

# STRENGTHENING THE GOVERNANCE OF PUBLIC HEALTH SERVICES IN THE SOUTH-EASTERN EUROPE HEALTH NETWORK (SEEHN)



**Banja Luka, Bosnia and Herzegovina**  
**15 November 2017**



## ABSTRACT

The policy dialogue on strengthening the governance of public health services in the South-eastern Europe Health Network (SEEHN) was held in Banja Luka, Bosnia and Herzegovina on 15 November 2017. Participants included members of the SEEHN, subject matter experts and staff from WHO Regional Office for Europe and the European Observatory on Health Systems and Policies. This report summarizes the key objectives and messages obtained from the policy dialogue, including the outcome of working-group sessions.

### Keywords

PUBLIC HEALTH  
PUBLIC HEALTH SERVICES  
HEALTH REFORM  
HEALTH SYSTEMS  
HEALTH POLICY  
EUROPE

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# **Strengthening the governance of public health services in the South-eastern Europe Health Network (SEEHN)**

## **Policy dialogue hosted by the health authorities in Bosnia and Herzegovina**

**Banja Luka, Bosnia and Herzegovina**

**15 November 2017**

**Dialogue Report**

### **1. Background and Context**

This policy dialogue on strengthening the governance of public health services in the SEEHN was prepared in the scope of the project “Developing and Advancing Modern and Sustainable Public Health Strategies, Capacities and Services to Improve Population Health in Bosnia and Herzegovina (BIH)”, which has been developed and financially supported in partnership between the Swiss Government and the World Health Organization (WHO), and implemented by WHO Regional Office for Europe (WHO EURO)/WHO Country Office (CO) in BIH (2013-18).

Public health services are faced with a multitude of challenges, including a growing burden of chronic disease, recurrent infectious diseases and an often challenging financial and organizational context. Despite cutbacks to public health services in many countries, member states of the WHO/Europe region, have a renewed interest in the organization and financing of public health services and the strengthening of the public health workforce. They are increasingly requesting information on effective arrangements and on ongoing reforms of public health services in Europe. The health policy framework of the WHO European Region, Health 2020, adopted by the member states in Malta in September 2012, has emphasized the need for public health action. One of its main pillars is the European Action Plan for Strengthening Public Health Capacities and Services.

## 2. Objectives and Expected Outcomes

The objectives of the policy dialogue were to:

- provide an understanding of the different approaches and divergent models being implemented to organize and finance public health services;
- explore some of the efforts being made in selected countries in south east Europe to strengthen the organization and financing of public health services;
- review challenges and policies around a strong public health workforce;
- discuss available mechanisms for measuring and improving the quality of public health services.

Expected outcomes were:

- provide an insight into the different public health strategies across the area covered by the SEEHN;
- be informed about the efficient hands-on approaches used in specific targeted public health policies in the different countries – ‘the success stories’;
- be acquainted with the plans for the forthcoming public health interventions across the region;
- provide recommendations for the future course of public health governance and reforms.

## 3. Programme Outline

The workshop programme (**Annex 1**) was organized in three main sessions, as follows:

**Session 1:** Organization of public health services

**Session 2:** The financing of public health services

**Session 3:** The public health workforce

**Session 4:** Measuring and improving the quality of public health services

## 4. Proceedings from the Meeting

### 4.1. Opening/Introduction

Dr Victor Olszavsky, Head of WHO CO for BIH greeted the participants, delegates and guests of the policy dialogue and opened the policy dialogue with a short introductory speech. He proceeded to give the floor to the host, the Minister of Health and Social Development of the Republika Srpska, Dr Dragan Bogdanić, who gave a short introductory speech and explained the recent public health and health care reforms as well as the forthcoming plans in the Republika Srpska. In continuation, greetings and best wishes to the policy dialogue were expressed by the Head of Department of Health and Other Services of the Brčko District of BIH, Dr Sabrija Čandić, then by the Assistant Minister of Health of the Federation of BIH, Dr Goran

Čerkez, by the Head of planning, human resources and information systems in the healthcare sector, Ministry of Civil Affairs of Bosnia and Herzegovina, Mr Dalibor Pejović, by the Programme Coordinator at the Swiss Embassy in Sarajevo, Ms Maja Zarić and finally by the Chair of the SEEHN, Dr Nicolae Jelamschi.

After the introductory and welcome speeches, Dr Bernd Rechel from the London hub of the European Observatory on Health Systems and Policies presented the main topic of the day, the definition and the framework for the public health services and the concept of the 10 essential public health operations (EPHOs). He initially described terminological issues and difficulties related to the translation of the English term 'public health' into other languages. Even in some of the biggest European nations this leads to both problems, the problem of the term and its local meaning as well as to the problem of understanding what it encompasses. Another problem related to public health terminology is that of public health services, which could mean actual services or, alternatively, structures providing public health. The concept of EPHOs was developed in order to reconcile these dilemmas and to provide a framework, which would be understood equally well across the entire European Region of WHO.

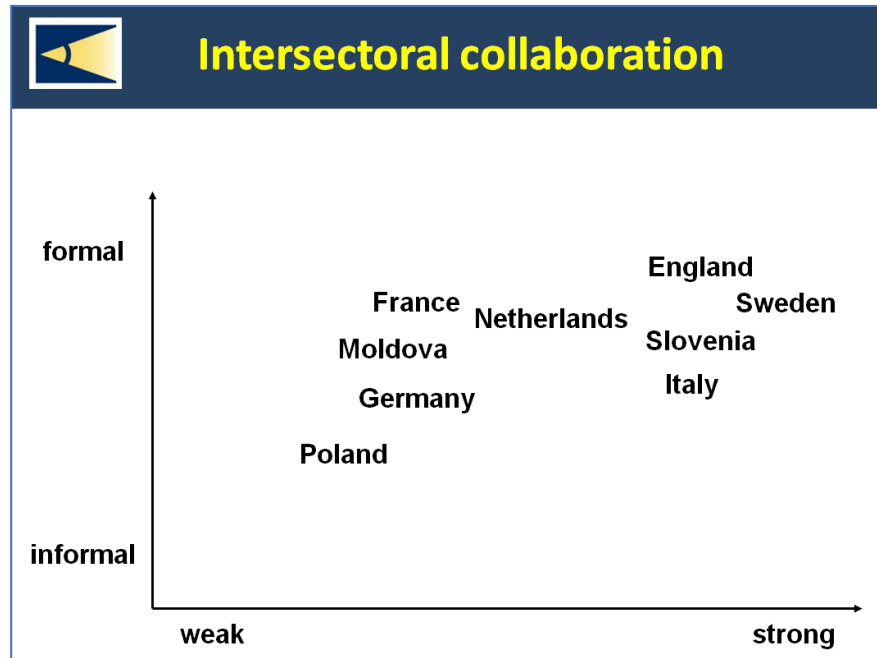
#### **4.2. Session 1: Organization of public health services**

The session on the organisation of public health services was opened by the facilitator of the session, Ms Suszy Lessof from the European Observatory.

The first presentation in this session was given again by Dr Rechel, who presented the results of a study, which looked into the developments in public health organization and structures across the region. The focus was on nine countries, namely on England, France, Germany, Italy, Moldova, the Netherlands, Poland, Slovenia and Sweden. A review of grey and academic literature was carried out, using national and international databases. There was a cross-country thematic analysis of key challenges, opportunities and key lessons. They decided to use three tracer issues – antimicrobial resistance (AMR), obesity and alcohol control, which would cover the main areas involving modern public health and address key health determinants. They analysed the forms of vertical organisation in terms of the organisation of public health services and the relationship with the health care providers. In general terms, the national level, where usually the national institute of public health is the key actor, provides the strategic guidance, the regional level provides coordination and plans the public health services, while the local level mainly delivers services (sometimes jointly with the health care services). Generally, health care delivers those public health services, which have been clearly designated. It is evident that there is wide variation in terms of command and control versus the full local independence. The former is more present in France, Moldova, Poland and Slovenia, while latter was clearly better developed in the remaining five countries. It is true that England, Germany, Italy and Sweden are also more strongly decentralised in the general administrative sense. Nevertheless, examples of good practices come from both groups:

1. In Italy, there is coordination between the state level and regional services through national/state-level conferences
2. In England and in Slovenia there is provision of local health information to provide for local health (care) planning.

3. Often there is a mechanism in place for exchange of best practices and for accountability. In examples of inter-sectoral collaboration, it is worth mentioning Sweden's work on AMR, and the Swedish alcohol, narcotic drugs, doping and tobacco (ANDT) strategy 2011-2015. Involvement of other sectors was crucial for a successful policy development and implementation. Countries show variation in the formalisation of the intersectoral collaboration and its strength.



The initial presentation by Dr Rechel was followed by the country presentations, which were all shaped according to the same template provided in advance.

Bosnia and Herzegovina (the Federation of BIH and the Republika Srpska)

- Israel
- Moldova
- Montenegro
- Romania
- Serbia

The first presentation was by the Federation of Bosnia and Herzegovina (FBIH). We learned that public health services are defined through the Law on Health Care of the FBIH following a vertical hierarchy. The same law also designates the Ministry of Health of FBIH as the creators of health policy, strategy and legislation. Public health is institutionally organised at all three levels – entity, cantonal (i.e. regional) and municipal. A process of transformation has been running where transformation from the hygienic-epidemiological services in health services moved to the Cantonal PHIs. Institutes at the cantonal level enjoy a high level of independence and can get involved in different projects and financing schemes. A part of the preventative services is delivered at PHC level. In terms of horizontal integration, there is formal intersectoral collaboration in development of health-related strategies and legislation (e.g. Policy and Strategy for Mental Health, Tobacco Control Law, Tobacco Control Strategy). There

is collaboration with local communities in development of their local strategic plans (through support provided by UNDP and UNFPA) and developed collaboration and networks with NGOs.

In the Republika Srpska, there is the Institute of Public Health and 6 regional institutes, while there is a total of 123 hygienic-epidemiological services in 54 health centres. They work closely with around 700 family medicine teams. The system operates on top-down command system through health institutions, while there is a high level of local independence, coordinated through health boards of municipalities. The main challenge was in the turbulence of restructuring triggered by the austerity measures, while the main opportunity lies in intersectoral cooperation and local responsiveness. As far as the horizontal collaboration is concerned, there is a Government Working group for Public Health (representatives of all ministries are members), while all ministries are obliged to ask Ministry of Health and Social Welfare in Government of the Republika Srpska for opinion before passing laws and planning documents. Another example lies in the fact that the Policy for Improvement of Health of the Population in the Republika Srpska by the Year 2020 was passed by the entire government.

Moldova inherited a very extensive three-level network of public health institutions. Until November 2017, there was a Department of public health at the MoH and the National Centre for Public Health, while there were 2 municipal and 34 district (rayon) PHI. All of the institutes are directly subordinated to the MoH with some independence at the local level. District Centres of Public Health are responsible for the development and implementation of local public health programmes based on national ones. These are coordinated and endorsed by the Municipal/District Public Authorities. Since 2016, public health councils were established at the district level in order to coordinate public health activities. The reform to be launched in this period is to address the main challenge, which lies in the numerous institutions and in the fragmentation of the organization and delivery of PH services in Moldova. At national level, there is coordination council activity related to each of the programmes at the level of deputy prime minister, while at the local level, district public health councils carry out the coordination and this represents a major opportunity for the future to plan, coordinate and implement PH activities.

As Montenegro is the smallest country of the Network, it has only the National Institute of Public health with 6 organisational units as well as hygienic-epidemiological services with the primary health centres. In the board of directors of the NIPH there are representatives from the MoH and other health institutions. The main opportunity lies in the Master Plan for the development of Health care system in Montenegro 2015-2020.

In Romania, there is a classical vertical hierarchy with a two-level structure of both, public/state administration as well as that of public health institutions. At the national level, the main actor is the MoPH, while at the county level and at Bucharest Municipality there are public health authorities, which link and work closely to the adequate public health institutes. The latter are responsible for the establishment, elaboration and implementation of strategies in public health both at the national and regional level. The main challenge is the development, organization and monitoring as well as control of national public health programmes by the MoH. Horizontal integration runs through the local public administration authorities, where, unfortunately, there is lack of specialized personnel and necessary funding.

Serbia has a vertical hierarchy, which, apart from the PHIs at the national and district level, includes the National Public Health Council (representation from all ministries) as well as Expert groups for Public Health Challenges. As far as the horizontal integration is concerned, this is organized at the community level and with primary care centres, both of which are coordinated by the Municipal Health Councils. Challenges are in international and cross-border cooperation, while the opportunity lies in intersectoral collaboration.

There were also presentations from three countries that do not belong to the SEEHN but work closely with its members, Croatia, Poland and Slovenia. Croatia has another typical two-level structure with the NIPH and 21 county PHIs. Though county PHIs enjoy a high level of independence, most activities are coordinated by the MoH or financed based on contract with the Croatian Health Insurance Fund. There is a lack of comprehensive public health policy and priority-setting. This is additionally complicated by the weak authority of PH institutions and professionals. The opportunity lies in the capacity and the power of PHIs, especially through proven examples of local planning. Horizontal integration and inter-institutional coordination are weak or limited. There is a lack of priority-setting processes, decisions are taken under strong political influence. Successful pilots of coordination with county stakeholders in health care are an important opportunity and asset for the future.

In Poland, there is no clear hierarchy of governance of PH services. Public Health Department within the MoH has a weak position. Institutionally, there is the National IPH, Sanitary Inspection with branches in all districts for hygienic and environmental health purposes. Additionally, there are separate agencies that manage alcohol, drugs and AIDS prevention. There is lack of coordination and management of cross-cutting issues and lack of visible leadership in public health. Public Health Law from 2015 represents an opportunity with new coordination mechanisms within the MoH (establishment of the Public Health Council) and designate persons with authority to manage PH programmes within the MoH. Public Health Council (est. in 2016) is going to coordinate PH services and the national health programme is to coordinate PH actions through institutional PH.

As the main challenge lack of interest in PH issues was identified as well as lack of good management and leadership at the MoH. Opportunity lies in the existence of a legal framework for cooperation.

Slovenia saw a restructuring of institutional public health in 2014, when previous NIPH and 9 regional institutes joined in order to make two new key institutions in public health – the NIPH and the National Laboratory for Health, Environment and Food (NLHEF). Both institutions are closely linked to the Public Health Directorate at the MoH. Larger municipalities have their own departments for chronic diseases and their epidemiology. Horizontal integration is done through multi-sectoral policies (e.g. on nutrition and physical activity, road safety and ageing). Challenge is in the lack of integrative public health approaches at the local level, while the recently established municipal health profiles represent a step in the right direction.



In the discussion, two discussants, Goran Čerkez and Vesna-Kerstin Petrič were reflecting upon the meaning of the word policy and its meaning in different countries. It was interesting to see the development between public health as a whole and its respective institutions and the NGOs working in the field of public health. It seems that there had been quite some development in that respect.

#### **4.3. Session 2: The financing of public health services**

The session on financing was introduced by Dr Bernd Rechel with a presentation on financing of public health in Europe. An interesting case is the example of Italy where the share of financing for public health through the crisis years increased from 0.6% in 2007 to 3.7% in 2014. Interestingly, national data suggest that this share may be even at 4.2%. Public funding on preventative care shows a wide range. In the Netherlands, there has been an increasing expenditure trend on prevention per capita. The relative share of funding for public health is generally in decline, with the exception of Greece (this effect may be caused by the long periods of austerity prior to the current developments). There are sometimes important regional disparities in funding, such as regional variations in Italy ranging from 2.7% to 5.9%.

In the FBiH public health services are funded as a part of comprehensive health system financing and are planned in the annual budgets at the federal and cantonal levels. There are differences between the respective plans, where some PHI receive financing mainly from the budget, while others from contracting of services and from other sources (donations, grants, loans, etc.). Challenges are in decreased funding from the budget and in maintaining the level of technology costs. The opportunities lie in the development of new services in laboratories and in training and applying for funding in different international projects and networking.

Currently, the financing scheme does not allow for long-term planning and there is no sustainable mechanism for health promotion interventions. Earmarking could potentially become an opportunity for the best-buys interventions in health promotion.

Sometimes, the challenge is in the definition of public health services, as in Croatia most of the teams in PHIs working on communicable disease prevention and health promotion are financed by the compulsory health insurance. Public health services in Slovenia in primary care services and teams are covered predominantly by the Health Insurance Institute of Slovenia but the teams in health promotion centres are supported through training and professional development, which is organised and financed through PHIs. In Poland 35 million EUR will be spent on projects from the national level. In Moldova, financing from the state reaches 2.6% of the total health expenditure, 80% of which goes to salaries, even if these are low, but there are additional revenues raised by the PHI, mostly from services, training and additional funding from international agencies.

One of the important challenges is the sustainability of financing. In Croatia, the main problem is the financing model, which is designed to provide enough money for the staff and not for the programme financing or funding. About 50% of the incomes of the PHIs comes from the health insurance fund. Additional raised sources from freely provided services are an important source of financing and securing day to day functioning. In Slovenia, separation

between laboratories and the core public health took place. Mostly, financing still relies on paying for staff with little flexibility. There have been intense activities in raising additional financing for NGOs. Additional financing was also obtained through project funding and from EU cohesion funds. Poland managed to secure sustainable funding for local authorities and governments with earmarked funds from alcohol. There is an additional fund under development, which will be tackling gambling addiction. Moldova is struggling with the fact that at present public health services are unattractive for younger professionals. There is a need to build capacity and use earmarked taxes on tobacco and alcohol.

Regarding 'sin taxes' there were tough discussions on tobacco control in Slovenia where the MoH wanted to make a decisive step forward in controlling and limiting tobacco use further and increase significantly the taxes. It was faced with opposition also from within the Government as the MoF was trying to shy away from more decisive action fearing drops in earmarked taxes from tobacco as a total income for the budget. In Bosnia and Herzegovina, it was perceived that there was discrepancy between the initiatives from the WHO and IMF respectively, leading to counter-actions between the objectives and the determination of the financial authorities. Additionally, lottery funding was seen as a source for public health (even if coming from another addiction). Dr Džakula stressed the challenge of a discrepancy between raising funding and creating capacity of the services. The latter is as big a problem as is the identification of additional sources of funding. In Moldova, there is national budget funding of all PH agencies with National Health Insurance Fund to become an additional funder of PH services. There are additional special national programmes, including international funding mechanisms. Hepatitis C treatment became available for 5000 persons (increased from the initial number of around 100). Public health services should be flexible with mixed funding but also with clear definition of their scope and objectives.

Project funding is generally an opportunity that might achieve both flexibility and diversification of services. In Serbia, the trend is to finance not only staff but increasingly programmes, mostly those in health promotion and diseases prevention. There has been intense activity in raising additional funds from other sources.

#### **4.4. Session 3: The public health workforce**

Introductory presentation was given by Dr Rechel, who reported on the part of the study on public health concerning the public health workforce. The most important findings are:

- There is a lack of common understanding which professionals are a (necessary?) part of the public health workforce
- Consequently, there is lack of reliable statistics
- There is also lack of public health workforce planning
- Countries studied show clearly defined training pathways for public health specialists
- Mostly working conditions and/or pay are often worse than for mainstream health workers/professionals

Public health workforce usually comprises of different professional groups, such as: physicians, dentists, health engineers, inspectors, disinfectors, medical technical assistants, social workers, nursing and midwifery staff, psychologists, social and political scientists, health planners. One of the main questions remains: Who belongs to the 'core' public health workforce? Information on that is sometimes available by public health doctors or by public health units.

In England, there is an advantageous position for public health specialists, who generally earn the same as doctor of other specialties. This has partially changed since the transformation of public health and the move of staff to local levels (where their salaries had been equalized with local administration levels). Entering Public Health specialty is still highly competitive as the Faculty of Public health receives 11 times (!) as many applications as there are training positions. There are very good career progression opportunities and retention in posts is high.

In other countries, the situation is not always as good as in England. In France, they experience problems in filling all the open positions and training posts. At the same time, in Germany, it is often 'a job for life' with office hours and stability, but with at least 1000 EUR lower salary than in the mainstream health care. As a result, over the last 20 years the number of doctors in local PH offices in Germany declined by about one third.

As concerns training, in England PH since early 2000s PH specialty is open to professionals of any background. Currently, half of all PH specialists are not holding a medical degree, which is in clear contrast to other countries, where there is a specialty of public health medicine.

Public health workforce strategy exists only in England and not in other countries, which were under study as presented by Dr Rechel.

In the Republika Srpska (RS) the salaries for public health specialists are better than for the mainstream health service staff. There are good opportunities for career development and generally, there are no shortages of staff. Obviously, there are problems with distribution, especially between the capital and Eastern regions of RS. This sometimes and, in some places, leads to the problems of sustainability of services. Match between skills and training and the needs of the system should be improved. Public health staff should be distributed more appropriately for public health service needs, including regional and local priorities. One of the main challenges is in the improvement of education and in organisation. There has been big support from WHO and their programmes for the professional development of staff in public health.

In Montenegro, there are 60 professionals with PH specialty, which means 9,6 PH professionals per 100,000 population. Over the last 10 years the number has doubled, salaries are the same as for the mainstream staff. The vast majority of PH professionals work in the NIPH but there are 16 specialists working in PHC as a part of the HESs. Continuous professional development (CPD) is well established and developed and there are special funds for education and training allocated to the Clinical centre of Montenegro and the NIPH.

In Romania, PH professionals are highly qualified as they will have gone through compulsory residency, MPH and PhD programmes. The volume of work is increased due to the lack of professionals. Overall in Romania there is general shortage of physicians, as the country has

only 2.9 doctors per 1000 inhabitants. There are important problems with the distribution of PH professionals across the country. As a special challenge and opportunity, Romania sees the free movement of persons, goods and facilities. There has been important support by WHO and other international organisations, among others in education of many professionals abroad in several countries.

In the subsequent discussion, relevance of international platforms and settings was underlined. There are traditionalist reasons why we do not move from the traditional concepts and medicine-based education and medically-led public health service and workforce. There is a need to run this transformation through a gradual change and assurance of financing and structure.

One of the most important challenges lies in the development of workforce and presence and authority of the public health workforce where there is a need to increase visibility. One of the tasks is in the inclusion of other professionals into the broader public health community. It has been evident that there need to be two directions in the professional development; both horizontal and vertical development.

In Slovenia, a lot of attention was put on the development of multidisciplinary teams in public health, also through increasing awareness of the need of different professional and academic backgrounds needed for the successful delivery of the different tasks and to face challenges in public health. This process, originally bearing the clear sign of a strong top-down approach, managed to introduce a multitude of health and other professionals into processes, which require implementation of different activities, which cannot be delivered by health professionals alone.

An important challenge for the future development is introduction and/or continuous development of multi-professional and multi-disciplinary teams in PH. In the RS, primary care teams consist of a GP and two nurses. Especially nursing education was quick to respond to the PH challenges and this resulted in the development of specific targeted studies in health promotion and health education. There are serious problems and other issues with workforce retention for other professionals in public health. A special and important problem in this respect is the retention of IT professionals. It was clearly shown that motivation for professionals is an important element of a meaningful job. In any case, there is a need for CPD and the development of the workforce.

#### **4.5. Session 4: Measuring and improving the quality of public health services (PHS)**

The last introductory presentation for the sessions by Dr Rechel was dealing with the measurement and improvements in the quality of public health services across Europe, again based on the findings from the study. He mentioned that the main problem lied in the absence of explicit frameworks for ensuring the quality of PHS in most European countries. Institutions exist at national and regional level and some standards and guidelines are well-established (such as the case for vaccinations and screening). There are many open questions concerning accreditation and licensing, while the measuring of the quality of PHS is carried out either

through very narrow or very broad indicators. He presented two definitions: one for the quality of health services and the other one adapted for public health services respectively. An important issue in that respect is that the key dimensions of the quality of PHS are different and most of them based on societal values, rather than pure scientific evidence. International actors who are dealing with the quality of PHS are: WHO-EURO, EU, ECDC and OECD, while in countries they are mainly actors belonging to the institutional public health. Dr Rechel presented the cases of Italy and England. In Italy, the MoH is responsible for monitoring of the provision of the essential levels of care through a monitoring system developed throughout the regions and with the national coordination. The National Observatory on Health Status in the Italian Regions provides the technical support to this activity. They can focus on specific topics, populations and settings. In England, NICE published 65 guidance documents that cover different public health topics. They are linked to measurable quality standards designed to promote quality improvement in the respective fields.

There is Agency for Accreditation of Public Health Education in Europe and at the national level all 9 countries included in the study had some mechanism of accreditation, though mostly based on procedures for general accreditation of health care providers. Often indicators are linked to specific programmes, such as cancer screening programmes. In England, they have a Public Health Outcomes Framework, which started in 2012, which focusses on trends in healthy life expectancy and reductions in life expectancy and healthy life expectancy in the communities.

There has been the activity carried out in the RS for the verification of the national programme for health promotion. In Romania, the National Health Insurance Fund supported the quality assurance activities related to TB and HIV prevention programmes.

The main challenge remains in the development of the adequate analytical capacity and in the ability to triangulate the vast quantities of data that public health deals with on a daily basis. The extent of data is not crucial for the proper decision-making support. Among other activities, there appears to be a strong commitment to ISO standardisation, which in itself does not solve all the open issues within the institutional public health as such.

## **5. Closing thoughts/Key messages**

- Countries of the SEEHN for the time being mostly kept the organisational structure of the institutional public health, which had been in place for several decades.
- The most important forthcoming and currently ongoing reform is taking place in Moldova, where merging of the district PHI will occur following the transformational change and is ongoing at the time of the writing of this report.
- Governance of public health mostly follows a top-down command-style approach.
- In the years when there was a drop of financing from the budgets, PHIs re-oriented themselves to funding from different sources: laboratory services, projects, development of training programs.

- Budgetary funding still predominantly finances salaries and does not cover sufficiently the programme-oriented work necessary on health promotion, working on health determinants and on NCD prevention.
- Public health services should be flexible with mixed funding but also with clear definition of their scope and objectives.
- Generally, PH professionals receive more or less the same salary as health professionals elsewhere in the health system.
- There is a general absence of focused and targeted public health workforce strategies.
- A strong tendency is evident in strengthening multidisciplinary in public health with the introduction of a range of other professionals with diverse academic backgrounds.
- Important investments have been made in the upgrading of public health education at all levels.
- Top level and top-down decisions are crucial in securing the initial push for the workforce decisions to be implemented and restructuring secured.
- Quality assurance in PHS is still quite limited as sometimes the critical mass of professionals is too small for nationally based QA programmes.
- What is missing is a list of explicit criteria, indicators and a stable framework for the monitoring of quality in PHS.

# Annex 1 – WORKSHOP PROGRAMME

## Day 1 – Wednesday, 15 November 2017

08.30 – 09.00 Registration

09.00 – 09.30 **Opening session: Introduction and objectives of the policy dialogue**

*Representatives of the Health Authorities in BIH, Swiss Embassy in Bosnia and Herzegovina, South-eastern Europe Health Network and WHO CO/EURO*

### **Structure and objectives of the Policy Dialogue**

What we mean by public health services: the 10 essential public health operations in south-eastern Europe

*Bernd Rechel, European Observatory on Health Systems and Policies*

09.30 – 11.00 **Session 1: Organization of public health services**

Facilitator: *Suszy Lessof, European Observatory on Health Systems and Policies*

*The opening session will look at the organization of public health services as they have evolved over recent years. It will discuss the different types of organizational structures and the challenges and opportunities associated with them. The focus will be on the following dimensions:*

- **Vertical hierarchy of public health services:** *How are your services organized? Is there top-down command, local independence or something in between?*
- **Horizontal integration across sectors:** *Are there formal mechanisms in place to encourage collaboration with other sectors (education, social care, agriculture) or do you rely on informal networks?*

### **Presentation: The organization of public health services in Europe –key findings of the WHO/Observatory study**

*Bernd Rechel, European Observatory on Health Systems and Policies*

### **Participant presentations: The experience of South Eastern European countries**

- Bosnia and Herzegovina
- Israel
- Moldova
- Montenegro
- Romania

- Serbia

**Reflections: How the experience of Poland and Moldova can help understand the models for organizing public health services in south east Europe**

- *Łukasz Balwicki, Medical University of Gdansk, Poland*
- *Angela Ciobanu, WHO Country Office Moldova*

11.00 – 11.30

**Concluding observations: Identifying key patterns and messages**

11.30 – 12.45

*Tit Albreht, Rapporteur*

*Coffee Break*

**Session 2: The financing of public health services**

Facilitator: *Suszy Lessof, European Observatory on Health Systems and Policies*

*This session will examine the financing of public health services. The focus will be on the following issues:*

- ***Sustainability of funding for public health:*** *Where does funding come from? Is it from dedicated / earmarked sources? Is it ring fenced (protected)? Is it multi-year or decided on an annual basis?*
- ***Allocation of financing:*** *Where does it go? Is it being spent in line with public health priorities or does it just cover existing public health institutions? Who is involved in deciding where the funds go?*

**Presentation: The financing of public health services in Europe – key findings of the WHO/Observatory study**

*Bernd Rechel, European Observatory on Health Systems and Policies*

**International expert panel: Financing of public health services in Croatia, Moldova, Poland and Slovenia**

The panellists will reflect on the challenges and opportunities for the financing of public health services in their countries.

- *Łukasz Balwicki, Medical University of Gdansk, Poland*
- *Vesna Kerstin Petric, Ministry of Health, Slovenia*
- *Angela Ciobanu, WHO Country Office Moldova*
- *Aleksander Džakula, Andrija Štampar School of Public Health, Croatia*

**Questions from selected network members (to be agreed), who will ask the international experts how the evidence relates to their own national experience.**

Leading into facilitated discussion



12.45 – 13.45

**Concluding observations: Identifying key patterns and messages**

13.45 –15.30

*Tit Albreht, Rapporteur*

*Lunch*

**Session 3: The public health workforce**

Facilitator: *Martin Krayer von Krauss, WHO Regional Office for Europe*

*In this session, we will explore the role of public health professionals. The focus will be on staff whose primary role is explicitly to work on public health functions, such as directors of public health, public health specialists and health promotion professionals etc. We will address the following issues:*

- **Working conditions:** *Is pay worse than for mainstream health service staff? Are the working conditions discouraging engagement? Are there opportunities for career development?*
- **Distribution and sustainability:** *Is there a good match between skills and training and the needs of the system? Are specialist staff distributed appropriately for public health service needs? Is there an adequate plan in place to replace staff as they retire?*

**Presentation: The public health workforce in Europe – key findings of the WHO/Observatory study**

*Bernd Rechel, European Observatory on Health Systems and Policies*

**Participant presentations: The experience of the South Eastern European countries**

*Short interventions from selected network members (to be agreed) using no more than 1 slide – see template attached – and a maximum of 5 minutes*

**International expert panel commenting on the challenges and opportunities of the selected countries based on their own national experience**

- *Angela Ciobanu, WHO Country Office Moldova*
- *Vesna Kerstin Petric, Ministry of Health, Slovenia*
- *Aleksander Džakula, Andrija Štampar School of Public Health, Croatia*

*Leading into facilitated discussion*

15.30 –16.00

**Concluding observations: Identifying key patterns and messages**

16.00 –16.45

*Tit Albreht, Rapporteur*

*Break*

**Session 4: Measuring and improving the quality of public health services**

Facilitator: *Suszy Lessof, European Observatory on Health Systems and Policies*

*This final session will look at how the quality of public health services can be measured and improved. The focus will be on the following issue:*

- ***How is quality being measured?*** *Is it clear what is meant by quality and what needs to be included? Are indicators well defined? Are responsibilities for quality specifically assigned? Are there incentives for quality services?*

**Presentation: Measuring and improving the quality of public health services in Europe – key findings of the WHO/Observatory study**

*Bernd Rechel, European Observatory on Health Systems and Policies*

Leading into facilitated discussion

**Concluding observations: Identifying key patterns and messages**

*Tit Albreht, Rapporteur*

16.45 –17.00

**Workshop conclusions presented by Tit Albreht, presenting in 3 slides the summary of his conclusions session by session**

**Closing remarks**

## Annex 2 – LIST OF PARTICIPANTS

	<b><i>Name</i></b>	<b><i>Position / Institution</i></b>
1.	Dalibor Pejovic	Head of planning, human resources and information systems in the healthcare sector, Ministry of Civil Affairs of Bosnia and Herzegovina
2.	Dusan Kojic	Ministry of Civil Affairs of Bosnia and Herzegovina
3.	Goran Cerkez	Assistant Minister, Ministry of Health of the Federation of Bosnia and Herzegovina
4.	Ljiljana Pavlovic	Assistant Minister, Ministry of Health of the Federation of Bosnia and Herzegovina
5.	Davor Pehar	Director, Public Health Institute of the Federation of Bosnia and Herzegovina (Project Coordinator)
6.	Aida Ramić-Čatak	Public Health Institute of the Federation of Bosnia and Herzegovina
7.	Irena Jokic	Head of Department for Social Medicine, Public Health Institute of the Federation of Bosnia and Herzegovina
8.	Kenan Spahic	Head of Department for Pension Insurance, Ministry of Labour and Social Policy of the Federation of Bosnia and Herzegovina
9.	Melka Mercvajler ( <i>on behalf of Ahmed Novo</i> )	Agency for Quality and Accreditation in Health Care (AKAZ) in the Federation of Bosnia and Herzegovina
10.	Zarina Mulabdic	Director, Public Health Institute of Una-Sana Canton, FBiH
11.	Danica Jozic	Director, Public Health Institute of Posavina Canton, FBiH
12.	Maida Mulic	Director, Public Health Institute of Tuzla Canton, FBiH
13.	Boris Hrabac	Public Health Institute of Zenica, FBiH

14.	Zumreta Kusljugic	Clinical Centre of the University of Tuzla
15.	Dragan Bogdanic	Minister, Ministry of Health and Social Welfare of the Republika Srpska
16.	Amela Lolic	Assistant to the Minister, Ministry of Health and Social Welfare of the Republika Srpska (Project Coordinator)
17.	Jelena Djakovic-Devic	Senior Assistant for Public Health, Ministry of Health and Social Welfare of the Republika Srpska
18.	Alen Seranic	Senior Assistant in Department for Public Health, Ministry of Health and Social Welfare of the Republika Srpska
19.	Miodrag Marjanovic	Director, Public Health Institute of the Republika Srpska
20.	Dragana Stojisavljevic	Specialist in Hygiene, Public Health Institute of the Republika Srpska
21.	Dijana Strkic	Specialist in Social Medicine, Public Health Institute of the Republika Srpska
22.	Bojan Savic	Ministry of Family, Youth and Sports of the Republika Srpska
23.	Nada Grbic	Ministry of Finance of the Republika Srpska
24.	Borislav Adamovic	Ministry of Industry, Energy and Mining of the Republika Srpska
25.	Svjetlana Zivkovic	Ministry of Economic Relations and Regional Cooperation of the Republika Srpska
26.	Mira Vasic	Ministry of Labor and War Veterans and Disabled Persons Protection of the Republika Srpska
27.	Zorica Garaca	Head of department for EU integrations, Ministry of Education and Culture of the Republike Srpske
28.	Nada Lipovac	Ministry for Refugees and Displaced Persons of the Republika Srpska
29.	Miliana Dragojevic	Ministry of Administration and Local Self-governance of the Republika Srpska

30.	Sinisa Stevic	Director, Agency for Certification, Accreditation and Health Care Improvement (ASKVA) of the Republika Srpska
31.	Senka Dimitrijevic	East Sarajevo unit, Public Health Institute of the Republika Srpska
32.	Sladjana Arsenovic	Head of unit Foca, Public Health Institute of the Republika Srpska
33.	Milenko Nikolic	Head of unit Zvornik, Public Health Institute of the Republika Srpska
34.	Sabrija Candic	Head of Department of Health and Other Services of the Brcko District BIH
35.	Andja Nikolic	Department of Health and Other Services of the Brcko District BIH
36.	Emina Lukac	Budget Specialist, Department of Health and Other Services of the Brcko District of BIH
37.	Semsudin Ahmetbasic	Department for Education of the Brcko District of BIH
38.	Ines Katic-Vrdoljak	PROSES Project
39.	Maja Zaric	Programme Coordinator for Health, Embassy of Switzerland in Bosnia and Herzegovina
40.	Arta Kuli	South-eastern Europe Health Network Technical Consultant
41.	Renata Balestero Brunner	WHO Regional Office for Europe
42.	Daniel Verman	Ministry of Health, Senior counsellor
43.	Einav Shimron	Deputy Director General for Information and International Relations, Ministry of Health, Israel
44.	Ioana Filip	National Institute of Public Health. Regional Centre of Public Health in Sibiu, Romania

45.	Iurie Pinzaru	National centre of Public Health, Director
46.	Krayer von Krauss Martin Paul	WHO Regional Office for Europe
47.	Marija Palibrk	Public Health Institute, Montenegro
48.	Mira Dašić	Head of South-eastern Europe Health Network
49.	Nicolae Jelamschi	Chair of South-eastern Europe Health Network
50.	Ruxanda Glavan	South-eastern Europe Health Network Observer
51.	Verica Jovanovic	Institute of Public Health of Serbia "Dr Milan Jovanovic Batut", Director
52.	Bernd Rechel	European Observatory on Health Systems and Policies
53.	Tit Albreht	National Institute of Public Health of the Republic of Slovenia - NIJZ
54.	Vesna Kerstin Petric	European Observatory on Health Systems and Policies
55.	Aleksandar Dzakula	European Observatory on Health Systems and Policies
56.	Angela Ciobanu	WHO Country Office for Republic of Moldova
57.	Lukasz Balwicki	European Observatory on Health Systems and Policies
58.	Suszy Lessof	European Observatory on Health Systems and Policies
59.	Natalia Caterinciuc	National centre of Public Health, Republic of Moldova
60.	Victor Olsavszky	Head of WHO Country Office for Bosnia and Herzegovina

61.	Boris Rebac	Project Manager, WHO Country Office for Bosnia and Herzegovina
62.	Mirza Palo	Project Officer, WHO Country Office for Bosnia and Herzegovina
63.	Vlajcic Sanid	Project Assistant, WHO Country Office for Bosnia and Herzegovina
64.	Dubravka Trivic	Administrative Assistant, WHO Country Office for Bosnia and Herzegovina
65.	Damir Lazic	Logistician Assistant, WHO Country Office for Bosnia and Herzegovina
66.	Dalibor Kesic	Interpreter, <i>Oxford prevodi</i>
67.	Gordana Ivancevic	Interpreter, <i>Oxford prevodi</i>

## **Annex 3 – LIST OF DOCUMENTS DISTRIBUTED ON USB STICK**

### **Eng and B/H/S Folders**

#### **- *Materials***

1. *Evaluation Form Governance;*
2. *Programme Governance;*
3. *Scope & Purpose Governance.*

#### **- *Presentations'***

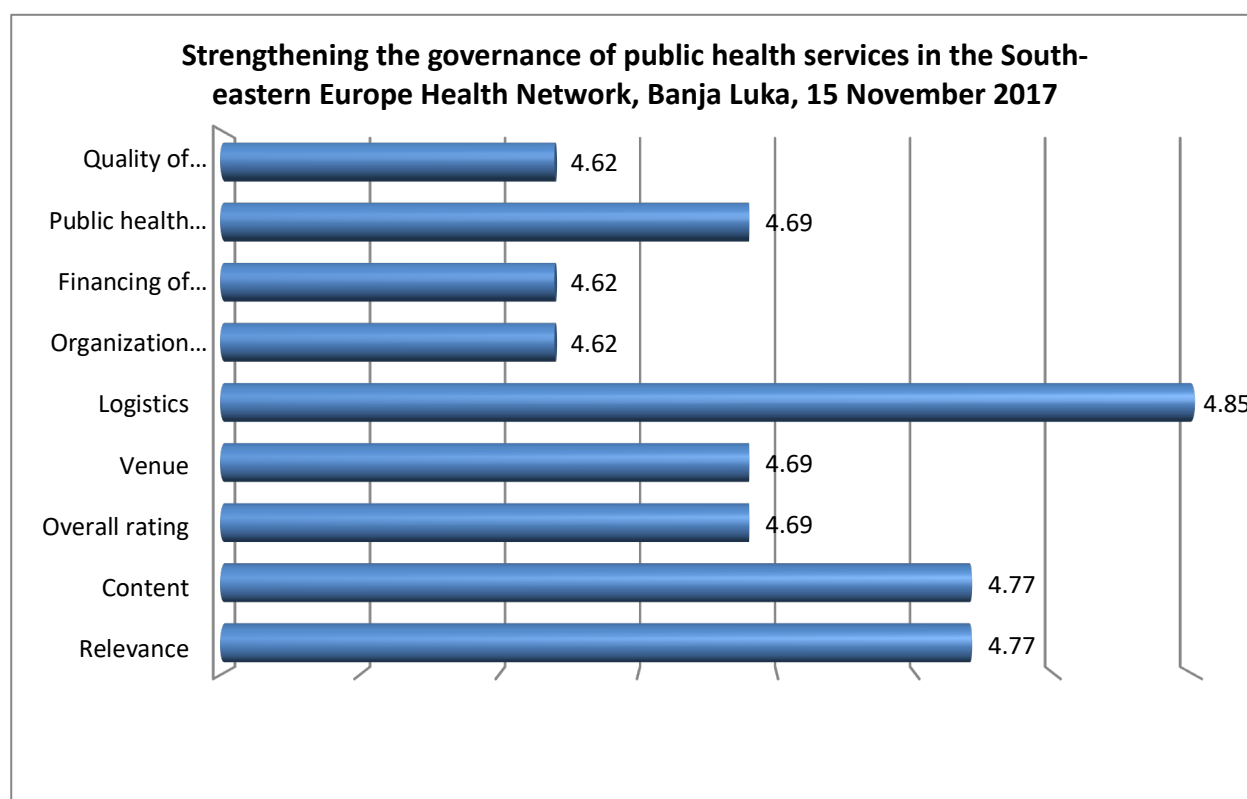
1. *Rechel Opening;*
2. *Rechel Session 1 - PH Organization;*
3. *Rechel Session 2 - PH Financing;*
4. *Rechel Session 3 - PH Workforce ;*
5. *Rechel Session 4 - PH Quality ;*
6. *BIH MoCA Presentation;*
7. *BIH Republika Srpska Presentation;*
8. *BIH Federation of BIH Presentation;*
9. *Moldova Presentation;*
10. *Montenegro Presentation;*
11. *Romania Presentation;*
12. *Serbia Presentation;*
13. *Poland Presentation;*
14. *Slovenia Presentation;*
15. *Croatia Presentation.*



## Annex 4 – WORKSHOP EVALUATION

<b>Rating*</b>	1 (poor)	2	3	4	5 (excellent)	Average score
Relevance	0	0	0	4	10	4,77
Content	0	0	0	4	10	4,77
Venue	0	0	1	2	10	4,69
Logistics	0	0	0	2	11	4,85
Organization of public health	0	0	1	3	9	4,62
Financing of public health	0	0	1	3	9	4,62
Public health workforce	0	0	1	4	9	4,69
Quality of public health	0	1	0	5	8	4,62
Final mark	0	1	0	4	9	4,69

\* Number of returned and completed anonymous questionnaires: 13



## Annex 5 – PHOTOGRAPHS FROM THE WORKSHOP









## The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

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