforce in publicly-owned PHC facilities, together with penalties for over-prescribing, excessive referrals for laboratory diagnostics, and high sick leave rates further disincentivize the provision of NCD prevention and control services according to the clinical guidelines.

Several key informants from the private sector stated that private providers do not have the interest or resources to provide the contracted types of services without some form of additional reimbursement. A key informant stated that contracts with the Health Insurance Fund of Republika Srpska did not incentivize the private sector to deliver prevention services, noting that if prevention services would receive additional payments, then private facilities would provide them. Private provider informants recommended revising the list of services to include prevention, changing prices of services, and revising the capitation rate in line with market prices to stimulate growth in the number of family medicine practices and to encourage them to deliver more NCD prevention and control services.

Federation of BiH

Legislation in the Federation of BiH also allows for the contracting of the services from private health care providers.\textsuperscript{39} The Unified Contracting Methodology in the FBiH defines the criteria and standards for contracting between a health insurance funds and a health care facility. The document entails contracting details such as the population by age and gender structure; number of insured persons by age and gender structure; general information about the area (size, settlement density, facilities, terrain configuration, traffic connectivity, and morbidity of the population); health care standards; health care program on provision; prices of health services; fees for financing the annual health program; and participation of insured persons in paying for health care.\textsuperscript{40}

The health ministries and health insurance funds at the cantonal level regulate the conditions for contracting through their bylaws. Consequently, there are differences in contracting regulation and practices among the cantons. Privately-owned pharmacies are usually contracted by the cantonal health insurance funds to dispense prescription medicines. The health insurance fund of Sarajevo Canton contracts private polyclinics for the provision of family medicine services and spas for medical rehabilitation. Bosnian-Podrinje Canton contracts private polyclinics for the provision of diagnostic services—computer tomography and magnet resonance. Tuzla Canton contracts private practices for the provision of family medicine services and rehabilitation.

\textsuperscript{39} Parliament of Federation of BiH, 1997 and 2010a.
\textsuperscript{40} Federal Institute for Health Insurance and Reinsurance, 2013.
4. Financing of NCD Prevention and Control

medicine services, polyclinics for the provision of specialist medical services, and hospitals for the provision of hospital care to the insured population. The health insurance fund in Zenica-Doboj Canton has been contracting private family teams since 2005, and private providers for mammography screening since 2018. Health insurance funds in other cantons still have not started contracting private providers.

Health officials from the Federation of BiH stated that there were differences in approach between cantons in the contracting of private facilities. According to some health officials, unclear legislation regarding the contracting of health services contributes to the different private provider contracting approaches by cantons in the Federation of BiH. While the health insurance funds of Tuzla and Sarajevo cantons contract private providers in family medicine, the counterpart fund of Herzegovina-Neretva canton does not contract private providers, except pharmacies. Within the pooling mechanism, a representative from the Federal Health Insurance and Reinsurance Fund stated that the institution contracts public and private providers that have been verified for the provision of services financed from the Solidarity Fund. Health officials from Sarajevo Canton remarked that the cantonal health insurance fund was preparing specific health programs to finance, aiming to encourage private providers to apply for health service provision contracts. However, a key informant pointed out that although the legislation allowed for the private health facilities to be contracted by public health insurance funds, it was still necessary to prepare for this reform. There was some disagreement on the need to contract the private sector. For example, a representative from Herzegovina-Neretva Canton emphasized that public health care providers meet the needs of the population for health care and therefore there was no need to contract private providers.

In some cantons in the Federation of BiH, public primary health care centers are financed through line-item budgets, while in others, the centers are financed through capitation. Some cantons contract public and private providers for the provision of family medicine services, paying them through capitation. The Federal Institute for Health Insurance and Reinsurance through the Solidarity Fund pays for medical services through a fee-for-service model and also covers the costs of diabetes treatment for insured persons in the Federation of BiH. In the majority of cantons, there are limited incentives for the provision of NCD prevention and control services, except in Herzegovina-Neretva, Zenica-Doboj, and Tuzla cantons, where the cantonal health insurance fund has introduced additional remuneration for the provision of NCD prevention and control services.

4. Financing of NCD Prevention and Control

4.4 Pricing of the private health care providers’ services

Pricing of the services provided by the private health care facilities differs in the Federation of BiH and Republika Srpska. While in both entities, capitation rates and prices of health care services for contracted facilities are determined by the health insurance funds with limited or no input from the service providers, the setting of prices for non-contracted services by private providers differs between entities.

Republika Srpska

The Health Insurance Fund of Republika Srpska determines the prices of health services provided in the contracted health facilities. The Law on Mandatory Health Insurance has defined that the Fund sets the prices of health services by adopting the pricelist, aligned with the nomenclature of health services. The prices of contracted health care services are the same for public and private health care providers contracted by the Fund. Private health care providers that are not contracted by the Fund are allowed to set prices for their services by themselves.

The interviews revealed that setting of prices was not fully transparent and inclusive. Key informants from private facilities said the Fund independently decides the reimbursement levels without asking for comments from public or private facilities. Furthermore, the same informants stated that the Fund did not allow room to negotiate prices or other elements of the contract, demonstrating a “take it or leave it” attitude. Representatives of the health authorities deemed that the Fund had been using published methodology for price setting, had been considering reality and validity of prices, had to—as the health services purchaser—determine contracting conditions, and had been concluding contracts only after negotiations that were conducted after formally issuing contracting proposal. Respondents from family medicine practices emphasized that present capitation coefficients were low and had not been adjusted for ten years, which undermined the financial stability of private facilities providing family medicine services. They stated that the funds obtained based on capitation could not cover labor costs. Family medicine practices have to supplement their scope of services with others, such as visiting specialists, or associate with other specialists in specialist centers to be sustainable. Representatives of the health authorities considered important that many private health facilities do not report actual salaries, but the minimum legally mandated salary; using the minimum salary for calculation of taxes and contributions—in a reduced amount, comparing to actual salaries—unlike public health facilities that pay taxes and contribution on the basis of full salaries.

42 National Assembly of Republika Srpska, 2022b.
Federation of BiH

The prices of health services used in contracting are determined by the cantonal health insurance funds. The maximum price of health services for a private health care provider without a health insurance fund contract is set by the relevant health chamber. Private providers confirmed that capitation rates were determined independent of the private sector, and they also pointed out that although there were opinions that prices in the private sector were too high, the rates were determined based on the price of procured materials and labor costs. Some health officials said prices of services provided by the private and public health facilities were expected to be different, because the private health providers were not bound by the labor, employment and procurement regulations that public facilities had to use in hiring the necessary staff and procuring medical equipment and medicines. They could also obtain the desired staff and medical equipment and medicines on the market without any obstacles while achieving more favorable prices and conditions than public facilities.
5. NCD Prevention and Control Service Delivery

Key takeaways

• The primary health care workload increased in health systems in BiH between 2013 and 2020, but provision of NCD prevention and control services remains insufficient.

• The main reasons for insufficient provision of NCD prevention and control services are: (1) lack of comprehensive NCD prevention and control programs; (2) insufficient financial resources for the implementation of NCD prevention and control programs; and (3) an insufficient number of trained health professionals that are needed.

• Most private practices and polyclinics in the Federation of BiH and the specialist practices and specialist centers in Republika Srpska provide internal medicine, ophthalmology, gynecology, radiology, and family medicine; their scope of work includes NCD prevention and control services.

• Based on the available data, it is not possible to ascertain the significant differences in the quality of NCD-related health care between private and public health care providers.

• The COVID-19 pandemic has negatively impacted service provision in the health systems in BiH.
This chapter describes the current delivery of NCD prevention and control services in the health systems of BiH, focusing on the role of private health care providers. After an overview of service provision at the PHC level and the impact of the COVID-19 pandemic on service delivery, the chapter discusses existing private health care providers in Republika Srpska and Federation of BiH—their staffing, scope of services, and quality of NCD prevention and control services.

### 5.1 Provision of NCD prevention and control services in primary health care

The primary health care workload increased in health systems in BiH between 2013 and 2020. In Republika Srpska, there was a sharp increase in doctor visits, and house visits also rose (Table 5.1). Preventive check-ups have increased but, relative to the population, still lag the Federation of BiH. Also, primary care capacity seems to be insufficient to address the growing burden of NCDs, with just about 3.3 visits in the Federation of BiH and 3.5 visits in Republika Srpska to a family doctor per person per year, compared with the Organisation for Economic Co-operation and Development (OECD) average of 6.8 visits per person per year.\(^43\)

<table>
<thead>
<tr>
<th>Table 5.1.</th>
<th>Family medicine and general medicine’s workload in primary health care</th>
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<tr>
<td><strong>Federation of BiH</strong></td>
<td></td>
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<tr>
<td>2013</td>
<td>2018</td>
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<td>Systematic and preventive check-ups per 100,000 population</td>
<td>796</td>
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<td><strong>Republika Srpska</strong></td>
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<td>2018</td>
</tr>
<tr>
<td>Systematic and preventive check-ups per 100,000 population</td>
<td>364</td>
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<td>Doctor visits per 100,000 population</td>
<td>301,217</td>
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<tr>
<td>House (doctor) visits per 100,000 population</td>
<td>1,613</td>
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Note: — = not available.
Source: Original figure for this publication based on data from Institute for Public Health of Federation of BiH (2019a and 2020b); Public Health Institute of Republika Srpska (2021 and 2023); and Republika Srpska Institute of Statistics (2019b and 2021b).

**Republika Srpska**

Provision of NCDs prevention and control services is not sufficiently addressed by primary health care professionals in Republika Srpska. Figure 5.1 below indicates that the percentage of reported preventive services provided by family medicine teams is insufficient and that it is decreasing over the last years. According to representatives of health authorities, multiple factors are causing this decline in preventive visits, including: (1) lack of budget allocation and financial incentives for family medicine teams and occupational medicine specialists for

\(^{43}\) OECD, 2021.
provision of NCD-related services – preventive examinations are considered to be part of regular activities of the family medicine teams; (2) lack of competencies of staff in private practice; and (3) non-standardized approach in NCD prevention and control—clinical guidelines exist but are not respected or applied equally by all teams and facilities. The lack of equipment for delivery of NCD-related services is also mentioned as a reason for inadequate provision of services. As of July 2022, four preventive services – anthropometric measurements, blood glucose test, antismoking advice, and blood pressure measurement – are funded for publicly owned PHC centers only.

The high number of registered patients per family medicine team adds to the inadequate provision of NCD-related services. Private providers noted that with an average of 2,000 registered residents per team, it is not possible to provide the full range of prevention services, including those related to NCD, to the patients. Interviews with private providers stated that the main reasons for limited NCD prevention and control services are insufficient awareness among the population about the importance of prevention and healthy lifestyles, and excessive administrative work related to service delivery that leaves no time for the actual provision of the services. Representatives of the health authorities and private providers stated that significant underreporting of preventive health services is prevalent among public and private providers and that official data on provided NCD services are unreliable.

Figure 5.1. Percentage of preventive examinations in Republika Srpska 2015-2019 public and private facilities

While most care for NCDs occurs in PHC settings, admissions in hospitals for conditions that could be treated in outpatient settings have increased. High and increasing levels of admissions for conditions that could be treated in outpatient settings, such as diabetes and hypertension (Figure 5.2), as well as pneumonia, COPD, and asthma further illustrate the need to strengthen primary health care in Republika Srpska.
The underdevelopment of family medicine negatively impacts care for people living with NCDs. Health officials and private providers from Republika Srpska hold the view that another reason for increasing numbers of patients with NCDs is that the family medicine model in primary health care has not fully taken root. Also, family medicine doctors do not actively monitor their patients and do not invite them for regular examinations. On the other hand, the accuracy of data regarding the number of patients with chronic diseases is questionable, due to the practice of assigning chronic diagnoses to patients to avoid copayment charges, and underutilization of electronic health records.

Federation of BiH

Several reasons contribute to the inadequate provision of NCDs prevention and control services in the Federation of BiH. According to health officials in the Federation of BiH, the main reasons are: (1) lack of a comprehensive NCD prevention and control program; (2) Lack of a specific package of related services, primarily for preventive programs for NCDs – screening programs, regular annual exams – and for the PHC level; (3) insufficient financial resources for the implementation of NCD prevention and control programs on all levels; and (4) an inadequate number of the trained health professionals. Private providers added to the list a lack of coordination between the different levels within the health care system and a lack of relevant educational programs for the health professionals.

5.2 Impact of COVID-19 pandemic on health service delivery

The COVID-19 pandemic has negatively affected service provision in the health systems in BiH. Based on data from Republika Srpska and the Federation of BiH (Figure 5.3), a decrease in hospitalizations for over 20 percent in 2020 indicates that patients had reduced access to hospital health services due to the COVID-19 pandemic.
Reduced access to health care services due to the COVID-19 pandemic has directly impacted patients suffering from noncommunicable diseases in both health systems. Health officials from both the Federation of BiH and Republika Srpska stated that there has been a significant decline in the number of services provided to the population, including patients with chronic diseases, caused by the COVID-19 pandemic. Respondents from the Federation of BiH emphasized that in the last two years, there has been a reorientation of the health care system to COVID-19 at the expense of NCDs. Health officials from Republika Srpska commented that the situation with the provision of NCD prevention and control services was alarming even before the pandemic, and that it has further deteriorated. They worry that reduced access to health care and prevention and control of NCDs will result in increase in the incidence of cardiovascular diseases, malignancies, and mental illnesses.

**Republika Srpska**

The COVID-19 pandemic has also created opportunities, particularly around private sector engagement. Private provider informants stated that pressure on the private sector for all types of health services including NCDs has increased during the COVID-19 pandemic, which has shown that the public health system has been struggling to function properly and deal with the consequences of pandemic. Further, other private provider informants pointed out that the pandemic has also shown that the public sector is too slow to adapt and respond to patients’ needs. In fact, some private provider respondents had observed a noticeable increase in patients to their clinics from public facilities, also evident from the number of discharges in private and public hospitals (Figure 5.4).
**Figure 5.4.** Hospitalizations in private and public hospitals in Republika Srpska 2018-2020

Source: Original figure for this publication based on DRG database from Agency for Certification, Accreditation and Improvement of Health Care Quality of Republika Srpska (ASKVA).

**Federation of BiH**

COVID-19 has influenced the number of hospitalizations for NCDs in the Federation of BiH. Based on data from the Institute for Public Health in the Federation of BiH, there was a significant decline in the number of hospitalizations for NCDs in the year 2020, as presented below in Figure 5.5, mostly due to redistribution of beds and health workforce towards COVID-19 care. Health officials from the Federation of BiH affirmed that data collected in 2020 are a direct reflection of the COVID-19 pandemic.

**Figure 5.5.** Hospitalizations due to selected NCDs in Federation of BiH, 2018-2020

Source: Original figure prepared for this publication based on data from Institute for Public Health of Federation of BiH, 2021.
5.3 Overview of existing private health care providers

NCD prevention and control services are provided by a variety of private health care facilities in BiH. The number of private health care facilities in Republika Srpska and the Federation of BiH highlights their significant contribution to the provision of health care services. Private practices and polyclinics in the Federation of BiH and the specialist practices and specialist centers in Republika Srpska, are the main types of providers whose scope of work includes NCD prevention and control services.

Republika Srpska

Most of the private health care facilities in Republika Srpska are registered as pharmacies, dental practices, or special practices. The available registries of private health care providers and pharmacies in Republika Srpska listed 453 pharmacies, as of the time of writing this report, and 595 other private health care facilities – see Figure 5.6 below. Almost all community pharmacies (95 per cent) are privately owned, and they play a major role in assuring access to medicines for the population. The high number of dental practices reveals their importance in the provision of dental services to the adult population. Ten special hospitals provide secondary and tertiary care services in the areas of hemodialysis, radiotherapy, general surgery, internal medicine, gynecology, oncology, and ophthalmology. Recently two specialized health care homes for long term medical care have been established.

Figure 5.6. Private health care facilities registered in Republika Srpska, October 2021

Source: Original figure for this publication based on data from the Ministry of Health and Social Welfare in Republika Srpska, 2021b and 2021c.

The focus on pharmacies, dentistry, and specialist services in the private health sector is a common pattern for an emerging private sector. Without strategies and incentives, the private health sector will continue to grow in these areas and neglect the establishment of other facilities that could contribute to better prevention and control of NCDs. According to public

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officials, the basic motive for establishing a private health facility is profit, which explains the existing structure and distribution of the private facilities. Some respondents commented that although private health care facilities are being opened, they are mostly small and medium size establishments due to the high cost of large-scale facilities. Private providers feel that the lack of a health network plan is contributing to the current structure of private facilities; they suggested that the number and type of health facilities in the respective regions should be legally determined.

In Republika Srpska, the scope of work in private specialist practices and specialist centers includes NCD prevention and control services. Specialist practices provide services in one medical field, while specialist centers provide services in two or more fields, including family medicine. Family medicine services are provided by family medicine specialists in specialist practices and specialist centers. The breakdown of registered private specialist practices shows that more than half of them provide internal medicine, ophthalmology, gynecology, and family medicine services, as shown below in Figure 5.7. Internal medicine practices and family medicine practices are of particular importance for this review because they have a key role in NCD prevention and control.

High cost and lack of trained health professionals contribute to the low number of privately-owned family medicine practices in the health system of Republika Srpska. Public officials and private providers share the view that the relatively small number of private family medicine practices is caused by the low number of family medicine specialists and nurses with family medicine education, and by high costs connected with meeting the requirements to establish a family medicine practice—space, staff, equipment. The private providers also pointed out that family medicine in the private sector is not cost-effective and can be financially viable only as part of specialist centers which, through the provision of other services, can cross-subsidize the financial losses of family medicine practices.

Figure 5.7. Services provided by the specialist practices in Republika Srpska, April 2021

<table>
<thead>
<tr>
<th>Type of services provided</th>
<th>Number of registered special practices</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internal medicine</td>
<td>29</td>
</tr>
<tr>
<td>Paediatric</td>
<td></td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>16</td>
</tr>
<tr>
<td>Gynecology and obstetrics</td>
<td>19</td>
</tr>
<tr>
<td>Family medicine</td>
<td></td>
</tr>
<tr>
<td>Occupational medicine</td>
<td>12</td>
</tr>
<tr>
<td>Oral surgery</td>
<td></td>
</tr>
<tr>
<td>Ultrasound diagnostic</td>
<td>8</td>
</tr>
<tr>
<td>Care treatment and rehab</td>
<td></td>
</tr>
<tr>
<td>Dermatovenerology</td>
<td>12</td>
</tr>
<tr>
<td>General surgery</td>
<td>6</td>
</tr>
<tr>
<td>Physical rehabilitation</td>
<td>3</td>
</tr>
<tr>
<td>Urology</td>
<td></td>
</tr>
<tr>
<td>Radiology</td>
<td>2</td>
</tr>
<tr>
<td>ENT</td>
<td>2</td>
</tr>
<tr>
<td>Mammography</td>
<td>7</td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

Source: Original figure for this publication based on data from the Ministry of Health and Social Welfare in Republika Srpska, 2021b.

Most of the privately-owned health care facilities are concentrated in urban areas. According
to health authorities in Republika Srpska, private providers are not interested in operating in rural areas with a small population without economic and/or financial incentives. As a result, the burden of providing family medicine and emergency medical services in rural areas falls on public facilities. On the other hand, private providers contend that in smaller communities, a monopoly of public health care centers crowds out the opportunity for private family medicine practices. They said that in such communities it is harder to register the population as a private provider. They also described the problems of referring a private patient to public emergency services, where the private patient is not always well received.

**Federation of BiH**

In the Federation of BiH, cantonal ministries of health are responsible for maintaining registries of private health care providers. There is no federal registry of private health care providers for the Federation of BiH. The number of private facilities in the Federation of BiH is stated in the annual reports on the health status of the population and health care, published by the Federal Public Health Institute. The accuracy of reported data is questionable, as the annual reports on health statistics published by the same institution provide only information about the number of privately-owned pharmacies. The cantonal registries are publicly available for four cantons: Sarajevo Canton, Hercegovina-Neretva Canton, Bosnian-Podrinje Canton, and Canton 10.\(^{45}\) The cantonal health ministries present the data in different formats and with different levels of detail. Based on the available data, dental practices, pharmacies, and specialist practices appear to be the main types of private health care providers in the Federation of BiH, as illustrated below in Figure 5.8.

**Figure 5.8.** Private health care providers registered in five cantons of Federation of BiH, April 2021

<table>
<thead>
<tr>
<th>Types of private health care providers</th>
<th>Sarajevo Canton</th>
<th>Hercegovina-Neretva Canton</th>
<th>Bosnian-Podrinje Canton</th>
<th>Canton 10</th>
<th>Tuzla Canton</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental practices</td>
<td>209</td>
<td>132</td>
<td>90</td>
<td>45</td>
<td>4</td>
</tr>
<tr>
<td>Pharmacies</td>
<td>48</td>
<td>36</td>
<td>27</td>
<td>32</td>
<td>1</td>
</tr>
<tr>
<td>Specialist practices</td>
<td>3</td>
<td>2</td>
<td>8</td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td>Polyclinics</td>
<td>9</td>
<td>1</td>
<td>12</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Laboratories</td>
<td>5</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Hospitals</td>
<td>4</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>


Private practices and polyclinics in the Federation of BiH are mandated to provide NCD prevention and control services. Services provided by private practices are limited to one medical field, while polyclinics provide services in two or more fields, including family medicine and laboratory diagnostics. The number of private health care providers appears to be higher in more populated cantons. Detailed data on the private health care providers, available for five cantons shows that private practices and polyclinics most often provide internal medicine, gynecology and obstetrics, and radiology services, as illustrated by Figure 5.9 below. A larger number of private providers of family medicine services, mostly polyclinics, is present only in Sarajevo Canton—six polyclinics that provide family medicine services.

A continuous increase in the number of privately owned laboratories, specialist practices, and polyclinics is noticeable in the health system of the Federation of BiH. Health officials pointed out that the number of private facilities had been increasing, but the exact number and trends in the rise of the number of providers could not be determined as certain cantons did not keep records of the number of private health facilities in their area. Also, the annual reports of the health status and health care in the Federation of BiH do not provide details on the type of private facilities. Health officials are of the opinion that private providers are oriented mainly towards the provision of diagnostic services, which reduces the long waiting lists for that type of service in the public sector.

Health officials agree that the number and type of health facilities seem to correlate with the population density. They stated that private facilities are being established in areas with a large portion of the population and there is a noticeable gap in health facilities in rural areas and small communities. They note that, with appropriate incentives, the private sector could cover most of the health needs of the underserved population in certain rural areas, thus reducing the pressure on public health facilities. The low number of private family medicine practices in rural areas was explained by the low capitation rates and low service prices, which do not attract for-profit organizations.

Private providers confirmed that the distribution of private facilities favored the urban areas. Still, they stated, private facilities are being opened in the rural areas. They pointed out that they could not fully respond to the needs of the population in rural areas, as the same health professionals were working in both the public and private sectors. They also agreed that health professionals had no financial interest in the establishment of family medicine practices. They remarked that health insurance funds favored contracting public providers for family medicine services, compared with private facilities.
Figure 5.9. Services provided by the privacy practices and polyclinics in five cantons of Federation of BiH, April 2021

<table>
<thead>
<tr>
<th>Type of services provided</th>
<th>Number of registered private health care providers in Sarajevo Canton</th>
<th>Number of registered private health care providers in Hercegovina Neretva Canton</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gynecology and obstetric</td>
<td>21</td>
<td>3</td>
</tr>
<tr>
<td>Internal medicine</td>
<td>11</td>
<td>1</td>
</tr>
<tr>
<td>Radiology</td>
<td>11</td>
<td>2</td>
</tr>
<tr>
<td>General surgery</td>
<td>13</td>
<td>2</td>
</tr>
<tr>
<td>Dermatovenerology</td>
<td>13</td>
<td>2</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>10</td>
<td>2</td>
</tr>
<tr>
<td>Ears, nose, and throat</td>
<td>12</td>
<td>2</td>
</tr>
<tr>
<td>Family medicine</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Anesthesiology</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Orthopaedic</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Physical rehabilitation</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Occupational medicine</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Pediatric</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Pulmonology</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Type of services provided</th>
<th>Number of registered private health care providers in Tuzla Canton</th>
<th>Number of registered private health care providers in Bosnian-Podrinje Canton</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gynecology and obstetric</td>
<td>10</td>
<td>2</td>
</tr>
<tr>
<td>Internal medicine</td>
<td>10</td>
<td>4</td>
</tr>
<tr>
<td>Radiology</td>
<td>10</td>
<td>2</td>
</tr>
<tr>
<td>General surgery</td>
<td>10</td>
<td>2</td>
</tr>
<tr>
<td>Dermatovenerology</td>
<td>10</td>
<td>2</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>10</td>
<td>2</td>
</tr>
<tr>
<td>Ears, nose, and throat</td>
<td>10</td>
<td>2</td>
</tr>
<tr>
<td>Family medicine</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Anesthesiology</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Orthopaedic</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Physical rehabilitation</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Occupational medicine</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Pediatric</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Pulmonology</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

5.4 Health workforce and provision of NCD prevention and control services

Though the number of health workers per 100,000 increased in both Federation of BiH and Republika Srpska between 2013 and 2020 (Table 5.2), it remains substantially below the average of OECD countries—3.6 doctors and 8.8 nurses per 1,000 population. This is a concern given the rising demand for health care for NCDs among the country’s aging population. The lack of health workers will adversely affect the ability of the health systems in BiH to provide NCD prevention and control services efficiently.

Respondents from the Federation of BiH and Republika Srpska agree that there are not enough nurses with education in the field of prevention and control of NCDs in the health system. Health officials are aware that nurses can make a significant contribution to the provision of NCD-related services and confirmed that presently the education of nurses for the work in the community is ongoing through the SDC-financed nursing project. Private providers from both Republika Srpska and the Federation of BiH declared that there are no qualified nursing staff on the market to be hired which presents a problem for the establishment and operation of the private and public facilities.

Table 5.2. Number of physicians, nurses, and administrative staff per 100,000 population in health systems of Republika Srpska and Federation of BiH, 2013, 2018, and 2019-2020

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Federation of BiH</th>
<th>Republika Srpska</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2013</td>
<td>2018</td>
</tr>
<tr>
<td>Physicians per 100,000 population</td>
<td>198</td>
<td>224</td>
</tr>
<tr>
<td>Nurses/technicians per 100,000 population</td>
<td>547</td>
<td>561</td>
</tr>
<tr>
<td>Administrative staff per 100,000 population</td>
<td>305</td>
<td>323</td>
</tr>
</tbody>
</table>

Sources: Original table for this publication based on data from Institute of Public Health of Federation BiH, 2020; and Public Health Institute of Republika Srpska (2021, 2022, and 2023).

The emigration rate of health professionals from BiH presents a challenge to the provision of NCD prevention and control services. Emigration is occurring at the same time as stagnation in the country’s ability to produce, recruit, or retain skilled health workers. This poses a serious threat to meeting the growing demand for complex health care in an aging society. Specific data on health professional emigration trends are not available in BiH, but data collected from destination countries suggests an accelerating rate of emigration of health care workers from BiH. OECD data collected from Germany, for example, shows a threefold increase in BiH-origin medical doctors employed in Germany between 2012 and 2018 – see Figure 5.10 below. A rapid increase in the flow of nurses from BiH to Germany has also occurred in the same period.

OECD, 2021.
There are different views regarding the effect of emigration on the provision of NCD prevention and control services. According to health officials from Republika Srpska, the emigration of health workers does not significantly affect the provision of those since the departing medical staff are not from PHC facilities where the majority of NCD services are provided. They also said that emigration does not exacerbate the need for additional staff, because the reduction in the number of health workers is accompanied by a decrease in the number of inhabitants. Some private providers stated that emigration did not affect the private sector as much as the public sector; they could retain quality staff because they offer higher salaries and more modern working conditions. Others stated that health staff first move to private facilities before deciding to emigrate and that COVID-19 has now stopped the emigration. Yet other private sector respondents stated they have challenges finding sufficient staff to work in outpatient settings or retaining newly employed staff due to emigration opportunities.

Key informants in the Federation of BiH expressed similar views on the effects of emigration on the provision of NCD prevention and control services. Some health officials were of the opinion that the provision of those services is not endangered by emigration, while others held that the insufficient provision of preventive services is caused by the lack of qualified health professionals. Private providers were unified in their view that the emigration of health professionals represents a significant problem for the entire health system and endangers the provision of quality health care.
Republika Srpska

Published data on staffing and services provided by the private health care facilities in Republika Srpska is not complete and, therefore, not reliable. The annual analysis of population health, published by the Public Health Institute of Republika Srpska, relies on data provided by the health facilities. Data in the annual report are two to three years late, due to a reporting system based on paper forms. The annual report does not provide an overview of all private health facilities; it only provides basic staffing and services data on pharmacies, dental practices, and specialist practices. About 173,000 patient visits to private specialist practices were reported in 2018. The completeness of the data is unknown, as the reports have not provided information on the number or share of private facilities that submitted their reports. For the same reason, data on the staff of private specialist practices might not be complete either. The number of medical doctors employed in private specialist practices dropped from 230 in 2017 to 182 in 2018, with a few services remaining at the same level. The annual report does not provide data on services provided by family medicine teams in specialist centers and specialist practices.

Federation of BiH

Data on the number of employees in the private health care facilities and several services provided in the Federation of BiH is not complete or reliable. Private health facilities have a legal obligation to report regularly on their staff and the services they provide. Since most private health care institutions do not provide the required data, it is difficult to have complete insight into the services they provide to the population. The annual health statistics report for the Federation of BiH also does not include precise data on the number of private health care providers. The latest report on the health status of the population and health care stated that there were 1,228 private health care facilities and private practices with 5,024 employees registered in the Federation of BiH in 2019. There has been a noticeable trend in growth of the number of health care facilities and employees in the private sector since 2016, when 4,297 employees in 1,113 privately-owned health care facilities were documented.

Private facilities in the Federation of BiH do provide NCD prevention and control services, but the information on the number and structure of the services is not available. Health officials in the Federation of BiH stated that it was difficult to define the scope of preventive activities carried out by the private sector given that they covered a wide range of diseases. They noted that there was no special form for reporting on the prevention and control of NCDs. There are obligations to report on the number of visits and examinations and established diagnoses, but there are no clear requirements for reporting data on disease prevention. There is no doubt that the private sector diagnoses and treats NCDs, but mostly for the population that pays for the services. Information on this is incomplete, due to issues related to reporting, as discussed earlier.

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49 Institute of Public Health of Federation BiH, 2019b.
5.5 Private health care providers and quality of NCD prevention and control services

The Agency for Certification, Accreditation and Improvement of Health Care Quality of Republika Srpska (ASKVA) and the Agency for Quality and Accreditation in Health Care in Federation of BiH (AKAZ) run mandatory certification and voluntary accreditation programs for health care facilities and monitor the quality of health care for both private and public health care providers. Based on the available data there are no significant differences in the quality of NCD-related health care between private and public health care providers.

Republika Srpska

Private health care facilities are covered by the mandatory certification program in Republika Srpska. The Law on Health Care and the rulebook on certification regulate certification of health care facilities in Republika Srpska.51 The process of certification implies the external assessment of both private and public health care providers involving the trained assessors and adopted safety standards. Since the introduction of the mandatory certification of health care facilities in 2012, a significant number of private health care facilities has completed the certification procedure, as indicated below in Figure 5.11.52

Figure 5.11. Number of certified private health facilities in Republika Srpska, April 2021

Source: Original figure for this publication based on data from Agency for Certification, Accreditation and Improvement of Health Care Quality of Republika Srpska.

52 ASKVA, 2021.
Box 5.1. Quality indicators monitored by ASKVA in primary health care facilities

- The percentage of registered male and female patients older than 50 years who, in the preceding 24 months have a record of a fecal occult blood test.
- The percentage of registered female patients ages between 25 and 60 who, in the preceding 36 months, have a record of discovering the early stage of cervical cancer.
- The percentage of registered female patients ages between 50 and 70 who, in the preceding 24 months, have a record of mammography.
- The percentage of patients with hypertension who, in the preceding 12 months, have a record of blood pressure.
- The percentage of patients with hypertension who, in the preceding 12 months, have a record of smoking cessation advice (if a smoker).
- The percentage of patients with hypertension who, in the preceding 12 months, have a record of dietary and exercise advice.
- The percentage of patients with hypertension who, in the preceding 12 months, have a record of blood pressure 140/90 mmHg or less.
- The percentage of patients with hypertension who, in the preceding 12 months, have a record of Body Mass Index.
- The percentage of patients with angina pectoris who, in the preceding 12 months, have a record of Body Mass Index.
- The percentage of patients with angina pectoris who, in the preceding 12 months, have a record of smoking cessation advice (if a smoker).
- Percentage of patients with angina pectoris who have been advised on dietary nutrition and physical activity in the past 12 months.
- The percentage of patients with myocardial infarction who, in the preceding 12 months, have a record of Body-Mass Index.
- The percentage of patients with myocardial infarction who, in the preceding 12 months, have a record of dietary and exercise advice.
- The percentage of patients with myocardial infarction who, in the preceding 12 months, have a record of blood pressure measurement.
- The percentage of patients with COPD who, in the preceding 12 months, have a record of measuring of a percentage of FEV1.
- The percentage of patients with COPD who, in the preceding 12 months, have a record of smoking cessation advice (if a smoker).
- The percentage of patients with diabetes who, in the preceding 12 months, have a record of Body Mass Index.
- The percentage of patients with diabetes who, in the preceding 12 months, have a record of foot examination.
- The percentage of patients with diabetes who, in the preceding 12 months, have a record of retinal screening.
- The percentage of patients with diabetes who, in the preceding 12 months, have a record of blood pressure 130/80mmHg or less.
- The percentage of patients with diabetes who, in the preceding 12 months, have a record of HbA1c.
- The percentage of patients with diabetes who, in the preceding 12 months, have a record of HbA1c 7% or less.
- The percentage of patients with diabetes mellitus (E10, E11) whose serum low-density lipoprotein (LDL) value was measured during the previous 12 months.
- Percentage of diabetic patients with the last recorded LDL value <2, measured in the previous 12 months.
- The admission rate due to diabetes mellitus and complications (E10-E14).
- The admission rate due to hypertension (I10-I15).
- The admission rate due to COPD (J40, J41, J42, J43, J44, J47).
- The admission rate due to angina pectoris (I20).

Private health care providers do not apply for the voluntary accreditation program in Republika Srpska. The Rulebook on Accreditation of Health Care Facilities defines the rules for conducting the health care facilities accreditation program in Republika Srpska. The accreditation process for health care facilities is voluntary and is a more advanced step than certification, involving external peer assessment of the health care providers based on published health care quality standards. Presently, there are no private health care facilities involved in the accreditation program in Republika Srpska, most likely due to the lack of financial and other incentives for participation. Key informant interviewers suggested the possibility that ASKVA is underfunded and therefore has insufficient staff to conduct the accreditation assessments or to conduct training to assist private facilities to meet accreditation quality standards.

ASKVA monitors the quality of NCD prevention and control services provided by the private and public PHC providers in Republika Srpska. The rulebook on quality indicators has defined the indicators that are used for measuring the quality of the services provided by family medicine teams from PHC facilities in Republika Srpska. ASKVA monitors the quality of family medicine teams working in all PHC facilities that have a contract with the Health Insurance Fund of Republika Srpska, using their electronic health records for the calculation of 28 process and outcome indicators related to the provision of preventive services and management of chronic NCDs (Box 5.1). ASKVA collects the quality of health care data for 55 public and 21 private health care facilities that provide family medicine services and use the electronic patient records. However, the availability of data on the quality indicators for some services is still limited, because some providers still keep patient records in paper form and the transition to electronic health records within the recently introduced integrated health care information system has not been completed.

There is not enough information on the quality of health care provided by private and public facilities in Republika Srpska. According to the health officials, it is difficult to determine exactly the quality of health care, because not all health facilities keep data in the electronic form necessary for the calculation of the values of quality indicators. Although the coverage of preventive services is insufficient in both public and private facilities, patients registered with private family medicine teams have been slightly better covered by the cancer screening services, for example – see Figure 5.12 below. Private providers seem to have slightly better outcome indicators than public providers related to the management of chronic diseases. Compared to the public facilities, more of their patients with diabetes had well-regulated blood sugar levels and more of their patients with hypertension had well-regulated blood pressure levels. Patients with angina pectoris or COPD who had been registered with private facilities had lower hospitalization rates than patients with the same conditions registered with the public facilities. Private key informants offered a possible explanation for why private sector service quality may be better: that it was in the financial interest of the private provider to deliver quality care to survive in the market. Also, they stated that private facility staff were more patient-oriented, resulting in higher patient satisfaction. Others in the public sector posit that private sector NCD services are easier to access, obtained faster, and

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generally less complex in some areas—such as urban areas; NCD-related services in the public sector are more complex but less accessible, but more accessible to population in smaller and rural area.

**Figure 5.12.** Comparison of quality indicators for private and public health care facilities, Republika Srpska, 2020

Private providers emphasized that there were significant differences between the quality of services in public and private institutions. They reported that private providers were more patient-oriented, that the attitude of their staff toward patients was kinder, and that their patients were more satisfied. They also pointed out that services provided in private facilities were more accessible and adapted to the needs of the patient, and that patients desired to register in private family medicine practices. However, one of the respondents commented that due to many patients, private facilities were starting to behave like public facilities; specifically, that they did not provide enough attention and time to the patients.
Clinical practice guidelines for the prevention and control of NCDs have been developed through international projects and are available to health care providers in Republika Srpska. The development of the clinical practice guidelines for the prevention and control of NCDs was organized and coordinated by the Ministry of Health and Social Welfare in Republika Srpska and supported through various projects. The clinical practice guidelines are available on the ministry’s website. The latest set of seven guidelines was developed under the SDC-supported project, “Reducing Health Risk Factors in BiH–Developing and Advancing Modern and Sustainable Public Health.” Current values of the process and outcome indicators related to NCD prevention and control, presented above in Figure 5.12, indicate that measures for more intensive utilization of the guidelines should be introduced. Also, the system of regular updates of clinical guidelines and their integration in electronic health records in the form of care pathways should be established for more complete data entry on patient health status.

The level of application of clinical guidelines is inadequate. Health officials in Republika Srpska pointed out that there are no data on the level of utilization of clinical guidelines in health care facilities. They stated that no research has been done in the last 10 years to determine this. Based on analysis of (incomplete) entries in electronic records, it can be assumed that utilization of clinical guidelines is rather low for private and public health care providers.

There are up-to-date clinical guidelines for the prevention and control of NCDs in Republika Srpska, but the private sector had limited input in their development. Some private sector informants stated that they were not invited to participate in the development. Others stated that they were invited but were presented with complete drafts for comments only. Some said that the health authorities did not actively promote the availability of the guidelines or actively disseminate them to the private sector. Representatives of health authorities believe that online versions of the guidelines are publicly available to anyone, private facilities included, and the insufficient awareness on the guidelines indicates lack of private sector interest for use of the guidelines. Additionally, private key informants shared that although the clinical guidelines existed, they were not applied equally to public and private health facilities. Despite these challenges, several private key informants affirmed that they were familiar with the clinical guidelines and used them in their practice. Private providers are aware of the existence of the guidelines, but they got the information about them on their initiative. It was also noted that consistent application of clinical guidelines would create a financial problem for private facilities, as insufficient funds are allocated to private providers for laboratory services which are essential for successful control of NCDs. The private providers emphasized that implementing a prevention program would be an additional cost which would negatively affect the financial standing of private facilities.

Federation of BiH
Certification and accreditation programs in the Federation of BiH involve private health care facilities. The Law on the System for Improving Quality, Safety and Accreditation in Health Care in Federation of BiH and the Rulebook on Certification and Accreditation of Health Care Facilities define the rules for the implementation of mandatory certification and the voluntary

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accreditation program in the Federation of BiH. Since the establishment of the certification program in 2014, more than 30 percent of private polyclinics and over 40 percent of private pharmacies in five observed cantons have completed the certification procedure (Figure 5.13). Five private pharmacies have completed the accreditation process in the same period (Figure 5.14).

**Figure 5.13.** Number of certified polyclinics in five cantons of the Federation of BiH, April 2021

![Chart showing the number of certified polyclinics in five cantons of the Federation of BiH, April 2021](chart)

**Cantons in Federation of Bosnia and Herzegovina**

- Registered polyclinics
- Certified polyclinics

Source: Original figure for this publication based on data from the Agency for Health Care Quality and Accreditation in Federation of BiH.

**Figure 5.14.** Number of certified and accredited pharmacies in five cantons of the Federation of BiH, April 2021

![Chart showing the number of certified and accredited pharmacies in five cantons of the Federation of BiH, April 2021](chart)

**Cantons in Federation of Bosnia and Herzegovina**

- Registered pharmacies
- Certified pharmacies
- Accredited pharmacies

Source: Original figure for this publication based on data from Agency for Health Care Quality and Accreditation in Federation of BiH.

In addition to the implementation of certification and accreditation programs, AKAZ monitors the quality of health care provided by public hospitals and PHC centers. The AKAZ has developed a set of quality and safety indicators for hospitals and health centers. Next to the general quality and safety indicators, AKAZ monitors the quality of the preventive services and services related to the management of NCDs by the family medicine teams working in primary health centers through a set of ten specific indicators (Box 5.2). Comparison of the quality of

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services provided by public and private health care providers is not possible, as private providers are not obliged to participate in the quality monitoring program.

The clinical practice guidelines for NCD prevention and control are available to the health care providers in the Federation of BiH. Like Republika Srpska, the set of eight clinical practice guidelines for NCD prevention and control has been recently developed by the Federal Ministry of Health with the support of WHO and SDC, and are publicly available on the AKAZ website. There is no official information on the utilization of the guidelines by private health care providers in the Federation of BiH. A private provider stated that they (private providers) regularly use clinical guidelines because the private sector is in the public focus and the number of lawsuits for malpractice against the private sector providers is growing.

The difference between the quality of care provided by public and private providers in the Federation of BiH cannot be objectively determined. According to the health authorities, no objective measurable indicators are available in the Federation of BiH to inform determination of the difference in quality of care provided by public and private providers. Health officials also believe that there is no major difference in the quality of care provided between the public and private sector. But patient satisfaction might be slightly higher regarding service provided by private providers due to better equipment, kindness of the health workers, and expedited service. Several private providers had the view that the level of quality in the private sector is much higher compared to the public sector. Respondents indicated that health workers in the private sector are more accessible and have more time for individual approach; their relationship with patients is more personable, and their equipment for diagnostics and treatment is better than what public facilities have. A respondent believed public facilities have a far greater number of specialists of different profiles to enable provision of better service, and thus quality.

Box 5.2. Indicators for family medicine teams monitored by AKAZ

- Documented counselling about smoking cessation.
- Patients with hypertension with a pressure lower than 140/90 mmHg.
- Patients with diabetes mellitus with retinal screening in the previous 15 months.
- Patients with diabetes mellitus with neuropathy testing in the previous 15 months.
- Patients with diabetes mellitus with the latest HbA1C score of 7.0%.
- Percentage of a woman between the ages of 20 and 65 in which the Pap test was recorded.
- Percentage of a woman between the ages of 40 and 74 for which a finding was recorded in the card.
- Mammographic breast examination.
- Flu vaccination age 65 and older.
- Influenza vaccine counseling rate of persons over the age of 65 and over.
6. Policy Recommendations

As a signatory to the Sustainable Development Goals, Bosnia and Herzegovina has high-level political commitment for the health care systems to work towards Universal Health Coverage. Given the existence of public and private sector provision, it is important for policies to strengthen the health system to account for the specific context and incentives in either. For example, given the profit incentive that exists in the private sector, governance of delivery may involve regulatory controls that mitigate the attendant risk selection or introduce payment mechanisms that directly incentivize quality improvements. It is also critical to build capacity in the respective health authorities to adequately steer the private sector consistent with improvements in health system performance and outcomes.

This assessment of the scope of private sector provision aimed to inform policy directions in Republika Srpska and Federation of BiH, and identified the following constraints:

There are no specific policies that define the role of the private sector in both health systems. Although the policy documents related to NCD prevention and control do not specifically mention the involvement of the private sector in their implementation, the existing legal and regulatory frameworks allow the inclusion of the private sector in the Federation of BiH (FBiH) and Republika Srpska. Still, important changes in regulation defining the provision of NCD services need to be introduced to secure more comprehensive involvement of the private sector in NCD prevention and control activities.

Financing of NCD prevention and control services is insufficient in both entities. The contracts offered to public and private health providers do not include sufficient incentives for
6. Policy Recommendations

the provision of NCD prevention and control services, except for several cantons in FBiH and for certain services in Republika Srpska. The nomenclatures of services in both entities need revision, including the revision of prices of selected NCD prevention and control services aiming to enhance the interest of private providers to be involved in the implementation of the Action Plans.

The number of private providers is growing in both health systems and their potential for participation in the provision of NCD prevention and control services is significant. The details of registered private specialist practices show that most of them provide internal medicine, ophthalmology, gynecology, radiology, and family medicine services. The latter is of particular importance because they may play an important role in NCD prevention and control. Defining the network of public and private facilities for the provision of services for NCD prevention and control is the main prerequisite for the comprehensive involvement of the private sector in the implementation of appropriate plans.

6.1 Recommendations for policy makers in Republika Srpska

Governance for NCD prevention and control

1. Specify the responsible staff in the Ministry of Health and Social Welfare in Republika Srpska and define the roles and responsibilities for engagement with private providers in policy development.

2. Specify the responsible staff in the Health Insurance Fund of Republika Srpska and strengthen capacities for contracting and monitoring the provision of contracted NCD prevention and control services, as part of the wider contract monitoring process.

3. Hire additional staff and provide training for ASKVA in the development of clinical guidelines and care pathways, and monitoring the quality of NCD prevention and control services at the PHC level.

4. Specify the responsible staff of the Public Health Institute of Republika Srpska and define roles and responsibilities for the development of the comprehensive NCD prevention and control program and monitoring its implementation.

5. Secure public availability of updated information regarding the number and structure of all private health care facilities in Republika Srpska; restructure the registry of private facilities; and include details regarding services provided by the specialist centers in the registry.

6. Revise legislation defining the number of registered users per family medicine team to enable more effective provision of NCD prevention and control services.

7. Revise legislation regarding the establishment of private facilities – specifically family medicine specialist practices – with the involvement of representatives of the private and public sector.

8. Revise legislation regarding the public-private partnerships to provide incentives for attracting additional investors in the health sector, specifically for investments in NCD prevention and control.
6. Policy Recommendations

**Financing of NCD prevention and control services**

1. Continue increasing allocation of funds for the financing of NCD prevention and control services in the budget of the Health Insurance Fund of Republika Srpska in a transparent manner and include the private providers in the contract.

2. Define and adopt a payment-for-performance system which would incentivize the provision of NCD-related services.

3. Strengthen cooperation between the Health Insurance Fund of Republika Srpska and ASKVA regarding the implementation of the payment-for-performance model, based on quality indicators.

4. Redefine the model of reporting and/or data sharing among health care providers, Health Insurance Fund of Republika Srpska, and ASKVA required to monitor the quality of NCD prevention and control services. The model should include data from the private facilities contracted by the Fund to implement the NCD prevention and control program.

5. Refine the Health Insurance Fund of Republika Srpska’s contracting practices with a focus on the provision of NCD-related services by private providers, to enable the same conditions for the contracting and provision of NCD services for public and private health care providers.

6. Define a more transparent methodology for pricing of NCD prevention and control services, including the revision of capitation rates, with the involvement of public and private providers.

7. Revise and enact bylaws and nomenclature of services, with the involvement of private providers, to include the provision of NCD prevention and control services by family medicine teams and other health professionals and to redefine the prices of such services.

**Service delivery for NCD prevention and control**

Develop and adopt a comprehensive NCD prevention program with the participation of private providers.

1. Redefine the network of public and private facilities for the provision of services for NCD prevention and control with the involvement of private and public providers.

2. Establish a system for efficient referrals and provision of NCD prevention and control services among different levels of care including private facilities.

3. Revise the existing clinical guidelines for the prevention and control of NCDs, with the participation of private and public providers.

4. Stimulate the utilization of the electronic health records in facilities providing NCD-related services, including private facilities contracted by the Health Insurance Fund of Republika Srpska implementing the NCD prevention and control program.

5. Develop care pathways for the prevention and control of NCDs and integration of the pathways in electronic health records in family medicine teams at the PHC level.
6.2 Recommendations for policy makers in the Federation of BiH

**Governance for NCD prevention and control**

1. Ensure consistent monitoring of the application of legislation in the cantons in connection with the establishment of private health institutions based on the respective Rulebook in the FBiH, given the relevance for NCD care.

2. Train competent staff within the Federal Health Insurance and Reinsurance Fund, cantonal Health Insurance Funds, Federal and cantonal ministries of health, and Federal and cantonal institutes for public health to effectively and efficiently prepare contracts, monitor the implementation of contracts via determined indicators and reports on the provision of services, and evaluate the output.

3. Provide additional training in AKAZ for the development of clinical guidelines and care pathways, and in data management to facilitate the monitoring of the quality of NCD prevention and control services provided by public and private service providers.

4. Integrate the existing separate health information systems at the cantonal level into a single integrated health information system that enables centralized access to the electronic medical record of each patient, and establish the use of electronic health records in institutions that provide services related to NCDs, including private providers, as a condition for contracting with the health insurance funds.

5. Enable the active participation of the medical chambers and professional associations of private healthcare providers in the processes of strengthening the health system as well as in systematic NCD prevention and control activities, in accordance with the Action Plan for NCD control in FBiH through the consolidation of competencies by including their members as examiners, curriculum developers, and instructors in medical training institutions and programs.

**Financing of NCD prevention and control services**

1. Refine payment methods, including introducing payment for the performance and revision of capitation rates and tariff lists, to encourage the provision of NCD prevention and control services at the Federal and cantonal level in the public and private health sectors.

2. Define in clear terms the obligations of public and private providers regarding the provision of services related to NCDs contracted by health insurance funds.

3. Outline the model of reporting and data sharing between health care providers, health insurance funds, public health institutes, and AKAZ required for monitoring the quality of NCD prevention and control services, including data from the private facilities contracted by the health insurance funds to implement such services.
Service delivery for NCD prevention and control

1. Create and adopt a comprehensive operational plan for the prevention and control of NCDs for the federal and cantonal level based on the Action Plan for the prevention and control of NCDs in the FBiH—with the defined activities, budget, actors, and reporting indicators (input, process, output, and outcome), and the necessary promotional and preventive health services for NCD control, such as screening programs and regular examinations across the life cycle, especially for the PHC level.

2. Establish the system for effective referral and provision of NCD prevention and control services between different levels of care, including private institutions.
Annex A:
Interview guide for ASKVA and AKAZ

Section 1: Context

1. What is your opinion about the present situation regarding noncommunicable disease (NCD) prevention and control in entity/canton?
   • Prevalence and reduction of risk factors.
   • NCD burden and epidemiology.

2. How do you perceive the present situation regarding the role of private health care providers in the provision of health services?
   • Number.
   • Type.
   • Growth of number.
   • Reasons for the growth of number – for example, low quality of public health sector, absence of or weak private health sector regulation, public demand, income, weak public sector capacity to deliver services.

Section 2: Policy making

3. Are there specific policies or strategies in the health system that relate to the role and scope of private health care providers in the provision of health care services?
   • Are private providers involved in the development of strategies related to the quality of health care?
   • Should they be involved in policy making and planning in health care?
   • What are possible reasons for the lack of involvement of private providers in policy development in health care?
   • What are possible mechanisms for the involvement of the private sector in policy and planning?

4. Does ASKVA/AKAZ include the private sector in policy design and regulations related to quality of care? If so, how?

5. Are you informed on the adoption of an Action plan for the Prevention and Control of NCDs? If yes:
   • What is the role of ASKVA/AKAZ in the implementation of the Action plan for Prevention and Control of NCDs?
   • What are the obstacles in the advancement of the implementation of the planned activities defined in the Action plan for Prevention and Control of NCDs?

Section 3: Regulation

6. What is your opinion on existing regulations that regulate the provision of services for the prevention and control of NCDs?
   • How well are these regulations enforced?
   • Is there a perceived difference in implementing these regulations regarding public and private health providers?
7. What is your opinion on existing regulations related to private health care facilities?
   • Establishment of private facilities?

Section 4: Market conditions supporting private provision of care

8. What do you think about the financing of private primary health care (PHC) and hospital care providers?
9. Are there differences in the financing of PHC providers in the public and private sectors?
10. Should there be specific payment for the provision of NCD services?

Section 5: Provision of NCDs prevention and control services

11. What do you think about the present organization of provision of services for prevention and control of NCDs?
12. What is the role of private providers in the provision of NCD prevention and control services?

Section 6: Quality of care

13. Are there significant differences in the quality of NCDs prevention and control services between private or public providers?
   • If so, what are they?
   • Major challenges for private providers to deliver quality of care?
14. Are you aware of the level of utilization of clinical guidelines among private health care providers?
15. Are you aware of the level of utilization of electronic health records at the PHC level?

Section 7: Closing questions

16. Do you have suggestions on how to improve involvement of private providers in the provision of NCD prevention and control services?
Annex B: Interview guide for health insurance funds

Section 1: Context

1. What is your opinion about the present situation regarding noncommunicable disease (NCD) prevention and control in entity/canton?
   - Prevalence and reduction of risk factors.
   - NCD burden and epidemiology.

2. How do you perceive the present situation regarding the role of private health care providers in the provision of health services?
   - Number.
   - Type.
   - Growth of number.
   - Reasons for the growth of number – for example, low quality of public health sector, absence of or weak private health sector regulation, public demand, income, weak public sector capacity to deliver services.

Section 2: Policy making

3. Are there specific policies or strategies in the health system that relate to the role and scope of the private health care providers in the provision of health care services?

4. Are there specific policies or strategies in the health system that relate to the financing of the services provided by the private facilities?

5. Are private providers involved in the development of health insurance fund’s (HIF) bylaws that regulate the financing of health services? If yes, how?
   If not:
   - Should they be involved in the development of HIF bylaws?
   - What are possible reasons for the lack of involvement of private providers in the development of HIF bylaws?
   - What are possible mechanisms for the involvement of the private sector in the development of HIF bylaws?

6. Are you informed on the adoption of an Action Plan for the Prevention and Control of NCDs? If yes:
   - What is the role of HIF in the implementation of the Action Plan for Prevention and Control of NCDs?
   - Are there strategies or policies in HIF to facilitate the improvement of prevention and control of NCDs?
   - What do you think about the participation of private providers in the implementation of the Action plan for Prevention and Control of NCDs?
   - What are the obstacles in the advancement of the implementation of the planned activities defined in the Action plan for Prevention and Control of NCDs?
Section 3: Regulation

7. What is your opinion on existing legislation that regulates the provision of services for the prevention and control of NCDs?

8. Are you aware of plans/initiatives for the development or improvement of bylaws or other operational documents for the improvement of provision of services for prevention and control of NCDs?

9. Are there plans or initiatives for the development of a specific list of NCD prevention and control services in the HIF?

10. Are there plans/initiatives for the development of bylaws for the improvement of the provision of preventive and screening services?

Section 4: Structure and number of private facilities

11. Are you aware of the present structure of private facilities in the health sector? If yes:
   - What is the reason for the low number of private family medicine teams in the private sector?

12. Are there obstacles to the establishment of private facilities – for example, entry to the market, competition, taxes, input costs?

13. What type of incentives could be used to motivate the private sector to invest more in the health sector? To deliver more NCD prevention and services?

14. How important is HIF contracting as an incentive for the private sector to invest more in the health sector?

Section 5: Market conditions supporting private provision of care

15. What do you think about the financing of private care providers from public funds?

16. Is there competition in the health sector between public and private providers? Between private providers?

17. Are there differences in the financing of primary health care providers in the public and private sectors? If yes, what are they?

18. What challenges do private health providers face with current health financing mechanisms – for example, reimbursement too low, payments too slow, paperwork cumbersome?

19. What incentives can the government put in place to encourage greater private investment in health? In NCD services?

20. How do you set the prices for services of the private providers that have a contract with HIF?
   - How do you set the prices of preventive services?
   - Are there plans for the development /improvement of methodology for formulation of prices for NCD services?

21. Are there incentives for the provision of NCD prevention and control services (contracting and payment); if not, should they be introduced?
22. Do you think that private providers should be included in the design of incentives for the provision of NCD services? If so, how?

23. Are there plans for the development of a specific payment mechanism for provision of NCD prevention and control services?

24. Is there an out-of-pocket payment for the provision of preventive services with private providers?
   • Do patients incur these out-of-pocket in public facilities? Private facilities? Both?

Section 6: Provision of NCDs prevention and control services

25. What do you think about the present organization of provision of services for prevention and control of NCDs?

26. What is the role of private providers in the provision of NCD prevention and control services?

27. What is the present method of reporting on NCD prevention and control services both from public and private providers?
   • What do you think about the accuracy of reporting?
   • Is there a place for improvement of existing reporting practices and how?

28. What do you think of the regional distribution of private providers?
   • Are there differences between rural/urban areas?

Section 7: Public-private partnerships (PPP)

29. What is your opinion about existing PPP arrangements?

30. Do you think there is the possibility of using additional PPP arrangements for the provision of NCD prevention and control services?

Section 8: Quality of care

31. Are there significant differences in the quality of NCDs prevention and control services between private or public providers?

32. Are current payments under health insurance / contracting linked to quality outcomes?

Section 9: Closing questions

33. Do you have suggestions on how to improve involvement of private providers in the provision of NCD prevention and control services?
Annex C: Interview guide for medical chambers

Section 1: Context

1. What is your opinion about the present situation regarding noncommunicable disease (NCD) prevention and control in entity/canton?
   • Prevalence and reduction of risk factors.
   • NCD burden and epidemiology.

2. How do you perceive the present situation regarding the role of private health care providers in the provision of health services?
   • Number.
   • Type.
   • Growth of number.
   • Reasons for the growth of number – for example, low quality of public health sector, absence of or weak private health sector regulation, public demand, income, weak public sector capacity to deliver services.

Section 2: Policy making

3. Are there specific policies or strategies in the health system that relate to the role and scope of the private health care providers in the provision of health care services?
   • Are there plans/initiatives to formulate specific policies or strategies in the health system that relate to the role and scope of the private health care providers?

4. Are private providers involved in the development of policies in health care? If no:
   • Should they be involved in policy making and planning in health care?
   • What are possible reasons for the lack of involvement of private providers in policy development in health care?
   • What are possible mechanisms for the involvement of the private sector in policy and planning?

5. Are you informed on the adoption of the Action Plan for the Prevention and Control of NCDs?
   • If yes: What is the role of the Medical Chamber in the implementation of the Action Plan for Prevention and Control of NCDs?

6. What are the obstacles in the advancement of the implementation of the planned activities defined in the Action plan for Prevention and Control of NCDs?

Section 3: Regulation

7. What is your opinion on existing regulations that regulate the provision of services for the prevention and control of NCDs?
   • How well are these regulations enforced where they exist?
   • Is there perceived difference in implementing these regulations between public and private health providers?

8. What is your opinion on existing regulations related to private health care facilities?
Section 4: Establishment of private facilities

9. Are you aware of the present structure of private facilities in the health sector? If yes:
   • Why there is a small number of private family medicine teams in the private sector?
10. Are there obstacles to the establishment of private facilities – for example, entry to the market, competition, taxes, input costs?
11. What incentives can the government put in place to motivate the private sector to invest more in the health sector? In NCD prevention and services?
12. How important is health insurance fund (HIF) contracting as an incentive for the private sector to invest more in the health sector?

Section 5: Market conditions supporting private provision of care

13. What do you think about the financing of private providers?
   • Are there differences in the financing of primary health care providers in the public and private sectors?
14. What is the role of the medical chamber in setting the prices for the private providers that have a contract with HIF?
   • Are you involved in setting the prices for the services that are financed by the HIF?
   • Is there a specific methodology for setting the prices of preventive services?
15. Are there plans for the development of a specific payment mechanism for the provision of NCD prevention and control services?
16. What challenges do private health providers face with current health financing mechanisms – for example, reimbursement too low, payments too slow, paperwork cumbersome?
17. Is there an out-of-pocket payment for the provision of preventive services? Do patients incur these out-of-pocket payments in public facilities? Private facilities? Both?
18. What market conditions encourage/constrain private provision of health care services? Of NCD prevention and services?

Section 6: Human resources

19. Are there continuous education programs that include NCD prevention and treatment? If yes
20. Are private providers interested in attending the training in NCD prevention and treatment?
21. What is the influence of the emigration of staff from the public and private sector on the provision of NCD prevention and control services?

Section 7: Provision of NCDs prevention and control services

22. What do you think about the present organization of provision of services for prevention and control of NCDs?
23. What is the role of private providers in the provision of NCD prevention and control services?

24. What do you think of the distribution of private providers?
   • Differences in rural/urban areas?

Section 8: Quality of care

25. Are there significant differences in the quality of NCDs prevention and control services between private or public providers?

Section 9: Closing questions

26. Do you have suggestions on how to improve involvement of private providers in the provision of NCD prevention and control services?
Annex D: Interview guide for ministries of health

Section 1: Context

1. What is your opinion about the present situation regarding noncommunicable disease (NCD) prevention and control in entity/canton?
   • Prevalence and reduction of risk factors.
   • NCD burden and epidemiology.

2. How do you perceive the present situation regarding the role of private health care providers in the provision of health services?
   • Number.
   • Type.
   • Growth of number.
   • Reasons for the growth of number – for example, low quality of public health sector, absence of or weak private health sector regulation, public demand, income, weak public sector capacity to deliver services.

Section 2: Policy making

3. Are there specific policies or strategies in the health system that relate to the role and scope of the private health care providers in the provision of health care services?
   • Are there plans/initiatives to formulate such policies or strategies?

4. Are private providers involved in the development of policies in health care? If yes, how are they involved? With what type of mechanism? If not involved, why not?
   • Should they be involved in policy making and planning in health care?
   • What are possible reasons for the lack of involvement of private providers in policy development in health care?
   • What are possible mechanisms for the involvement of the private sector in policy and planning?

5. Are you informed on the adoption of the Action Plan for the Prevention and Control of NCDs?
   • If yes: What are the obstacles in the advancement of the implementation of the planned activities defined in the Action Plan for Prevention and Control of NCDs?

6. What is the role of private providers in the implementation of the Action plan for Prevention and Control of NCDs?
   • Are there intentions for the involvement of private providers in Action Plan implementation? If so, how they will be involved?

Section 3: Regulation

7. Are there plans/initiatives for the development of bylaws for the provision of preventive and screening services?

8. What is your opinion about existing regulations related to private health care facilities?
• Regulation on establishment of private facilities?
• Are there obstacles to the establishment of private facilities – for example, entry to the market, competition, taxes, input costs?
• Are there plans/initiatives to amend existing regulations related to private health care providers?

9. What is your opinion about existing regulations that regulate the provision of services for the prevention and control of NCDs?
   • How well are these regulations enforced where they exist?

Section 4: Number and structure of private facilities

10. Are you aware of the present structure and number of private facilities in the health sector? If yes:
   • How complete is your data on private facilities and their staff?
   • Why there is a low number of private family medicine teams in the private sector?

11. What do you think of the distribution of private providers?
   • Differences in rural/urban areas?

Section 5: Human resources

12. What is the influence of the emigration of staff from the public and private sector on the provision of NCD prevention and control services?

13. What do you think of the role of nurses in the provision of NCD prevention and control services? What can be improved?

Section 6: Provision of NCDs prevention and control services

14. What do you think about the present organization of provision of services for prevention and control of NCDs?

15. What is the role of private providers in the provision of NCD prevention and control services?

Section 7: Market conditions supporting private provision of care

16. Is financing of private primary health care (PHC) and hospital care providers sufficient to attract private investment in health?

17. Are there differences in the financing of PHC providers in the public and private sectors?

18. What market conditions encourage / constrain private sector role in health? In NCDs prevention and control services?
   • How to incentivize the private sector to invest more in the health sector?
   • How important is health insurance fund contracting as an incentive for the private sector to invest more in the health sector?

19. Should there be specific payment for the provision of NCD services?

20. What is your opinion about existing public-private partnership (PPP) arrangements?
21. Do you think there is the possibility of using additional PPP arrangements for the provision of NCD prevention and control services?

**Section 8: Quality of care**

22. Are there significant differences in the quality of NCDs prevention and control services between private or public providers?

**Section 9: Closing questions**

23. Do you have suggestions on how to improve involvement of private providers in the provision of NCD prevention and control services?
Annex E:
Interview guide for public health institutes

Section 1: Context

1. What is your opinion about the present situation regarding noncommunicable disease (NCD) prevention and control in entity/canton?
   - Prevalence and reduction of risk factors
   - NCD burden and epidemiology

2. How do you perceive the present situation regarding the role of private health care providers in the provision of health services?
   - Number – Enough? Too many?
   - Type – Not enough general practitioners? Too many hospitals?
   - Size of private providers – Too small? too big? want growth? do not want growth?
   - Reasons for the size of the private sector – for example, low quality of public health sector, absence of or weak private health sector regulation, public demand, income, weak public sector capacity to deliver services.

Section 2: Policy making

3. Are you aware of government plans/initiatives to formulate specific health policies or strategies that will shape the role and scope of the private health care providers?
   - New NCD prevention program?

4. Are private providers involved in the development of policies in public health? If yes, how are they involved? With what type of mechanism?
   If not:
   - What are possible reasons for the lack of involvement of private providers in policy development in public health?
   - Should they be involved in policy making and planning in public health care?
   - What are possible mechanisms for the involvement of the private sector in policy and planning?

5. Are you aware of the Action Plan for the Prevention and Control of NCDs? If yes:
   - What is the role of the public health institute in the implementation of the Action Plan for Prevention and Control of NCDs?
   - What are the obstacles in the advancement of the implementation of the planned activities defined in the Action Plan for Prevention and Control of NCDs?

6. Does the government intend to involve private providers in Action Plan implementation? If so, how will they be involved?

Section 3: Regulation

7. What is your opinion on existing regulations that regulate the provision of services by the private sector providers?
8. Are public health institutes involved in design and updates of regulations that directly impact private health care providers role in provision of NCD prevention and control services?

9. What is your opinion on existing regulations that regulate the prevention and control of NCDs – too cumbersome, not enough, areas for improvement?

Section 4: Establishment of private facilities

10. Are you aware of any obstacles to the establishment of private facilities – for example, entry to the market, competition, taxes, input costs?

11. What incentives can the government put in place to motivate the private sector to invest more in health? To deliver NCD prevention and treatment services?

12. How important is health insurance fund contracting as an incentive for the private sector to invest more in the health sector?

Section 5: Human resources

13. How complete is your data on private facilities and their staff?

14. What can be done to improve the completeness of data on private facilities?

Section 6: Provision of NCDs prevention and control services

15. In your opinion, what is the current role of private providers in the provision of NCD prevention and treatment?

16. What is the present method of reporting of NCD prevention and control services both from public and private providers?
   - What do you think about the accuracy of reporting?
   - Is there a place for improvement of existing reporting practices and how?

Section 7: Closing questions

17. In your opinion, do you think the private sector can play a greater role in NCD prevention and treatment? If so, what?

18. What are the barriers to increasing the private sector’s role in NCD prevention and treatment?

19. Do you have suggestions on how to improve involvement of private providers in the provision of NCD prevention and control services?
Annex F:
Interview guide for private health care providers

Section 1: Context

1. What is your opinion about the present situation regarding noncommunicable disease (NCD) prevention and control in entity/canton?
   • Prevalence and reduction of risk factors.
   • NCD burden and epidemiology.

2. What is your perspective on the present situation regarding the role of private health care providers in the provision of health services?
   • Number.
   • Type.
   • Growth of the number of private providers.
   • Reasons for the current situation of private sector role in health – for example, low quality of public health sector, absence of or weak private health sector regulation, public demand, income, weak public sector capacity to deliver services.

Section 2: Policy making

3. What are the critical health policies or strategies that relate to the role and scope of the private health care providers in the provision of health care services?

4. Are you aware of government plans/initiatives to formulate specific health policies or strategies that will shape the role and scope of the private health care providers?

5. Are private providers involved in the development of policies in health care? If so, how does the government involve the private sector?

6. If not:
   • Should they be involved in policy making and planning in health care?
   • What are possible reasons for the lack of involvement of private providers in policy development in health care?
   • What are possible mechanisms for the involvement of the private sector in policy and planning?

7. Are you aware of the Action Plan for Prevention and Control of NCDs? If yes:
   • What is the role of private providers in the implementation of the Action Plan for Prevention and Control of NCDs?
   • What are the obstacles in the advancement of the implementation of the planned activities defined in the Action Plan for Prevention and Control of NCDs?

8. Does the government intend to involve private providers in Action Plan implementation? If so, how they will be involved?

Section 3: Regulation

9. What is your opinion on existing regulations that regulate the provision of services by private health care providers? (Prompt: Are they cumbersome? Restrictive? A Barrier?)
10. Are you aware of the plans/initiatives to amend existing regulations that regulate the provision of services by private health care providers?

Section 4: Establishment of private facilities

11. Are you aware of the present structure of private facilities in the health sector? If so:
   • Why there is a low number of private family medicine teams in the private sector?
12. Are there obstacles to the establishment of private facilities? If so, what are they?
   (Prompt: entry to the market, competition, taxes, input costs)
13. What can the government do to incentivize the private sector to invest more in the health sector?
14. How important is health insurance fund (HIF) contracting as an incentive for the private sector to invest more in the health sector?

Section 5: Financing and contracting

15. What do you think about the financing of private providers?
16. Are there differences in the financing of primary health care providers in the public and private sectors?
17. How do you set the prices for the services you provide?
18. How does HIF set prices for services delivered by eligible private providers?
19. Does the HIF involve representatives of private facilities in setting the prices for the services that are financed by the HIF?
20. What methodology does HIF employ for setting the prices of preventive services?
21. Are there incentives for the provision of NCD prevention and treatment services – for example, contracting, subsidized inputs, vouchers, payments? If not, should they be introduced? What type of incentives?
22. Do you think that private providers should be included in the design of incentives for the provision of NCD services? If so, how?
23. Is there an out-of-pocket payment for the provision of preventive services?

Section 6: Human resources

24. Do you report human resources data? How often? To whom? What challenges do you face in reporting data to the government?
25. What challenges do you face in staffing your facility – for example, staff availability on the market, access to the training programs for specialization training and additional education?
26. How does emigration of healthcare professional affect private sector ability to stay in business? Provide quality services?
Section 7: Provision of NCDs prevention and control services

27. In your opinion, what is the current role of private providers in the provision of NCD prevention and treatment services?

28. Do you currently provide NCD prevention and treatment services? If so, which ones?

29. Do you report the delivered NCD prevention and treatment services? To whom are those reports submitted? What challenges do you face in reporting the government? How can reporting on NCD prevention and treatment be improved?

30. Are there differences between the responsibilities and roles of nurses in private sector facilities and public sector facilities?

31. What do you think of the distribution of private providers?
   • Differences in rural/urban areas?
   • Influence of market conditions?

Section 8: Quality of care

32. Are there significant differences in the quality of NCDs prevention and control services between private or public providers?

33. Are you aware of the existence of clinical guidelines for the provision of NCD prevention and control services? If yes: Are you using clinical guidelines? If not, why not?

34. Are you using electronic health records? If yes: Is their structure adequate for the reporting of NCD prevention and control services?

Section 9: Closing questions

35. In your opinion, do you think the private sector can play a greater role in NCD prevention and treatment? If so, what?

36. What are the barriers to increasing the private sector’s role in NCD prevention and treatment?
Annex G: Interview guide for public private partnerships

Section 1: Context
1. How do you perceive the present situation regarding the role of private health care providers in the provision of health services?
   • Number – Enough? Too many?
   • Type – Not enough general practitioners? Too many hospitals?
   • Size of private providers – Too small? Too big? Want growth? Do not want growth?
   • Reasons for the size of the private sector – for example, low quality of public health sector, absence of or weak private health sector regulation, public demand, income, weak public sector capacity to deliver services.

Section 2: Policy making
2. Are there specific health policies or strategies that relate to or directly affect the role and scope of the private health care providers in the provision of health care services?
3. Are private providers involved in the development of policies in health care? If yes, how?
4. If not:
   • Should they be involved in policy making and planning in health care?
   • What are possible reasons for the lack of involvement of private providers in policy development in health care?
   • What are possible mechanisms for the involvement of the private sector in policy and planning?
5. Are you aware of the Action Plan for the Prevention and Control of Noncommunicable Diseases (NCDs)? If yes:
   • Are you aware of the role of private providers and public-private partnerships in the implementation of the Action Plan for Prevention and Control of NCDs?

Section 3: Regulation
6. What is your opinion on existing regulations on the establishment of private health care facilities?
7. What is your opinion on regulation about PPP?

Section 4: Establishment of private facilities
8. Are there obstacles to the establishment of PPP – for example, entry to the market, competition, taxes, input costs?
9. In your opinion, what type of incentives can the government use to encourage the private sector to invest more in the health sector?
10. In your opinion, do you think HIF contracting is an effective incentive to encourage the private sector to invest more in health sector?
Section 5: Financing and contracting

11. What do you think about the financing of private primary health care (PHC) and hospital care providers?
12. Are there differences in financing of PHC providers in public and private sector?
13. What do you think about the present way of financing of PPP arrangements?

Section 6: PPP

14. How can the government use PPP arrangements to attract more private providers to deliver NCD prevention and treatment services?

Section 7: Quality of care

15. Are there significant differences in the quality of NCDs prevention and control services between private or public providers?
16. How does current PPPs arrangement ensure quality of services delivered?

Section 8: Closing questions

17. In your opinion, do you think the private sector can play a greater role in NCD prevention and treatment? If so, what?
18. What are the barriers to increasing the private sector’s role in NCD prevention and treatment?
19. Do you have suggestions on how to improve involvement of private providers in the provision of NCD prevention and control services?
Annex H: Questions for focus group session

Section 1: Leadership and stewardship
1. How do you think the private health sector could participate in promotional-preventive activities in the control of NCD risk factors?
2. What do you think is the importance of public-private partnership (PPP) in the health system in the FBIH and in the prevention and control of NCDs?
3. What do you think is the importance of the private health sector in the health system in the FBIH in the prevention and control of NCDs?
4. Can private practice as supplementary work have an impact on NCD control and how?

Section 2: Service delivery
1. How can the private health sector improve the prevention and control of NCDs (chronic non-communicable diseases)?
2. Can and how can accreditation of private health care institutions by AKAZ improve NCD prevention and control?

Section 3: Health personnel
Do you think that health personnel from the private health sector must undergo regular NCD prevention and control training organized by the Institute for Public Health?

Section 4: Health information system
Do you consider it possible (acceptable) to use public electronic patient records (electronic records from existing software solutions used in the public sector) in your work (in private healthcare institutions)?

Section 5: Health financing
1. Do you think that the private health sector should/can be paid by health care programs for the prevention and control of NCDs (flat rate)?
2. What payment method is acceptable to the private health sector?
3. How does the public health sector view the possibility of competition between the public and private sectors?
4. What do you think is the perspective of the private health sector in NCD prevention and control?
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