HEALTH INSURANCE SYSTEM AND FINANCING OF HEALTH CARE IN THE REPUBLIC OF MACEDONIA

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ЗДРАВНООСИГУРИТЕЛНА СИСТЕМА И ФИНАНСИРАНЕ НА ЗДРАВЕОПАЗВАНЕТО В РЕПУБЛИКА МАКЕДОНИЯ

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Summary: *This article gives an insight to the current health insurance system in the Republic of Macedonia. Special emphasis is given to the specificities and practice of both obligatory and voluntary health insurance, to the scope of the insured persons and their benefits and obligations, the way of calculating and payment of the contributions and the other sources of revenues for health insurance, user participation in health care expenses, payment to the health care providers and some other aspects of realization of health insurance in practice. According to the Health Insurance Law, which was adopted in March 2000, a person can become an insured to the Health Insurance Fund on various modalities. More than 90% of the citizens are eligible to the obligatory health insurance, which provides a broad scope of basic health care benefits. Payroll contributions are equal to 9.2% of gross earned wages and more than 70% of health sector revenues are derived from them. Within the autonomy and scope of activities of the Health Insurance Fund the structures of the revenues and expenditures are presented. Health financing and reform of the payment to health care providers are of high importance within the ongoing health care reform in the Republic of Macedonia. It is expected that the new introduced methods of payments at the primary health care level (capitation) and at the hospital sector (global budgeting, DRGs) would lead to increased efficiency and quality of health care in hospitals and overall system.*

Key words: *health care; insurance, health; health insurance; health expenditures; Macedonia (FYR); resource allocation reform; capitation; global budgeting, DRGs.*

INTRODUCTION

Health insurance, as one of the most significant civilization gains of the contemporary world, presents a legal normative and regulatory organized mechanism for acquiring funds on different bases, in order to provide prompt quality and efficient prevention and protection of people's health.

The current Health Insurance System in the Republic of Macedonia was introduced by the Health Insurance Law (1), which was adopted in March 2000, and modified and supplemented by the amendments in 2000, 2001, 2003, 2005 and 2007. The Health Insurance Law was enacted on April 7th, 2000, replacing the articles of the 1991 Health Protection Law related to the health insurance (2,3). In fact, the current health insurance system in the Republic of Macedonia is somehow a continuation of the previous one, with some modifications. New elements are the way of regulating relationships within the health insurance concerning obligatory and voluntary insurance, the scope of the insured persons and their rights and obligations, the way of calculating and payment of the contributions and the other sources of revenues for health insurance, new policy for user participation in health care expenses, reform of provider payment, as well as public accountability measures and defining the scope of activities and responsibilities of the Health Insurance Fund that was established as an independent institution outside of the Ministry of Health (4,5).

Basic Types of Health Insurance in R. Macedonia

There are two types of health insurance according to the Law on Health Insurance: obligatory and voluntary insurance for some forms of health care.

Obligatory health insurance was established for all citizens of the Republic of Macedonia in order to provide social and health security and to realize certain rights in case of disease or injury and other rights from health care established by Health Insurance Law. Obligatory health insurance is based on the principles of obligation and universal coverage, solidarity, equality and effective usage of financial resources in accordance with the Law. It means that, each insured person can use health care services in the event of illness and injury (basic ones as covered by the obligatory health insurance) and health insurance benefits (pecuniary compensations) in an unlimited amount when necessary. On the other side, there is an obligation to all employees and other bearers of

insurance for continuous payment of contributions for health insurance. The contribution rate is the same for all employees, regardless of the level of salary or income, or the frequency and amount of the health services used on the account of the health insurance funds. The principles of solidarity and equity are compulsory (6).

Some special risks and services, which are not covered by the obligatory health insurance, should be provided for by the employers of certain groups of workers. It includes preventive and screening measures and use of health care in case of injury at work and occupational diseases of the insured on the employment basis, due to the increased risk at work. It also applies to the insured professional sport persons, drivers, pilots and other aircraft crude etc.

Voluntary health insurance was introduced for the health services that were not covered by the obligatory health insurance. It covers use of some specific health care services, as well as services at a higher level of standard or comfort than those offered by the obligatory health insurance, in accordance with the agreements and norms set by the agency/company that provide voluntary insurance. Voluntary health insurance is an additional insurance, allowed only for the insured within the obligatory health insurance. However, due to the lack of interest shown by the citizens for realization of the voluntary health insurance rights, as well as due to the wide range of obligatory health insurance rights, voluntary health insurance has not yet been implemented in practice.

Modalities of Becoming an Insured through Obligatory Health Insurance

2000 Health Insurance Law promotes various modalities for a person to become member of the obligatory health insurance offered by the Health Insurance Fund (HIF). Almost all citizens (about 95% of the total population) of the Republic of Macedonia are insured by the obligatory health insurance system, in various modalities: (a) on the basis of their employment - employed individuals (workers), individuals working in the private sector, and individuals performing agrarian activity (farmers); (b) on the basis of their retirement rights - retirement, disability and family pensions, as well as pensions and disability rents from foreign insurance bearers; and (c) on other grounds - unemployed persons registered by the Employment Office, beneficiaries of basic social care, war-disabled persons (soldiers and civilians), family members of the insured who serve in the Army of the Republic of Macedonia, persons who are in prison or sentenced to other punitive measures, persons in religious communities (monks, nuns) etc.

Citizens who are not included in any of the above-mentioned groups, can voluntarily obtain obligatory health insurance for themselves and for their family members by paying health insurance contributions in accordance with the Law.

The obligatory health insurance, apart from covering the active insuree (bearer of insurance), also covers his/her close family members: spouse and children up to the age of 18 or to the age of 26 respectively if they are students involved in regular education. In addition to the citizens of the Republic of Macedonia, obligatory health insurance is also valid for foreign citizens and individuals without any citizenship, if they are employed on the territory of the Republic of Macedonia, in domestic or foreign firms, in international organizations or diplomatic residencies, or if they are involved in an expert training or education in the Republic of Macedonia. Foreign citizens from countries having international agreements with the Republic of Macedonia for social insurance, use health care benefits according to those agreements.

The expenses of the health care services for the citizens of the Republic of Macedonia who do not undergo any form of the obligatory health insurance, i.e., who are not Fund insurees, are covered by the State budget in the following cases: (a) health care of children and adolescents up to the age of 18 and pupils and students up to the age of 26; (b) health care of women related to pregnancy and delivery; and (c) treatment of infectious diseases, mental diseases, rheumatic fever with complications, malignant diseases, diabetes, chronic dialysis, progressive nervous and muscle diseases, cerebral paralysis, multiple sclerosis, cystic fibrosis, hemophilia, thalassemia and similar diseases, epilepsy, alcoholism and drug addiction.

Benefits from the Obligatory Health Insurance

The Health Insurance Fund provides the right to health care as well as the right to a sick-leave and other financial reimbursements to the insured.

The obligatory health insurance, on the principle of solidarity as a key element for providing health care benefits, provides the insured with a broad scope of basic health care rights/benefits or "basic package of health care services":

I. Health care rights/benefits at the Primary Health Care (PHC) level: (a) medical examinations and other kinds of medical assistance in order to determine the diagnosis, follow-up or check the health status; (b) undertaking expert medical measures, other measures and procedures for promoting the health condition, i.e. prevention

and early detection of diseases and other health disorders; (c) providing emergency medical assistance; (d) outpatient treatment or home care treatment at the beneficiaries' home; (e) health protection related to pregnancy and delivery; (f) implementation of preventive, therapeutic and rehabilitation measures; (g) prevention and treatment of oral and dental diseases; (h) providing medicines in accordance to the List of medicines, issued by the HIF and approved by the Minister of Health;

II. Health care rights/benefits at the Specialist-consultative Health Care level: (a) examination of the health status of the insured and establishing diagnosis and giving recommendation for further treatment; (b) performing specialized diagnostic, therapeutic and rehabilitation procedures; (c) prosthetic, orthopedic, and other facilities, supporting and sanitary instruments and dental technical devices according to the General Act issued by the HIF and approved by the Minister of Health;

III. Hospital (in-patient short-term and long-term) services: (a) examination of the health status, providing treatment, rehabilitation and care, accommodation (in standard conditions - hospital room with two or more beds) and meals during hospitalization; (b) providing medicines in accordance to the List of medicines, issued by the HIF and approved by the Minister of Health, as well as supporting materials for application of medicines and sanitary materials needed for treatment; (c) accommodation and meals for the accompanying person of a child up to 3 years of age during hospitalization up to 30 days if necessary.

The following services are not covered by the obligatory health insurance and might be a subject to voluntary health insurance: (a) aesthetic surgery, sanatorium treatment and medical rehabilitation of certain chronic non-communicable diseases (except for children up to 18 years of age); (b) in-patient health services with higher standard or comfort; (c) medicines not included in the List of medicines determined by the HIF and approved by the Minister of Health; (d) orthopedic facilities and instruments not included in the list prepared by the HIF and approved by the Minister of Health or made of higher standard of materials; (e) accommodation (lodging and food) in gerontology facilities. The areas of care not in the benefits package include also pregnancy termination unless clinically indicated, issuance of medical certificates and treatment for alcohol abuse.

In addition to the basic health care benefits, the obligatory health insurance also provides some other benefits to the active insured: (a) reimbursement of salary due to temporary incapacity to work due to illness or injury, medical examination, voluntary donation of blood or biological tissues, during sickness leave or during temporary absence from work due to pregnancy, childbirth and maternity leave for 9 months as well as for the care of a sick child up to age of 3 years (no limit) or other family member (up to 30 days); (b) all insured have the right to reimbursement of the travel expenses related to the usage of health care services, and some other reimbursements.

Realization of the Rights to Health Care

The obligatory health insurance benefits are used by the active insured persons and their family members through Health Insurance Fund on the basis of the so-called health book showing a confirmation of paid health insurance contributions (blue tickets/marks).

The insured person has a right and obligation to choose a physician (doctor of choice) within the appropriate service at the PHC level (Service of general medicine, occupational medicine, service for health care of the children up to 6 years of age or school medicine for school children and adolescents up to 18 years of age and students up to 26 years of age, service for health care of women related to their reproductive functions, for women over 14 years of age and dental service for general dental care for all insured). The doctor of choice is responsible to follow the health status and to provide preventive measures and activities for health promotion and prevention and early detection of diseases as well as treatment of diseases and injuries, to determine the need for sickness leave and referral of the patient to the higher levels of the health care system, if necessary.

Basic health care benefits might be realized on all levels of the health care system as follows: 1) primary health care, including general practice, occupational medicine, pediatrics, school medicine, gynecology, and general dental practice; primary health care also covers emergency medical assistance and home treatment; 2) consultative-specialist health care provided in health centers and medical centers; 3) sub-specialist health care provided at the clinics and institutes of the Medical Faculty in Skopje and some other health institutions at the national level; 4) hospital health care; and 5) medical rehabilitation at outpatient services, medical centers, and hospitals during the hospital treatment as well as specialized medical rehabilitation in specific rehabilitation centers as a continuation of the hospital treatment.

An insured has a right to the treatment in a foreign medical institution (hospital) if the disease can not be treated in the Republic of Macedonia

and if there is a possibility for a successful treatment in the country to which the insured person is referred. The conditions and procedure for sending the insured abroad for health care treatment are regulated precisely by the General Act of the Health Insurance Fund (HIF) approved by the Minister of Health. Physician recommendation and the approval for treatment abroad by the HIF Committee is required before granting the insurance coverage. Coverage for services obtained abroad that are available in Macedonia is not provided in order to protect against erosion in utilization of Macedonian medical care.

Resources for Health Financing

Health care system services and certain broader public health activities are financed by the monthly payroll (profit) contributions of the employed persons in public and private sector and contributions from the general budgetary revenues, external assistance and limited imposition of user's fees. Most of the revenues (about 96%) are raised from the obligatory health insurance contributions and transfers in accordance with determined rates. About 56.96% of domestic health sector revenues, in the year 2007, were derived directly or indirectly from individual's payroll contributions to the Health Insurance Fund, with the rest, about 40.39%, from transfers from other state agencies such as the Pension Fund and Employment Institute, and 2.64% other non-taxable revenues (table 1). Direct contributions from public and private sector wage-earners (all persons engaged in different forms of socially organized or personal labor) were equal to 8.6% of the monthly salary up to June 2001 when the contribution rate was formally increased to 9.2% because of changes in the basis and the way of calculation of the health insurance contributions. In fact, this change was induced by a decrease of the personal income tax (as a part of the gross wages) from 23% to 15%, which means that the real contribution for health insurance by rate of 8.6% and personal income tax of 23% is about equal to the contribution by rate of 9.2% and personal income tax of 15% within the gross earned wages and reimbursements during sickness leave. Direct payroll contributions to the Health Insurance Fund were withheld from the source (employer).

A certain percentage of money from payroll contributions to the Pension and Disability Fund and the Employment Fund is transferred to the Health Insurance Fund for health coverage of the retired/pensioners, disabled and eligible unemployed persons. For pension beneficiaries, the contribution rate (14,694%) is applied to the

Table 1. Revenues of the Health Insurance Fund of the Republic of Macedonia in 2007 (7)

Sources of revenue	Budget plan	Actual		Structure (%)
		MKD (1000)	Eur (1000)	
1. Employee's gross salaries contributions	7,506,459	8,446,726	137,793	48.29%
2. Self employed	495,199	234,927	3,832	1.35%
3. Farmers	63,677	59,782	975	0.34%
4. Additional contributions (workers at risk)	480,577	501,695	8,184	2.87%
5. Other insured	120,875	110,012	1,795	0.63%
6. Contributions from previous years	591,783	610,202	9,954	3.49%
Total employment revenue	**9,058,736**	**9,963,345**	**162,533**	**56.96%**
7. Contributions from beneficiaries of pension	3,796,200	3,715,149	60,606	21.24%
8. Contributions for unemployed persons	2,171,262	2,145,054	34,993	12.26%
9. Contributions for social care beneficiaries	74,715	69,287	1,130	0.40%
10. Transfers from the budget of RM	923,548	911,383	14,867	5.21%
Total transfers	**6,965,725**	**6,840,873**	**111,597**	**39.11%**
11. Other non-taxable revenues	79,500	65,869	1,075	0.38%
12. Revenues from co-payment	471,902	396,667	6,471	2.27%
13. Transfer from previous year	0	224,501	3,622	1.28%
TOTAL REVENUE	**6,575,863**	**7,491,257**	**285,339**	**100%**

Source: Health Insurance Fund of the Republic of Macedonia (2008)

net pension payment, while for the unemployed and for the recipients of social assistance the contribution rate of 8.6% is applied to 65% of the average net salary in the country. These funds are transferred to the Health Insurance Fund by the Pension and Disability Fund, the Employment Fund, and by the Ministry of Labor and Social Policy. About 33.5% of domestic health revenues in 2007 were transferred from the Pension and Disability Fund and from the Employment Fund (Table 1). Farmers have to contribute 9.2% of the cadastre income. For the citizens with a private enterprise and their employees, the rate is 9.2% of the gross earned wages and reimbursements. Additional contributions for health insurance in case of injury at work and professional disease, for the employees in public and private sector who are exposed to an increased risk for injury at work and professional disease, are determined at a rate of 0.5% of the gross earned wages and reimbursements.

The general budget was also a weak/poor source of revenue for the health sector until 1992, when financing of the most Governmental prevention programs was shifted from Health Insurance Fund to the budgetary financing. The general budget accounted 5.9% of domestic health revenues in 2002 and 5.2% in 2007, which is remarkable increase comparing with 1996 when accounted about 3.5% (2,4,7).

Revenues generated through user fees for health services and applied devices in the public health system amounted 2,3% of domestic health revenues in 2007 (table 1).

User Participation in Health Care Expenses (Co-payment)

The active insured persons and their family members have the obligation to co-pay from their personal funds a certain percentage of the health services price, but not more than 20% of the total cost of the health service or drug. In 2001, the HIF decided on the level of user's participation in the health care expenses, as follows: (a) 10-20% of the price of health services and of medicines at the PHC level; (b) 10-20% of the price of health services for treatment of oral and dental diseases (except prosthetic devices); (c) 10-20% of the costs of services in the specialist-consultative care and hospital treatment, including all costs for services and medicines; (d) 20% of the total expenses for approved treatment abroad; (e) 20-50% of the price of hearing and visual (eye's) facilities; (f) 20% of the costs of dental prosthetic devices; and (g) 20-50% of the price of some other prosthetic devices in accordance with the General Act issued by the HIF and approved by the Minister of Health.

Introducing co-payments for health care services and drugs was one of the most controversial questions in Macedonia after gaining independence in 1991. An attempt of the Ministry of Health, through Health Protection Law in the 1991, to introduce co-payments on all goods and services covered by the health insurance, was struck down by the Constitutional Court as infringing on the fundamental rights to health care. In order to erase financial constraints in the health sector, the Ministry of Health once again, proposed co-payments on all insured goods and services by the 1993 Amendment (20% for outpatient care, drugs, hearing aids and dental devices; 10% for hospital care; 50% for prosthetic and orthopedic devices). The Amendment was adopted and the system of co-payments had been in place since 1994 whereby fixed tariffs were levied from all patients including children (2). The 2000 Health Insurance Law continued this practice for co-payments with fixed charging scales by introducing a general principle of inversion of the level of user's charge and the price of a service or drug. It means that the co-payment rate/percentage is higher for the lower price services, but not more than 20% of the service/drug price, and the opposite, lower co-payment rate for the higher price services/drugs.

There is no co-payment for health care services in the following cases: (a) follow-up of the health status of the insured by the physician of choice and for emergency medical services on call; (b) users who receive permanent social assistance, persons placed in an institution for social protection or in another family, except for medicines prescribed at the PHC level and for the treatment abroad; (c) psychiatric patients placed in psychiatric hospitals and persons with mental retardation without parent's care; (d) insured who, during the calendar year, have paid user charges for specialist-consultative and hospital treatment (except for medicines prescribed at the PHC level and for treatment abroad) in cumulative amount over 70% of the average income per month in the country in the previous year. Certain age categories of citizens might be excluded of co-payment when they reach a limit of user charges paid during the year; (e) additional exemptions, in accordance with some special health care programs with social dimensions and related to the entire population. Those exemptions are adopted and financed by the Government of the Republic of Macedonia each year, and are determined for users of health services in relation to the treatment of certain debilitating, costly, and often life-threatening diseases (rheumatic fever, progressive nervous and muscle diseases, cerebral paralysis, multiple sclerosis, cystic fibrosis, epilepsy, penfigus, lupus erithematodes,

infectious diseases - list of about 20 diseases, drug-addiction and alcoholism, up to 30 days, chronic dialysis, conditions after transplantation of the organs, malignant diseases, hemophilia and diabetes, hormones for growing-up the children and compulsory immunization); (f) prosthetic, orthopedic and other devices for children up to the age of 18; (g) women in relation to pregnancy and delivery; (h) infants, up to one year of age; (i) blood donors who voluntary have donated blood more than 10 times; and persons exempted by some special regulations (war-disabled persons or families of soldiers who were killed in action).

User participation in health care expenses have eliminated overuse of services, but have raised fewer funds than expected, contributing less than 5% of the revenues of health care providers. They also raise questions of equity.

There are also informal (under the table) payments, which extent is difficult to assess. It is believed that this practice is common for surgeons to levy further, informal payments from their patients.

Payment to the Health Care Providers

According to the Law on Health Insurance, health care organizations and the HIF are obliged to plan the necessary funds for providing health care services and realization of the benefits to health care to the insured coming from the obligatory health insurance. Each year, the HIF prepares a plan and program for health services to be financed from the obligatory health insurance. Moreover it determines criteria, by the General Act approved by the Minister of Health, for contracting with health care organizations and for the ways of payment to the providers of health care services.

According to the Law in Health Insurance, there are three basic methods of payment to the providers for health services: (a) number of insured persons registered for health care on the list of the physician (doctor of choice) at the PHC level (capitation); (b) determined price for each unit of health service or intervention (fee-for-service); and (c) programs for certain kinds of health services. In addition to that, the HIF determines some other criteria for coverage of emergency medical services for the entire population, home visits by nurses (patronage) to pregnant women and babies regardless of the status of insurance, providing continuous health care during the day and night (24 hours) and during the holidays and weekend days, etc. The Law does not make any difference between public and private health care providers in relation to the possibilities for contracting with the HIF in order to provide equal financial conditions and incentives for efficient performance in delivering health care for both types of providers.

Doctors and other health care professionals in the public health sector were paid a salary on scales negotiated by the Union of Health Care Workers and the Ministry of Health and some of the physicians at primary health care level were paid by the principle of capitation. In 2007, after the performed transformation of public health institutions and privatization of chosen physicians in primary health care level (general medicine, occupational medicine, health care of the small and pre-school children, school medicine, and health care of women over 15 years of age), the method of capitation is applied for health services payment at primary health care level.

Within the last ten years fully-trained physicians were paid between 12000 and 18000 denars (200 to 300 Euro) a month (5). This situation was slightly improved by increasing the net salary of doctors and other health workers in 2007 for 17.5% and increasing the value of the points for calculating the capitation for physicians at the primary health care level (7). Nevertheless, when it is considered that the value of the consumer basket for food and drinks for a four-member family for November 2008, calculated by the State Statistical Office upon the market prices, is amounted about 12.238,oo denars, there is a clear incentive to seek alternative sources of income.

Revenues and Expenditures of the Health Insurance Fund

Obligatory health insurance is the main source for health care revenues. The revenues of the HIF are used to fund the programs for which the HIF is responsible and to finance the government's share of the health insurance costs for those additionally enrolled in the program, who are not Fund insurees and the health care costs for them are covered by the state budget. Direct contributions by employers and workers for health insurance were 52.9% of the total HIF revenues in 2007 (Table 1). In addition, their contributions to pension and unemployment schemes include components that are used for health insurance for persons who are retired, unemployed, disabled veterans or recipients of social (welfare) benefits. These amounts, which were about 33.9% of the HIF revenues, are paid by the State Funds for Pension, Unemployment, and other social programs. HIF revenues from the general budget in 2007 amounted to 5.21%. The Ministry of Finance sets the budgets for the Ministry of Health's vertical programmes, and examines and approves budgets for the Health Insurance Fund.

Expenditures of the HIF for contract health care services in 2007 are about 90.7% of total expenditures. Salary reimbursements for sick

leave and maternity leave compensations accounted for another 6,7% (Table 2). The structure of the expenditures on health care services of the HIF in 2007 is presented in table 3. Outpatient services (at the PHC level and outpatient specialist-consultative health care services including medicines from the HIF List of medicines) accounted for about 65.0% and hospital care/services for 32.1% (Table 3).

The proportion of GDP recorded as spent in the formal health care system appears to be about 6,5% in 2008. But, in the context of remarkable inflation figures vary and the GDP figure also has to be treated with caution. Nearly all health expenditure (more than 95%) is reported to be in the public sector but this figure seems to be an overestimate.

through international competitive procurement. Health care reforms undertaken in 1990-ties have proved unsustainable, and have in practice largely been abandoned or revised. The development and implementation of policies and plans for reform have been hampered by weak capacity in the state health sector agencies (the Ministry of Health, the HIF and the Republic Institute for Health Protection.), and the lack of data and information systems for surveillance, monitoring, and analysis. The result of this situation is that Macedonia has been slower to undertake health care reform than many EC countries.

Adoption and enforcing the new Health Insurance Law and separation of the Health Insurance Fund from the Ministry of Health were key and the most successful implemented reform processes suggested by the international consultants of The

Table 2. Expenditures of the Health Insurance Fund of R. Macedonia, 2006 and 2007 (7)

Expenditures	2006 MKD (1000)	2007		Structure 2007 (%)
		MKD (1000)	Euros (1000)	
Contract health care services	14,710,787	14,891,325	242,925	90.66%
Pay checks leases and compensations for social insurance from the employers	169,094	190,617	3,110	1.16%
Payment of compensations for sick leave from HIFM	496,592	537,848	8,774	3.27%
Compensations for maternity leave from HIFM	605,098	591,869	9,655	3.60%
Other operational expenditures	127,006	29,999	489	0.18%
Capital expenditures	63,711	76,184	1,243	0.46%
Other expenditures	108,106	107,159	1,748	0.65%
Total Expenditures	16,280,394	16,425,001	267,945	**100%**

Source: Health Insurance Fund of the Republic of Macedonia (2008)

Current Trends in Health Care and Health Insurance System

In spite of a rapid expenditure growth in the last more than ten years and accumulation of significant debts of the public health care institutions and the Health Insurance Fund, the health system does not appear to have significantly improved access to basic health services and remains inefficient and inequitable. Resource distribution was concentrated in secondary and tertiary care, particularly in the capital city of Skopje, while access to basic services in some rural parts of the country is still limited and of poor quality. Available efficiency indicators of the public health care institutions are below EU norms. Prices paid for pharmaceuticals by the HIF in Macedonia were significantly higher than prices obtainable World Bank. The HIF is now centralized, hospitals are in practice subject to detailed Ministry of Health and HIF controls. Technical efficiency has improved as the average length of stay in hospitals has decreased. Public providers are in practice paid on the basis of global budget contracts. PHC reform has increased patient choice through patient enrolment and capitation-based payment to physicians.

The second World Bank financed project for continuation of the health care reforms in Macedonia (The World Bank, 2004) was initiated in 2003 and approved in 2004 with the following specific objectives: 1) to upgrade Ministry of Health and Health Insurance Fund capacity to formulate and effectively implement health policies, health insurance, financial management

Table 3. Structure of the Health Care Services Expenditures of the Health Insurance Fund of R. Macedonia, 2006 and 2007 (7)

Health care expenditures	2006 MKD (1000)	2007		Structure 2007 (%)
		MKD (1000)	Euros (1000)	
Outpatient services (PHC)	4,781,845	5,051,195	82,401	33.92%
Specialist-consultative health care services	4,247,093	4,628,756	75,510	31.08%
Hospital health care services	5,162,261	4,785,826	78,072	32.14%
Treatment abroad	194,518	113,916	1,858	0.76%
Orthopedic gadgetry and aids	320,771	307,209	5,012	2.06%
Other health care services	4,300	4,424	72	0.03%
TOTAL	14,710,789	14,891,325	242,925	**100%**

Source: Health Insurance Fund of the Republic of Macedonia (2008)

and contracting of providers; and 2) to develop and implement an efficient scheme for restructuring of hospital services with emphasis on developing day-care services and shifting to primary care (8). The expected improvement in primary care and increased access to essential health services, especially for the poor and uninsured, would help bring further reductions in infant mortality and improvement in other health status indicators, which would help the country meet its Millennium Development Goals. Health financing and reform of the payment to health care providers are of high importance within the ongoing health care reform in the Republic of Macedonia. It is expected that the new introduced methods of payments at the primary health care level (capitation) and at the hospital sector (global budgeting, DRGs) would lead to increased efficiency and quality of health care in hospitals and overall system.

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