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THE ROLE OF THE STATE IN THE HEALTH CARE REFORMS IN WESTERN EUROPE AND REPUBLIC OF MACEDONIA

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This paper discuss the components of health care system, the introduction of entrepreneurial behavior in the health care systems in Europe, it compares two European countries (United Kingdom and Germany) with emphasis on the role of government and introduction of planned markets in the health care systems. Furthermore, it analyses the situation in the health care system in Republic of Macedonia, the current role of the government and the role that it is expected to play in health care reforms. The paper concludes by recommending the importance of the public health training for the health policy makers and development of academic research in the Republic of Macedonia prior to the implementation of changes in the health system.

1. 0 Background

During the last twenty years, in varying degrees, most of the countries of Western Europe started the process of health care reforms. The ever rising cost of the health care services, aging of the population, demographic and epidemiological transition, advances in medical technology, better informed patients, rising public expectation were some of the important changes facilitating this process.

To understand the development of this process one needs to look into the organization of the various health care systems. In many aspects the organization of the health care systems in different countries is a reflection of their cultural and historical characteristics and although the main components of the system can be schemed in all of them, the approaches used in the reforming of the systems were rather different.

Conceptually, the health care systems dominating European countries can be divided into the three main components: financing, allocation and production (delivery) of the health care[i]. The financing component refers to how governments are raising money for the health care systems. The countries are using tax based, social insurance and private systems to raise money for the healthcare. One of the important differences between different systems is that while the countries that are using the tax based and social insurance systems look on the health as a social good, and solidarity is the central aspect in the delivery of the health care, the privately financed systems look onto healthcare more as a commodity, and this is what makes the functioning of the system more expensive as well as not equally accessible to all citizens (e.g the U.S).

In addition to this, when the health care system is financed by single source (tax, social), the transaction costs are lower than does the multiple source as in competitive private sector financing[ii]. Experience so far has shown that the cheapest way of financing health care is in the tax-based countries (UK), and the more expensive are the social systems like Germany. As expected, the most expensive systems are mainly the privately financed ones like the US.

Looking through the frame of these three main components of the health care system, the focus on the current process of health care reform in Western Europe was mainly based on the allocation and production component of the health care services. So far, experience has shown that there were no changes in the system of financing, although there were unsuccessful attempts in Germany and Netherlands. These countries were about to introduce competitive mechanisms of private insurers with rational behind supported by the theory of neoclassical economy that struggle for market share and profit will lead insurers to compete on the prize as well as quality[1]. These changes were expected to affect indirectly on the other components of the health care system. However, both countries are facing permanent problems during the implementation of the reforms.

The governments that have introduced reform in the allocation component of the health care system offer the opportunity for the patient to choose his or her doctor or insurer. This is used as an allocative device to create incentives for providers to be more responsive to patients concerns.

The last group of reforms on the production component of the health care systems were concerned with increased efficiency, effectiveness and responsiveness to the patients by imposition of regulatory and market derived mechanisms.

1.1 Entrepreneurial behavior in health care systems[iii]

The purpose of the health care reforms in Western Europe was the efforts of the governments to introduce market derived competitive systems hence changing previously command and control inflexible health system structures. Regardless of where the governments are focusing their reforms process, it is important to note that throughout the countries of Western Europe the State remains with the central role in initiating and creating national health policies. The governments started introducing entrepreneurial incentives to stimulate the services, innovation including increased quality and greater efficiency.

The entrepreneurial behavior of the governments can be defined within the frame of its earlier economic definitions by Franch economist Say, as "*shifting the economic resources from as area of lower and into an area of higher productivity and greater yield*". In the public sector enterpreneuralisam can be seen as the process of achieving a better match between resources invested and the output obtained, in other worlds better value for money.

In a frame of an optimistic view Drucker summarize the entrepreneur as someone who "*searches for change, responds to it, and exploits it as an opportunity*". In any case the last 15 years were characterized with the substantial organizational reconstruction in the health sector and the increased entrepreneurial behavior has been the core of that process of change[iv]. The introduction of the entrepreneurial incentives in the health care systems throughout Western Europe was expected by certain politicians, economists and journalists to lead to the decreased role of the state regulations. It seems that these expectations were reinforced by the neo classical theory, which is support the logic that once the economy is organized along the correct principles, it would be self-regulating, and the state would wither away[v]. Although this logic seems rather reasonable in theory the same was not reflected in the health systems most of all due to the value of the health as social good and public concern rather than the commodity.

Experience has shown that the role of the State is increasing but now more in terms of regulation and stimulation than in before command and control role. This new role of the State started in order to achieve micro-efficiency at the institutional managerial level to that already achieved by macro-efficiency in the health system and to combine the entrepreneurial behavior with solidarity that will keep health as a social good. The governments in the ongoing era of health care reforms are expected to be good stewards of the health care changes and "to steer more, row less" in order to implement successful health reforms[4].

2.0 Planned markets in UK and Germany

In order to improve the performances of health care systems, governments started the process of creating planned markets into the health care systems by introducing of competition. It is important to note that this process was not followed by privatization (transfer of public assets over the private ownership) of the public health care systems, but on the contrary, it resulted into the creation of the publicly owned firms or self-governing trusts with independent managerial status. With the creation of these new entities, governments transferred part of their authority to lower levels with high autonomy, but without transfer of assets, so now they became public but non-state[vi].

The United Kingdom is a unitary state and its health care system is financed through general tax revenues. The creation of planned markets in UK started under the leadership of the Conservative government in 1991 changing the previous command and control degree of state

authority with more steer and channeled regulation. The reforms that were introduced have separated the purchasers from the providers of health care.

In the UK, in the first phase of the reform there were two types of purchasers: district health authorities and general practice fund holders (GPF). The purchasers remained to be funded by the government from general taxation. Providers became quasi-independent entities, with full state ownership but independently managing their own budgets and securing finances from the contracts with purchasers[vii]. This resulted into the requirement of hospitals to earn their money depending on their performance replacing the former bureaucratic incentives. The main emphasis was put on competition instead of the command and control and some argue that this turned out to be more effective in theory than is applicable in practice[7]. Most patients could not choose their own purchasers, and therefore little competition existed between the purchasers for clients.

When the Labor government came into power in the UK in 1997, they proposed abolition of internal markets and replacement with a new set of organizational structure. In the end, the key elements of internal market remained as follows: the split between the purchaser and providers remain but with an emphasis on cooperative relation not competitive; the GPF were absorbed into primary care groups (PCGs) and district health authorities lost their power. The government's reforms continued in the following years with the implementation of the Quality reform in 2000 with more emphasis on the government's role of the monitoring and evaluation. The National Institute for Clinical Excellence was created for evidence-based medicine[viii]. In the first half of 2003, the so called "salvage operation" started with the aim of cutting down the queues in the hospitals by signing contracts for hospital interventions with other countries from the EU. Although there has been little evidence to support the improvements introduced by these reforms in economic terms, the quality of services improved significantly with increased rights of the patients. It is important to note that in Britain, reforms didn't change the funding side of the health care system, but mostly on the production and to a less degree on the allocation side.

On the other hand, Germany is a federal state with a social based system of health insurance where the funds are raised through shared 50-50 mandatory contributions for employer-employee. Throughout the more than one hundred years this system has existed, the German health care system has been resolutely noncompetitive[ix]. The introduction of the internal market in Britain made huge effects elsewhere and also it raises the competitive question in Germany. In Germany the planned markets were introduced by the Structural Reform Act in 1993. They led to increased State intervention and strong corporatist relation between the State and self regulating insurance system. The federal government has the power to set policy but has none to implement the policy. These powers are delegated by law to sickness fund associations, national associations of physicians, dentists, pharmacists, and the Land based hospital associations. With the regulation of the government to introduce patient choice between the social insurance funds that were entirely publicly established but privately owned, it ended the long tradition of stratifying along age, social class and occupational lines[x]. Also the risk adjustment mechanisms were created to cover all types of public insurance carriers. The competition resulted in dramatic reduction in the number of sickness funds from about 1000 in 1993 to 477 in early 1998[10], and 453 in 2000[xi].

Thus the important characteristics of the health policy making in Germany is the set of corporatists, arrangements at national and regional level. This makes Germany competition system unique, with collective bargaining tradition based on cooperation and strong corporatist representation. The direction of the changes was more in the direction of state intervention and facilitating the competition in rhetoric and action.

2.2 The Role of the State in Western Europe

The process of creating internal markets in the health sector instead of the pure economic expectation led both to more regulatory and creating- incentive role of the State. This is the case both in UK where the government control has been traditionally strong, and in Germany where

the range of central government initiatives and regulations has grown considerably in the past several decades. The increased role of the State is associated with its two main activities: regulation and incentives.

Broadly, one can define regulation as an imposition of external constraints upon the behavior of the individual or an organization[5]. Some authors argue that regulation is rather different when one approaches it from different disciplinary perspectives of economics, management, law and politics[3]. The objective of the governments when introducing the new set of regulation is to facilitate change from the preferred behavior of the individuals and organizations. In order to achieve this, the individual or an organization has to be structurally capable of some degree of autonomous and independent decision-making process. On the other hand, the period of this expanding regulatory responsibilities of the governments showed that the good regulation is a rather complex process. The rationale why the State engages in regulation according to Baldwin et al.[xii], can be summarized in three rather contradictory aspects. First is public interest (best interest of the vast majority of the population), second interest group perspectives, (reflect the interest of the various interest parties), and the third rationale behind regulation is the interest of the individual (the economically powerful can afford it as a commodity).

Chinitz summarizes the role of the State in regulation as "*to improve the manner in which different institutional structures allow participants to see through to completion the transaction in which they are engaged*"[3]. In addition, two different public purposes for undertaking regulation can be separated and termed as *policy objectives* and *managerial mechanism*[3]. The first one is concerned with the broad public interest that is expressed in the national constitution and in the creation of the National Health Service (Britain) or in creation of a statutory health insurance (Germany). The second term refers to the mechanism that the decision makers seek to attain the type of policy objectives by effective and efficient management of both of the human and material resources. In both aspects, the State has clear responsibilities both in the social policy as well as in the management decisions. On the other hand, using Prof. Saltman phrase that "*the health care system is holding the bag for all other failures of the society*", the regulation design should include intersectorial and integrated cooperation with other systems like the education, transport and agriculture to achieve the overall policy objectives.

Incentive can be defined as an explicit or implicit reward for performing a particular act[5]. The concept of incentives is not limited only to the financial payments or individual self interest, but is reflects broad range of desirable rewards. The notion of incentive is closely connected with the system of payment and motivation. For instance, the introduction of the Primary Care Groups in Britain that are holding the funds for the hospitals motivate both primary care doctors to improve their efficiency and to handle more of the services in their settings and to refer fewer patients to the hospitals. On the other hand it increases competition among hospitals for patients.

In Germany, federal legislation in 1989 and 1993 offered new incentives for office based physicians to reduce unnecessary visits and drug prescriptions and as already mentioned increased the role of the State.

However it has to be noted that the role of the State in the process of health care reforms is to implement both regulation and incentive as a strategic mixture and to closely monitor and evaluate the outcomes. Shifting of the command and control mechanism of regulation to more supervision and oversight requires better trained and motivated personal, better information and greater financial and accounting expertise. For instance, the administration costs due to the internal market increased in UK as well and in other countries but also the performances and quality has been improved. The adoption of the market style incentives as a mechanism to manage health care systems was proved to be expensive and it is questionable how it would work in the developing countries.

The necessary precondition in the introduction of a more entrepreneurial behavior and incentives is the restructuring of the state bureaucracies as much as restructuring health care

insurers and providers. It seems that this follows after the achieved macro-efficiency in the health sector mentioned above, both aspects that are still elusive in the developing countries.

3.0 The Role of the State in the Republic of Macedonia

The Republic of Macedonia is a unitary country. It is a "young" country of only twelve years experience with democracy following the collapse of Yugoslavia. The country has a social system of health care introduced by the Health Protection Law adopted in 1991 and modify by the amendments in 1993, 1995, 2001. According to this Law the health insurance was based on the principles of obligation, mutuality and solidarity[xiii]. The majority of the citizens (80%) are insured on the basis of their employment with the same contribution rates, on the basis of retirement rights (the Pension fund is paying for the pensioners) and unemployed persons are insured through the Employment Office[15].

Since its independence in 1991, five democratically elected governments and nine different ministers of health have run the health care system. Similar trends were observed in other eastern European countries as well. Frequent changes of the top of the ministers are a reflection of the functioning of the health care system at large and in the performances of the providers due to consequent changes in the directors of these institutions.

The health care system is traditionally highly centralized and this has prevailed up to now. Until 2000, the ministry of health (MoH) was in charge of the Health Insurance Fund (HIF) -the main source of health care financing. These resulted in poor financial accountability, and as a consequence poor health indicators in the population and almost collapse of the system[16]. All decisions were top-down (bureaucratic) resulting in military style of command and control practice of power. One cannot make clear-cut division between the purchasers and the providers of health care since HIF is the only purchaser of health care services and all expenses of the providers including salaries for the employees are paid by the HIF.

In the mid 1996, the government of the Republic of Macedonia received loan from the World Bank for implementation of reforms in the health care system. The reform project started with two general objectives: to improve the health of the population by enhancing the quality of basic health care services and to support an initial phase of policy reforms[xiv]. Although the project was simplified in the midterm the objectives of the project were enthusiastic and not measurable what was acknowledged in the final evaluation report[xv]. With regards on the first objective there is evidence in improvement in the quality of Perinatal and primary care offered by the graduates of Centers for continuing medical education that were opened within the project. The second objective had three specific objectives: to separate the HIF from the MoH and to create a new independent entity, process that can be defined as deconcentration (passing power from the national government to independent government agencies) and to introduce co-payment for the hospital services; second to improve the primary health sector by creating planned markets among the primary health care physicians (introduction of the gate keeper and capitation); and third to create a central informational system.

In the second/ upcoming phase, the reform process will include hospitals. The concept of the health care reform in Macedonia was aimed at achieving decentralization of the health care system by replacing the military command and control structures with a regulatory steer and channeled approach. However, while in the developed countries the governments initiated this process by choosing the most appropriate of the possible four possible options for decentralization (deconcentration, devolution, delegation, and privatization)[4], in Macedonia the decentralization process was initiated through contracting of international consultants, with partial/less involvement of the locals. Accordingly, the doctors and health administrators were not prepared and trained to accept the challenge to implement the reforms. On the other hand, the Macedonian people culturally and traditionally are resistant and skeptical to any change. As expected, the introduction of these changes led to distinct advantages and disadvantages. The

advantages can be seen in the facilitating the process and increasing the responsibilities among the parties in charge of the health care. At one stage some authors even saw the advantage of the health care reform that the system did not disintegrate[xvi]. The main disadvantage is the low regulatory power of the State, luck of continuous political commitment to implement changes and poor motivation and incentives. Also, this part of reforms is ending up with the reemergence of new centralized institution (HIF), with great political and financial power. It seems that while the reforms managed to ensure the financial accountability, leading to increased macro efficiency, it didn't achieve its primary objective of shifting the command and control to a steer and channeled option that should have resulted in micro efficiency. In addition, the attempt by the government (by the initiative of the British consultant) to introduced planned markets and competition in the primary health care inform of contracts signed between the physicians and HIF was just partially successful because these contracts were limited to the private doctors with independent practices while the great majority of the existing doctors remained salary based state employees. In Macedonia, unfortunately, luck of relevant State incentives in all sectors including the health system led to the emergence of bribery and corruption placing the country among the most corrupted countries in the world[xvii].

It is very difficult to evaluate the current process of health care reform since there is poor availability of information, although it seems more as uncompleted task. The financial credit of the World Bank was closed in 2002 and now the reform process stopped, most likely until another credit is received. This has resulted in distrust among the doctors, employees in the health care sector and the general public in the health care reform process. Thus the Macedonian experience confirms the observation that the introducing of the entrepreneurial incentives is not a poor state game and it asks for certain preconditions to be successfully implemented.

Personal observation is that the process of Macedonian health reform lucked understanding and skills among the parties involved and a continuous political will to conduct the process to the end. The frequent change of the ministers of health (six ministers were changed over the duration of the health sector transition project 1996-2002[17,]) prevents the continuation of the health care reform process due to the short-term political and financial interests of each minister or director of HIF.

Out of the six main parts of the health care system (hospitals, general practice, social care, dental care, pharmaceuticals and insurance) that are already affected with entrepreneurial activity in Western Europe, Macedonia has partial changes in the general practice, social care and in pharmaceuticals, and no change in the others. A brief look on the current functioning of the hospitals as one of the major expenses in the health sector shows that they are funded by the HIF on the submission of invoices[xviii] and the hospital doctors are state employees mainly employed on the requirements of the political parties in the government and not according to the real hospital needs. Hospital administrators have limited power to introduce change since they do not manage their budgets and most of the decisions are come from the ministry of health or HIF. For example, if the hospital roof is leaking, the hospital administrators have to ask for permission and financing up the bureaucratic line. In addition, hospital directors are always doctors with no previous training in management or public health. In other words, the positioning of the directors is due to political ties, and in some cases as result of significant practical achievements in the practice, but almost never as a result of appropriate health management training[xix]. As it can be expected, the performances are poor although the information is limited and difficult to access[19].

It is important to emphasize the five types of accountability that characterize developed health care systems: ethical, professional, legal, political, and financial. While almost all of them have big influence in the countries discussed above, this is not the case in Macedonia. In other words there is certain mix of influence among all of these accountabilities, but neither in particular is directly influencing the health care system.

4.0 Discussion and recommendation

The hallmark of the successful reform can be achieved if it arises from the realized needs of the governments and not as a result of suggested approaches used in individual countries. The country needs to achieve certain level of macro efficiency in the functioning of the health care system, and to invest in more local trained and motivated people who can conduct the successful reforms. It can be also argued that although the introduction of the entrepreneurial behavior in the health sector in Western Europe was not directly consequence of the privatization in the health sector, its routs can be sought in the long history of capitalistic design of the societies, industrial and technological revolution and commercialization of the markets. In other words the entrepreneurial behavior was present in other segments of these societies. Unfortunately, this is not the case in the Republic of Macedonia. There is no tradition of competition in the health sector, and relatively few years of free market experience in other parts of the economy. The introduction of this new approach will be a long-term process and not over a quick change. According to the Enthoven in one of his comments on British National Health Service, "it is doubtful whether a culture of innovation, efficiency and good customer service is possible in a public sector monopoly whose services are in excess demand and whose units do not get more resources for caring for more patients"[xx]. This should be changed with introduction of more competitive forces in the health sector.

The government of Macedonia is expected to sign a new agreement with the World Bank for the reform of the hospital sector. The government prior to this process should initiate three preconditions; first to urge and to provide funds to hospitals to train young persons for public health, health care management and financing and to use their expertise; second to introduce a set of adequate incentives for the hospital managers to overcome the local resistance to change and thirdly to start changing the current financing of the hospitals by introducing a system of contracting between HIF (purchaser) and hospitals (providers) by which hospitals will be paid according to their performance. This will motivate the hospital managers and it will increase their responsibilities, as they will start managing their own resources including the personnel. This will be in preparation for the following phase of delegation of authorities of the hospitals to elected managers who will have more independent and autonomous decision-making process. However, if the government decides to pursue this path the process should be conducted stepwise and with caution since its inappropriate development might result in de-freagmentation instead of devolution of the health care system as a social good of the country. Professors at the St Cyril and Methodius University in Skopje expressed these concerns in the daily newspapers[xxi].

If we follow the Western Europe experience the hospitals in the nearest future will become independent (state but not private bodies), and this will lead to opening up of internal markets, competition and improvement of the effectiveness and quality of the health care. It seems that the current hospital administrators are not prepared to accept the entrepreneurial responsibilities and a drastic change will result in failure. The already introduced competition in the primary sector among private doctors should be expanded as planned to the state employed doctors as well. On the other hand similar preparation should be organized in the public health sector responsible for the evaluation of the outcomes of the health care by increasing the access and transparency of the information. In addition regulating the new process will be a great challenge for the government since currently it is not adequately equipped to face the challenge. It seems reasonable recommend that international community in order to give the loans should demand that the government fulfills certain conditions. This can motivate the government to start thinking on the health care reform process prior the receiving of the money, and be more committed and prepared to implement the changes in the interest of their citizenry. The international community should provide assistance to the governments and communities where it can do most good and develop incentives and reinforcement for wise and efficient use of resources.

The implementation of the health care reform in the Republic of Macedonia and countries with similar problems need to be relieved from the influence of the short-term daily politics. An attempt to use this approach has been put in practice by the World Bank with the creation of the International Project Unit within the Ministry of Health responsible for facilitating the process of health care reform. However, operating of this unit is with temporary character and it was still influenced both by the current politics as well as by the contracted consultants.

An additional problem is the luck of relevant epidemiological research on the ongoing health status of the population, performances of the system, and information on available health care policy instruments. This resulted in misconception in the rational behind the reform both among the public and the health care workers making the transformation unpopular.

It is expected that the opening of the new School of Public Health in the capital Skopje with the support of the Braun School of Public Health and Community medicine in Jerusalem[xxii] will initiate the academic research and public debate and tailor the direction of these changes. On the other hand, this will provide an opportunity for the current health care administrators to start acquiring relevant management skills necessary for the diffusion of the forthcoming innovations. This can result in creating a critical mass of "reform champions" pushing the process from inside.

Although aware of the gap between academic work and implementation in practice my hope is that the recommendations above can help the government to more easily grasp the challenge between the achieved entrepreneurial behavior in health systems in Western Europe and direct the health care reforms in the Republic of Macedonia.

References:

[i] Saltman R. A conceptual overview of recent health care reforms. European Journal of Public Health. 1994; 4: 287-293.

[ii] Saltman R. The context for health care reform in the United Kingdom, Sweden, Germany, and the United States. Health Policy 1997; 41: S9-S26.

[iii] Saltman R, Busse R, Mossialos E. Regulating Entrepreneurial Behavior in European Health Care Systems. Buckingam-Philadelphia Open University Press Chapter; WHO 2002.

[iv] Slatman R, Figueras J. European Health Care Reform. Analysis of Current Strategies. WHO 1997.

[v] Saltman R. Regulating incentives: the past and the present role of the state in the health care systems. Soc. Sci. and Medicine 2002; 54:1677-1684.

[vi] Saltman R. Melting public-private boundaries in European health systems. European Journal of Public Health, 2003; 13: 24-9.

[vii] Le Grant J. Competition, Cooperation, or Control. Tales from the British National Health Service. Health Affairs 1999; Vol. 18: No.3:27-39.

[viii] Rowlins M. In Pursuit of Quality: The National Institute of Clinical Excellence. Lancet 1999; 353:1079.

[ix] Brown L, Amelung V. Manacled Competition" Market reforms in German Health Care. Health Affairs 1999; Vol 18: No 3:76-91.

[x] Altenstetter C. From solidarity to market competition. Chapter 4.

[xi] Health Systems in Transition, HIT Germany 2000. http://www.who.dk/observatory/Hits/TopPage

[xii] Baldwin at al. A reader on regulation. Oxford: Oxford University Press.1998.

[xiii] Donev D. Health Insurance System in the Republic of Macedonia. Croatian Medical Journal. Vol 40, No. 2. 1999.

[xiv] Staff Appraisal Report No 15399-MK. Accessed October 8, 2003
http://www-wds.worldbank.org/servlet/WDSServlet?pcont=details&eid=000009265_3961214123024

[xv] Implementation completion report. Report No: 25735

http://www-wds.worldbank.org/servlet/WDSServlet?pcont=details&eid=000009265_3961214123024

[xvi] Ivanovska L. Ljuma I. Health Sector Reform in the Republic of Macedonia. Croatian Medical Journal. 1999; Vol. 40. No. 2.

[xvii] Transparency International Corruption Perception Index 2003. http://www.transparency.org/pressreleases_archive/2003/dnld/cpi2003.pressrelease.en.pdf

[xviii] Health Systems in Transition. Republic of Macedonia. http://www.who.dk/observatory/Hits/TopPage

[xix] Gjorgov A, Lazarevik V. The number of hospital beds and utilization in acute hospitals in Skopje. Health Insurance Fund. 2001

[xx] Enthoven, A. In pursuit of an improving national health service. Health Affairs 1999; Vol. 19, No.3., 102-119.

[xxi] Slaveski T. Rokovi i Ramki. Dnevnik 15 August, 2003 (in Macedonian)

[xxii] Tulchinsky, T. Developing Schools of Public Health in countries of Eastern Europe and the Commonwealth of Independent States. Public Health Reviews 2002; Vol 30. 179-197.