THREE PERIODS OF HEALTH SYSTEM REFORMS

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Abstract: Aim: To investigate, describe and classify main health policies and reform activities within the healthcare system undertaken over the past twenty years in R. Macedonia.

Methods: Desk research was conducted on scientific literature and relevant documentation (in English and Macedonian) about healthcare reforms. Relevant documents available at the Ministry of Health, Health Insurance Fund, World Bank and World Health Organization were reviewed. Official data on demographic and health status indicators were collected from the Institute of Public Health and the State Statistical Office. A working hypothesis, that the health system reforms were not continuous, was generated following the shifts in decision-making power over allocation of resources and political influences.

Results: Our study identified three periods of health system reforms in Macedonia: post-socialistic, pro-market and manifesto-driven. Throughout these periods poor maintenance, low efficiency and high operational costs increased out-of-pocket expenditures for health services and drugs and reflected on the deterioration of public hospital infrastructure. In parallel, liberal healthcare market regulation initiated commercialization of the healthcare services. Disappointed in the quality of healthcare services provided in the public health sector, many citizens opt to ask for services in private health care facilities, where social health insurance largely does not cover the costs.

Conclusion: The pace of the reforms is not continuous and the influence of politics is highly visible over the whole period of transition in the Republic of Macedonia. The main problems of the healthcare system in the Republic of Macedonia are politicization of the health sector, high centralization and government control, and poor
efficiency of public health institutions. Evaluation framework should be developed to further assess the impact of the health reforms.

**Key words:** Health reforms, health policy, health financing, politicization, Republic of Macedonia.

**Introduction**

In the period after independence, the Republic of Macedonia faced many challenges as a new country emerging after the collapse of the former Yugoslavia. One of the specifics of the old Yugoslavian model of health system organization that left its mark in further development of the Macedonian health system was the notion of universal and free access of health services for all citizens regardless of their ability to pay [1]. Such a system gradually improved the health status of the population, but the gap in regional disparities in health between more and less developed republics of the former Yugoslavia increased [2]. Unfortunately, within the republics of former Yugoslavia, the Republic of Macedonia was always at the lower level of the scale as measured by the key health indicators, i.e. infant and maternal mortality, life expectancy, etc [2].

After independence in 1991, the country moved towards developing parliamentary democracy and a welfare state based on citizens’ participation and the right to private ownership in the social sectors. The reestablishment of the healthcare system followed the principles of solidarity, mutuality and citizens’ participation in policy formulation and decision-making processes. There was also a tendency to protect some positive experiences and advantages of the previous socialist system such as strong prevention, control of communicable diseases and free access to healthcare at the point of use. The new Constitution adopted in 1991 included the right to healthcare protection (article 39) and obligations of citizens to protect personal health and the health of the others [3]. The organization and functioning of the healthcare system was re-established under the Health Care Law, first adopted in 1991 [4, 5] and was amended numerous times over the transition years. Our paper describes and classifies the main health policies and reform activities within the healthcare system undertaken over the past twenty years in the Republic of Macedonia. An overview of the key health related indicators over the past twenty years shows improvements in the health status of the population, but much more should and needs to be accomplished [6, 7]. The infant mortality rate has been significantly decreased from 31.6/1000 live births in 1990 to 7.6/1000 live births in 2011 (Table 1). The life expectancy at birth both for males and females has been improved on average by around two and a half years (72.5 for males, and 76.1 years for females). The out-of-pocket expenditure for health has increased to over 32% of total health expenditure, and this figure is very likely to be underestimated [6, 7].
Three periods of health system reforms…

Methodology

For the purpose of this study the authors reviewed the relevant documents and literature on health care reforms in the Republic of Macedonia published in English and Macedonian. We further reviewed initial legislation on the healthcare system and subsequent legislative changes since 1991, as well as unpublished reports and policy documents. Based on the main political developments in the country since it gained independence in 1991 we developed the working hypothesis that health care reforms are not continuous and are strongly associated with the political changes in the country. The hypothesis was generated following the political developments in the health system since 1991 and linked with shifts in decision-making power over allocation of resources and political influences. The main features of each of the reform periods are discussed and compared to international experience.

Results

Three main periods are evident in the development of healthcare reforms in the Republic of Macedonia: post-socialist (1991–1998), pro-market (1998–2006), and manifesto-driven (2006-continuing). Each of these periods carries its own specifics that have left a stamp on the current structure of the system (Table 1).

Table 1

*Republic of Macedonia, Selected Categories of Health System Related Data (1990–2011)*

<table>
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<tbody>
<tr>
<td>Population</td>
<td>2 028 000</td>
<td>1 965 984</td>
<td>2 031 541</td>
<td>2 036 855</td>
<td>2 055 004</td>
</tr>
<tr>
<td>Population density (per km²)</td>
<td>78.9</td>
<td>76.5</td>
<td>79.0</td>
<td>79.2</td>
<td>79.9</td>
</tr>
<tr>
<td>Urban (percent)</td>
<td>59.76</td>
<td>59.44</td>
<td>59.66</td>
<td>57.8</td>
<td></td>
</tr>
<tr>
<td>Life expectancy at birth (male)</td>
<td>69.98</td>
<td>70.04</td>
<td>71.18</td>
<td>71.44</td>
<td>72.5</td>
</tr>
<tr>
<td>Life expectancy at birth (female)</td>
<td>74.53</td>
<td>74.48</td>
<td>75.74</td>
<td>75.88</td>
<td>76.14</td>
</tr>
<tr>
<td>Infant Mortality Rate per 1000 live births</td>
<td>31.6</td>
<td>22.67</td>
<td>11.81</td>
<td>12.8</td>
<td>7.6 (2011)</td>
</tr>
</tbody>
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<tbody>
<tr>
<td>Public outlays as percentage of total intergovernmental budgets</td>
<td>n/a</td>
<td>n/a</td>
<td>15.8</td>
<td>15.8</td>
<td>n/a</td>
</tr>
<tr>
<td>Private out-of-pocket outlays (estimates)</td>
<td>n/a</td>
<td>n/a</td>
<td>29.1</td>
<td>29.6</td>
<td>33.26</td>
</tr>
<tr>
<td>Total health expenditure (PPP$ per capita)</td>
<td>n/a</td>
<td>368</td>
<td>452</td>
<td>601</td>
<td>702</td>
</tr>
<tr>
<td>Total health expenditures (% of GDP)</td>
<td>n/a</td>
<td>7.6</td>
<td>7.6</td>
<td>7.8</td>
<td>6.88</td>
</tr>
</tbody>
</table>

Source: State Statistical Office 2011; WHO HFA database
The periods of the healthcare reforms are determined by the shifts in political decision-making, change of governments and their influence over the health policy priorities and goals, as well as allocation of resources.

**Post-socialist period**

The post-socialist period of healthcare reforms covers the first seven years after the independence of the country from 1991 to 1998, when the first transition of government from socialist democrats to Christian democrats took place. The main features of the post-socialist period were oriented primarily to prevent the collapse of the health care system and to maintain some positive characteristics of the old socialist system such as strong prevention, free access, and solidarity in financing. In this period the government signed the first Loan Agreement with the World Bank for health sector reforms [8], but its effects on the health care system were felt later. In the years between 1991 and 1995 health revenues decreased by 40% which had direct negative implications on the maintenance of the old infrastructure of the health care system, on the satisfaction of health personnel, and on the health status of the population [5, 9]. Due to lack of funds and motivation and poor efficiency, all health care providers started acquiring financial debts that by 1997 totaled US$ 40 million [9]. In the post-socialist phase HIF was an integral part of the Ministry of Health and all decisions on allocation of resources, financing of health care providers, and planning of investments were predominantly influenced by different ministers of health in line with government programmes and priorities. The influence of the HIF management in the allocation of funds was minimal, and completely dependent on the positions of the ministers of health, thus creating a gap between political promises and financial capabilities. In order to prevent overuse of unnecessary services and to alleviate the severe shortage of funds for health care system financing, the government in 1993 introduced co-payment for health care services, with safety nets for children up to 14 years, the elderly over 65, pregnant women and chronic diseases patients [4–8]. Citizens had the possibility of selecting their personal doctor, while a referral system was introduced to access specialist-consultative and hospital services [5]. This period is also marked with huge humanitarian assistance for the healthcare sector from international donor agencies and friendly countries in pharmaceuticals, medical devices and equipment [5, 9].

**Pro-market period**

The pro-market period in healthcare reforms coincides with the first official shift in political power from left-oriented former socialists to centre-right conservatives that took place after the parliamentary elections in 1998 [10]. This period is marked by very intensive health sector reforms, mainly initiated and guided by the World Bank’s Health Sector Transition Project [8,
The influence and pressure of the World Bank were crucial in the design of structural and financial reforms in the health care sector. The most important feature of the reforms within this period was the formal separation of the Health Insurance Fund from the direct control of the Ministry of Health [12]. In 2000 a new Health Insurance Law (HIL) was adopted and the HIF was established as semi-autonomous health insurance agency governed by a managing board of 13 representatives, including six patients, two employers, three health providers delegated by the medical chambers and by one representative of the Ministries of Finance and Health [12]. The establishment of the HIF as a semi-autonomous agency was expected to improve transparency and efficiency in financing and delivering health care services. Also, it was important to guide the purchase of health care services according to a defined volume and scope of services, towards the most cost-effective health interventions, thus ensuring fiscal sustainability [8]. However, regardless of the official functioning of the managing board of the HIF, the influence of its members over the allocation of financial resources continued to be minimal.

The next important developments were preparations for the privatization of the primary health care clinics and implementation of the capitation-based model for payment of physicians. These preparations went in parallel with the development of centres for Continuing Medical Education (CME). Four training centres for perinatal care improvement were opened and over 40% of primary physicians in the country completed the programme and received certificates as well as personal medical equipment [11, 13]. Following the internal armed conflict in Macedonia in 2001 [14] the pace of the healthcare reforms declined to resume in the following years in parallel with the process of consolidation and democratization of the country [15, 16]. Decentralization of the country emerged as one of the tenets of the Ohrid Framework Agreement. A new law on local self-government was passed and basic healthcare was decentralized to municipalities. Fortunately, the health insurance remained under central government control [17] which in fact prevented further fragmentation of scarce healthcare resources. In 2004 the Ministry of Health introduced changes in the Health Care Law (HCL) to open for the first time the possibility of privatization of parts of the public healthcare system including dental clinics and pharmacies. In 2005 additional amendments to the law were adopted to initiate the privatization of the practice of primary health care doctors [18]. By October 2007, less than three years since the adoption of the first changes in the legislation, a total of 3,521 health workers (doctors, dentists, pharmacists and nurses) were privatized (Table 2) [19]. The expectations on the effects of the primary health care reforms were placed high by the Ministry of Health, but we have not been able to find a written report of its evaluation. A recent study conducted among primary health care doctors identified a high self-reported
burden of administrative workload which may reflect on the quality of the services doctors deliver to their patients [20].

Table 2

<table>
<thead>
<tr>
<th>Primary sector</th>
<th>Rented premises</th>
<th>Number of employees</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Doctors</td>
</tr>
<tr>
<td>Primary health care</td>
<td>888</td>
<td>944</td>
</tr>
<tr>
<td>Dentistry</td>
<td>431</td>
<td>616</td>
</tr>
<tr>
<td>Dental laboratories</td>
<td>72</td>
<td>210</td>
</tr>
<tr>
<td>Pharmacies</td>
<td>21 sold</td>
<td>64</td>
</tr>
<tr>
<td></td>
<td>51 rented; State pharmacies sold</td>
<td>91</td>
</tr>
<tr>
<td>Total</td>
<td>1,463</td>
<td>3,521</td>
</tr>
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</table>

*Source: Ministry of Health 2008

The pro-market wave of the reforms was also felt in the private health care sector. This period marked the development and opening of big private hospitals for cardio-surgery, gynecology and obstetrics, and one general hospital. The private hospital sector started its prompt development in parallel to the state hospital system. HIF signed contracts to cover the services provided in the cardio-surgery hospital but not in the other private hospitals. Thus, unavailability of insurance requires the patients who choose the private hospital sector to pay out-of-pocket for the services provided.

Manifesto period

The elections in 2006 marked a turning-point in the promotion of new health system reforms as an integral part of the political manifesto of the upcoming government. This has paved the way for the third period of health sector reforms in Macedonia: the manifesto period. Key features of the government programme were to decrease out-of-pocket expenditure (OPE) for health, to improve efficiency and transparency at the level of health care providers, to advance patients’ rights in all medical interventions, and to strengthen the position of the HIF as strategic purchaser of health care services. The initial legislative changes introduced a new concept in the governance to all the public health providers replacing the previous system of traditional appointment of medical doctors as directors, with a diarchal system of two directors with shared responsibility but different backgrounds – one of them a medical doctor, and the other an economist [21]. The health care providers gained more responsibilities
Three periods of health system reforms…

over the financial management, but in practice they lacked autonomy. The budgets of the individual providers (health centres, hospitals and university clinics) were still decided on the basis of historical allocations. The differences in allocations were mainly driven by political influences as during the previous phases of reforms. In 2007 under the leadership of the Ministry of Health, a new provider payment reform for hospitals was introduced based on diagnostic related groups (DRG) [22]. The period of preparation lasted almost three years and, since January 2009, all inpatient services in 56 selected health care providers have started to code hospital cases according to the Macedonian version of the adopted Australian DRG system [22, 23].

In 2008 the Government of R. Macedonia announced the transformation of public hospitals into autonomous corporations by drafting an initial version of the law on the autonomy of health providers. However, political interest in not giving away power has prevented the adoption of the final version of this law [24]. Thus although health management was officially introduced as part of the government strategy to improve the performance of public health providers, direct interference by the political parties has blocked all mechanisms for successful reforms. In early 2010 many hospitals started to acquire new debts [25], followed by many scandals in the local media about the poor quality in the provision of health care [26, 27]. These developments were followed by information in the media about poorer provision and lowered quality of health services in many general hospitals in the country. In addition, despite continuous problems in financing, the government was reluctant to deal with inefficiencies in the system. By 2008 the privatization within the Health Centres was not completed and 437 specialist doctors, 720 medical nurses and around 1500 (1456) administrative staff remain state-employed doctors, paid by fixed salaries [19]. Fear of losing patients and, more importantly, limited budgets to the private hospital sector have forced the government to be more protective of the state-run system. Despite new private investments in the health sector, the HIF was careful in signing contracts with the private hospitals. Such a policy created in Macedonia a two-tier hospital system: the public hospital system covered by health insurance, limited budgets, poor infrastructure and equipment and a lowered quality in provision of health services [28], and on the other hand a private “state of the art” hospital system where citizens privately finance their own health services consumption. Moreover, in January 2010 the Constitutional Court opened the possibility for reimbursement of costs in the provision of health services to all citizens regardless of the ownership or contracts of the providers with the HIF [29]. According to this decision, any patient who wishes to obtain services in the private hospitals is eligible for reimbursement as a portion of the total costs, according to the price-list of services authorized by the HIF [30]. These developments have encouraged hundreds of high quality

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trained personnel to leave the public sector and to join the private hospital sector. The private health sector has become a preferable alternative for health service delivery for those with the ability to pay. Gradually over the last three years (2010/2012) the number of contracts between HIF and private providers has increased. The HIF slowly but steadily continues to build up its profile as strategic purchaser of health care services, which was one of the main objectives of the health system reforms.

This period in healthcare reforms will be remembered for its promising start, great enthusiasm, profusion of activities, and political promises to improve the health system delivery [31], but overall with limited success. The main objective of the manifesto period of the reforms, to decrease the out-of-pocket expenditure, has not been accomplished [32].

Table 3

| Three periods of health system reforms in the Republic of Macedonia 1991–2011 |
|---|---|---|
| • Constitutional right to health protection | • Adoption of Health Insurance Law | • Political platform (manifesto) for health sector reforms |
| • Adoption of the Health Care Law 1991 | • Purchaser/provider split reform | • Health management – two directors in public health institutions |
| • Development of health insurance system | • Separate Health Insurance Fund from the Ministry of Health | • Reorganization of the University Clinical Centre |
| • Transfer of ownership from social to public | • Development of the capitation model | • Strategic purchasing function of HIF |
| • Reestablishment of professional associations and medical chambers | • Continuous medical education | • Decentralized procurement |
| • Introduction of the system of referral and choice of doctor | • Purchasing equipment | • Advanced rights of patients |
| • Introduction of co-payment for health services | • Strengthening perinatal care | • Reference and set-pricing of pharmaceuticals |
| • Promotion of private practice ownership | • Decentralization and new territorial organization | • Development of contracting process; |
| • Humanitarian and development assistance programmes | • Privatization (dentistry, pharmacies, primary clinics) | • Health insurance for all |
| • Maintaining features of the old system | • Opening of private hospitals | • Purchasing new equipment; |
| • 1996 World Bank – Health Sector Transition Project #1 | • World Bank- Health Sector Transition Project #2 | • Renovating health facilities |
| | | • Development of DRG system |
| | | • More private investments in health |
| | | • Migration of health personnel to private hospitals |
| | | • Constitutional Court Decisions |
| | | • Medical map |
| | | • New Health Care Law 2012 |
| | | • Pay for performance (reporting) |
Discussion

Our study results indicate that the three periods in Macedonia’s healthcare reforms analysed provide a mixed picture of some successes and many failures. The key successes during the post-socialistic period were the establishment of social health insurance and the prevention of fragmentation and collapse of the healthcare sector due to rising unemployment in the country after the collapse of the socialist enterprises. In addition, this period promoted the possibility of private ownership of medical practices. The second, or pro-market period promoted privatization of primary health care, adoption of the Health Insurance Law, purchaser-provider division in the organization of the health care system and replacing the centralized command and control system directed by the Ministry of Health. The third, or ‘manifesto’ period created great enthusiasm and a social atmosphere for change in the public health sector and was marked by the increased role of the political party election promises for healthcare reforms to voters. Many amendments to the health legislations were adopted while new laws and by-laws were drafted. This period is also marked by the official introduction of health management within public health facilities, including a new concept of governance in public health institutions represented by two directors, including an economist beside a doctor. A few years later, this concept was abandoned for the primary health care centres, and it still remains only in the hospital sector.

Our study marks a gradual process of increasing the role of the state in regulation and control of the healthcare reforms in the Republic of Macedonia. The role of the state in the first period was limited mainly towards consolidation of the healthcare system. Over the second period, international institutions such as the World Bank and International Monetary Fund (IMF) influenced the development of health policies. Finally, the third period of healthcare reform has been predominantly initiated and carried out by the political parties in power.

Putting the Macedonian experience in health care reforms in a broader international context, one can find many similarities [33] but also many differences which are specific to the Macedonian local culture. Saltman has investigated the role of the state in the healthcare reforms in a broader international context [34]. He distinguishes two main aspects of state interference in the reforms: regulation and incentives. According to Saltman, in order to respond to the mix of regulations and incentives healthcare organizations must have some degree of independence in decision-making. Unfortunately, in Macedonia, although initial government policies were in favour of increasing providers’ autonomy, in practice public healthcare providers were forced to follow the narrow interests of the political parties. These had direct negative consequences for the healthcare system in stimulating inefficiency, nepotism and poor management that has led to systematic degradation of the public hospitals [24].
Toth in his recent article has made an attempt to classify the healthcare policies in six Organization for Economic Development and Security (OECD) countries over the past twenty years [35]. According to his study the first wave of healthcare reforms was influenced by neoliberal economic policies such as competition, strengthening the private healthcare sector and pro-market healthcare policies, a purchaser/provider split, and similar concepts. Toth’s second wave of international healthcare reforms includes concepts such as integration and regulation of the health systems along with an increased role of the state due to declined enthusiasm in the pro-market style reforms. This is a period of counter-reforms and ideological struggle between the different political interests of various governments. Finally, Toth argues that internationally the third wave of reforms is focussed on increased patient rights. Toth’s categorization of the healthcare reforms over the past twenty years is an attempt to show a trend and pattern in the development of the international health policies. As the Macedonian example in healthcare reforms may indicate, various models of healthcare reforms first started in higher income countries, and were then transferred towards the lower income countries. The global healthcare reform movement started with transfer of the reforms by the international organizations (WB and IMF), while furthermore their role as reform leaders was taken over by the state actors. Our study found a similar pattern of health reforms development in Macedonia. Regardless of how the further health reforms will develop, a priority for the government and the Ministry of Health should be to learn from the mistakes and utilize the international experience. There is strong international evidence based on experience of health policy-making which should be used in the development of further reforms. Finally, an evaluation framework needs to be developed to monitor the impact of the health sector reforms. The recently promoted new WHO Health 2020 policy framework and strategy for Europe, adopted by the 53 Member States, have paved the way in that direction [36]. The new European strategy for health has identified six key targets areas that should be addressed by the member states within the development of their own health priorities. Countries are encouraged to develop their own health targets and indicators to measure the progress of specific health reforms. This is an excellent opportunity for Macedonia to identify its own health priorities for the next decade.

Limitations of the study

Our study has certain limitations. We have generated a working hypothesis that health care reforms are not continuous and are strongly associated with political changes in the country. This hypothesis needs to be tested in further studies. Our findings and division into three periods of reforms are based
on literature review, analysis of policy documents and the personal perception of the authors, which may be subject to the authors’ bias and is open to further critiques. We have not listed all health reform processes, but have focussed on the main policy developments following the shifts in political power.

Conclusion

An overview of the healthcare reforms in the Republic of Macedonia presents a very fragmented picture without long-term sustainability and proper planning, coordination and leadership of various health policy processes. The reforms were influenced by many external and internal factors. On the external side the most influential factors were policy pressures and project activities financed by the World Bank (WB) loans. These projects initiated certain changes in the health system, but the processes were confronted with many internal political changes, struggles of various interest groups and lack of political will to provide sustainability of the long-term reforms. The most important internal factor for pursuing or obstructing the reforms was the interest and influence of the political elites in power. Furthermore, the initiative for health reforms is primarily led by the state and main political factors, but the politicization of the health care system in the Republic of Macedonia has become a negative trademark of the transition. All decision-making mechanisms relate to the financing of hospitals, recruiting staff, and to hiring and firing directors in public hospitals are based on political influence and decisions. Continuity of the health care reforms in Macedonia needs to be maintained in parallel, learning from past mistakes and using the international experience. Strong efforts should be employed to diminish the influence of political parties and provide the necessary autonomy of managers of public healthcare institutions.

REFERENCES


Резиме

ТРИ ПЕРИОДИ НА РЕФОРМИ НА ЗДРАВСТВЕНИОТ СИСТЕМ ВО РЕПУБЛИКА МАКЕДОНИЈА (1991–2011)

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Методи: Систематски е прегледана научната литература и релевантните документи за здравствените реформи достапни на англиски и македонски јазик. Консултирани се официјални документи од Министерството за здравство и Фондот за здравствено осигурување, Светската банка и Светската здравствена организација. Официјалните податоци за демографските и здравствените индикатори се добиени од Институтот за јавно здравје и Државниот завод за статистика во Скопје. Работната хипотеза, дека здравствените реформи немале континуитет, беше развивена согласно промените во метода на одлучување за распределбата на здравствените ресурси и политичките влијанија.

Резултати: Утврдени се три периоди на здравствени реформи во Македонија: пост-социјалистички, пазарно ориентиран, и период базиран на предизборен манифест. Низ сите три периода слабото одржување, ниската ефикасност и високите оперативни трошоци ја зголемуваат личната потрошувачка за здравствените услуги и лекови и се одразуваат врз амортизацијата и застарувањето на апаратата и инфраструктурата во државните болници. Параелно со тоа, либералната регулатива во здравствениот сектор инициира процес на комерцијализација и приватизација на здравствените сервиси. Разочарани од услугите во државните здравствени установи, голем број граѓани се одлучуваат да побараат услуги во приватните здравствени установи, каде во најголема мера здравственото осигурување не ги покрива трошоците.
Заклучок: Процесот на реформите во здравството не е континуиран и влијанието на политиката е големо во текот на целниот период на транзиција во Република Македонија. Главните проблеми на државниот здравствен систем во Р. Македонија се политизијата на здравствениот сектор, високата централизација и контрола од Владата, како и слабата ефикасност на државните здравствени установи. Потребно е да се направи рамка за евалуација на реформите со цел да се проценат ефектите.

Ключни зборови: реформи во здравството, здравствена политика, финансирање во здравството, политизија, Република Македонија.

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