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Abstract

On December, 17th, 2005, the European Counsel approved a candidate status for the Republic of Macedonia for a full membership in the European Union. In the process of integration of the Republic of Macedonia to the EU, the health system reform has a strategic meaning. The scope of the research in this paper is covering explanation of the public health system reforms in the country for a 20 year period (1991-2010).

A combination of different methodology aspects are used that are based on content analysis of various governmental documents and research papers that are dealing with health reform issues in public administration in the Republic of Macedonia. The main reasons for undertaking a reform activities in public health system in the Republic of Macedonia are multiple and naturally different. It is a time when the governments in Macedonia can not ignore the health reforms anymore and its practical implementation in the public administration and consequently in the health system of the country.

Introduction

Public administration reforms in Macedonia are an essential and one of the most important aspects of governmental efforts during the last 13 years (1998-until present). They are essential because of their successful implementation depends the future integrations of the country in the regional and global world, more precisely, the EU integrations. Since 1998, four different governments (1998-2002; 2002-2006; 2006-2008; 2008-present) are trying to “solve” the many problems connected with public sector in the country. The main problems identified by the past and current governments, researchers and experts in the field are the following: highly politicized administration; lack of professionalism, high-level corruption, red tape, nepotism, cumbersome and expensive administration, inflexible and most important, less transparent and non-democratic institutions in relations with the citizens and other institutions.

One of the most important questions in the course of modernizing the public administration in the country during the past 13 years was the question of successful implementation of the reform. No matter how many Strategies and Action plans theoretically we have on hand and no matter numerous declarative political supports for public administration reforms given by the top political party officials in the last 13 years, the citizens, the academic researchers and EU Commission has the last word to say. And, we must agree that the implementation of these types of reforms is very complex.

Very close to the question of successful implementation of public administration reform is the preparation and successful implementation of the health reforms in the country. To say, health sector reforms and development must be an inherent part of the overall public administration reform in the country. The good management of the reform process in the health sector is the most important part during the implementation process. Therefore, the main research question in this paper is the following: What is the organization and management of public health system reforms in the Republic of Macedonia Or more precisely, what are the best possible institutional alternatives as a recommendation on a road for a successful implementation of the process of public administration reforms and accordingly, the health reforms in the country

Methods

The idea of health being a prerequisite for human and social development was the basis of the health care reform. The guiding constitutional principle defined the Republic of Macedonia as a welfare state (5). Thus, health care, social security and insurance, including health insurance, special care of maternity, children and minors, and healthy environment are constitutional issues in articles 34, 39, 42, and 43 of the Constitution of the Republic of Macedonia (Macedonian Constitution, 1991). In the following section, we shall describe the elements of the health care system, i.e., facilities, manpower, services, legislation, insurance, and financing for the period between 1991 until 2010.

Review
Health care was provided by both public and private sector institutions, through a network of organizational units and specialized personnel. Out of total 145 public health care institutions, distributed on three levels, 59 were on primary health care level (8 medical stations, 34 health care centers, 10 out-hospital dispensaries, and 7 pharmacies); 39 institutions were on the secondary health care level (16 general hospitals, 6 specialized hospitals, 7 treatment and rehabilitation centers, and 10 regional health protection institutes); and 47 on the tertiary level (25 university clinics: 18 medical and 7 dental, 15 university institutes at the Medical School, 4 specialized hospitals, National Medical Rehabilitation Institute, and National Health Protection Institute). Recently, efforts have been made for restructuring the health care system, i.e., to decrease the number of pharmacies and medical centers into health centers and general hospitals to distinguish primary from secondary level of health care. Also, university clinics have been reorganized as the University Clinical Center and University Dental Center, both in Skopje, established to cover tertiary level of health care services. The private sector has been continuously increasing since 1991 and at present comprises 1,065 health care units: 401 medical and 347 dental offices, 316 pharmacies, and 24 other institutions.

The network of public health care institutions was relatively well distributed across the country. It includes over 1,500 different health care units providing relatively equitable access for the whole population. In the rural areas, there are 298 public and 116 private health care units; some of them have, however, only visiting doctors, which is particularly true for the poorly inhabited mountain villages.

Manpower. Health care system employs 23,612 persons. Of these, 4,464 are physicians, 1,078 dentists, 342 pharmacists, 10,646 qualified nurses and other health personnel, and 6,192 non-medical staff. In the private sector there are 565 physicians, 347 dentists, and 317 pharmacists (State Statistical Office, 1991-97). Compared to the total number of citizens the ratio was 410 citizens per one physician, 1,398 per one dentist, and 3,032 per one pharmacist, which is a good prerequisite for a quality health care (Ivanovska and Ljima, 1999).

The back-bone of the health care system is the primary health care, which offered services in 34 health care centers, providing integrated preventive, diagnostic, therapeutic, and rehabilitation services. At the primary level, each of the following was separately organized: general medicine services, health care of preschool and school children, teenagers, women and workers, dental care, home visits and emergency services, hygiene and epidemiological services, health statistics, and supply of pharmaceuticals. Primary health care services were also available in rural areas. Primary health care were provided according to the principles of integrated preventive, diagnostic, therapeutic, and rehabilitation services. The secondary level consisted of specialist counseling services as well as general and specialized hospitals providing diagnostic, therapeutic, and rehabilitation services for persons recommended by the primary level services. The tertiary level consisted of the university clinics and institutes, and other health care institutions providing highly differentiated health care.

Since health care was provided at three levels, physicians’ recommendations were used to refer patients to a higher level. The health care institutions had satisfactory space capacities, comparatively large for the existing economic resources. However, due to financial constraints, their maintenance was sometimes neglected, leading to deterioration of part of the facilities. Maintenance of the existing medical equipment and the supply of new equipment were also limited. Part of the equipment was out-of-date or malfunctioning, which posed a difficult problem in diagnostics and treatment. Over the past few years, there had been some improvements due to international aid and loans, and purchases by the Health Insurance Fund.

In the period 1991-1995, there had been a noticeable decrease of health care services in the public sector, followed by a moderate increase in 1996/97/98. The reason was the change in the use of health care due to economic and legal factors, i.e., non-mandatory referral by primary level physicians to higher levels of health care services and lack of funds due to irregular payments of health contributions. The analysis of the structure of health care services clearly indicated that, up to 1995, services on the secondary and tertiary levels were used to a greater extent than recommended by the World Health Organization, thus imposing a heavy financial burden on the Health Insurance Fund. With the amendments on the Health Care Law, compulsory referrals were reintroduced and there was a consequent reduction in the service abuse at secondary and tertiary levels. The hospitals had a long hospitalization period of treatment time and a low occupancy rate, especially in general hospitals, where the occupancy rate was bellow 60%. The reforms undertaken in the health sector had been focused on alleviating those unfavorable conditions.

The Health Care Law was adopted in 1991 and
defined the organization and functioning of health care system, rights and access to health care, health insurance, responsibilities of individuals, employers, and the state, type of services, partnership negotiations, financing of health care, professional associations, etc. The novelties of the law were a new role of the key subjects of the system, reintroduction of private practice, introduction of voluntary insurance, reintroduction of compulsory and additional compulsory insurance, establishment of the Health Insurance Fund, introduction of medical, dental, and pharmaceutical chambers, and reintroduction of health professionals associations. In 1993/95, amendments to the Health Care Law were adopted, which defined in detail the rights of citizens under this law. The eligibility requirements for exercising this right were more rigidly defined, following the principle of previous payment of health insurance over the period of 6 months and continuous payment of the contributions. The amendments also related to the citizens' right to choose their physician in the primary health care, and an obligatory use of referral for higher level health services.

In that period, the Government also called for the adoption of two additional laws: (a) on the health care system, establishing the rights and obligations of citizens who enter the health care system, and possibly some alternative types or functioning of health care institutions; and (b) on the health insurance system, requirements for insurance of citizens and their rights, as well as restructuring of the health insurance services. The health insurance system, set and developed over the past decades, has been gradually covering citizens and reached full coverage at the beginning of the nineties. There was a sharp decline in the coverage in 1994 and 1995, (67.6% of the population in 1995), followed by a gradual increase in the next two years, 80.5% in 1996 and 83% in 1997 (State Statistical Office, 1991-1998). Access to health insurance has been established through the participation by enterprises and other organizations, through a private practice, and through regular monthly payment of the health care insurance contributions. The contributions for the unemployed have been paid by the Employment Office, for the social welfare recipients by the Ministry of Labor and Social Policy, and for the retired by the Pension and Disability Insurance Fund. The insured persons exercise their rights through the Health Insurance Fund.

According to the Health Care Law, there are three types of health insurance: (a) compulsory or mandatory, (b) additional compulsory or mandatory-supplementary, and (c) voluntary. The voluntary insurance has not been implemented in practice. The Law listed the groups for which insurance was mandatory. The solidarity principle was a key element for exercising the basic health care rights. The State Budget finances some basic health care rights for uninsured persons who belong to a high-risk group with regard to age, sex, or disease. Health Insurance Fund provided an extensive list of health care services, drugs, sanitary materials, orthopedic devices, sick leave reimbursements, and cost coverage for health care abroad for certain cases. It must be stressed that in the time of excessive political, economic, and social changes, a health policy provided wide coverage and health care services for the unemployed, the needy and uninsured included in the risk groups, largely contributed to preserving the feeling of security of the citizens. The constitutional right to health care was granted by the state. Health care services were provided even for insured persons who did not pay their contributions in full or in time, so late or insufficient payment was tolerated and the continuity of insurance was not interrupted. Although economically weak, the Republic of Macedonia still kept the status of a social state.

The health care system was financed by the Health Insurance Fund established in the Ministry of Health. During the 1991-1995 period, the revenues from contributions decreased by approximately 40% in real terms as a result of the reduction in employee incomes, breakdown of socially-owned enterprises, payment evasion by many enterprises, and increased unemployment. In this situation, the only option was to decrease the funds allocated to the health care institutions, since it was not regarded feasible to reduce the network and employed personnel in the health care institutions. Since then, the situation changed only slightly. The revenues of the Health Insurance Fund in 1995 were 8.41 billion denars, in 1996 9.56 billion denars, and 10.6 billion denars in 1997 (State Statistical Office, 1991-98). Additional efforts were made to collect revenues by accepting decreased payments to settle outstanding debts. Also, a new program for drugs supply by public tenders was introduced, resulting in sustainable price reduction. All these measures partly alleviated the finance deficit in the health care system.

In the 1991-1998 period, the reduced revenues of the Health Insurance Fund resulted in decreased funding of the health care institutions. The employee salary funds decreased by 45% in real terms and salaries were paid with a two-month delay; the funds for medications were down by approximately 40%, as well as those for medical expendable material and maintenance of the equipment, and investments were
almost frozen. Many of the health care institutions were not able to regularly pay their liabilities toward the suppliers of food, drugs, electric power, heating, etc. Thus, at the end of 1995, the debts amounted to 790.5 million denars (US$19.3 million) and the Fund reprogrammed a part of those obligations for the succeeding year. In 1996 and 1997, the losses of the health care institutions amounted to 801.4 and 1,602 million denars, respectively. In the efforts to find alternative options for supplementary funding, co-payment for health care services was introduced as the participation of the insured persons. However, the effects were not as great as expected because of the wide range of exemptions (determined by age, sex and disease). Pursuant to global trends in the economic policy, the co-payment of the insured persons was doubled, but still with minor financial effects (4.5-5% of the revenues in the health care institutions) (State Statistical Office, 1991-98).

Immediately after political changes in 1991, the Government initiated a program for health care reforms by revising the existing health legislation and addressing certain structural problems in the health system. A single, centralized Health Insurance Fund was established in order to maximize risk-sharing and alleviate regional inequities in the quality of care. Socially-owned facilities were transformed into a network of public sector facilities, and private sector services were authorized, with the possibility of reimbursement for private services. Free choice of the physician was granted, but only the amendments in 1993 instituted an appropriate referral system. Financial participation or co-payment by patients in the costs of services was also introduced in 1993.

Bearing in mind the stagnation of the health system associated with the early phase of transition, along with the financial constraints of the health sector following the real reduction in national income, a strategy for the health sector reform was developed. The main points of this strategy were: (a) maintaining the universal access to basic preventive and curative health services and essential drugs; (b) promoting diversity and patients' choice in provision of health services; (c) redefining the role of the public sector in health policy and service delivery, as well as establishing a more appropriate public/private mix of health services; (d) improving fiscal sustainability of public spending for health; and (e) increasing the efficiency of resource allocation and use.

For the next three years (1996-1999), the plan was to implement the core policy agenda focusing on: (a) health financing and reimbursement; (b) organization and management of health services; and (c) pharmaceutical policies and supply. Starting from the middle of 1996, with the aid from domestic and foreign experts and in cooperation with the World Bank, functioning of the health care system in those three areas has been analyzed. The primary objective of the project was to find the most appropriate solutions to rationalize the health care network, and improve the financing and quality of the services in order to meet the demands of the citizens. The main idea introduced in the financing of the health care institutions was payment on the principle of capitation in the primary health care, and fee-for-service payment on the secondary and tertiary level, however, limited in quantity and type of services. In order to support this kind of financing, a package of guaranteed basic health services was being considered, which would structure the obligatory insurance by clearly differentiating the primary health care services, the outpatient services in specialized institutions, as well as the short-term and long-term hospital stays. The expensive services included in the package would be subject to previous approval or covered by the voluntary insurance. However, strict implementation of legislative program of the contracting was a prerequisite for this type of financing.

In order to alleviate negative effects caused by the deficit, the Ministry of Health and Health Insurance Fund introduced several measures including the centralized public purchase of drugs, sanitary materials, and equipment (previously such purchase were made independently by each health care institution, leading to excessive spending). The major objective of the planned reforms was further strengthening of the primary health care, mainly by the introduction of the right to choose a physician, continuous training of the physicians in the primary health care, and modernizing of the medical equipment, as well as focusing on closing the gap between urban and rural areas.

During 1996, 1997 and 1998, necessary arrangements for the support of the reforms were made, including the choice of a physician, improvement of the equipment on the primary health care level, designing the packages of health services, and adjusting the information system. Also, possibilities were being considered to introduce modern market-based managing of the health care institutions through training of their managers and other employees. The key elements of the reforms had been considered, including review of the mechanisms for regular revenue income in the Health Insurance Fund, relocation of funds according to the burden of diseases, introduction of new methods of co-payments or additional payments by the citizens for health services, used as a corrective method to reduce
misuse of the higher-level services and provision of additional income for the health care institutions, use of different types of insurance, and active participation of the citizens in sustaining and improvement of their health. Some of the amendments to support these programs in the health legislation had been already drafted.

The advantage of the health care reform was that the system did not disintegrate. To build up a new health care system had required time, efforts, and resources (human resources, facilities and equipment). Following the experiences of other countries, it was agreed that the reform measures should be gradually implemented so as to prevent the dissolution of the system. There were also efforts to restructure the health insurance system. Outdated Self-managing Communities of Interest for Health Care on national and municipal level, 31 in total, were replaced with a single Health Insurance Fund with branch-offices on the local level. Institution of a single Insurance Fund provided for a rational utilization of reduced financial resources, prevented a financial collapse of the health care institutions, and allowed further functioning of the health care system.

The second advantage of the reform was the promotion of the private health care sector. Before 1991, there were no legal provisions that would allow private health care institutions except for dental care. Competition between the private and public sector is one of the elements of boosting the quality of health care. Also, the citizens had the possibility to choose better quality of health care services. Further promotion of the primary health care and reintroduction of referral system were also among the advantages of the reform, due to their positive impact on the financial sustainability of the health sector.

The initial amendments in the health legislation adopted after the independence of the Republic of Macedonia did not stem from previous cost-benefit or cost-effectiveness studies. Also, the citizens were not consulted or invited to give comments and suggestions, so those amendments were widely criticized and caused negative functional effects.

Another significant negative effect was the shift of the service use from primary to higher health care levels. There were efforts to stop that trend and to reduce inadequate use of hospital health care, i.e., long average hospital stay, low bed occupancy rate in general hospitals, and increased use of the highly specialized hospitals or tertiary level of services. The positive attempts to preserve the public sector by reducing funds for wages and material costs resulted in decreased motivation of the employees in the health care institutions and, consequently, a fall in the quality of health services.

There were still no significant changes in the financing of health care institutions. The proposed regulations stipulated financing on a contractual basis and invoicing of services in accordance with the Health Services Price List. However, these rules were implemented only in the private sector, while the public sector was awarded funds by the Health Insurance Fund to cover the wage costs, material costs and maintenance, even without signing any contracts for the type and quality of the services rendered. This delayed the necessary organizational and management restructuring in the public sector and lead to increased scope and decrease in the quality of health services, as well as inefficient use of resources.

After 1998 until 2006, there were many pro-reform changes in the health system that were characterized by adoption of Health Insurance Law, separating Health Insurance Fund from the Ministry of health, development of capitation model, permanent training and intensive purchasing of a medical equipment, further strengthening of a perinatal care, decentralization and new territorial organization of the country, mass privatization of the dentistry, opening the first private clinics and purchaser/provider split reforms. There were intensive health sector reforms, mainly initiated and guided by the World Bank’s Health Sector Transition Project (HSTP) [Staff Appraisal Report, 1996]. In 2000, the new Health Insurance Law (HIL) was adopted, and the HIF was established as autonomous health insurance agency governed by managing board of 13 representatives (patients, employers, health providers delegated by the medical chambers and a representative of the ministries of finance and health [HIL, 2000]).

The privatization process in health sector started with the development of so-called Centers for continuous medical education (CME). The health reforms between 1998 ad 2006 were characterized by active involvement of many representatives from the Ministry of Health, HIF, medical chamber and professional association. The successful implementation of the reforms largely depended on the government willingness, but more importantly on the local support of the reforms.

Besides the adoption of the new law on local self-government in 2002 by which health care was decentralized to municipalities, still, the health insurance remained in central government control. In 2004 the Ministry of health has introduced changes in the Health Care Law that for the first time opened the possibility for privatization including dentistry and pharmacies. The privatization process followed long administrative procedures of preparation and
development of plans and bylaws by the Ministry of health. According to the legislative changes, each Health Center was obliged to prepare special program for privatization to be finally approved by the Minister of health. The doctors received capitation, an income that was related to the number of citizens enrolled to doctor’s lists and medical reviews appointments held by the doctor. During the privatization process, the first big private hospitals for cardio surgery, gynecology, obstetrics and one general hospital was opened. Finally, the period between 2006 and 2010 was characterized by putting a focal point on health management issues by adopting pro-modern new public management principles in the work of public hospitals and medical centers. The principles were incorporated in the manifesto of the ruling political party in the government. There were 2 directors (one economist and one medical doctor) in public health institutions, there was re-organization of the University Clinical Center, decentralization of public procurements, the patients rights were advanced (patients treated as customers), setting and a development of the contracting process, massive purchasing of a new medical equipment, revitalizing the public health centers countrywide and further private investments in health sector while at the same time a massive migration of the medical staff from public to the private hospitals. The period is characterized with a massive introduction and development of the so-called E-health concept in the public health institutions in the country. E-health reforms

As a main characteristic of the modern health system in the Republic of Macedonia is the concept of E-health development. The concept is particularly highly valued in the last 5 years (2006-10) and is always put on the top of public policy agenda by the health officials. In most recent document of the national health strategy adopted by the newly established Ministry of Information Society and Administration for a three year period (2010-2012), the concept of E-health services is broadly defined as: “group of health services including interactive advices for the availability of certain services in different hospitals as well as medical review appointments”. From the above definition it can be said that E-health services are all public services by which is defined any type of relationship between the medical staff and patients in any hospital within the territory of the Republic of Macedonia. The whole responsibility of initializing the E-health concept in the public sector will bear the Ministry of Health and Ministry of Information Society and Administration of the Republic of Macedonia. According the Strategy, the main contributions and effects of the E-health concept will be costs and time savings, efficient and transparent health process and decreased corruption. The central indicators for measuring the success of E-health concept implementation will be the increased number of medical review appointments set electronically, improved efficiency of the health process and increased patient’s pleasure of quality of the received health services by the medical staff in the hospitals. In order to fully establish the E-health concept in the society, the government will spend 1.845.000$ public money. The project will be implemented by the help of numerous experts in the same and similar field: medical personal, IT personal from the Ministry of Information Society and Administration and National Fund of Health Insurance[1].

According the national Health Strategy, the following activities are planned to be undertaken:

1. Adopting a new legislation and administrative framework on e-health in accordance with the Law on e-management;
2. Further clarification of the administrative procedures and service delivery quality in implementing the services after which follows an implementation of an appropriate e-health solutions;
3. Further development of the horizontal solutions provided by the Ministry of Information Society and Administration for all public sector health institutions (i.e. common web-portal for e-management, e-applications, e-identification, e-payments, e-delivery etc.);
4. Developing a system of e-health documents management in all public healthcare institutions;
5. In concordance with the budget possibilities, organizing an info-centre for the citizens and the businesses about health system in the country;
6. Introducing an internet services for the health sector businesses;
7. Introducing 5 integral internet services that have a high degree of citizens influence in health management (application, payments, data integration and administrative decisions/documentation delivery);
8. Internet services that will provide an access to the data registers that are needed for decision-making in the administrative procedures with the purpose of exchanging data and information between health institutions;
9. Increased budget and implementation of the projects of e-health services;
10. Increasing the consciousness level about the e-health services and training for the qualified managers on projects in the health sector. (Ministry of Health, National Health Strategy, 2010-2012). However there are many pre-conditions and numerous
risks for a successful implementation of the concept. Some of the pre-conditions include: First, an already developed IT infrastructure to all health institutions in the Republic of Macedonia and second, an E-health service provider must prepare and adopt the appropriate documentation for undertaking technical and organizational measures of securing protection of the personal data during the process of E-health personal data processing and protection of the personal data during the implementation of the provisions for personal data protection. As well as advantages, the full implementation of E-health concept characterizes with certain risks, such as: insufficient use by the citizens because of reasons of weak training or IT infrastructure unavailability of the citizens and insufficient use by the citizens because of in-confidence in the system. Besides all implementation risks, challenges and financial constraints, there are certain positive examples of successful implementation of E-health concept in Macedonian health system. Those are the implementation of E-treasury and Diagnostic Related Groups (DRG).


Discussion

SOME SUCCESSFUL STORIES

E-Treasury

The treasury of the public health institutions is a transparent system of payments for all public health institutions in the country. The main purpose of the treasury is to secure efficient and purposeful use of the financial resources of the public health institutions. The treasury is located in the Health Fund and is totally independent of the treasury held and managed by the Ministry of Finance. The treasury is directly connected with the National Bank for income and expenditures realization.

By adopting E-treasury, there will be far away better financial planning and management, purposeful use of the health resources, transparency of payments and improved financial and budget discipline from the public health institutions in the country. The crucial measures and activities of E-treasury implementation depends on the availability of hardware equipment and software solutions in the health fund, training of the employees in the fund and in the public health institutions for preparing and adopting annual financial plans for 2011, training of the IT personal for maintaining the IT equipment and the needed IT skills and knowledge in the field of E-data exchange.

The health treasury account is a system of accounts that is managed by the Treasury of Health Fund of the Republic of Macedonia by which is performed an efficient and accurate evidence and rigorous control of all financial transactions from the budget in financing the public health institutions and the annual plans for total revenues and expenditures by the public health institutions. Each public health account differs from the national treasury account held by the Ministry. Each sub-account holds a specific amount of money and that money can be used independently from the other public health institutions. Within the health treasury account, as a specific accounts in the health main book are the separate accounts of every public health institution, as: the account for Health Fund resources, account for own revenue sources and account for donations.

Diagnostic Related Groups (DRG)

The DRG policy measure is a budgetary tool used to create savings in the public health sector, and increase efficiency of hospitals. The Macedonian health system had rather poor financial performance in the past and accumulated a significant debt to the Health Insurance Fund. At the same time patients remained dissatisfied with the quality of services provided by the health institutions while medical staff was continuously discontented with the level of their salaries that could not match the increasing life expenditures. The Macedonian government believes that introducing the DRG payment system will solve all problems: decrease health care expenditures, increase the numbers of services delivered, and pay the medical staff per number of cases they have treated. In fact, there are estimations (based on data from 12 clinics out of 33 at the Clinical Centre; another 6 specialized hospitals and 14 general hospitals where the DRG system is applied) that the health system will save up to 34% of the Ministry of Health’s budget per year using the DRG[1].

DRG is based on wide application of IT and its successful implementation depends on the available IT hardware and software as well as professional and trained IT personal and medical staff in the field of information technology. DRG is a typical story of successful implementation of IT in the health system in the Republic of Macedonia.[1] CPRM (2008). Diagnosis related groups and unpaid care work of women. Centre for Research and Policy Making, Skopje, pp. 66-69.

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Conclusions

After almost 20 years of Macedonian independence to date, the Macedonian governments did not provide any real political, economic and social analysis of the public sector reform activities that they undertook in the country. The two main documents that are of particular interest to public service reform were the two Strategies and its Action plans from May 1999 and December 2010. Both Strategies are lacking an important analysis of the impact of the reform concepts on the society. Both Strategies are very theoretical and its Action plans do not describe the activities in political, economic and social terms. There are just theoretical assumptions in areas of intervention (public finances, human resource management, E-government & management and corruption) without real expected political, economic and social output of each planned activity on a society expressed in numbers.

It seems that both Strategies are “the best desires” of the political party elites on power and not the real impact that will have those activities on the citizens. We fully agree that both Strategies (particularly the Strategy from December 2010) are very well prepared documents with an accent on the most important areas of intervention. And they are very difficult to implement. It requires a huge amount of public investments, time and people involved for the Action plan of the Strategy to be successfully implemented. Even then, the citizens and researchers have the last word to say about the results of the implementation.

The research on health system reforms in R. Macedonia revealed that they had been implemented all over the transition period from 1991 until today. And they were not complete and are still very fragmented. The implementation of the reforms was largely influenced by many external and internal factors. On the external side the most influential factor were policy pressures and project activities financed from the World Bank loans. These projects initiate certain changes in the health system, but the processes were confronted with many internal political changes, various interest groups struggles and lack in continuity. The most important internal factor for pursuing or obstructing the reforms was the interest of the political parties. Over politicization of the system and populist political motives to gain more votes result in almost collapse of the public hospitals sector. The further success in the health system reforms would very much depend on the decreased influences of politics over the health care institutions. Promising step in such direction may be adoption of the new legislation for autonomy of selected health care providers that would transform selected hospitals into corporate entities.

Besides the minor positive effects, today’s global economic recession requires very serious public sector reform activities measured and expressed in real numbers. There is no “space” for political agendas and declarative rhetoric of the official authorities in Macedonia. The high unemployment rate, low-level investments and decreased production must be permanently resolved by measuring, assessing and implementing all the theoretically defined concepts in the practise. Otherwise, the principles of “saving public money”, “improving productivity, effectiveness and efficiency” and “accelerating entrepreneurship behaviour” in the public sector can not be implemented in the country. In other words, the Strategy for public sector reform must be an inherent part of the overall national strategy for improving the political, economic and social system of the country, especially in times of global recession.

In this research, we generally agree that one of the reasons (not to say the main reason) for unsuccessful implementation of the public administration reform and the health reforms as a part of them in the country in the last 13 years was the bad management of the health reform. If we look in the past, the institutions that were responsible for implementing the Strategy from 1999 were very broad, very general and there was a lack of synergy in deriving the decisions. Most of the decisions in those bodies were treated as highly political in the public and there was no any space for the introduction of professional management of the whole process. The implementation of the Strategy failed because of bad coordination, control, planning and leadership which were the main reasons for increased internal and external public non-confidence in the reform. And, that is true for the public health...
sector in the country as an inherent part of the overall public sector in the country.

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