

Europeanization of health policy in post-communist European societies

Citation for published version (APA):

Tresa, E., Czabanowska, K., Clemens, T., Brand, H., Babich, S. M., Bjegovic-Mikanovic, V., & Burazeri, G. (2022). Europeanization of health policy in post-communist European societies: Comparison of six Western Balkan countries. *Health Policy*, 126(8), 816-823. <https://doi.org/10.1016/j.healthpol.2022.05.015>

Document status and date:

Published: 01/08/2022

DOI:

[10.1016/j.healthpol.2022.05.015](https://doi.org/10.1016/j.healthpol.2022.05.015)

Document Version:

Publisher's PDF, also known as Version of record

Document license:

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Europeanization of health policy in post-communist European societies: Comparison of six Western Balkan countries

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ARTICLE INFO

Keywords:

Europeanization
Health policies
Health system
Post-communist
Western Balkan

ABSTRACT

Europeanization is assumed to influence health policy in the Western Balkans, but little is known about the actual impact of this process in these countries which constitute a complex geopolitical region of Europe. In this context, we used time trends to explore the Western Balkans health policies during the Europeanization through a cross-country comparative analysis of six countries. We conducted a health policy analysis by adapting the framework for globalization and population health coined by Huynen et al. in 2005. We analyzed 90 progress reports of Albania, Bosnia and Herzegovina, Croatia, Montenegro, North Macedonia and Serbia from 2005 to 2020. In particular, we considered chapter 28 on “Consumer and health protection” and other chapters that contained the words “health” or “population health”. Evidence indicates that Europeanization influences Western Balkans’ policies at different levels. Western Balkan countries revise national legislation in accordance with new European Union *acquis* as addressed in the progress reports and build cooperation with international institutions. They build national health reforms and reorganize relevant institutions to better address regulations in accordance to Europeanization. However, it is necessary to monitor law implementation so that the current legislation is enforced and further positive impact can be measured on population health.

1. Introduction

The Western Balkan countries (WB) – Albania, Bosnia and Herzegovina (BiH), the Republic of North Macedonia (RNM), Montenegro, Serbia, and Croatia - have undergone significant transitions in the past three decades [1]. Long health reform processes continue during two and a half decades in WB [2]. They share a similar aspiration to join the European Union (EU) which exerts an important influence on health policy [3].

Currently, the WB are at different stages of the European Integration process (EI) [4]. Bosnia and Herzegovina is a potential candidate country [5]. The Republic of North Macedonia, Montenegro, Serbia and Albania are candidate countries [6]; and Croatia is already an EU member state [7]. Europeanization as a potential consequence of EI, is defined as the “processes of (a) construction (b) diffusion and (c)

implementation of formal and informal rules, procedures, policy paradigms, styles, ‘ways of doing things,’ and shared beliefs and norms which are first defined and consolidated in the EU policy process...” [8].

The prospect of EI requires compliance to firm conditions prescribed by the EU, including an obligation for democracy to protect fundamental values of the EU, for a market economy to meet EU-wide competition and the ability to comply with other obligations resulting from the Treaties and secondary legislation [9].

To monitor the progress towards these obligations, candidate countries have to report on measures to adhere to the *acquis annually*. The EU monitors these criteria and the countries’ capacities to deal with them [10]. The main challenge of WB in the health domain is to continue to make progress towards achieving a strong health system goals, as described in the chapter 28 on Consumer and Health Protection [11,12]. The focus is on improving population health while providing protection

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<https://doi.org/10.1016/j.healthpol.2022.05.015>

Received 29 April 2021; Received in revised form 4 May 2022; Accepted 23 May 2022

Available online 25 May 2022

0168-8510/© 2022 Published by Elsevier B.V.

against the financial costs of illness, and establishing financially sustainable healthcare systems [13]. However, taking in consideration of the literature and theories about the possible influence of the EI process on respective countries, little appears to be known about how the Europeanization process impacts WB healthcare policies.

In this context, the aim of this paper is to identify public health policy development in the WB linked to the Europeanization process and to explore the progress time trends, though a cross-country comparative analysis of six countries: Albania, BiH, Croatia, RNM, Serbia and Montenegro. The health policy agenda (as a consequence in the WB region) is focused on health systems, health insurance and health services [14]. For this reason, we report on public health legislation, regulations and strategies, health insurance policies, and the healthcare system and services in six WB.

2. Material and methods

2.1. Methodology

We based our study methodology on a traditional policy analysis, which “involves deploying a rational comprehensive approach to problem solving, in a world that is objectively knowable” [15]. We analysed the progress reports (a joint effort of the EU and the respective country governments) that six WB submitted to the EU from 2005 to 2020 assessed though European Commission webpage [16]. The full list of all reviewed documents, which were included in this analysis, is presented in Annex 1.

Overall, we analyzed 90 reports using Conventional Content Analysis, “coding categories were derived directly from the text data” where we identified 27 main health related topics [17]. Next, each of the identified topics was further elaborated using framework analysis defined as a “qualitative method that is aptly suited for applied policy research” [18]. The results were presented by means of directed content analysis “to validate or extend conceptually a theoretical framework or theory” [17]. In this case, we used the framework for globalization and population health coined by Huynen et al. in 2005 [19].

In addition, the Chapter 28 (of the EU country progress reports) on “Consumer and health protection” and all other chapters that contained the words “health” or “population health” were considered in the analysis.

2.2. Conceptual framework

The conceptual framework employed herewith is based on the framework for globalization and population health which discerns a contextual, distal and proximal level to impact population health [19]. The contextual level addresses the globalization process with regards to governance structures. The distal level covers the health-related policies at the national level. The proximal level addresses local policies [19]. We used this model previously to assess the influence of the Europeanization process on alcohol consumption in the WB [20]. We adapted the model for population health suggested by Huynen et al. [19], as indicated in Figs. 1 and 2.

The contextual level addresses the EU policies of the European Market, taxation, European communication and environmental change. The distal level covers the policies built up in each country as laws related to health policy, economic development, knowledge and social interactions, and ecosystem goods and services. The proximal level addresses services, social environment, lifestyle and physical environmental.

3. Results

Based on the content analysis, we identified 27 categories as per Table 1:

In this paper we focus only on three out of the 27 identified topics: public health legislation, regulations and strategies, health insurance policies, and the healthcare system and services. These three main topics have been consistently high on the health policy agenda in the WB. [14] At the same time they are featured frequently in the EU progress reports making all three of them most likely cases of Europeanisation in the area of health in the WB.

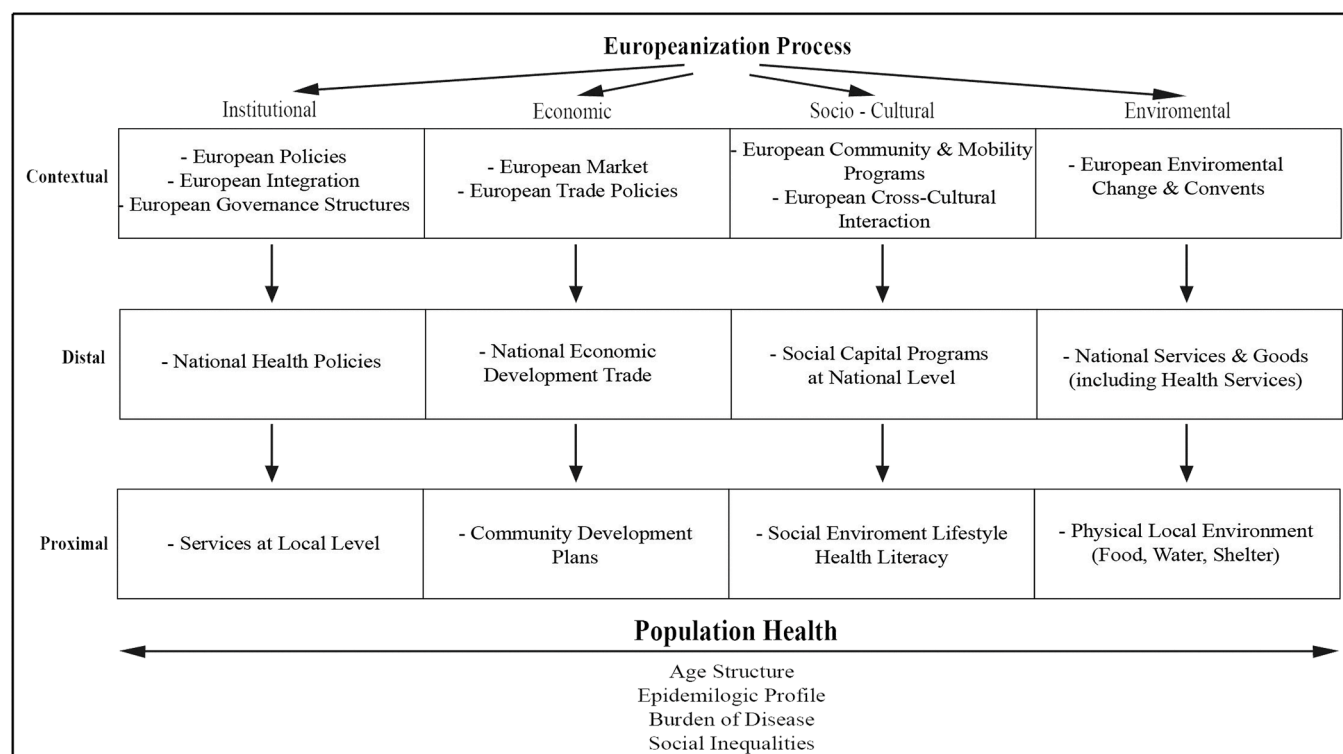


Fig. 1. The Influence of the Europeanization process in population health in the Western Balkan countries (adapted from: Huynen et al. 2005) [19].

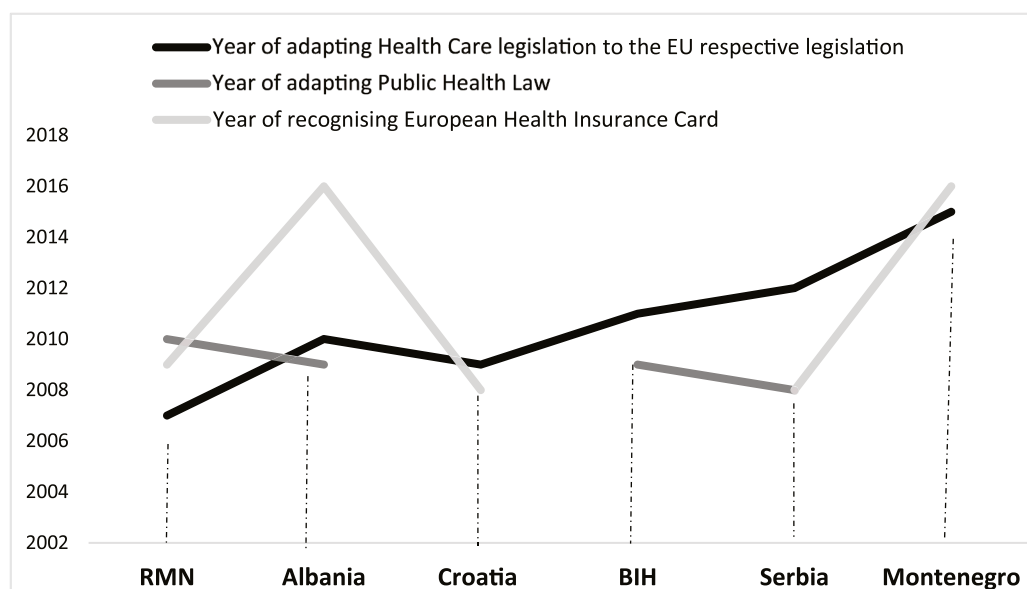


Fig. 2. Year of adapting Healthcare and Public Health laws and Health Insurance Card.

Table 1

Categories identified in the EU Progress reports (see Appendix 1).

NO.	CATEGORIES
1	Alcohol
2	Animal Health and Phyto-sanitary policy
3	Blood safety and transfusion
4	Cancer
5	Communicable diseases
6	Consumer protection
7	Drugs
8	E-health and health data
9	Environmental Health (air pollution and chemicals)
10	Food safety
11	Gender based violence and discrimination towards disadvantaged groups
12	Health care systems and services
13	Health in Prisons, Refugees and asylum seekers'
14	Health insurance
15	Health of people with disabilities
16	Lesbian, gay, bisexual and transgender health
17	Mental health
18	Non-Communicable diseases and risk factors
19	Occupational health and safety
20	Pharmacy, medical drugs and clinical trials
21	Public Health legislation, regulations and strategies
22	Rare diseases
23	Roma Community health
24	Sexual reproductive health and HIV/AIDS
25	Tobacco
26	Transplantation of tissues cells and organs
27	Vaccination

We included in the Public health legislation, regulations and strategies category all laws related to public health and regulations and strategies undertaken at the national level addressing these laws. Moreover, in the health system category, we included all measurements initiated by WB to reform their healthcare systems. The health insurance category included issues related to the financing of healthcare, insurance and pension policies of each country.

3.1. Public health legislation, regulations and strategies

At the contextual level,

- WB revised national legislation in line with the acquis.

Serbia was the first WB country that adopted a law on public health in 2008; Albania adopted the law on public healthcare in 2009, meanwhile RNM enacted the law on public health in 2010. The new legislations were built to be in line with the EU directives and legislations. Bosnia and Herzegovina adopted in 2010 the 2008 roadmap for EU integration of the sector.

- Cooperation with international institutions:

The European center for Disease Prevention and Control started cooperation with Serbia in 2009 and BiH and RNM in 2012. In 2009, BiH established a state level commission for implementing the World Health Organization (WHO) International Health Regulations (IHR) and in 2014 adopted the Technical Report of Implementation of IHR. In 2011, Albania established the Institute of Public Health (IPH) as a focal point and a coordinating institution and therefore, raised the capacities of epidemiologists, public health professionals and physicians on emergencies and IHR. Meantime, Montenegro adopted an action plan to implement IHR. In 2014, RNM improved cooperation and exchange of information between national and foreign medical institutions. In 2017, Serbia was an observing member of the EU Health Committee.

In 2009, Albania took part in the 7th EU Research Framework Program by achieving successful participation in research projects in the health field together with European partners.

At the distal level,

- Western Balkans countries built national health reforms

Serbia started to prepare health system reform in 2005. Meanwhile, Albania drafted the health system Strategy 2007 – 2013 in 2007. In 2008, Albania put in place a national strategy for development and integration including public health-related activities. In the same year, Croatia enacted health reform measures which was considered as an important step towards addressing the sector's financial difficulties that included a more effective system of co-payments. Serbia adopted in 2008 the outstanding strategy on public health and in 2010 prepared a strategy, 'Health Protection Development Plan', for 2010–2015. Albania undertook in 2010 reforms in the health sector, including a new regulation on the referral system, and set up structures for developing public health policies, providing national leadership on health promotion and gathering public health information. In 2011, Croatia adopted a National Generic Integrated Plan for Coordination Action in Public Health

Table 2
Differences among Western Balkan Countries regarding main health policy development.

	Albania	BiH	Croatia	Montenegro	RNM	Serbia
Public health legislation, regulations and strategies						
Cooperation with international institutions	2011 - IPH - focal point and coordinating institution on emergencies and IRH	2009 - Built cooperation with the European center for Disease Prevention and Control		2011 - Adopted an action plan to implement IHR.	2012 - Built cooperation with the European center for Disease Prevention and Control	2009 - Built cooperation with the European center for Disease Prevention and Control
Build national health reforms	2007 - Drafted the health system Strategy 2007 – 2013		2008 - enacted health reform measures 2011 - National Generic Integrated Plan for Coordination Action in Public Health Emergencies		2018 - Two new public health programmes, and the Strategy for Health 2020 entered into force	2005 - Prepare health system reform 2008 - outstanding strategy on public health 2010 - Strategy, 'Health Protection Development Plan', for 2010–2015
Health care system and services						
Health Services	2011 - Hospital infection control guidelines and provided 2012 - New infrastructure for primary healthcare services 2015 - Provided a package for primary healthcare services addressing prenatal and postnatal care and new-born and child care -launched hospital a information system	2014 - Presented a master plan for reorganization of hospital care providing measures for further changes in hospital financing that would lead to improvement of cost-effectiveness.	2005 – In place complaints Commissions on service provision 2014 -Strengthened the cost-effectiveness of the healthcare sector, including hospitals 2019 - National Hospital Development Plan	2008 - reorganized the service provision 2009 - Adopted a Law on emergencies	2008 - Allocated funds for purchasing new medical equipment for clinics and restructuring public health institutions.	2014 - Put into force a rulebook on medical equipment
Health Insurance policies						
Revision of health insurance legislation	2005 - Transfer of the social and health insurance contributions collection section to the tax administration 2011 - Adopted the Law on Compulsory Health Insurance	2011 - Adopted amendments to the Law on health insurance harmonized with the provisions of the Law on the unified system and registration control and collection of contributions	2005 - Intention to reduce the share of social spending to more sustainable levels, measures to improve the financial situation of the health and pension system		2007 - Amended the law on health insurance	2005 - Steps in pension system reform 2007 - Put into Force a Law on social (health and pension) insurance

Emergencies. As result, in 2014 Croatia achieved reasonably good health outcomes and accessible services. In 2018, RNM promoted two new public health programmes, and the Strategy for Health 2020 entered into force. In 2020 in Croatia, progressed in areas such as good health and well-being.

- WB addressed new legislation though public health programs

The Republic of North Macedonia addressed in 2008 the socioeconomic determinants of health and health inequalities through funding of public health programs. In 2010, it enacted a strategy on the adaptation of the health sector to climate change (2010–2015), and in 2013 it amended legislation on public health, crisis preparedness, the health system, and resources. Montenegro approved in 2009 the strategy, 'Health Policies in Montenegro up to 2020', a master plan for the health sector for 2010 – 2013 (broadly in line with the EU health strategy) and, in 2016, it adopted a master plan for health development. Bosnia and Herzegovina undertook in 2012 measures on improving its capacity for planning and decision-making; on establishing a uniform system for reporting on public health in order to fulfill international obligations; and on developing an electronic database providing indicators of public health used to report to EUROSTAT and WHO. The Republic of North Macedonia in 2013 secured funding from an excise duty on beer and alcohol for public health programs.

The most recent WB country to adopt a national health strategy was Albania in 2018. Meantime, Croatia focused on improving access to

healthcare in deprived areas and for vulnerable groups; supporting education of medical personnel in primary healthcare; and promoting specialization programs and the development of analytical tools in health management.

- WB improved internal coordination among national institutions

Bosnia and Herzegovina established in 2007 a regular conference of health ministers serving as a permanent advisory and coordinating body in the country. This led to improved decision-making and coordination in the public health sector (2008). In 2009, the Conference of Health Ministers met regularly and arranged for coordination among the various Ministries of Health. In the same year, Albania signed collective agreements in the public health and education sectors. Meanwhile, RNM established in 2010 a register for human resources in health. Serbia, signed in 2013 an agreement on cooperation for the production of national health accounts between the Ministry of Health (MoH), Institute of Public Health, the Fund of Health Insurance and the Ministry of Finance and Economy. Croatia in 2017 enlarged the network of emergency medicine as health outcomes were below the EU average, revealing a challenge in preventing non-communicable diseases. Bosnia and Herzegovina adopted a national Generic Integrated Plan for coordinated action in public health emergencies in 2010.

At the proximal level,

- Western Balkan countries have reorganized their institutions to better address regulations related to Europeanization of health systems.

In 2008, BiH established a new Department of Health. The public health system consists of 18 public health institutes at entity, cantonal and regional levels. The capacity of these institutes varies. The Republic of North Macedonia increased in 2009 the capacity of the laboratory of IPH. In 2011, the Albanian IPH conducted an assessment of primary healthcare needs, mapped the services, and attempt to strengthen the public health sections at local levels to include reproductive health, cancers and awareness raising materials into the current services. The IPH was reorganized in 2012, and a Regional development center was established within the Department of Infectious Diseases at the IPH. Later in 2014, an anti-corruption monitoring unit was established in the MoH and a 'green line' to lodge complaints against corruption concerning medical personnel was made available. The Republika Srpska entity National Assembly focused the Reform Agenda on the health sector (BiH 2018).

- Establishment of new institutions

Croatia in 2008 was the first WB country to formally recognize for action the area of non-ionizing radiation. The example was followed by BiH, which established in 2009 a State Regulatory Agency for radiation protection and nuclear safety.

3.2. Healthcare system and services

At the contextual Level

- Legislative changes as per *acquis* recommendations.

Amendments of the legislation of healthcare started in RNM in 2007. In 2009, Croatia amended its healthcare act and Albania adopted the Public Healthcare Law and the Health Services Law in 2010. Bosnia and Herzegovina as well adopted legislation implementing the laws on healthcare in 2011 and adopted amendments to the Law on the Improvement of Quality, Safety and Accreditation in Healthcare. Serbia amended the Law on Healthcare in 2012 and RNM adopted a Law on Healthcare. Montenegro did the same in 2015. Meanwhile, RNM amended the Healthcare Law in 2019 to provide increased salaries and an improved retention policy for healthcare staff.

The Law on Sanitary and Health Inspection was enacted in RNM in 2006 and in Serbia in 2009. Montenegro adopted in 2011 the Law on Health Inspection which was designed to be aligned to the EU *acquis*.

Croatia was the first WB country to put into force the Patients' Rights Act in 2005. This legislation was amended in 2008 in RNM and BiH adopted in 2010 the Law on Health protection, the Law on the Rights, Duties and Responsibilities of Patients. Serbia adopted in 2013 the "*Law on Patients' Rights governing the rights of patients in the use of healthcare and the manner in which they exercise and protect such rights*". (Appendix 1)

In 2019, Serbia adopted a Law on Medical Devices, which was designed to be fully aligned with the EU *acquis*.

- Cooperation with international institutions

The Institute of Accreditation of RNM signed in 2016 agreements with the International Accreditation Forum, the European Cooperation for Accreditation and the International Laboratory Accreditation Cooperation.

At the distal level

- Reforms in the Healthcare sector

Croatia and RNM initiated reforms in the healthcare sector in 2006,

especially in the financing of healthcare. Bosnia and Herzegovina in 2013 reformed the payment system in secondary healthcare. Croatia put in place the 2014–2016 National Hospital Development Plan and continued Hospital Financing reform. The reform proved to be successful in reducing prices, achieving savings and standardizing the quality of procured goods though enhancing quality assurance and prevention programs. Furthermore, this reform was expected to achieve savings by further strengthening referrals, primary care financing, sick-leave applications and e-health.

- National Strategies and programs

The Republic of North Macedonia adopted a national healthcare strategy in 2007. Serbia adopted a strategy on healthcare quality and patient safety in 2009 and in 2011 adopted the Healthcare Development Plan. Montenegro adopted in 2012 the national strategy for improving the quality of health protection and the safety of patients.

In 2013, RNM adopted 17 public health programs in accordance with the Law on Healthcare. Albania in 2019 adopted the National Programme for Community Healthcare and noted progress was reported regarding access to healthcare.

In 2020, RNM implemented a program for active healthcare, offering access to healthcare to vulnerable target groups such as Roma community, people living in remote areas, people living with HIV/AIDS or/and people with disabilities. The program provided as well, contraceptives to women from socially vulnerable groups.

At the proximal level

- Health services

Croatia was the first WB country to establish in 2005 a Complaints Commissions on service provision throughout the country, and RNM was in line with international trends regarding the level of health sector funding and key inputs into the healthcare sector, such as clinical staff.

Montenegro reorganized in 2008 the service provision by fragmentation of services which was reflected in the quality of services. In 2009, it adopted a law on Emergencies and put into place a strategy for managing medical waste and a rulebook on reporting hospital infections. Meanwhile in 2008, Serbia launched awareness raising campaigns on communication between health professionals and patients. In the same year, RNM allocated funds for purchasing new medical equipment for clinics and restructuring public health institutions. In 2013 it funded continuous training programs for health professionals, and in 2014 it distributed protocols for testing susceptibility to all microbiological laboratories. It amended legislation on orthopedic devices and put into force a rulebook on medical equipment. Serbia as well put into force a rulebook on medical equipment in 2014 and Croatia strengthened the cost-effectiveness of the healthcare sector, including hospitals. This led to reasonably good and consistent improvement in the overall accessibility of health services in Croatia in 2015. The access to outpatient medical goods was comparable with the rest of the EU. Croatia put into effect a new reimbursement scheme for hospitals.

Albania prepared in 2011 hospital infection control guidelines and provided in 2012 new infrastructure for primary healthcare services. Meantime, RNM provided training for health professionals. In 2014, BiH presented a master plan for the reorganization of hospitalcare providing measures for further changes in hospital financing that would lead to improvement of cost-effectiveness. The steps included rationalization of the hospital network, reduced average lengths of hospital stays and a better allocation of hospital beds, including for long-term care.

In 2015, Albania provided a package for primary healthcare services addressing prenatal and postnatal care and new-born and childcare and launched hospital a information system. The Republic of North Macedonia established a free telephone line for medical counseling. In 2016, Albania adopted amendments to the Law on Compulsory healthcare to secure free visits to family doctors for uninsured persons

(targeting vulnerable groups, including Roma and Egyptian communities) and in 2019 regulated the activities of public and private reproductive health institutions through the Law on Reproductive Health.

Croatia adopted in 2019 the National Hospital Development Plan, and access to healthcare was relatively good.

- Local and regional regulations of healthcare

In BiH in 2010, “Republika Srpska” enacted a Law on healthcare. In 2013, based on the model of Diagnostic Related Groups, started implementation of a new payment system that led to improvement of the efficiency and quality of secondary healthcare. The Republic of North Macedonia undertook in 2013, measures to ensure availability of medical staff in rural areas without health centers. Later in 2019, Croatia gave counties the possibility to buy certain types of equipment for the health centers on their territories by amending the Healthcare Act.

In Croatia in 2019, “some hospitals provided services in excess of the limits set by the Croatian Health Insurance Fund, while some maintained capacities greater than the needs of the population they served. While the authorities announced plans to increase the spending limits in hospitals across the board, the system is likely to remain prone to accumulation of arrears as long as the spending limits are not brought closer in line with types and amounts of services provided in each of the hospitals”. (Appendix 1: Croatia progress report 2019)

3.3. Health insurance policies

At the contextual level,

- Revision of health insurance legislation based on acquis recommendations

The first steps to improve legislation on health Insurance were taken in 2005 by: Albania- Transfer of the social and health insurance contributions collection section to the tax administration; Serbia - Steps in pension system reform; Croatia - Intention to reduce the share of social spending to more sustainable levels, measures to improve the financial situation of the health and pension system and to restore expenditure control in the health system by introduction of administrative fees for medical services. As a result, in 2007, Serbia put into Force a Law on Social (health and pension) Insurance, and the RNM amended the Law on Health insurance. The implementation of the law continued in 2008 in Serbia and in 2009 new articles were added. The Republic of North Macedonia amended its Law on Health Insurance and adopted a Law Extending the Coverage of Health Insurance. This legislation was enacted in 2010. Albania adopted the Law on Compulsory Health Insurance in 2011, establishing a mandatory health insurance scheme and transferring its management to the Health Insurance Fund. At the same time, BiH adopted amendments to the Law on Health Insurance harmonized with the provisions of the Law on the Unified System and Registration Control and Collection of Contributions. In 2012, Albania amended its Law on Collection of Compulsory Contributions for Health and Social Insurance.

In 2014, almost all WB made progress on Health Insurance legislation. Bosnia and Herzegovina adopted a Law on a Single Reference Number. Its implementation ensured access to health, social benefits and travel documents for newborn children. Albania adopted an amendment to its Law on Healthcare Insurance which led to changes in calculation of healthcare contributions and removed the threshold of the maximum salary. Serbia and RNM amended their Laws on Health Insurance. Croatia integrated the pensions under special schemes after adopting the respective legislation that ensured enforcement of tighter disability pensions assessments and controls over the general pension system.

In 2020 Serbia put into force legislation on health insurance. This was also done in RNM, where women need to work at least 6 months

with the same employer to be entitled to maternity leave.

- European Health Insurance card (EHIC)

Croatia was the first country in the WB to report progress regarding EHIC in 2008 at the introduction phase. The Republic of North Macedonia concluded agreements on applying the European health insurance card with Bulgaria, Poland and Germany in 2009, with Luxembourg and the Netherlands in 2010, with Belgium in 2011, with Austria in 2013 and continued negotiations with Slovakia and Hungary in 2014. This process continued in 2015 and 2016. Montenegro and Albania adopted a Law on Health Insurance recognizing the European Health Insurance Card in 2016. In the same year, Albania signed cooperation agreements with Israel and Croatia. In 2020 RNM concluded 18 agreements for mutual health insurance that allow people from one country to use healthcare services in the other country.

At distal level,

- National Reforms

The national reforms go in the same line with adaptations of national regulations and laws. In 2007, Albania decided on a minimum monthly salary for the calculation of social and health insurance contributions. Montenegro did the same by adopting the strategy on social insurance contributions (pension and disability fund, health insurance and unemployment insurance) and started preparation for a framework for legislation on health protection. Meanwhile in 2008 Serbia continued the reformation of the health insurance system and strengthened its Information and Technology capacity of the Republican Health Insurance Fund. In 2010, Serbia simplified the registration procedure and completed a national database on all insurers, through establishing a system for social security registration in accordance with the national employment service. In 2011, this procedure was improved with the tax authorities, the social and health insurance fund and the employment agency. In the same year Montenegro unified in a single form of tax administration of national employment agency, health insurance fund and pension insurance fund. Bosnia and Herzegovina adopted in 2012 a decision on free basic health insurance for children under 18. Montenegro made available in 2018 an Integrated Information System (IIZS) across the Health Insurance Fund.

At the proximal level,

- Local Policies

The only example we found on local policies related to health insurance in the example of BiH: “In 2019 The Republika Srpska entity and the cantons had their own health insurance card that can be used within the other Entity or Canton only in cases of emergencies and for targeted treatment, subject to special conditions and approvals”. (Appendix 1: Serbia Progress Report 2019)

The WB have adopted their Public Health legislation, regulations and strategies; Healthcare system and services and Health Insurance policies as influence of the EU accession process.

4. Discussion

The accession process triggered policy actions in WB at contextual, distal and proximal levels to adhere to chapter 28 requirements regarding health. In this regard, *at the contextual level* WB revise national legislation on the basis of new acquis; build cooperation with international institutions; and adopt a European Health Insurance card. *At the proximal level* WB build national health reforms; address new legislation though public health programs; and improve internal coordination among national institutions; *At the distal level* WB reorganize their institutions and establish new institutions; reorganize health services and build Healthcare regulations at local and regional levels.

Similarly, Martinsen envisioned healthcare reforms, institutional legacy and insurance funds as main objectives of Europeanization of healthcare systems, with the media being the main influencing actor [21]. The EU has a unique and transformative effect on the politics of its member states, which is known as the Europeanization of European politics [22]. “Health has incrementally become a major EU policy field, and probably one of the most challenging concerns of future European activity” [23]. Healthcare continues to be a policy area of high political salience and legacy [22]. However, the Europeanization of health policy and politics has its limits given the mandate of the EU in health with little harmonizing legislation [24].

The example of Serbia shows how the government created a reimbursement policy based on the models of the developed European countries and shift financial burden of primary dentistry care from the government to citizens themselves [25]. On the other side, the citizens with scarce resources cannot afford to prioritize the reimbursement of health goods and services. In this case, the policy makers will come under increasing pressure to balance limits to governmental excess spending and to ensure broad access to health services for their population during the EU accession policy [26].

The presentation of the results of this study on the contextual, proximal and distal levels of national policies can be understood by the three policy streams model developed by Kingdon [27]. He argued that the public policy making process can be determined by three streams: problem, policy and politics [28]. Each of these three streams has its distinct life, but when they come together, a specific problem becomes important on the agenda, and policies that are related to the problem get the attention of stakeholders, making policy change possible [29].

Before 2006, the WB faced problems such as efficiency of the health system [1]. Due to the Europeanization process, this problem came to the forefront as the WB needed to adapt their laws to the EU *acquis*. Thus participants inside and outside governments of the WB - in our case, international institutions, the private sector, civil society groups, and the media gained a window of opportunity to construct resilience among each other and overcome the problem inside their countries [27] [30]. As a result, the WB improved their legislation regarding health insurance, Healthcare services and public health policies.

Other studies mention that the EU at least touches upon “*virtually every aspect of such policies*” [31]. The accession process provides an opportunity for health system reform by offering important support such as technical and financial assistance, capacity building as well as by overcoming local resistance to change [32]. This is aligned with our results that mention local communities’ engagements as crucial in the Europeanization process.

Significant health policy changes have occurred in terms of recognizing the need for evidence-based decision making influenced by other actors beside EU as the World Bank for instance, which has financed efforts to establish a formal Health Technology Assessment agency in Serbia [33]. Nevertheless, there is a prevailing consensus among health policy authorities in the EU that health financing efficiency will have to be substantially improved [34].

Greer et al. explain that the EU’s actions are affecting healthcare by shaping national health systems and addressing selected public health issues. These actions have had the greatest effects on policy and practice in tobacco control, access to essential medicines and, cancer care [35]. We found this to be true in the WB region including in the EU member state Croatia, potential candidate country BiH, and candidate countries Albania, Montenegro, Serbia and RNM.

4.1. Limitations

This study is limited by the fact that we used only qualitative methods through analysing country progress reports. Due to lack of quantitative data, we could not cross-reference and we could not prove “causality”. Further analysis of certain health indicators available per each country would give a better view of possible influence on health

status of WB population. Interviews with the stakeholders in WB would have provided additional useful insights into the barriers and facilitators of the Europeanization process and its implication in WB policy development.

However, this study has attempted to document how changes and pressures stemming explicitly or implicitly from the Europeanization process impact six WB healthcare systems.

5. Conclusion

The WB can learn from successful policies in other countries, and policy makers can take an advantage of the Europeanization process to adapt the same policies in their own countries.

The Europeanization process influences the overall health systems in the WB through EU general politics, directives and legislations at the contextual, proximal and distal levels. The WB have undertaken positive changes in adapting their laws to EU *acquis*, building national health reforms, reorganizing their institutions and health services and building local policies to address national reforms. However, it is necessary that WB monitor law implementation in order to reinforce the current legislation and measure further positive impact on population health. Further studies could support our finding with quantitative data to better explore how the Europeanization process influences health policies and population health status in the WB through including analysis of certain health indicators. In conclusion, the WB should profit out of this European agenda to improve the health policies and change the life of their people.

CRediT authorship contribution statement

Eni Tresa: Conceptualization, Formal analysis, Writing – original draft. **Katarzyna Czabanowska:** Methodology, Validation. **Timo Clemens:** Conceptualization, Resources, Writing – review & editing. **Helmut Brand:** Conceptualization, Writing – review & editing. **Suzanne M. Babich:** Writing – review & editing. **Vesna Bjegovic-Mikanovic:** Writing – review & editing. **Genc Burazeri:** Writing – review & editing, Visualization.

Declaration of Competing Interest

None.

Acknowledgment

We acknowledge Albano Alia for this contribution with graphic design.

Funding sources

This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

Supplementary materials

Supplementary material associated with this article can be found, in the online version, at doi:[10.1016/j.healthpol.2022.05.015](https://doi.org/10.1016/j.healthpol.2022.05.015).

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