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An Analysis of Reforms and Trends in The National Healthcare System of North Macedonia During the Transition Period

Elisabeta Bajrami Ollogu[1]

Daniel Pavlovski[1]

Urime Demiri Shaipi[1]

[1]Faculty of Social Sciences, Mother Teresa university, Skopje

Email: elisabeta.bajrami.ollogu@unt.edu.mk

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Abstract

This research provides an analysis of the healthcare system in North Macedonia aiming to address the results of reforms, current functioning of the system and analyze the trends whilst reforming some segments of the system with particular focus in the last two decades. HealthCare System, since the country's independence has been subject of many reforms that have brought various changes in terms of organization and governance and most importantly, in the delivery of health services and accessibility for the citizens. There is a dominance of public healthcare services and institutions but private institutions have quietly increased in the last two decades. One relevant and most emerging problems of current healthcare system may refer to a lack of accessibility of healthcare services for all citizens, which automatically leads to the social exclusion problem for some categories (i.e. Roma community; rural population, etc.). From a methodological aspect, the research makes use of different public policy documents by focusing in the following phases of healthcare system development: post socialist (1991-1998), pro-market (1998-2006) and manifesto-driven (2006-nowadays). In addition, it provides empirical evidence in the form of a survey conducted with various interest groups nationwide assessing their ideological

preferences regarding the healthcare system: functioning, financing, etc. The findings of this study show that regardless many improvements that the reforms have produced, still the country's healthcare system remains qualitatively far away compared to European countries. According to the perceptions of interest groups seems that there is a tendency of increased commercialization of health services nationwide, which from a socio-economic aspect, leads to potential social exclusion for some categories in terms of access to qualitative services.

Keywords: healthcare; North Macedonia; reforms; services, marketization

Introduction

The healthcare system since the country's independence has been subject of many reforms that have transformed the system in terms of organization and governance and most importantly, in the delivery of health services and accessibility. The country inherited a large and well-established healthcare system with good geographical and financial accessibility, long positive experience with health insurance covering nearly the whole population, qualified staff, good control of infectious diseases, and almost full coverage of the population with the national immunization programme (Kjosev & Nedanovski, 2008).

There is a dominance of public healthcare services and institutions but private institutions have quietly increased in the last two decades. Still, generosity of publicly financed system is not affordable and creates significant inefficiencies, ridden by corruption and balanced by expenditure cuts that are affecting the primary health care system, and the maintenance of facilities which are important for the poor' (Gerovska-Mitev, et al., 2007). One relevant and of most emerging problems of current healthcare system may refer to a lack of accessibility of healthcare services for all citizens, which automatically leads to the social exclusion problem. To this end, many individuals and vulnerable groups are predisposed to face two main risks: low accessibility of healthcare services and lack of benefits through the insurance system. Therefore, this research is an attempt to not simply analyze most important reforms in the healthcare system as one of the social policy domains in the country, but also measure the perceptions that different interest groups have regarding the functioning and the financing of the system. We consider this type of analysis of great relevance in terms of providing valuable recommendations policy driven for the next reforms. Therefore, a set of research objectives are defined:

- Provide an overview analysis of the healthcare system functioning in the country context.

- Explore the perceptions of interest groups and political parties regarding the provision of healthcare services through the health insurance system in North Macedonia.
- Identify interest groups and political parties' preferences regarding the financing of the healthcare system.
- Analyze the ideological influences in the reforming processes of the healthcare system in North Macedonia.
- Provide a set of policy driven recommendations regarding the functioning and the financing of the healthcare system.

An overview of the healthcare system: functioning and challenges

North Macedonia has a compulsory insurance-based health system. The system, "de jure" provides universal coverage for all its population. Although, in practice there are discrepancies between groups, for example, there is evidence of typical discrimination practices that the Roma population experiences within the system, which as an example will be discussed further in this paper.

The current benefits package is considered comprehensive since it covers all citizens, long-term residents and expats - as eligible to receive free state-funded healthcare. The only criteria to receive free primary healthcare services is to be registered in the system[1]. In terms of healthcare providers, healthcare services are provided by a combination of public and private healthcare institutions. Through the private healthcare sector, all citizens can access on a subsidized basis certain treatments that are not covered by the public system.

In terms of governing institutions, the highest institution responsible for the overall planning, coordination, and supervision of the healthcare system in North Macedonia is the Ministry of Health. The Ministry of Health and other public institutions operate public healthcare facilities, while private healthcare facilities are owned and operated by private entities. In terms of financial management, the Health Insurance Fund (HIF) is responsible for collecting the contributions, allocating funds, supervising nationwide operations, and contracting healthcare providers.

In regard to healthcare services, primary healthcare services, including general medical care, preventive services, and basic treatments, are usually provided through primary healthcare centers and family medicine clinics. Family medicine clinics remain the first point of contact with the healthcare system. The public healthcare system provides most of the medical services within the country free of charge and they include (hospitalization; emergency treatment including ambulance

[1] Primary healthcare consists of five separate activities: (1) general medicine (2) occupational medicine (3) healthcare for children/pediatrics (0-6 years) (4) school medicine (students and youth from 7 to 19 years) (5) women's health care (obstetrics and gynecology). For more see the Ministry of Health of North Macedonia. Available information at: https://vlada.mk/node/17970?ln=en-gb

transportation; home visits by doctors; dental treatment of oral diseases; some of the surgical operations; pregnancy and childbirth services).

Overall, the system faces its own challenges and has its limitations. The system faces constraints in terms of funding, infrastructure, and medical personnel, leading to limitations in the quality and accessibility of healthcare services, in particular for the marginalized and vulnerable groups. The accessibility and affordability of some medications and services remain a challenge. An evident concern for example remain the mental health services: the system faces challenges in providing adequate mental health services, including access to specialists and community support.

A serious threat for the qualitative system functioning remain the administrative management: inefficiencies in administrative processes, including bureaucracy and red tape, contribute to delays in accessing healthcare services and hinder the overall effectiveness of the system.

In addition, there are evident disparities in healthcare provision between the urban and rural areas. Rural areas are considered to have less access to healthcare facilities and specialized services compared to urban areas. Extreme poverty is higher in rural areas. "People living in rural areas can be more exposed to ill health because of greater income insecurity, poor living conditions, weaker social and human capital, unemployment, and poor working conditions, as well as inequitable access to quality health services across the continuum of care". [1]

When analyzing the overall system, another challenge is considered the infrastructure and quality of the services provided. Such challenges are faced in particular in rural and small cities: including outdated equipment, inadequate facilities, and a need for improvements in medical practices. Moreover, in the last years North Macedonia is experiencing increasing rates of medical workers emigration, which very soon will lead to staff shortages. Shortages of healthcare professionals, including doctors and nurses, can strain the system, leading to longer waiting times and reduced quality of care.

Reforms, trends and new policy pathways in healthcare system

Similar to the other domains, the healthcare system in the country has been reformed many often due to various emergencies since the country's independence. Lazarevik, et al., 2012 have identified three periods of different reformation policy trends: post socialist (1991-1998), pro-market (1998-2006) and manifesto-driven (2006-2011). Similar to parallel reforms in the pension and social protection systems, the reforms were guided and were supported by international financial institutions, mainly by World Bank. First wave of reforms tended to prevent the collapse experienced after

[1] This was pointed out also in a study conducted in 2022 by The World Health Organization and the Ministry of Health of North Macedonia that convened a range of stakeholders, including local and national authorities, international agencies, and civil society organizations, initiated to assess the barriers and enabling factors that impact access to primary healthcare in the country.

the country's independence. The country opted for the model of a welfare state and included the right to social security and social insurance and the right to health protection in the 1991 Constitution but in the same time, many feature from the former system were maintained. As an inheritance of the former political system, the development of different parts of healthcare services was unbalanced, insurance, and local network of health facilities were highly decentralized (Ivanovska & Ljuma, 1999).

The second wave of reforms, in contrast to the first urgent interventions, was characterized by an increased 'marketization and pro market' trend. In this wave of reforms, main processes were the privatization and decentralization. During the reforms of the thirst phase, (2006-2011) the aim was to modernize the system by introducing a new management approach in the healthcare system and in the same time improve the infrastructure since there was evident lack of equipment in many medical institutions, etc. In contrast to the two first reforms, the new reform in 2006-2011 is seen as a political guided reform, through which from as social policy perspective, introduced universalism concepts, such as health insurance for all. Besides the three reforms above analyzed, another reform took place between 2011-2014, in which additional management changes were brought by increasing at least bureaucracies between beneficiaries and providers.

Regarding the reforms, in 2011 the health informatisation system "moj termin[1]" was developed and introduced. Initially, this system was used to reduce waiting time for appointments for clinical examinations and diagnostic tests in three tertiary care facilities. Since 2012, this system has been upgraded with additional modules and now it is mandatorily used in public and private providers of health services that are part of the health system in the Republic of North Macedonia[2]. With this system, electronic files of patients are managed; referrals from primary to higher levels of healthcare and diagnostic services; sick leave; e-prescriptions for pharmaceutical products are issued (generated) etc. Inadequate health information systems can hinder efficient patient care and management, including issues related to medical records, data sharing, and communication among healthcare providers.

In 2020, Macedonia started reforming primary health care with a focus on:

- Improving of healthcare capacities at the primary level by: (1) encouraging the handling of health services at the primary level and reducing referrals, (2) increasing investments in technical and material resources;
- Improvement of preventive activities in primary healthcare;

[1] "My appointment" is a digital platform developed by the ministry of health in cooperation with other healthcare institutions, which tracks all appointments of patients in healthcare institutions in the country.
[2] In this paper, the name of the country is used as Macedonia and as North Macedonia following the change of the country's name (from Macedonia to North Macedonia) under The Prespa agreement in June 2018 between Greece and Macedonia.

- Defining and applying standards for the implementation of services in accordance with evidence-based medicine - drawing up guidelines and protocols.
- Encouraging the provision of certain health services by nurses and facilitating the administrative work;
- Improving the system of records of health services at the primary level;
- Establishing a system of collecting data on the morbidity of the population and registries of certain diseases;
- Improvement of the payment model for health services, which is planned to consist of a fixed and a variable part. The fixed part consists of a capitation for each patient, while the variable part consists of a part for: (1) basic health services provided (2) follow-up of chronic patients (3) health interventions (4) preventive services (5) allowances for staffing solutions;
- Specialization in family medicine;
- Improvement of the positive list of medicines;
- Informing and educating policyholders.

Summarizing, current health care system is a mixed, in terms of services, providers and financing of the system, in which public and private institutions contribute. In this mixed type of system, citizen are eligible to choose between free state-funded health care and additionally have the option of receiving private healthcare, as well.

In terms of institutional framework, the Ministry of Health (MoH) remains the head institution providing and managing public and private health in the country through a set of laws published and implemented[1]. In terms of health as a social right, the responsibility is shared with the Ministry of Labor and Social Policy under laws on Social Protection and Law on Insurance and Invalidity, etc.[2]. Main features of the health care system include various categories of services and various benefits, which are received due to categorizations made by law. For instance, the risks covered by social protection refer to all permanent residents who are not capable of looking after themselves and who are dependent on assistance and care from others (Gjorgjev, 2018). There are various benefits given based in different criteria, under a combined regulation of the above-mentioned laws. Some of them include cash benefits, in-kind benefits and combined benefits. In terms of policies, the low quality staff remains an issue, therefore many ongoing policies tend to increase staff education and training

[1] For more see: Ministry of Health, available at: http://zdravstvo.gov.mk/organogram/ , (Accessed June 2021).
[2] A basic legal foundation is provided by the Social Protection Law, Regulations on the criteria of acquiring the right to financial reimbursement for assistance and care, the Healthcare Law, the Law on Health Insurance, the Law on Employment and Insurance in Case of Unemployment and the Law on Pension and Disability Insurance.

in order to reinforce their capacities. There is a high demand for nurses and gerontologists. Additionally, there is a clear lack of specific support for carers, such as longer leave or in-kind benefits (Gjorgjev, 2018).

From a normative point of view, the system is regulated through the Law on Health Care (Law on Health Care, Official Gazette of the Republic of North Macedonia). [1] It regulates the issues related to the system and organization of healthcare and the performance of health activities, the guaranteed rights and needs of citizen and the state obligations in the provision of healthcare, health facilities, etc. It also foresees the rights and obligations of healthcare workers and healthcare associates, the quality and reliability in the health activity, the chambers and professional associations, the advertising and announcement of the health activity, the performance of the health activities in extraordinary conditions and the supervision regarding the performance of healthcare institutions.

In terms of trends, the deinstitutionalization trend, following the same trend as in the social protections system has been taking place in the light of decentralization processes, as well. Through the two processes, the range of institutions involved has been extended with an emphasis in increasing the role of local governments and for profit nonprofit sectors. Nevertheless, the inter-sectoral cooperation between the NGO sector and local government has deteriorated, due to the mismatch in terms of available facilities of the two sectors (Gjorgjev, 2018). The 'privatization' trend, and additionally the 'commercialization ' and 'pro-market' trends are evident as well. Along with other reforms in the public administration, the latest trend in the last years was the 'digitalization' that would at least ease many of the bureaucracies faced by beneficiaries. For instance, the 'Electronic Insurance Card' or the 'My Appointment' platform, etc.

Synthetizing, the reforms in healthcare systems are dynamic and can change over time but they should have in focus the importance of the so-called effective governance.

Financing of the system

Healthcare in North Macedonia utilizes a mixture of a public and private healthcare system. The country has a public healthcare system funded through mandatory health insurance contributions. It provides essential medical services to residents, and the Ministry of Health oversees the sector. Private healthcare options also exist, offering additional services. Access to healthcare has improved, but challenges such as infrastructure and resource disparities between urban and rural areas persist.

[1] For more, see: Law on HealthCare (Official Gazette of the Republic North Macedonia no.43/12, 137/12, 145/12, 65/13, 87/13, 164/13, 39/14, 43/14, 101/14, 132/14, 188/14, 10/15, 61/15, 154/15, 192/15, 17/16, 37/16, 20/19. 101/19, 153/19, 180/19, 275/19, 77/21, 122/21, 178/21, 150/22, 236/22).

Public Financing: The majority of healthcare funding comes from public sources. This includes contributions from mandatory health insurance paid by employed individuals, employers, and the government. These contributions support the public healthcare system, covering basic medical services and ensuring a degree of financial protection for the population.

Private Financing: Private healthcare services and insurance contribute to the overall financing of healthcare. Some individuals may opt for private health insurance or pay out-of-pocket for additional services beyond what the public system provides. Private healthcare facilities also generate revenue through direct payments for services.

There are financial barriers, such as high out-of-pocket expenses or lack of health insurance coverage, can limit people's ability to seek necessary medical care.

Besides the complex mixed financing scheme of the overall healthcare system, many social rights are realized through the social protection and social insurance system but the bureaucracy levels remain high, in particular in the public sector. Additionally, the 'wages' of medical workers remain as a persistent evident problem.

The health system in the Republic of North Macedonia is financed from three main sources:

1. mandatory insurance contributions (salary-based contributions);
2. transfers from the central budget (general taxation) and from other agencies, and
3. cash payments by the citizens themselves.

Additional contributions are made by donors and non-governmental organizations. Although voluntary health insurance exists as an option, it still has an insignificant role as a source of funding for health services.

The Health Insurance Fund is the main financial body that collects contributions from citizens and employers to finance the healthcare system. It also manages the disbursement of funds to healthcare providers. It provides a broad basic package of rights, which includes emergency medical care, outpatient treatment at the primary and secondary level, hospital treatment and preventive and rehabilitation services performed by service providers that have contracts with the Health Insurance Fund of the Republic of North Macedonia (HIFRNM). In addition, HIFRNM covers certain dental and mental health services, medical devices, prescription drugs, and sick and maternity leave benefits. Preventive services are available to all citizens and are paid for directly by the Ministry of Health. Most services in primary health care are free of charge, but for certain health services, especially for specialist outpatient examinations, prescribed drugs for outpatient treatment and hospital treatment, user costs (co-payments) of up to 20% of the price (50% for medical products) are payed by service users. Contributions are limited by service and there is an annual income cap on contributions and an exemption for certain people in vulnerable situations.

However, these safeguards do not apply to outpatient drug and medical product copayments, and there are no outpatient drug and medical product copayment exemptions for low-income households.

According to the data of the Ministry of Health, private expenditure on health care amounted to 42% of the total expenditure on health care in 2018, which is much more than the average of the countries of Southeast Europe (33%) and the EU countries (22%). Private expenditures mainly consist of co-payments for services that are partially covered by health insurance and direct payments for over-the-counter drugs and health services that are not covered by health insurance. Informal payments, which are common in Southeast Europe, are most prevalent in gynecological care and represent an important part of private expenditure, but are difficult to measure. High levels of private expenditure, including informal payments, make it less likely that low-income groups will receive the health services they need. Voluntary health insurance (VHI) is purchased by only 0.6% of the population, and most of these contracts are supplementary VHI policies, which mainly cover services provided by private hospitals (Dimkovski and Moska, 2021).

Efforts are ongoing to balance the financial sustainability of the healthcare system and address any disparities in access to quality healthcare services. Public financing remains a crucial component in providing affordable and accessible healthcare to the population. Developing a sustainable and equitable funding model for healthcare remains a challenge for the country. Besides others, the sustainability is highly related with the increasing of the funding of the system. Low funding is widely met in developing countries. Developing countries have low insurance coverage and weak modern medical care; they share the same questions as developed countries (. More in specific, as Stubbs (2020) stresses out, governments of North Macedonia as many regional countries massively underfund health care, education, and social protection (Stubbs 2020, pg. 9). Regarding the 'mixed economy of welfare", in most of the European countries, this trend is triggered predominantly by the need to reduce the financial contributions of the state (residualism) (Munday, 2003 as cited in Bornarova, 2019). Therefore, a major commitment in terms of funding is needed for long-term improvements of the system.

Methods

For the purposes of this research, a survey with different interest groups[1] and political parties nationwide was conducted taking into consideration the pressure that interest groups can exert towards governments and their role in pushing changes and reforms in terms of social policy. Interest groups represent the connection between those who provide welfare and those who have to benefit in each social policy domain. Up to 2020 a total number of 4185 entities are registered as active

[1] The interest groups that participated in the survey are trade unions, employee organizations, think tanks, non-governmental organizations, private social services providers and others.

entities in the sector of health and social protection in the country (The Central Register of the Republic of North Macedonia). In the country context, the civil society sector has experienced vigorous changes, due to many factors. Still, they remain predominant in the public sphere and compared to other interest groups, such as unions or political parties, they are perceived by the public as dependent, non-partisan and influential. These changes, among others, as Trajkovski (2013) argues, are also a result of overwhelming normative influence of the West (the USA and the European Union [EU]) over the local and regional legacies. Due to these influences, the development of civil society in the country context reflects the changes in the globally projected politics of state–civil society relations (Trajkovski, 2013).

This survey is conducted for a more extended research, assessing also other social policy domains, such as education, social protection, labor market, social insurance. We well present here only some of the results obtained for the health care system. The aim was to explore participants' preferences regarding the system. Two online questionnaires were administered by using a 7 and 5-point Likert scale of measurement. A total of 360 respondents participated in the survey, divided into two groups: 226 are members of different political parties and 134 respondents are members of other interest groups. The age range 35-44 was mostly dominant in both surveyed groups. In terms of ethnicity, all of the officially recognized ethnicities in the country context are represented, with a predominance of Macedonians and then Albanians. Fewer participants were from the Vlah, Turkish and Roma ethnic communities. In terms of education, there is approximately 47.76% of respondents with Masters or PhD studies completed. The majority of respondents have a regular occupational status as fully employed.

Limitations

This study has some limitations, which have to be pointed out. First, taking into consideration that the sampling is done in a purposive technique, based on specific population characteristics, one of the limitations remains the difficulty to involve a larger sample size and in addition. It was difficult to reach proper participants to participate in the study. A larger sample would provide more reliable results and more statistically significant findings. Secondly, the study concerns threats to external validity since it was not symmetric in terms of ethnicity (not all ethnic communities were equally involved). Thirdly, the research tool was designed for the needs of this research and it is not standardized, therefore there is concern about the validity of it, despite the fact, it resulted valid and reliable in the piloting phase.

Some empirical findings

Overall, the perceptions measured empirically in this research have an indicative character aiming to enrich some of the existing literature and provide a set of policy driven recommendations.

Initially, aiming to understand whether interest groups prefer a public, private or mixed healthcare system, a set of questions were asked. Table 1.shows interest groups' attitudes whether the system be managed (in terms of provision and financing) by the state or including other stakeholders as well. As we see from the results, the majority prefer the government as main provider of the system.

Table 1. Preferences regarding the provision of health care services through the health insurance system (interest groups)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly disagree	7	5,2	5,3	5,3
	Disagree	7	5,2	5,3	10,6
	Somewhat disagree	2	1,5	1,5	12,1
	Neither disagree nor agree	5	3,7	3,8	15,9
	Agree	33	24,6	25,0	40,9
	Somewhat agree	20	14,9	15,2	56,1
	Strongly agree	58	43,3	43,9	100,0
	Total	132	98,5	100,0	
Missing	System	2	1,5		
Total		134	100,0		

Similar results are obtained from political parties members as well, regardless of their political ideological orientation. Even, political parties seem more inclined to agree with this statement compared to interest groups if we compare the frequencies.

Table 2. Preferences regarding the provision of health care services through the health insurance system (political parties)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly agree	100	44,2	46,5	46,5
	Agree	73	32,3	34,0	80,5
	Neither disagree nor agree	23	10,2	10,7	91,2
	Disagree	17	7,5	7,9	99,1
	Strongly disagree	2	,9	,9	100,0
	Total	215	95,1	100,0	
Missing	System	11	4,9		
Total		226	100,0		

Considering interest groups as more representative in the preferences shared we will present here briefly some descriptive statistics of interest groups only and furthermore, at the end of this session a few statistical tests regarding differences in perceptions between the two groups will be presented.

To test any discrepancy with the first question, participants from interest groups were asked to express their preferences regarding the mixed system. As we see from the results, the majority prefers the mixed system of public and private institutions in health care services delivery but the financing of the system should be managed through the health care system.

Table 3. Public and Private health institutions can provide (deliver) health services but they should be financed through the health insurance system - mixed system

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly disagree	2	1,5	1,5	1,5
	Disagree	5	3,7	3,7	5,2
	Somewhat disagree	6	4,5	4,5	9,7
	Neither disagree nor agree	9	6,7	6,7	16,4
	Agree	45	33,6	33,6	50,0
	Somewhat agree	24	17,9	17,9	67,9
	Strongly agree	43	32,1	32,1	100,0
	Total	134	100,0	100,0	

In the current system, the government is responsible for establishing a network of health facilities to ensure equitable geographic access to health care, especially hospital care and specialized diagnostics and treatment. On the other hand, the Ministry of Health (MH) certifies public and private providers of health services so that they can be included in the network of health institutions. The role of the Health Insurance Fund of the Republic of North Macedonia (HIFRNM) is to conclude contracts and procure services from the certified providers of health services. Public and private health providers (institutions), which perform activity based on a license, perform the health activity in the network. The network of health institutions of the Republic of North Macedonia consists of the following institutions: Public Health Institute of the Republic of North Macedonia and 10 Public Health Centers; 67 hospitals (public and private); 6 polyclinics; 1 Dental Clinical Center; 34 health centers and 5 health stations.

Moreover, the participants in the survey were asked to express their preferences regarding private providers in the health care system. Table 4. shows that the

majority doesn't prefer private institutions as main providers of health care services. This result is in line with the previous results in which the majority of respondents from both groups are more oriented to considering the state public institutions as central in the health care provision and financing.

Table 4. Health care should be completely private (financing and delivery of services)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly disagree	62	46,3	46,6	46,6
	Disagree	51	38,1	38,3	85,0
	Somewhat disagree	5	3,7	3,8	88,7
	Neither disagree nor agree	4	3,0	3,0	91,7
	Agree	5	3,7	3,8	95,5
	Somewhat agree	5	3,7	3,8	99,2
	Strongly agree	1	,7	,8	100,0
	Total	133	99,3	100,0	
Missing	System	1	,7		
Total		134	100,0		

The following tests were applied to have a deeper understanding of the differences in perceptions between the two surveyed groups (interest groups members and political party members).

Table 5. A cumulative of differences between political parties and interest groups

Health care	Interest Group	134	10.28	2.185	.189
	Politic party	217	10.30	2.007	.136

According to the significances on these averages presented in the 4th column of Table 39, there isn't any statistical difference in the perceptions regarding the domain of Health Care sig=.928 (p>0.05). The results show similar preferences of both groups regarding health care system and services. More in specific, both groups prefer the public health care system through which public health institutions can provide (deliver) health services, financed through the health insurance system. In that regard, some additional frequencies from the results just to illustrate how interest groups' members prefer the public health care system (approximately 44% of the respondents) who prefer health care to be fully provided and financed by the state through state institutions (health insurance system). Very similar with interest

groups, political parties' members with 46.51% estimate the public health care as more appropriate for the country context. Similarly, both groups prefer as second most suitable model oh health care system, the mixed system, in which public and private health institutions can provide (deliver) health services but they should be financed through the health insurance system.

Table 6. Significance for T-test for perceptions regarding preferences in health care

Health care	-.090	349	.928	-.021	.228	-.469	.428
	-.088	263.568	.930	-.021	.233	-.479	.438

In addition, we wanted to assess whether interest groups and political parties share common perceptions regarding mixed health care system – as not fully efficient in terms of quality of medical services and in terms of expenses. Frequencies reveal that political party members have a strong tendency to agree with this statement, which means they are more predisposed to prefer the mixed health care system compared to interest groups members.

Table 7. Crosstable of respondents' attitude regarding Health care - mixed system

	Public and Private health institutions can provide (deliver) health services but they should be financed through the health insurance system - mixed system				
	Strongly Disagree	Disagree	I neither agree nor disagree	I agree	I completely agree
	Count	Count	Count	Count	Count
Interest Group	0	5	30	9	88
Politic party	3	10	31	108	61

These frequency differences are statistically significant according to the value of Chi-square 81.588 with sig = .000 p <0.01. Data revealed in Table 46 means that the political party group expresses a higher support for public and private health institutions-mixed systems, compared to interest group.

Table 8. Pearson Chi-Square Tests

		Public and Private health institutions - mixed system
Subject	Chi-square	81.588
	Df	5
	Sig.	**.000**[*,b,c]

*. The Chi-square statistic is significant at the .05 level.

b. More than 20% of cells in this sub table have expected cell counts less than 5. Chi-square results may be invalid.

c. The minimum expected cell count in this sub table is less than one. Chi-square results may be invalid.

Conclusion

Similar to other countries in the region, healthcare in North Macedonia utilizes a mixture of a public and private healthcare system. Primary healthcare is seen as the basis of the system in which most of the population's health needs are met. Access to secondary health care is provided through a referral from the selected physician in primary health care, while access to tertiary health care is provided through a referral from the secondary level.

Referring to the results provided through the empirical research, both groups surveyed prefer the public health care system through which public health institutions can provide (deliver) health services, financed through the health insurance system. They oppose the privatization emerged through reforms and prefer a more improved public healthcare system. They deem to prefer an expanded commitment to public healthcare, which should remain universally accessible for all people and reduction of 'out of pocket' charges for many not affordable.

Concluding, even though the reforms in the healthcare system have produced many improvements, still the country's system remains far away compared to European countries. Regarding private healthcare system, even though by law all citizens are entitled to equal access to healthcare, yet it remains a 'monopoly of the rich' and very often not accessible from individuals and families with low and middle income. Therefore, there is a tendency of increased commercialization of health services. Moreover, primary healthcare services delivered in public institutions are in part free of charge but they do not always meet the standards and many bureaucracies create difficulties in accessing these services. Furthermore, infrastructure arrangements in the public health sector remain an issue, despite the many investments and prioritization of the governments in the last decade. The covid19 crisis, more than

ever, highlighted the deficiencies in the public health institutions, in terms of infrastructure, staff qualification and availability, medications, etc.

Summarizing, the healthcare system in North Macedonia cannot be considered as very much influenced by the neoliberal influences as it has happened with other social policy domains. Still, governments have made efforts to maintain the universal approach inherited by the former system to avoid inequalities, although they have also promoted the free-market principles in the provision of healthcare services. Despite the dominance of the state sector and state intervention, some neoliberal tendencies exist, such as privatization and increase of the private healthcare system; competition among healthcare providers as a mean of improving efficiency and quality[1]; the financing scheme including user fees or co-payments, etc.

The reforms in healthcare systems are dynamic and can change over time but they should have in focus the importance of the so-called effective governance. Effective governance and well-defined healthcare policies are essential for the successful functioning of a healthcare system. Challenges may arise in developing and implementing policies that address the evolving needs of the population but good governance and political willingness in prioritizing health care is always needed and crucial for the further improvement of the system.

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