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Identity - an Influential Factor in Modernization of Healthcare Systems in Hungary and Serbia

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Abstract

The changing word and its economic trends are demanding adjustments in healthcare systems. The modernization of the healthcare appeared as global requirement, in connection with numerous changes in healthcare sector, including the financing and providing funds for unallayed services. Also, one of the crucial elements of the modernization is the development of the healthcare leadership and introducing elements of the shared leadership, in order to create an organizational culture, which can comply with the global changes resulting to economic and business transformations. Belonging to groups, families, and communities can empower leaders and increase commitment towards belonging. Through cultural humility, leaders are able to recognise and understand their own cultural self-identity and how this affects their leadership style. In this paper, the authors recognise that everyone has unique traditions, values, and beliefs (ethnic identity, language, religion, community, family ties), that everyone is connected to others, and that this greatly influences their leadership decisions. In order to provide a theoretical basis for the research, the authors aim to present a literature review of past research on identity as a factor influencing the modernization of healthcare (and leadership) in both Hungary and Serbia. Though there is a recognized need, opportunities for healthcare leadership development are limited both in Hungary and Serbia, including important limiting factors such as the fact that leaders are still sceptical about modern business and management elements in the healthcare sector. The ideal solution

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would be the combination of the early and mid-to-late career development and the integration of both the organizational and leadership development. This paper focuses on describing the healthcare systems in the two countries and understanding the factors that need to be highlighted in terms of their modernisation, both in the system and in relation to healthcare leadership.

Keywords: Healthcare management, leadership, Hungarian, Serbian, identity, modernization, healthcare systems

Introduction

The healthcare system represents the infrastructure that provides healthcare services and manages programs for individuals, families, and communities in order to improve and maintain the health status of the population.

The healthcare system is one of the most sensitive areas of the social system. As one of the social fundamentals, it must take responsibility and act in accordance with the needs and requirements of the population (Freedman, 2005).

The stage of the economy (economic development) of a country greatly influences the health status of its population. Conversely, the current economic situation of the country and its potential for future economic development actively depends on the health status of the population. Thus, it can be stated that the health status of the population and the development of the healthcare system can serve as an indicator in assessing the current and future economic situation and potential of a given country at the international level.

This study show a comparison between the positions of the healthcare systems and their management in Hungary and Serbia based on secondary data generated from the literature review.

Healthcare reforms should include and apply the elements of the modern healthcare management. Healthcare management became the crucial part of the healthcare systems in the developed European countries. In the developing countries, such as Serbia, where social and economic reforms started 15-20 years ago, the healthcare management is still considered as a fairly novel phenomenon, and it takes great effort to integrate the elements of the modern management into the healthcare system. It is extremely important to follow the examples of developed European countries and especially the examples of the neighbouring countries, as well as the continuous comparison of the position of the Serbian healthcare system with the healthcare systems of other more developed countries. Certainly, it is important to keep in mind the current economic development of the country, the stage of the accomplished reforms, and to evaluate the achieved results accordingly. On

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the other hand, in the case of Hungary, it may be useful to compare the progress in the improvement of the healthcare system with the less economically developed countries, e.g., Serbia. This could serve as evidence of the actual impact of the completed healthcare reforms and the development of the healthcare system compared to its previous state. Also, it could serve as the motivating factor in the further development. It is applicable for both countries as the comparison can increase the competitiveness of their healthcare systems and services and strengthen the role of the healthcare management.

Literature Review

The key challenge for all healthcare organisations is to ensure a continuously improving, high quality, safe, and compassionate healthcare. However, the position of healthcare managers can be defined as an authority role since they make important decisions and shape the organization. Such decisions are related to recruitment and development of staff, implementation of new technologies, allocation, and spending of the resources. Thompson (2007) stated that managers must consider two domains, external and internal. These internal domains reflect the operations inside the organization, where managers have most control.

Leadership is the most influential factor of the organisational culture, ensuring the necessary leadership behaviours, strategies, and qualities. Haslam et al. (2020) and majority of researchers reject pristine personality models of leadership, with most still advocating hybrid models in which the leaders refers to decontextualised personality as one of the most important components. In the case of leadership, there are several social and background factors that affect a leader's ability to impact others. Perhaps the most important of these are (a) the culture of the group being led and the culture of the wider society in which the group is located, (b) the nature of the institutions within which leadership takes place, and (c) the gender of the leaders themselves. Each of these factors is significant in its own right (Haslam et al., 2020).

The leader should be regarded as a prototype within the group. Leaders are seen to be "doing it for us". Their actions must serve the interests of the group. Leaders are supposed to "shape us". They do not simply work within the constraints of pre-existing identities handed down to them by others, but they are rather actively engaged in shaping a community. They are actively engaged in shaping a shared understanding of 'who we are'. Therefore, a large part of their success comes from their ability to represent themselves in terms that match members' understanding within the group. It is argued that leaders need to "make us matter". The point of leadership is not simply to express what the group thinks, but it is to translate the group's ideals, values, and

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priorities into reality. What counts as success depends on how the group thinks reality should be shaped and to clarify what a leader needs to do to become successful. This is even more important because societies are currently facing enormous challenges. With various global developments - military technology, religious extremism, political conflict, environmental degradation, etc. - the difference between the right and the wrong kind of leadership is rightly said to be changing everything in the world. Instead, the world, in this case Hungary and Serbia, needs leaders who not only have the right goals, but who can motivate people to support them. It needs arguments that are based less on opinion and more on solid scientific evidence (Haslam et al., 2020). Also, the identity of the leader plays an extremely important role in shaping and interpreting this. It is crucial to understand who they are and who they want to be. Not only social identity but also a sense of national belonging and political convictions would help him to do this.

According to Drath et al. (2008), the basic leadership task is to ensure direction, alignment, and commitment within teams and organisations. Effective leaders in healthcare services are continually focused on safe, high quality, and compassionate care as their top priority. They should ensure that the voice of patients is heard at every level, and patients' experiences, concerns, needs, and feedbacks (positive and negative) are consistently considered (West, 2015). They should offer supportive, empathic, fair, respectful, compassionate, and empowering leadership.

Team leaders should create a strong sense of team identity and ensure shared leadership inside the teams, with all the members appropriately involved in decision making, in order to improve high quality patient care. Bezrukova et al. (2012) stated that such alignment has an important influence on the reduction of the effects of 'fault lines', defined as group and status differences, interfering with effective collaboration, which is a common problem in healthcare organisations. West (2013) claimed that cultures focused on the high-quality care require leadership which could ensure that there are clear and challenging objectives at all organizational levels. According to Ham (2014), this is different from target-driven cultures that are applied by some governments and organisations in order to drive changes with limited success. Boyatzis (1982) was focused on the competencies related to managerial effectiveness and found the following skills important for leaders: technical competence, which brings the respect of the followers (knowledge about the organisation, strategy, structure and processes, healthcare services, treatments and technologies); conceptual skills (understanding of the complex environments of organisations, both internal and external); and interpersonal skills (understanding the needs and feelings of followers, monitoring the effects of own behaviours and being aware of emotional reactions to others).

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Objectives

Accepting the assumption that the changing world and its economic trends are demanding adjustments in the healthcare systems, which make the modernization of the healthcare a global requirement based on the analysis of the development of healthcare systems in Hungary and Serbia, it is important to put into consideration the phenomenon of healthcare management.

In response to these complex challenges, the aim of the current research is to serve as a useful material in the analysis of the management of healthcare systems, even as starting point for further research, primarily by answering the following questions:

What are the identification and assessment of the managerial competences, which are crucial for effective performance in healthcare systems, including possibilities for modernization and development of those competences?

What are the current prospects for learning and implementation of skills, competences, and new leadership models in healthcare systems in Hungary and Serbia?

Is there any correlation between identity and the new elements of the leadership?

Methods

The empirical literature review is more commonly called a systematic literature review and it examines past empirical studies to answer the author's research question. This literature review is a summary of research that has been conducted in the past on subject of identity as influential factor on modernization of healthcare in Hungary and Serbia, which helps in forming the theoretical basis of the research.

Due to the multidisciplinary topic, this paper focuses largely on providing empirical support for the unfolding theoretical basis that was introduced. Given the complex nature of the phenomena, leadership, on the one hand, can be a very creative sort of process, and on the other hand, the general psychological mechanisms are at work in the creation of effective leadership - this means assembling a range of evidence.

The authors have done the research and analysis of the results of the domestic (Hungarian and Serbian) and foreign literature on the subject. Data from secondary sources were used, e.g., publications in both Hungarian and Serbian languages, media appearances and statistical database, to present the current status of the investigated phenomenon.

One of authors main goals was to formulate the research problem as accurately as possible. Also, the collected data will support the preparation of the author's own survey, which is addressed as the next step in the research of healthcare leaders' identity.

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The authors expect that during this explanatory research, it would be possible to determine whether there is a deterministic relationship between the given criteria. Since these social phenomena can be extremely complex in causation, there may be a stochastic relationship between the factors, in which case only a tendency-like relationship can be observed between the characteristics.

Leaders bring their life experiences, history, and culture into every role and context. Belonging to communities, groups, and families can be a source of strength and contribute to a sense of belonging. It can also be a basis for exclusion if leaders are not aware of how different cultures and beliefs affect their actions. Cultural humility requires leaders to recognise and understand their own cultural identity and how this affects their leadership style. Recognising that everyone has unique tradition, values, and beliefs (ethnic identity, language, religion, community, neighbourhood, and family ties) helps us to see how we can relate to each other, and it also influences our leadership decisions.

Results

The structure and functioning of healthcare systems are greatly influenced by the economic and political environment. Healthcare reforms are essential for the development of the healthcare service. Systematic approach and science-based techniques lead to the efficient healthcare management, which plays an important role in the reform process and improvement of the competitiveness of the healthcare systems. This provides the opportunity to the developing countries to enhance their healthcare and to reach the level of well-functioning systems of the developed countries.

In this current research, the situation in the healthcare systems of Hungary and Serbia were analysed and compared. Thus, these are two former socialist countries in which political regime changes, together with the shift in the structure of the economic systems that took place at different times, thereby resulting to differences in the economic growth rates over the past two decades. Hungary became an EU member state in 2004, while Serbia has undergone throughout major changes in the social system (including the healthcare system) since 2000. In March 2012, Serbia became a candidate for EU membership.

In both countries, the identification and assessment of the competences, knowledge, skills, attitudes and initiation of adequate training programs, and studies of professional development are essential for effective healthcare management, including leadership and providing proper healthcare service consequently.

Central and Eastern European (CEE) countries are facing increasing challenges in the provision of equitable and comprehensive healthcare for their

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citizens, which is based on factors such as changing demographics and the continual launch of new premium priced medicines. Some CEE countries do well in this respect, but many do not, particularly in the Balkans (Brien et al. 2019). In the past 23 years, the post-socialist restructuring of health system funding and management patterns has brought many changes to small Balkan markets, putting them under increasing pressure to follow the advancing globalization (Jakovljevic, 2013). Dissatisfaction with healthcare remains widespread with restricted access to the healthcare. The process of enhancing this may require greater investment and a shift of focus in specific areas. Seven countries in the region rank below 70th globally in the aggregate health ranking, and average satisfaction levels with healthcare remain low at 57%, representing only a three-percentage point increase from a decade ago (Brien, 2019). Issues with quality and accessibility of healthcare services are not just a matter of underfunding. Socioeconomic inequalities in healthcare access are still growing across the region (Jakovljevic, 2013). Countries should learn from each other on how to address these challenges and maintain sustainable systems.

Healthcare Management in Serbia

Serbia is systematically rebuilding a stressed and severely underfunded healthcare system. Although the country's healthcare professionals are trained according to the global standards, outdated equipment and infrastructure impacted the quality of healthcare service delivery (The Healthcare IT System in Eastern Europe, 2008). The basic infrastructure and organization of the health system was inherited from the former Yugoslavia. However, general health reforms since 2000 have attempted to rehabilitate and modernize health facilities and equipment and to improve technology, supported by extensive international humanitarian aid (Bjegovic-Mikanovic et al., 2019).

Democratic changes in 2000 and the adoption of the Health Policy in 2002 initiated significant progress. The main aim of the reform programme, from 2004 to 2010, was to improve preventive healthcare services and to decrease rates of preventable diseases and total healthcare costs. After 2012, reforms focused on improving infrastructure and technology alongside implementing an integrated health information system.

The healthcare system in Serbia is based on compulsory health insurance, with contributions as the main source of financing and broad population coverage. The state owns majority of the healthcare facilities and equipment. The main purchaser of publicly funded health services is the National Health Insurance Fund (NHIF). National legislation allows private healthcare service, which is covered predominantly by private payments (Bjegovic-Mikanovic et al., 2019).

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Healthcare management needs to improve production of health institutions, and the lack of financial resources in the healthcare system of Serbia imposes the necessity to improve hospital management (Gajic-Stevanovic, Aleksic, Stevanovic, & Zivkovic, 2014). This would include synthetic and trans-disciplinary approach to solve business problems, with a number of alternative solutions. Highly skilled management personnel are the best solution for improvements, including knowledge, skills, and the applications of the latest technologies.

Health managers should follow the latest trends in theory and practice and propose new models for efficient implementation of contemporary management trends in all health facilities (Aleksic, Stevanovic, & Gajic-Stevanovic, 2004). Positive results in healthcare quality improvement could be expected together with the improvement of managerial skills in the knowledge and innovation support, leadership, teamwork, and goal orientation. Teamwork of managers and physicians in all medical institutions is critical to improve the quality of health services for patients (Barker, 2001). Effective management of healthcare institutions is important to achieve balance between personal and clinical autonomy and create positive environment for efficient and effective functioning of the health facility (Martinov-Cvejin, 2009).

An important challenge in the Serbian healthcare system is the mismatch between the production and the employment capacities for healthcare professionals (especially physicians and nurses), which contributes to high unemployment and migration (Santric-Milicevic et al., 2015). So far, there was an entirely centralized staff's planning. Producing a realistic plan for human resources in Serbian healthcare system should be prioritized as an essential future action, since many Serbian healthcare professionals currently work in EU countries and there could be even bigger outmigration in the future (Gacevic et al., 2018).

Expectations that only internal reforms will improve the overall health system in Serbia are not realistic, since the financing of the healthcare system continues to be a large item for the Serbian budget, as well as a significant part of the public consumption. However, it is necessary to work on establishing an efficient and effective healthcare management and implementing it in an adequate manner by educated experts who are trained to apply modern methods and techniques. This would serve as the first step and measure in initiating and reorganizing the healthcare system management in Serbia.

Healthcare institutions would require new professionals who fully understand the healthcare system processes, organizational problems, and have sufficient knowledge to manage health facilities and to encourage the application of technology. An important aspect should focus on the development and implementation of the communication skills, competences

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in managing human capital and information, and the methods for assessment of the organizational performance (especially the evaluation of the quality in healthcare).

Healthcare Management in Hungary

In the last 20 years, Hungarian state and its systems underwent significant, unique changes. Besides democratization and managing the immediate crises caused by the collapse of the economy in the early 1990s, there was a strong desire to build Western models of healthcare system and the necessary social and economic infrastructure (Szócska, Réthelyi, & Normand, 2005). The reform of healthcare services is still a priority in Hungary, but managing these changes is difficult due to the managerial inexperience.

Structural change is in progress in the Hungarian healthcare system and some efficiency gains have been reached. In October 2020, the Hungarian Parliament approved a new law regarding a significant pay rise to doctors, which will be implemented in several stages from January 1, 2021, to January 1, 2023. This, however, depends on the number of years spent in the healthcare service. The purpose of the law is to reorganize the healthcare system in order to separate public and private medical care and to change and improve the legal status of doctors employed in the public sector. This new law is considered as the most significant reform initiative in Hungarian healthcare so far (Albert, 2021).

Besides the proposed 'historic' pay increase, significant potential efficiency could be reached with better organization and management of health services, including dissemination and better incorporation of modern healthcare technologies (e.g., high number of acute care hospital beds in international comparison, regionally unequal access, mixed levels of progressive care and a nonuniform emergency service system with unequal access to the emergency room, heterogeneous quality of care, and unexploited opportunities of modern health technology including 1-day surgery, minimally invasive procedures, telemedicine).

The Political Shortcomings of Individualist Models

In addition to their significant theoretical deficiencies, many observers have argued that the engagement of researchers and public relations experts with individual leaders is politically problematic. Notably, they view this involvement as counterproductive because it is seen as perpetuating two disempowering biases. First, it implies that members of the public cannot hold leadership positions because they lack leadership qualities. This means that if they were capable enough, they would take high office. Second, it suggests that only individuals with special qualities are capable of envisioning and

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achieving social progress. In this sense, Gary Gemmill and Judith Oakley (1992) argued that the very notion of leadership is an 'alienating social myth' that encourages complacency and passivity on the part of followers who, if they accept the view that social transformation is brought about only by the actions of outstanding individuals, will resign themselves to their lesser role and be restrained from pursuing change for themselves. Furthermore, the desire to discourage others from questioning the legitimacy of their authority may explain why those in leadership positions often enthusiastically support highly individualistic models of leadership (Bennis, 1995).

James Meindl and his colleagues have argued in this regard that leadership and charisma are simply romantic attributions that people make to explain the success of a group (Meindl, 1993). However, like most romantic perceptions, Meindl argues that they have no firm foundation. This type of argument is supported by the historical evidence that the figure of the individual leader was strongly promoted particularly in 19th century Europe (e.g., through portraits, statues, and biographies) to negate the threat to the ruling elites of various nations, which was posed by the prospect of popular revolution (Pears, 1994). In the early 20th century, the same concepts were appealed to defend opposition (McDougall, 1921).

Discussion

In the current research, two important studies related to healthcare management in Hungary have been highlighted. One of these was The Hospital Survey on Patient Safety Culture (HSOPSC), a rigorously designed tool that measures inpatient safety culture. In this survey, 371 healthcare workers from six Hungarian hospitals participated (including nurses, physicians, and other healthcare staff). The most important findings revealed that the healthcare staff works in the "crisis mode," while trying to accomplish too much and too quickly. The "blame culture" does not also facilitate patient safety improvements in Hungary (Granel et al., 2019).

Another important research was an international study on obstacles to compassion-giving among nursing and midwifery managers, which was conducted in 2020. This was a cross-sectional, exploratory, international online survey involving 1,217 participants from 17 countries. Managers' responses on open-ended questions related to barriers for providing compassion were entered and thematically analysed. The conclusion showed that the obstacles to compassion-giving among managers vary across countries and the understanding of the variations across countries and cultures is of crucial importance. Regarding Hungary, it should be highlighted that the fear of losing authority by giving compassion appears to drive some managers towards emphasizing rules, tasks, and results. Also, stress and burnout were outlined as barriers to compassion (Papadopoulos et al., 2020).

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In order to simply investigate the current situation on the development of healthcare management and leadership in Hungary and Serbia, a search of internet sources on healthcare management/leadership related materials have been completed. This search was done in Google Browser and on Pubmed.gov database for relevant topics and keywords (Table 1). Based on the search results provided in the table below, it is obvious that the numbers of the documents related to healthcare management in Hungarian and Serbian language are not high, especially in the group of the scientific publications (PubMed.gov results). It is even more apparent if these numbers are compared to the numbers of the publications in English language. This fact may suggest two things: healthcare management is still on low level of development in these countries and/or when they talk and do research about it, they do it rather in English language. This means that they still refer to healthcare management as an international or foreign phenomenon and not as something that can be identified with.

Table 1. Google and PubMed.gov search on relevant topics/keywords (22-Sep-2021)
Source: Compiled by the authors based on Google Browser and PubMed.gov search results

Keyword	Number of Google results	Number of PubMed.gov results
Healthcare Management	5 200 000 000	694 328
Healthcare Leadership	623 000 000	25 439
Healthcare Manager	749 000 000	694 328
Egészségügyi menedzsment (EN: Healthcare management)	2 970 000	8
Healthcare Management Hungary	87 100 000	1 270
Egészségügyi menedzser (EN: Healthcare manager)	432 000	3
Egészségügyi szervező (EN: Healthcare organizer)	1 450 000	3
Healthcare Leadership Hungary	32 000 000	33
Menadzment u zdravstu (EN: Health Care management)	175 000	1
Healthcare Management Serbia	39 500 000	528
Liderstvo u zdravstvu (EN: Health Care Leadership)	12 000	39
Healthcare Leadership Serbia	10 800 000	16

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One of the barriers in developing leadership in healthcare systems in Hungary and Serbia is the fact that some of current leaders are still sceptical about including modern management elements in the healthcare. The essential underlying cause of scepticism towards implementation of elements of management and collective leadership structure in the healthcare sector is the still ongoing process of political, economic, and social transition. This transition poses a lot of questions related to identity on population and individual level. Complex healthcare environments and the specific nature of modern healthcare work require modern approach in healthcare management and leadership. Work is distributed between different healthcare professionals (physicians, nurses, residents, and other clinical support staff) and artifacts (information technology, machines) and there is a specific structure in the relationships between them. This is a complex network of actors, and the crucial factor is understanding its complexity and its different aspects including management, continuity of care, nursing, and decision-making.

The Theoretical Background of Social Identity Approach and the Exploration of Personal Identity to Leadership

According to the social identity approach (Tajfel & Turner, 1979), individuals can classify themselves and act on the basis of both their personal identity (i.e., "I" and "me") and their different social identities (i.e., "we" and "us"). The consequences of individuals categorising based on social identities and the development of strong group identity attachment have been the focus of many research. These studies have, for example, confirmed the importance of social identity and social identification for a range of behaviours, including individuals' commitment to group projects (Haslam et al, 2013), productivity (Worchel et al., 1998), and participation in a variety of health-related behaviours and physical activity (Stevens et al., 2018). Much of this work attests to a key claim of social identity approaches that categorize oneself in terms of a particular social identity, which is associated with a desire to align personal behaviour with that of members within the group (Turner et al., 1987). Commonly, the strategic leadership literature focuses on facts, which make leaders unique as individuals (Finkelstein, Hambrick, & Cannella, 2009). Nevertheless, recent researchers have incrementally highlighted leadership as a social group process (Dinh et al., 2014). According to this context, leaders are significant not just because they are unique as individuals, highly charismatic or based on the precise position of power they hold, but rather because they think and act in terms of a bigger context. They should be able to nourish a shared identity with those they seek to persuade (Hogg, 2001; Hogg, van Knippenberg, & Rast, 2012). The modern research in leadership paid considerable attention to the bond that exists between personality traits and identity (Harrison, Leitch, & McAdam, 2015; Lord et al., 2017). The

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social identity approach to leadership is seen as a method that is grounded in a sense of joint social identity between leaders and their employees (Ellemers, de Gilder, & Haslam, 2004). In line with these demands, this research points to the importance of leaders being seen as representatives of the group they want to lead (Barreto & Hogg, 2017). They embody the norms, values, and ideals that make the group different from other groups. At the same time, scholars have claimed that successful leaders do not simply cover received social identities, but instead actively attempt to create some kind of group identity (Augoustinos & de Garis, 2012). Among other things, leaders work as identity patrons to make social identity, enhance a sense of shared identity within the groups they lead, and make it their own. They typically do this by identifying shared norms and values or ideals that adapt members with their own agenda. The theoretical proposition that social identity includes all significant aspects of group behaviour is a theoretical basis for a novel analysis of leadership. Certainly, building on the foregoing knowledge, the social identity approach affirms that leadership is a constant, multidimensional course that focuses on leaders' abilities to represent, create, and incorporate a shared sense of social identity for group members (Haslam et al., 2020). This is because it is made by developing a shared sense of one group, which ensures that leaders can stimulate individuals' motivations and also exploit converted power. Meaningfully, from this context, successful leadership is a process of social influence that involves making followers want to contribute to shared goals.

There is limited data on impact of social identity and social identification to behaviours and commitment of leaders in healthcare systems of Hungary and Serbia. However, based on previous research results, it is obvious that in Hungary, the leaders are prepared for the renewal and development of the modern system of healthcare services. There is agreement among Hungarian health actors on the need to build a coherent, national approach to the healthcare system, considering all the interrelationships, interactions, and elements of the system (Lantos, 2010). Hence, this is a very similar situation in Serbia as well. The Serbian healthcare leaders are aware of the need to pay attention to professional capacity building, strengthening leadership skills and capacities, and using positive examples and experiences from best practices of foreign and developed countries in order to modernise the national healthcare system and improve the access to the system on all local levels (Mitrovic et al., 2013).

Limitations and Future Research

From a methodological standpoint, future research could aim to perform multilevel modelling to account for the nested structure of the data collected from the Serbian and Hungarian healthcare leaders' groups. This

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would allow the calculation of the proportion of variance that can be considered at the individual and group level. However, since multilevel modelling requires at least 30 participants per group (Maas & Hox, 2005), and since the number of leaders in the health systems of both countries is often low, such studies would probably need to be conducted in large groups. Research will be considerably slower due to the current COVID-19 pandemic situation.

Conclusion

Although there is a well-defined need, modernization and development of healthcare leadership and leaders' skills is still limited in both Hungary and Serbia.

Developed and improved healthcare management and leadership would provide a significant support in the process of healthcare reforms in Serbia and necessary assistance in providing effective healthcare services in Hungary. More training programmes are needed - both early and mid-to-late career development.

One of the important barriers in modernization of healthcare management and development of leadership in Hungary and Serbia is the actuality that some of current leaders are still sceptical about implementation of the modern management elements (including collective leadership structure) into healthcare systems.

Explaining further the causality, one of underlying causes of scepticism is the still ongoing process of political, economic, and social transition. The transition itself raises questions related to identity on population and individual level.

There is insufficient data on impact of social identity and social identification to behaviours and commitment of leaders in healthcare systems of Hungary and Serbia, which does not allow to make further conclusions. However, clear connection could be established in both countries between recognising the need for developing an effective social health protection system and effort to improve the leadership in healthcare.

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