Proceedings of EKONBIZ 2025
ISBN: 978-99955-45-50-5
UDK: 338.124.4:502.131.1

Submitted: 04.04.2025.
Accepted: 12.04.2025.
Review Article

FINANCIAL AND BUSINESS SUSTAINABILITY OF GENERAL PURPOSE PUBLIC SECTOR ENTITIES

Mirjana Manasijević
JKP „Beogradske elektrane“, Belgrade, Republic of Serbia
mirjana.manasijevic@bgdel.rs
ORCID: 0009-0006-0301-6157

Abstract: *The world is facing an intensive aging of the population, as well as an increase in healthcare costs. As a result, it is necessary to consider the financial sustainability of the healthcare system and the efficient use of resources. These issues, along with the increase in healthcare costs in GDP, became the most important motives for the reform of healthcare system in almost all countries of the world. The paper aims to analyze existing data on costs and financial performance and assess the financial viability of hospitals in Serbia. Quantitative and qualitative deductive analysis of data from WHO, OECD, World Bank, and Serbia's budget was used. If hospitals in Serbia are to operate sustainably, it is necessary to modify the Strategy for Optimizing the Network of Healthcare Institutions in Serbia until 2035. The research points to the need to introduce a clearly defined package of health services within mandatory health insurance. The healthcare system is efficient if it provides maximum quality services with minimal costs within allocated resources. The global economic crisis caused by the COVID - 19 pandemic showed that the public source of funding is unstable and it is necessary to find alternative sources. This led to health sector reforms in almost all countries of the world. The most acceptable solution is to introduce compulsory health insurance with a rationally defined package of services. As there is no ideal solution and result, the success of the undertaken reforms in the field of healthcare remains to be constantly reviewed.*

Key words: *financial sustainability, business sustainability, healthcare reform, quality of health services, way of financing hospitals*

JEL classification*: H51, H83, G30*

1. INTRODUCTION

Health represents essential resource of all living creatures, without which one can not imagine life and prosperity of the human society in its complexity. From the aspect of one state, the health is approached as great national resource. In accordance with Law on Health Care, health protection is represented as organized and comprehensive activity of the society, with aim to preserve and enhance health of the citizens of the Republic of Serbia. It encompasses a series of measures and activities directed to preservation and enhancement of health, prevention, suppression and early detection of diseases, injuries and other health disorders, as well as timely cerement, care and rehabilitation.

The financial and business sustainability of the health protection system is an important and complex topic, considering the primary task of the state to secure health protection for all citizens and the fact that public sector entities do not function on market principles, i.e. to maximize profits along with minimalization of the costs.

The financing of the health protection in the Republic of Serbia is bases of “Bismarck model”, where more than 90% of the funds, intended for exercise of rights from obligatory health insurance, are provided from the contributions for mandatory social insurance of the employed citizens. One part of the assets for financing health protection of the socially endangered individuals is provided from the budget of the Republic of Serbia, which actually represents “Beveridge model”. All these facts lead us to conclusion that combined public financing system is implemented in the Republic of Serbia. Besides financing from contribution means, the health protection is also being financed

from donations, as well as by direct payments by the users of the health protection.

The sustainability is based on operational, program and financial characteristics, which combined enable for an entity to fulfill its mission on stable foundations. In expert literature there is a number of publications, written by eminent experts in the field of economy and medicine, who are suggesting ways form more efficient usage of resources and possible concepts for the health system reforms, with aim to rise the quality and availability of the services to higher level while maintain the amounts which are secured from the state`s budget.

2. HELTHCARE SYSTEM IN THE EUROPEAN UNION COUNTRIES

The financial and business sustainability of the healthcare system represents huge challenge for European countries. Recent COVID-19 global pandemic has in full force reveal the topic of business sustainability of the hospitals, which had a task to secure adequate protection for population, to plan capacities filling and to adapt hospital infrastructure to newly developed situation (Ndayishimiye et-al,2022).

Duran and Wright (2020) consider that the role of the hospitals, being the most important member of the healthcare system, is not enviable at all, since the accent was put to permanent enhancement of the quality of medical services, with decrease in costs that are limited by state`s budget. The measuring and comparing of the financial sustainability of the hospitals throughout European countries is complex process, since they function within legally different management models: (1) private versus public entities; (2) profit versus non-profit entities; (3) corporations versus foundations versus consortiums.

The change of organizational structure and business model reform is more complex problem than it appears in first glance. Health care institutions represents rigid systems, in which noticeable bureaucracy is present, which slows implementation of new regulations, policies and procedures, which are introduced to strengthen business advancement. (Braithwaite et-al,2017)

Edwards and Salman (2017) claim that political segment represents structural factor of the hospitals, while commercial segment determines contextual factor of business. Both of these segments have negative influence to changes and make it difficult for policy makers and hospital managers to define strategies, make decisions and implement them, creating lasting improvements.

Research by Braithwaite, Runciman and Merry (2009) shows that clinical doctors play a prominent role in organizational culture. They are highly respected within the profession and have enormous informal power to decide whether or not to accept a particular change. They strongly influence not only the acceptance or rejection, but also the pace of change. Public hospitals change in countless ways, by introducing new medical techniques, methods of care, clinical practices, diagnostics, tests and treatments. As the changes relate to specific medical knowledge, it is easy to see that the adoption of change in public hospitals is much more bottom-up than top-down, and is mainly initiated and sanctioned by clinical groups.

A 2018 study of 805 hospitals in Poland highlighted a positive correlation between the financial position of healthcare providers and the quality of care. It found that the unstable financial situation and growing debt of public hospitals have been present for more than two decades. (e.g. Dubas-Jakobczyk, Kocot, Kozieł,2020). The researchers compared the financial performance of public hospitals in Poland, depending on their ownership and organizational form, and analyzed whether there was a relationship between financial performance and selected variables. The results of this study showed that in 2018, 52% of public hospitals in Poland made a gross loss, while 40% of hospitals had outstanding liabilities. There were statistically significant differences between hospital groups, with university hospitals and local hospitals in the worst situation. In addition, corporate public hospitals performed worse than those operating as independent health units. The researchers' general conclusion was that urgent measurements and monitoring of the potential impact of financial performance on the quality of care in hospitals are needed. A study conducted in Hungary in 2018 disclosed that public hospitals generated a debt of almost $192 million, which was paid by the state. However, in the following period, hospitals continued to create debts that led to the postponement of necessary healthcare, including diagnostic examinations, surgeries. The researchers, having seen the problem, suggested that the country's government turn to technological innovations, Healthcare 4.0, which integrates the most modern industrial technologies. The study concludes that the introduction of new technology in healthcare leads to an increase in costs, but increases the efficiency and effectiveness of service provision. Increasing efficiency and effectiveness thanks to technology will lead to the implementation of reforms, reducing costs and increasing profits (Healthcare Resource Guide – Hungary, 2023)

One of the most comprehensive studies was Dubas-Jakobczyk, Albreht and Behmane’s (2020) study of hospital sector reforms in 11 Central and

Eastern European countries (Bulgaria, Czech Republic, Estonia, Croatia, Latvia, Lithuania, Hungary, Poland, Romania, Slovakia, Slovenia). The researchers compared (2008–2019) hospital reforms in these countries and identified common trends, success factors and reform challenges. The results showed that reforms were more prevalent in the procurement and payment sector than in the sector related to relationships with other service providers. Most hospital management reforms aimed to transform hospital infrastructure, improve financial sustainability and/or improve the quality of care, while procurement and payment reforms focused on containing hospital costs and/or encouraging a shift to outpatient/day care. The same problem of lack of comprehensive approach, unclear outcomes and political influence was observed in all countries. It is encouraging that similar reforms are being implemented in different countries, so there is significant potential for common learning. The literature review leads us to the conclusion that there is a great deal of room for research work in the areas of comparative analyses of the financial sustainability of hospitals, i.e. their ability to perform their core business in the long term, with financial stability and efficient use of resources.

3. THE HEALTHCARE SYSTEM IN THE REPUBLIC OF SERBIA

In the previous period, both in European countries and in our country, health sector reform activities were carried out. The specificity of our situation was marked by the events of the early 1990s. During that period, the health system was faced with a reduced volume of examinations, as well as a reduced quality of hospital treatment services due to inadequate hygienic conditions. The procurement of medicines and medical supplies was difficult, while the equipment was outdated. This situation in the country was favorable to the development of the private sector, which provided comprehensive services, but not to citizens who paid for health services twice, through mandatory health insurance and the full price of health services in the private sector (Martinovic et. al, 2023). During this period, private health insurance was developed, which was supplementary in nature and guaranteed faster access to healthcare for the treatment of short-term illnesses. The process of healthcare reform in the Republic of Serbia began in 2002 with the adoption of the documents „The Healthcare Policy of Serbia“ and "The Vision of the Health Care System" in 2003 (Martinovic et. al, 2023). The Health Care Development Plan of the Republic of Serbia was adopted in 2008 on the basis of the Health Care Law and was based on the Government Strategy and the National Program. The Decision on the Health Care Development Plan of the Republic of Serbia (2010) envisaged the adoption of a set of documents such as: Health Policy of Serbia, Poverty Reduction Strategy in Serbia, National Millennium Development Goals in the Republic of Serbia, Youth Health Development Strategy in the Republic of Serbia, National Strategy on Aging 2006-2015, Mental Health Development Strategy, National Sustainable Development Strategy, Drug Strategy, Strategy for Improving the Position of Roma, Public Health Strategy of the Republic of Serbia, etc.

Seven key goals of the health policy of the Republic of Serbia have been set:

1. preserving and improving the health status of the Serbian population and strengthening the health potential of the nation;

2. fair and equal access to healthcare for all citizens of Serbia, for the same needs, as well as improving healthcare for vulnerable populations;

3. placing the user (patient) at the center of the healthcare system;

4. sustainability of the health system, with transparency and selective decentralization in the area of resource management, and expansion of sources and methods of financing;

5. improvement of the functioning, efficiency and quality of the health system with the definition of specific national programs in the areas of personnel, institutional network, technology and medical supply;

6. defining the role of the private sector in providing health services to the population;

7. improving the health care workforce.

3.1. FINANCING OF HEALTHCARE IN THE REPUBLIC OF SERBIA

Otto von Bismarck, the German Chancellor, influenced the passage of the Law on Compulsory Health Insurance for Workers in 1883, which provided for mandatory contributions to a sickness fund.

This law became the originator of the idea of compulsory health insurance for workers and the achievement of the social goals of the state. Bismarck's health insurance model was adopted by Austria in 1887, Norway in 1902, and Great Britain in 1910 (Totič, Marić-Krejović and Tripković, 2010).

William Henry Beveridge, an English baron, criticized Bismarck's model by proposing a model for financing social and health insurance. In order to ensure social security, Beveridge proposed dual financing, where maternity and child benefits

would be financed from the state budget, while pensions would be paid from the social insurance fund (Totič, Marić-Krejović and Tripković, 2010). Basically, the Decision on the Health Care Development Plan of the Republic of Serbia (2010) stipulates that the financing of health care in the Republic of Serbia is based on the Bismarck model, where more than 90% of the funds for exercising rights under mandatory health insurance are provided from the funds for mandatory social insurance contributions of employed persons.

The Law on Health Care guarantees the provision of health care to all citizens of the Republic of Serbia, including refugees and internally displaced persons from the territory of the Autonomous Province of Kosovo and Metohija, recipients of social assistance and others. Part of the funds for financing health care for socially vulnerable categories of the population are provided from the budget of the Republic of Serbia, which represents the Beveridge model. It can be concluded that a mixed financing system is present in the Republic of Serbia.

Healthcare in the Republic of Serbia is financed both by donations and by direct payments by healthcare users (participation and payment for services).

Total healthcare expenditure can be divided into public and private. Public expenditure represents expenditure from public revenues, such as mandatory health insurance, the budget of the Republic of Serbia, autonomous provinces and local governments, investments in the healthcare system from state funds. Private healthcare expenditure is from private sources, such as participation and payment by healthcare users and voluntary insurance.

Table 1. Share of healthcare spending in GDP in Serbia in the period 2007–2017

Indicator	2007	2015	2016	2017
Share of total healthcare spending in GDP (in %)	10.02	9.40	8.98	8.8
Share of public expenditures for health care in the gross domestic product	6.1	5.45	5.2	5.06
Share of private healthcare spending in GDP (in %)	3.92	3.95	3.78	3.74

Source: Institute of Public Health "Milan Jovanović Batut", National Health Account

In 2007, the share of total healthcare expenditures was 10.02% of GDP, while in 2017 it was 8.8%.

The share of public expenditures in GDP (in %) shows a greater tendency to decrease than that of private expenditures for healthcare.

Table 2. Indicators of expenditures for health care

Selected indicators of healthcare expenditure	2007	2015	2016	2017
Total health care expenditure (THCE) as % of gross domestic product (GDP)	10.02	9.40	8.98	8.8
External sources of healthcare financing as % of the THCE	1.3	0.35	0.39	0.1
Public expenditure on health care (PHC) as % of the THCE	61.4	58.07	58	57.6
Private health care expenditure (PHCE) as % of the THCE	38.6	41.93	42	42.4
THCE as % of total government expenditures	13.1	12.58	11.7	11.7
Health insurance funds as % of the THCE	93.4	93.91	93.86	94.0
Direct payments by households as % of the PHC	90.2	96.85	96.34	96.0

Source: Institute of Public Health "Milan Jovanović Batut", National Health Account

To analyze more precisely, Table 2 shows the growing trend of private healthcare expenditure as a % of total healthcare expenditure, as well as a large jump in direct payments by households from 90.2% to 96% as a percentage of private healthcare expenditure, while a decrease in public expenditure as a % of total government expenditure is observed.

Table 3. Analysis of resources in healthcare (in millions of dinars)

Analysis of resources in healthcare (in millions of dinars)	**2007**	**2015**	**2016**	**2017**
Total expenditures for employees in the public health care sector	10.02	9.40	8.98	8.8
Salaries of employees in the public health care sector	1.3	0.35	0.39	0.1
Medicines and medical devices (RC1.2.1.1.)	61.4	58.07	58	57.6
Private expenses for medicines and medical supplies	38.6	41.93	42	42.4

Source: Institute of Public Health "Milan Jovanović Batut", National Health Account

The period from 2007 to 2017 was marked by decrease in public sector salaries and an increase in private spending on medicines and medical supplies.

It should be noted that the exchange rate increased from 58.45 (DIN to US$) in 2007 to 107.76 (DIN to US$) in 2017.

Converted at the official exchange rate, salaries in US$ were 1,153 in 2007, while in 2017 they were 862 US$ (in millions).

In the following, we will analyze data from the Statistical Office of the European Union (Eurostat), which contains collected and published statistics data on health care expenditure, as well as the share of these costs in the total GDP of the Member States, countries outside the European Union and international organizations, in order to inform the institutions of the European Union and enable monitoring of the performance of the Community.

The table 4 shows the percentage share of health care expenditure in GDP in the period from 2019 to 2023.

Table 4. Percentage share of healthcare costs in GDP

	2019	**2020**	**2021**	**2022**	**2023**
European Union - 27 countries (from 2020)	9,94	10,9	10,9	10,4	:
Belgium	10,8	11,3	11,0	10,8	:
Bulgaria	7,1	8,5	8,6	7,7	:
Czechia	7,1	9,2	9,5	8,8	8,5
Denmark	10,6	10,7	10,8	9,5	9,4
Germany	11,7	12,7	12,9	12,6	11,8
Estonia	6,8	7,6	7,5	7,0	7,6
Ireland	6,7	7,0	6,6	6,1	6,6
Greece	8,2	9,5	9,2	8,5	:
Spain	9,1	10,7	10,3	9,7	:
France	11,1	12,1	12,3	11,9	:
Croatia	6,7	7,65	8,0	7,2	:
Italy	8,7	9,6	9,3	8,9	8,5
Cyprus	7,07	8,8	9,5	8,8	:
Latvia	6,6	7,3	9,1	7,6	:
Lithuania	6,9	7,5	7,7	7,2	7,3
Luxembourg	5,5	5,8	5,7	5,6	5,8
Hungary	6,3	7,3	7,4	6,7	6,4
Malta	9,1	10,6	10,4	9,5	:
Nether.	10,1	11,2	11,1	10,1	:
Austria	10,5	11,3	12,2	11,2	10,9
Poland	6,5	6,5	6,4	6,4	7
Portugal	9,5	10,6	11,1	10,5	10
Romania	5,7	6,2	6,5	5,8	:
Slovenia	8,5	9,4	9,5	9,6	9,4
Slovakia	6,9	7,1	7,8	7,7	:
Finland	9,2	9,6	9,8	9,7	:

Sweden	10,9	11,4	11,2	10,7	11,1
Iceland	8,6	9,7	9,7	9,1	9
Liech.	5,8	6,1	5,5	5,7	:
Norway	10,4	11,4	9,8	7,9	:
Switzerland	11,4	12	12	11,7	:
United Kingdom	10,2	:	:	:	:
Bosnia and Herzegovina	8,9	9,7	9,6	8,7	:
Montenegro	:	:	:	:	:
Moldova	:	:	:	:	:
North Macedonia	:	:	:	:	:
Albania	:	:	:	:	:
Serbia	:	:	10,0	9,7	:
Türkiye	:	:	:	:	:

Source: Eurostat - Total health care expenditure Data extracted on 07/03/2025 13:15:12 from [ESTAT]

The table shows that Germany and France allocate around 12% of GDP, while Liechtenstein, Romania and Luxembourg allocate only around 6% of their GDP to financing healthcare. The Republic of Serbia allocates around 10% of its GDP for the same purposes, which suggests that it ranks high in Europe in terms of allocating funds for financing healthcare

3.2. ENHANCEMENT OF THE FINANCIAL AND ORGANIZATIONAL SUSTAINABILITY OF HEALTHCARE SYSTEMS

The Republic of Serbia directs its activities, according to the Decision on the Health Care Development Plan of the Republic of Serbia (2010), to the rationalization of the network of health care institutions, decentralization and financing of the health care system. Priority issues relate to the continuous improvement of legal regulations and technical characteristics such as staff, equipment, space. Of particular importance are the development of skills and knowledge of service providers, management of the health care system at different organizational levels, the connection of health and other complementary sectors (social protection, education, ecology, economy, justice, etc.), as well as the adaptability of the health care system to changes in the environment.

Priority areas of healthcare organization and functioning are: integrated healthcare, human resources for health, integrated health information system, healthcare quality, patient safety and financing.

The financial stability of the healthcare system in the Republic of Serbia is based on compulsory health insurance, as the basis for exercising the right to healthcare. In order to ensure financial sustainability in the future, a number of measures have been envisaged, such as: defining a "basic package" of healthcare services, determining the basis for paying contributions for compulsory health insurance, improving the system for controlling regular payment of contributions, achieving comprehensive compulsory health insurance for all citizens of the Republic of Serbia, ensuring an appropriate amount of funds for healthcare from the budget, and improving and further implementing voluntary health insurance.

During 2019, the Health Care Institution Network Optimization Plan - Master Plan was developed (Varga et.al, 2020). The Master Plan does not represent the official position of the Ministry of Health, but is the direct responsibility of the authors themselves.

The authors propose basic goals such as ensuring high-quality, uniform and timely healthcare throughout the territory of the Republic of Serbia, with easier access to healthcare for all patients, within the framework of the envisaged healthcare budget. The greatest contribution of the Master Plan is that planning in the healthcare sector is carried out according to needs, following the practice of Great Britain, and not according to healthcare capacities in a particular territory.

The changes included in the Master Plan are of an organizational, geographical, functional and institutional nature, and as such require a certain amount of time for implementation and adaptation of both the healthcare system itself and patients.

The draft Masterplan envisages that the healthcare system will be divided into six regions (Vojvodina Region, Belgrade Region, Western Serbia Region, Šumadija and Central Serbia Region, Eastern Serbia Region and Southern Serbia Region). The centre of each region is one central hospital, with the best equipment and staff, which provides the most complex healthcare services at the regional level.

Institutional integration is planned, which would involve the merger or consolidation of two or more

institutions into one legal entity, which would not result in job losses or layoffs, but rather in improved administrative management - more efficient planning of equipment procurement, better personnel management, easier organization of on-call shifts, etc.

It is planned that by 2035 the number of healthcare institutions will be reduced from the current 313 to 117.

One of the key objectives of the Masterplan is to ensure that patients receive a uniform service, whether they live in the city or in rural and mountainous areas, and to ensure greater availability of specialist examinations in their region and health center. Accessibility of services to the older generation will be ensured through an increase in patronage visits.

The authorised ministry has proposed the establishment of a Center that will unify all personnel matters into one system, which are currently divided between the Ministry, the Milan Jovanović Batut Institute of Health and Social Welfare and the Federal Health Insurance Fund. The Center will enable faster adoption of the personnel plan, planning and management of professional development, and more efficient determination of the actual situation and needs for hiring new personnel. One speciale section of the Masterplan is dedicated to the improvement of the material resources of the health system. The successful adoption of the optimization plan opens the opportunity for Serbia to use World Bank funds to purchase the most modern and necessary equipment – magnetic resonance imaging, CT scanners and ultrasound machines – which will particularly strengthen the fight against oncological diseases. The goal of the Masterplan is to save an estimated 105,000 lives by 2035 through early detection of cancer.

CONCLUSION

The state is the main support for society in terms of health care. It is of utmost importance to establish a system that will enable the population to receive the maximum quality of services with optimal use of resources. Conducted research suggests that a large number of healthcare institutions operate on the edge of liquidity, which calls into question their financial and organizational efficiency. The possible solution can be found in the reform of healthcare institutions, connecting the primary, secondary and tertiary levels, through administrative decentralization, adopting a package of health services, introducing new technological solutions, reducing political influence, as well as the influence of clinical doctors on the process of implementing changes. A more efficient possibility of organization and functioning is sought in the joint action of the state and private sectors and various forms of partnerships. The global economic crisis caused by the COVID-19 pandemic has shown that the stability of public funding sources is questionable, and the global trend of increasing health spending has further confirmed the need to find alternative sources of funding. The common problems of sustainable financing and rising costs in health systems around the world have necessitated the implementation of health sector reforms in almost all countries in the world.

REFERENCES

[1] Braithwaite, J., Runciman, W. B., & Merry, A. F. (2009). Towards safer, better healthcare: harnessing the natural properties of complex sociotechnical systems. BMJ Quality & Safety, 18(1), 37-41.

[2] Braithwaite, J., Westbrook, J., Coiera, E., Runciman, W. B., Day, R., Hillman, K., & Herkes, J. (2017). A systems science perspective on the capacity for change in public hospitals. Israel journal of health policy research, 6, 1-4.

[3] Dollar, D. and Kraay, A., (2001): Trade, Growth and Poverty. Washington: The World Bank, Development Research Group.

[4] Dubas-Jakobczyk K, Albreht T, Behmane D, et al. Hospital reforms in 11 central and Eastern European countries between 2008 and 2019: a comparative analysis. Health Policy 2020;124, 368–79.

[5] Dubas-Jakobczyk K, Kocot E, Kozieł A. Financial performance of public hospitals: A cross-sectional study among Polish providers. IntJ Environ Res Public Health 2020;17.

[6] Durán, A., and Wright, S. (Eds.). (2020). Understanding hospitals in changing health systems. London: Palgrave Macmillan.

[7] Edwards, N., & Saltman, R. B. (2017). Re-thinking barriers to organizational change in public hospitals. Israel Journal of Health Policy Research, 6, 1-11.

[8] Eurostat. (2023). Retrieved March 6, 2025, from the website://www. ec.europa.eu/eurostat/web/main/ data

[9] International Trade Administration (ITA). Healthcare Resource Guide – Hungary 2023. Retrieved march 20, 2025, from the website://www.trade.gov/healthcare-resource-guide-hungary

[10] King, D., & Mossialos, E. (2005). The determinants of private medical insurance prevalence in England, 1997–2000. Health Services Research, 40(1), 195–212.

[11] Martinovic, B., Scepan Sinanovic, J., Sekulic, S. P., Subotic, S., Babic, V., & Bubanj, S. (2023). The influence of social networks on the development of addiction in adolescents. PONS, 66.

[12] Ndayishimiye, C., Sowada, C., Dyjach, P., Stasiak, A., Middleton, J., Lopes, H., and Dubas-Jakóbczyk, K. (2022). Associations between the COVID-19 pandemic and hospital infrastructure adaptation and planning—a scoping review. International journal of environmental research and public health, 19(13), 8195

[13] Odluka o planu razvoja zdravstvene zaštite Republike Srbije („Sl.glasnik RS“, br.88/2010)

[14] Totič, I., Marić-Krejović, S., & Tripković, V. (2010). Finansiranje zdravstvenog osiguranja i zdravstvene zaštite. Medicinski glasnik Specijalna bolnica za bolesti štitaste žlezde i bolesti metabolizma Zlatibor, 15, 27-42.

[15] Varga, S., Rikanović, S., Kovach, N., Prendja-Trupec, T., Novaković, T., & Mandić, V. (2020). Plan optimizacije mreže ustanova zdravstvene zaštite – masterplan (RFP: RS-SSHPAF-QCBS-CS-18-1.3.1). Kredit br: 8830-YF.

[16] Zakon o zdravstvenoj zaštiti. (2019). Beograd: Službeni glasnik Republike Srbije. (25/2019)