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GOOD GOVERNANCE IN HEALTH



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Skopje, October 2010

Good governance in health

**Case studies: Municipalities of Kisela Voda, Kriva Palanka,
Vrapchishte, Bitola, Strumica, Shtip, Kicevo and Veles**

Skopje, October 2010

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Background Information

Over the past 15 years, governance has become a key concept in the debates related to international development. Governance assessments vary according to the interests, needs and culture of the researchers. Some focus mostly on public sector corruption; others take a broader approach which can include elements of human rights and democracy examined across civil society, the private sector, the judiciary and government institutions.

Experience shows that emphasis to governance is crucial for health/education systems to fulfill their essential public health/ public education functions. Both health and education governance encompass institutions and linkages among citizens, government officials and health/education service providers. Ideally, good governance in health and education should have the traits of responsiveness and accountability, transparency, encompass engagement of citizens and the capacity of state actors (central and local government decision makers) to design and implement policies in these sectors.

For that reason, in the past 18 months (March 2009 – September 2010) SEE University teamed up with UNDP, has agreed to develop a nationally owned Governance Assessment Methodology (<http://www.seeu.edu.mk/en/research/international-projects/undp>). This methodology should provide the tools for assessing the governance in health and education sector with regard to social inclusion and poverty reduction. However, with minor adaptations, this methodology can be used as a foundation for governance assessment mapping in other sectors, and provide much needed overview of governance issues and their impact on social inclusion.

This methodology is developed to serve as a critical accountability mechanism for variety of stakeholders, especially the citizens of the Republic of Macedonia and non-state actors regarding governance as well as to the decision makers to have the necessary information to improve the governance system and as such substantively contribute to the governance reform processes initiated in the country.

Upon completion of the draft methodology, two research institutions were engaged to conduct governance assessment based on the Methodology on Governance Assessment on social

inclusion policies in education and health sector. The findings from the research were also used as a tool for fine tuning the methodology itself.

Once the methodology was agreed, the University embarked to pilot it in two selected sectors, in education and in health. Two research institutions were selected to organize and conduct the field research and analyze the gathered data. The education report is produced by the Center for Research and Policy Making (CRPM) and features governance assessment of the education sector in 6 municipalities. Whereas, the health report is produced by the Centre for Regional Policy Research and Cooperation 'Studiorum' (CRPRC Studiorum) and features governance assessment of the health sector in 6 municipalities.

Both reports were presented at a workshop held November 17, 2010, and the comments and recommendations from the participants have been taken into consideration in the process of fine tuning of the GA Methodology. In late January 2011, 40 stakeholders from different ministries, public institutions and Civil Society Organizations will be trained on the final GA Methodology.

The Final Assessment Methodology on governance issues and their impact on social inclusion in the education and health sectors in the Republic of Macedonia is scheduled to be launched in March, 2011.

I. Introduction

Good governance in health generally refers to the enhancement of the leadership and stewardship functions and the improvement of management support systems of both the central and local governments in terms of their collective responsibility for the overall performance of the health system. It also entails setting up the policies and the systems for transparency and accountability, mustering the political will to enforce the rules, and providing the right incentives to ensure positive behaviors of players in the health system.

Beyond the vision and mission to develop policies, programs and strategies that support the overall health goals and objectives, good governance also necessitates a clear system of data gathering about the implementation of these policies on every level in terms of accountability and transparency, but moreover – about the effects of these policies on the health status of the general population, and particularly on specific groups of interest, such as the vulnerable and most-at-risk population groups. A good health knowledge and data management system needs to be selective in the information it generates to avoid inefficiencies and wastage of limited resources. It is critical that knowledge is disseminated to provide support for policy and decision-making, to build constituency of public support for health policy, to form part of capacity-building program, and to inform and influence behavior and events within the health system.¹

This report is based on the pilot application of the good governance assessment methodology in the health sector, especially in the perspective of the social inclusion of the vulnerable population groups in the society. Based on the assessment methodology and for the purpose of this report, social exclusion and social inclusion are understood as: (1) Social exclusion: a process whereby certain individuals are pushed to the edge of the society and prevented from participating fully because of their poverty, lack of basic competencies and life-long learning opportunities, or as a result of discrimination; they have little access to power and decision-making bodies and thus often feel powerless and unable to exercise any influence on the decisions that affect their daily lives; whereas (2) Social inclusion: mainstreaming of human rights in development programming is a way of tackling certain forms of social exclusion and strengthening inclusion policies. A social inclusion approach implies addressing need or alienation wherever it exists. Social inclusion reaches beyond the enforcement of rights in legal terms by tackling material deprivation, stigmatization and social separation and hence

¹ World Health Organization. 2000. *Health Systems: Improving Performance, World Health Report 2000*, Geneva: WHO.

the approach seeks to understand this complex social phenomenon in terms of causes as well as outcomes. It also has an operational bias, devising workable policy responses, effectively recognizing that the State has a 'duty of care' to include and involve all members of society in political, economic and social processes.²

The quality of good governance, at a country level, can be assessed using a number of indicators, which have been identified in different ways. The United Nations Development Program (UNDP “Governance and Sustainable Human Development, 1997”) enunciates a set of principles that, with slight variations, appear in much of the literature.³ There is strong evidence that these UNDP – based principles have a claim to universal recognition.”⁴

This paper analyzes the present condition of Macedonian healthcare system, concentrating on the system coherence with good governance standards. For the purposes of this study we will apply the UNDP Principles of Good Governance, which are as follows:

Box 1 : Six Principles of Good Governance	
The Six Good Governance Principles	The UNDP-based Principles and related UNDP text on which they are based
1. Legitimacy and Voice	Participation – all men and women should have a voice in decision-making, either directly or through legitimate intermediate institutions that represent their intention. Such broad participation is built on freedom of association and speech, as well as capacities to participate constructively
2. Direction	Strategic vision – leaders and the public have a broad and long-term perspective on good governance and human development, along with a sense of what is needed for such development. There is also an understanding of the historical, cultural and social complexities in which that perspective is grounded.
3. Performance	Responsiveness – institutions and processes try to serve all stakeholders. Effectiveness and efficiency – processes and institutions produce results that meet needs while making the best use of resources.

² Ibid., p.10

³ Good governance practices have also been implemented by intergovernmental regional entities such as the European Union (EU) and the Organisation for Security and Cooperation in Europe (OSCE). In the Bucharest Declaration, the OSCE’s parliamentary assembly passed a resolution on the 25th Assembly of the Helsinki Final Act.38. The resolution addresses a host of issues which are addressed in a report entitled, Good Governance: Regional Cooperation, Strengthening Democratic Institutions, Promoting Transparency, Enforcing the Rule of Law and Combating Corruption. At the outset, this implies that good governance is understood by the OSCE to include the realization of multiple objectives from regional cooperation and the promotion of transparency and combating corruption. The Commission of the European Communities has contributed to the discourse on good governance through a publication entitled, European Governance: A White Paper.

⁴ Graham, J., B. Amos and T. Pluntre. 2003. *Principles for Good Governance in the 21st Century*. Policy Brief No. 15 - Institute On Governance, Ottawa, Canada, p.3

4. Accountability	Accountability – decision-makers in government, the private sector and civil society organizations are accountable to the public, as well as to institutional stakeholders. This accountability differs depending on the organizations and whether the decision is internal or external.
5. Transparency	Transparency – transparency is built on the free flow of information. Processes, institutions and information are directly accessible to those concerned with them, and enough information is provided to understand and monitor them.
6. Fairness	Equity – all women and men have equal opportunities to improve or maintain their wellbeing. Rule of Law – legal frameworks should be fair and enforced impartially, particularly the regulation on human rights.

1.1. The research problem, research objectives, research questions

Since the recognition of the healthcare as an investment in the population and economic growth rather than as mere expenditure⁵, much has been done in researching the governance policies and their implication on social inclusion in the development countries, one of which is the Republic of Macedonia. Exclusion from healthcare services, including lack of access to services or absence of minimal standards of care, results in exclusion and deprivation from other social services and benefits of the society, such as education, employment or housing, which also represent part of the basic and constitutionally guaranteed human rights and freedoms.⁶ However, a comprehensive approach in the assessment of access to healthcare in relation to social inclusion through a governance perspective has not been done insofar for the country. Thus, CRPRC Studiorum, on behalf of the South-East Europe University – Tetovo has undertaken the pilot application of the assessment methodology for governance in the health sector, in the attempt to address the following research questions:

- a) What are the current governance structures (policy-wise and on institutional level) in health sector;

⁵ World Bank, „World Development Report 1993: Investing in Health”, World Bank 1993.

⁶ Universal Declaration of Human Rights, General Assembly of the United Nations, adopted December 10, 1948. Available at: <http://www.un.org/en/documents/udhr/index.shtml> (last accessed: September 2010).

- b) What are the current governance practices in the health sector;
- c) How much Macedonian healthcare system is coherent with the good governance standards;
- d) How is governance affecting social inclusion in the health sector;
- e) How can the changes in governance improve social inclusion in the health sector.

The basis for this research was the “Assessment methodology on governance issues and their impact on social inclusion in the education and health sectors in the Republic of Macedonia”, prepared by SEEU – Tetovo, that was duly applied in the process.

1.2. Research method, research method limitations

Primary data for this research was gathered through focus groups. Six focus groups were conducted in 6 (six) different municipalities in Macedonia (Bitola, Kichevo, Kriva Palanka, Strumica, Shtip and Veles). All municipalities are representing different statistical regions, as defined by the State Statistical Office⁷. The remaining two statistical regions (Polog region and Skopje region) were not covered, for the reasons of saturation of the sample, after completing the six focus groups in the mentioned municipalities.

The limitations of this research in the health sector are several, including the lack of primary data on governance practices on local level. However, a more important drawback of this research is the fact that the health sector has not yet been a subject to fiscal and governance decentralization, as a result of what the focus groups’ participants have not been in position to discuss at large the governance problems and issues on the local level, in a similar manner to other sectors, such as education. In that sense, the conclusions are based on the current situation in regard to decentralization of the competencies in the health sector, and the recommendations are designed with the vision of the completion of this process in the near future.

From the aspect of the choice of research methods, i.e. interviews and focus groups on local level, while there have been no obstacles in obtaining the opinions of the healthcare providers and respective institutions in the healthcare system, the limitation of the selected methods has been on the side of ensuring representativeness of the patients’ opinions and experiences.

⁷ National nomenclature for territorial units of statistics (NTES-3), Official Gazette of the Republic of Macedonia no. 158/07

However, this limitation has been assumed negligible, due to the fact already mentioned, that the governance in health has not yet been decentralized, thus has no direct influence of the patient community on local level at the moment. However, the perspective of patients and patients groups is very important, even if processes are not in place. Some examples of discussions with communities of most-at-risk populations, proposals have occurred as to where to take necessary caution in transferring roles and responsibilities in public health, in order to avoid the bottlenecks that happened with education and social services.⁸

1.3. Research sample

The municipalities representing each of the eight statistical regions have been selected based on the previous knowledge and experience of the research team:

Statistical Region	Pilot Municipality
Pelagonia statistical region:	Bitola
Skopje statistical region:	Kisela Voda
North-eastern statistical region:	Kriva Palanka
South-east statistical region:	Strumica
Eastern statistical region:	Shtip
Vardar statistical region:	Veles
Polog statistical region:	Vrapchiste
South-western statistical region:	Kichevo

Besides the geographic representativeness of the territory of the country, in the selection of the pilot municipalities the urban/rural principle was also observed, as well as availability of healthcare settings of different health service provision level.

Within the selected municipalities, the participants invited for the focus groups were on average 15 per municipality; the invitees were representatives of healthcare settings, centers for social work, local government officials and civil society organizations (CSOs) that work in the field of or have interest in the healthcare, including CSOs and self-help groups that are working for or with vulnerable groups.

In each of the focus groups representatives of most of the invited categories of participants have been present; however, as mentioned above, due to the fact that the health sector is not decentralized, the response was average (number of participants in all six focus groups – 29), although the key persons were present in most cases (directors of healthcare facilities, directors of centers for social work, local government officials and representatives of CSOs).

⁸ Stefan Stojanovik, UNAIDS

II. The Macedonian health system and the social inclusion

In the light of general strategic determination of the country for European integration, in the past years the Government of the Republic of Macedonia has been working on the reduction of poverty and increasing the social inclusion of marginalized population. Since last year, the Ministry of Labor and Social Policy (MLSP) has initiated the process of preparation of the National Strategy for Poverty Reduction and Social Inclusion⁹ using the Open Coordination Method (OCM). The strategy recognizes the health sector as one of the key areas for action in improvement of social inclusion, and as such proposed measures and activities for addressing the problems of marginalized population especially on local level. The process of preparation of this strategic document that started in late 2009 and was adopted by the Government in early October 2010. Next step is preparation of the Operational Plans and translating the measures and recommendations from the Strategy into design of concrete actionable projects.

1.1. Health system in Macedonia

The healthcare system is only one of the multiple factors that influence maintenance of good health, healing or alleviation of the daily living in conditions of chronic disease. A number of external factors have their impact on health, such as environmental, economic, social, as well as factors related to lifestyle, culture and tradition. Therefore, despite the fact that for improvement of health system specific activities are required, the process of health policy making and implementation needs to be undertaken in line and in conjunction with other spheres of the society and sector policies (such as employment, education, poverty reduction, social protection, etc).

The healthcare system is an important link in the provision of social welfare and protection of the population through provision of healthcare services to all citizens. As defined in the National Development Plan 2005-2013, the key priorities in addressing the social inclusion in health sector are:

- Fight against all forms of discrimination;

⁹ Нацрт-Национална стратегија за намалување на сиромаштијата и социјалната исклученост [Draft-National Strategy for Poverty Reduction and Social Inclusion], Ministry of Labor and Social Policy website: http://www.mtsp.gov.mk/WBStorage/Files/strategija_socijalna.pdf (last accessed: October 1, 2010)

- Eliminating the inequalities in the healthcare provision and providing equity in the access to healthcare (geographic, financial and physical);
- Promoting the quality for healthcare services (investment in infrastructure, equipment, human resources);
- Providing appropriate healthcare for the vulnerable groups, with particular focus on the providing access to health insurance for the uninsured persons.

In particular, the National Development Plan is putting forward the following goals:

- Reduction of the existing inequalities in the health status of the population of the Republic of Macedonia and the EU member states by at least one third;
- Reduction of the differences in health indicators among socioeconomic groups of population by one fourth;
- Improvement of the health status of the newborns, infants and pre-school children, as well as persons above 65-yers of age;
- Improvement of the psychosocial welfare of people and provision of better and more comprehensive community services that will be accessible to the persons with mental health problems;
- Reduction of the unwanted health consequences resulting from the communicable diseases of public health importance, through systematically applied control programs, elimination and eradication of communicable diseases;
- Promotion of the healthy lifestyles, improvement of the quality of life and awareness raising among general population about the importance of protection of their health;
- Improvement of the access to primary healthcare services and strengthening of the secondary healthcare services;
- Maintenance of sustainable system of financing and allocation of healthcare resources, based on the principles of equality, economics, solidarity and optimal quality of care.

The healthcare system in the Republic of Macedonia consists of wide network of healthcare settings: outpatient facilities for primary healthcare, specialized-consultative services and inpatient (hospital) settings on secondary level and university clinics and institutes on tertiary level of healthcare. Since the independence in 1991, the healthcare sector has opened the possibility for private practice of healthcare, but only in the past several years the private initiative has been both spurred and encouraged, especially in the primary healthcare (PHC), since its stronger role was desired in the light of improvement of the efficiency and quality of

healthcare services.¹⁰ However, the role of private health care practices in the delivery of public health interventions has been underestimated and neglected. The contracts between Health Insurance Fund and PHC services needs to enlarge and closely monitor their role in delivering public health interventions and thus securing this component of the good governance in health.¹¹

Within this system, the Ministry of Health is responsible for creation of policies and monitoring of their implementation, whereas the Health Insurance Fund bears the responsibility for collection of and operation with the health resources, gathered through employment contributions, direct transfers from the Central budget and other sources. The Health Insurance Fund manages 95% of the public health finances in the country. Despite this, HIF lacks proper tools for monitoring the delivery of public health interventions envisaged in the contracts with primary healthcare physicians. Currently, HIF is predominantly focused on the financial control and expenditure reduction; thus the quality of care is in the background rather than at the forefront of the aims of the healthcare services delivery.

The 2006 data states that in the Republic of Macedonia, 8% of the gross domestic product (GDP) is spent on healthcare; 70.6% are covered from the public funding, whereas the remaining 29.4% are covered from other sources, including private funding, co-payments and out-of-pocket payments.¹²

According to the National development Plan¹³ it is a striking fact that the poor spend more on healthcare as part of their total household income than those with higher income, which at the same time hinders their access to healthcare services. Some of the main reasons include out of pocket expenditure¹⁴ and the way funds are allocated within the health sector, for example, more investments in the specialist care rather than the community and preventive healthcare. These are determinants of wider social exclusion and have to be addressed through good governance practices.¹⁵

On the other hand, those with higher income express dissatisfaction from the healthcare services, as a result of paying higher contributions to the system for the same basic benefits package provided by the health insurance. Dissatisfaction exists also in the quality of care; in

¹⁰ Nordyke R.J., Peabody J.W. 2002. Market reforms and public incentives: finding a balance in the Republic of Macedonia. *Social Science & Medicine* 54:939-953.

¹¹ Stefan Stojanovik, UNAIDS

¹² World Health Statistics. 2009. WHO http://www.who.int/whosis/whostat/EN_WHS09_Table7.pdf

¹³ National Development Plan 2008-2013, The Government of the Republic of Macedonia

¹⁴ Suhrcke M., Rocco L., McKee M. 2007. *Health: a vital investment for economic development in eastern Europe and central Asia*. WHO, Geneva

¹⁵ Igor Veljkovic, UNICEF

a majority of cases, the public healthcare facilities have lack of equipment and personnel and usually use obsolete and poorly maintained medical technology.

All of the above contributes to creation of disparities in the health status of the population, on socio-economic, educational, geographical and even ethnical grounds.

1.2. Access to healthcare services

The changes in the Law on health insurance¹⁶ have provided the grounds for health insurance of all citizens of the Republic of Macedonia, which includes coverage with the basic benefits package paid by through the Health Insurance Fund (HIF). The Government, through HIF provides funding from the Central Budget for those categories of persons which are uninsured for multiple reasons (unemployed, persons without property or persons that have not been registered through the Employment Agency of Macedonia, persons who are not users of social assistance and persons of age above 64 years who are not pension users, homeless and other vulnerable groups). Using this new mechanism of health insurance, since its introduction in May 2009, about 3,000 persons have the possibility for using state-funded health services. At the same time, for ensuring equitable access to health services, the government is redrafting the basic benefits package that can suit the needs of all population groups.

Relevant for the improvement of the social inclusion issues in health sector is also the newly enacted Law on medical records,¹⁷ which is expected to provide sound and reliable data collection that with this new law can be disaggregated by several new categories, such as ethnicity. This, in turn, will enable addressing of health issues that are specific for targeted groups of citizens, and in that way reduce the disparities in health status of different, including socially excluded population groups.

The numerous changes of the Law on health protection¹⁸ (such as including the legal grounds for implementation of preventive programs, introduction of stipulations pertaining to the establishment of the Health Insurance Fund, enabling additional private activity of medical personnel employed in public healthcare settings, enabling the disintegration of the clinical centre and formation of separate entities of 30 university clinics, introduction of stipulations

¹⁶ Law for changing and amending the law on health insurance, Official Gazette of the Republic of Macedonia, 67/09

¹⁷ Law on medical records, Official Gazette of the Republic of Macedonia no. 20/09

¹⁸ Law on health protection, Official Gazette of the Republic of Macedonia no. 38/91, 46/93, 55/95, 10/04, 84/05, 111/05, 65/06, 5/07, 77/08, 67/09

pertaining to privatization of the primary healthcare physicians, etc.) since its enactment in 1991 fairly well illustrates the dynamics of the changes in the healthcare sector, especially from the aspect of health services provision and health system governance, which proves the lack of clearly focused National Strategy for Health during this period.

The Republic of Macedonia has drafted and adopted a number of strategic documents relevant to the health system. Among the most important document is the Health Strategy up to 2020, which defines the vision for health promotion of population and improvement of the health system that will respond to the needs of the population, including those marginalized and vulnerable. “The analysis of the health status of the population in the Republic of Macedonia and globally shows that health problems of highest priority are the chronic non-communicable diseases and urgent [epidemic] conditions. Maintenance and promotion of the health are the key instruments in improvement of the health status of the population, especially the vulnerable groups.”¹⁹

1.3. Social inclusion and healthcare

Socially excluded and vulnerable groups are part of the general population and the health system is obliged to provide access and quality of care tailored to the needs of these groups. Despite the fact that there are still discrepancies in the provision of appropriate care for these groups for the reasons already mentioned, some activities and policies do exist and are implemented in this respect.

- 1) Prevention and control of HIV/AIDS is addressed through a separate preventive programme, funded directly from the Central Budget, administered through the Ministry of Health (MoH). To ensure good governance and accountable use of funds, UNAIDS last year with UNICEF and this year with WHO conducted a planning workshops with all relevant stakeholders, including CSOs and most-at-risk representatives in order to ensure proper management of these funds. In addition to this, MoH is receiving grants from the Global Fund for Fight against AIDS, Tuberculosis and Malaria (GFATM), with the aim of keeping low prevalence of HIV/AIDS, especially among the vulnerable groups such as intravenous drug users (IDUs), men who have sex with men (MSM), commercial sex workers (CSWs) and prisoners, with occasional activities directed towards Roma communities.

¹⁹ Health Strategy of the Republic of Macedonia up to 2020

- 2) As the highest prevalence of tuberculosis is among socially excluded groups, the MoH administers a special Preventive programme for control of tuberculosis and implements the Strategy for Control of Tuberculosis 2008-2012, both funded through central budget allocations and grants from the GFATM. To ensure good governance and accountable use of funds, UNAIDS last year with UNICEF and this year with WHO conducted a planning workshops with all relevant stakeholders, including CSOs and most-at-risk representatives in order to ensure proper management of these funds.
- 3) The program for early detection, diagnosis and treatment of breast cancer has been established and running in the past three years. Special campaigns are organized for marginalized communities, such as the Roma population. As a pilot, the MoH has also started to implement a program for free PAP-smears in 4 municipalities (Gostivar, Sveti Nikole, Prilep and Shtip). The results of these preventive programs have still not been assessed regarding their effectiveness and cost-benefit. Furthermore, these programs are regarded of low priority, and usually are the first to get budget cut-offs during Central budget rebalances. Thus, such programs cannot be considered a strong commitment towards diminishing the social gap between the general population and the socially vulnerable.
- 4) MoH has prepared two key strategies for improvement of perinatal mortality indicators in relation to achievement of MDGs. These strategies are Strategy for sexual and reproductive health and Strategy for Safe motherhood. The latter has been adopted by the Government in July 2010, after what the implementation started in September 2010. The former one is still in the procedure of finalization, and this process will be finalized by the end of 2010. On the other hand, good governance ensures funding for implementation of Strategies. Currently, there is an increasing practice of health authorities to endorse strategies with no precise fiscal implications, which directly risks the implementation and encourages decreased accountability.

There are other programs and activities that are aimed at addressing specific issues targeting vulnerable groups, such as prevention of domestic violence, prevention and mitigation of drug, alcohol and tobacco use, deinstitutionalization and re-socialization of persons with mental health problems, promoting free medical check-ups and health lifestyles, etc. Most of these are implemented in multi-sector interdisciplinary fashion, involving other line ministries, healthcare facilities, CSOs, media and sometimes citizens. Yet, the insufficient capacity of the Ministry of Health in planning, budgeting and implementation of the public health programmes are well documented. Currently,

planning and budget decisions are made entirely at the central level, without taking into account local level planning and health needs, as well as the regional disparities in basic health indicators.²⁰

Participants in the focus group discussions have pointed out that the socially vulnerable groups are not sufficiently recognized and there are still lack of communication and policy issues to be resolved between the social welfare system and the health care system; in other words, if a person is recipient of social welfare, it is not automatically registered for health insurance, as it is assumed that it receives funding from the state to cover the health insurance costs.²¹

In another focus group,²² participants have pointed out that some of the preventive programs are not being implemented properly, or there is lack of information of their existence; main reasons were assumed to be that the primary healthcare was given under concession and the funding for the preventive programs is not timely and fully transferred to the healthcare facilities.

²⁰ UNICEF. 2009. „*Child Focused Public Expenditure Review*”, UNICEF, Skopje

²¹ From the Focus group discussions in Stip, September 15, 2010

²² Focus group discussions in Veles, September 21, 2010

III. Good Governance in Macedonian healthcare system

1. Legitimacy and voice

The Constitution of the Republic of Macedonia²³ is explicit in guaranteeing the right to healthcare (defined in the Law on Healthcare) to every citizen (Art. 39). In this respect, the non-discrimination clauses providing for access to health services and „highest attainable standard of health”²⁴ and pertaining to healthcare legislation are part of: the Constitution of the Republic of Macedonia,²⁵ which states that “every person has the right to healthcare protection” (Art. 39, Para. 1); the Law on Healthcare,²⁶ which states that “every person has the right to healthcare” (Art. 3, Para. 1); the Law on Mental Health,²⁷ which states that “discrimination is any kind of isolation, exclusion, separation or other treatment, which will have an effect of harming or violating the equality of exercising the rights, except in cases determined by law” (Art. 4) and that “the person suffering from mental illness has the right to protection from any kind of molestation, degradation, and abuse and the person must not be discriminated on grounds of his mental health” (Art. 7); the Law on Occupational Safety and Health,²⁸ which holds that all regulations arising from it are applied in all practices in the public and private sector for all persons with insurance covering workplace-related accidents or professional illnesses, according to regulations on pension, disability, and health insurance, and for all other persons included in work processes (Art. 2); the Law on Biomedically Assisted Reproduction (BAR),²⁹ and so on. Thus, legally and system-wise there should be no obstacles for exercising the right to health and other human rights in healthcare.

²³ Official Gazette of the Republic of Macedonia, no. 52/91, 1/92, 31/98, 91/01, 84/03, 107/05, 3/09

²⁴ Article 12 of the International Covenant on Economic, Social and Cultural Rights, Office of the UN High Commissioner for Human Rights: <http://www2.ohchr.org/english/law/cescr.htm> (last accessed: September 14, 2010)

²⁵ Official Gazette of the Republic of Macedonia no. 52/91, 1/92, 31/98, 91/01, 84/03, 107/05, 3/09

²⁶ Official Gazette of the Republic of Macedonia no. 38/91, 46/93, 55/95, 10/04, 84/05, 111/05, 65/06, 5/07, 77/08, 67/09

²⁷ Official Gazette of the Republic of Macedonia no. 71/06

²⁸ Official Gazette of the Republic of Macedonia, no. 92/07

²⁹ Official Gazette of the Republic of Macedonia, no. 37/08

1.1. Citizen participation in health policy making

Regardless of the fact that the legal milieu is providing for uninterrupted and equitable exercise of the basic human right to healthcare, the health-related policies are those that trigger the mechanisms and effective use of respective rights. At the center of the participatory democracy are the citizens and their participation representing their interests in the policy and decision-making.³⁰

The citizens' participation - and patients' participation in particular - in the decision making processes in the healthcare has only a very recent history. Public hearings on legislative drafts have started several years ago, and the public involvement in the health reforms was the experience that citizens and civil society had met in 2009.³¹ While direct involvement of patients in the healthcare decision-making regarding their own health is regulated in the Law on Healthcare and Law on Protection of Patients' Rights, their involvement in the general health policies and decision making is limited to participation in committees and management boards of healthcare institutions (Health Insurance Fund, healthcare settings) mostly of declarative nature.

Since the financing of the healthcare is yet to be transferred to the local authorities through decentralization processes, the citizen's participation in management and governance of healthcare facilities on local level will get its meaningful role after the completion of those processes. However, it is of paramount importance that mechanisms for ensuring proper and meaningful participation are well considered and set in place beforehand, for this not to become a replication of the lack of coordination and funds that happened with education and social protection.

1.2. Citizens' monitoring of health services

One of the major identified obstacles of the citizens' involvement in monitoring of health services is that the current laws are not envisaging established formal mechanisms for direct monitoring of the health services by citizens, although citizens and CSOs can get involved and informed through written correspondence with healthcare institutions, based on the provisions of the Law for Free Access to Public Information.³² In reality, however, this is a very rarely used instrument for monitoring of health services by individuals – slightly more

³⁰ Poverty Reduction Dictionary, <http://www.srds.co.uk/mdg/participation.htm> (last accessed: September 14, 2010)

³¹ Steering Committee for Advancement of the Healthcare was established in 2009, in a form of one central committee and 5 subcommittees on: organization of healthcare, healthcare management, financing of healthcare, patients' rights

³² Official Gazette of the Republic of Macedonia no. 13/06 and 86/08

by the CSOs working on health policies or patients' organizations. A wider used approach is written or oral communication with institutions, especially with the Ministry of Health for requesting access to particular medicines, or waiver of co-payments for particular patients' groups.

Some efforts for monitoring of health care spending have been made on general issues (by international organizations)³³ or particular problems affecting specific groups, such as Roma population (by local CSOs).³⁴ Yet, these efforts are neither citizens'-based, nor continuous processes that establish regular monitoring mechanisms to which citizens might have access to participate in the policy-making processes in order to represent and protect their rights.

1.3. Participatory budgeting

Participatory budgeting is a process of democratic deliberation and decision-making, in which ordinary residents decide how to allocate part of a municipal or public budget, through identifying, discussing and prioritizing public spending projects.³⁵

The process of budgeting (both preparation and implementation) in the healthcare sector happens on central level, although information is collected from all public healthcare settings. Each year, around mid-June the Ministry of Finance prepares the guidelines for preparation of budget proposals by the budget users. Ministry of Health invites all healthcare facilities and other publically funded institutions that are users of the preventive programs funded directly from the State Budget to prepare and submit a budget request for the upcoming year. Despite this segment of the budget cycle being critical for the budget allocation for the next year, this planning process on the healthcare facility-level excludes patients, patients' groups, most-at-risk and community in general. The collected information is processed in the Ministry and the budget for the preventive programs is finalized for incorporation in the Ministry's overall budget and for submission to the Ministry of Finance. The final decision is made by the Ministry of Health, and other healthcare institutions have no possibility to participate in its making. In other words, this process is still very centralized, where neither budget users nor end users of the public healthcare funding have the possibility to participate in the budgeting.

³³ WHO/MOH Project on Good Governance of Medicines, UNICEF/MOH Project on Improvement of National Immunization Plan, UNICEF report „Child Focused Public Expenditure Review”, etc.

³⁴ Foundation Open Society Institute Macedonia (FOSIM) Project on Budget Monitoring of Immunization Activities among Roma population in the Republic of Macedonia, 2008-2010.

³⁵ OECD/World Bank Institute Working Paper” 2006
http://www.oecd.org/LongAbstract/0,3425,en_2649_34129_38983243_119666_1_1_37405.00.html (last accessed September 2010)

Currently, UN agencies have been successfully involved in monitoring and advising this process in the past 3 years, putting high priority on most-at-risk groups and the content of the respective preventive program. However, a more sustainable mechanism of participation should be employed based on active-citizenship approach, empowering the citizens and the communities to take part and have their say in the decision-making and budget-formulation processes.

The major part of the public healthcare funding is managed by the Health Insurance Fund (HIF). The budgeting process within the HIF is similar to the one described for the Ministry of Health; the difference is that patients are represented in the HIF Management board, although most of the time this participation is only declarative, i.e. for example, lacking meaningful choice of members for patients' representation.

At this stage of decentralization, no budget is allocated to the municipalities for the healthcare. Thus, the municipalities, their elected officials and the citizens that have elected them have no possibility to change the budgeting process for healthcare on local level.

Nonetheless, some municipalities, such as the Municipality of Shtip, has introduced a budget line in the municipal budget for providing financial assistance to the persons who cannot afford to pay for healthcare, and especially persons that cannot pay the obligatory co-payments. The amount given per person is not very high (between 4,000 and 6,000 Macedonian denars), but the overall amount provided by the municipality for this purpose has been steadily growing from 60,000 MKD per year in 2006 to about 800,000 MKD per year in 2010. The decision on how these funds are allocated is made by a Committee in which doctors and municipal staff participate.³⁶ The influence that the citizens can have on the healthcare budgeting is thus indirect and informal, for example through participatory budgeting of the municipal budgets, although these are not obliged to provide health funding. In the focus group discussions in Strumica participants have stated that some efforts for involvement of citizens in decision-making are made, but most of these are related to started and unfinished projects, as result of lack of funding.³⁷ In the focus group held in Shtip, it was concluded that the civil society cooperation with local government is more of declarative nature, and that more efforts should be made for enabling the citizens an access to decision making in the health sector, which is directly related to their own and community's wellbeing.³⁸

³⁶ From the focus group discussions held in the Municipality of Shtip, on September 15, 2010.

³⁷ Focus group discussions in Strumica, September 15, 2010

³⁸ Focus group discussions in Shtip, September 15, 2010

2. Leadership

Leadership has been described as the process of social influence in which one or more persons can enlist the aid and support of others in the accomplishment of a common task.³⁹ In governance, leadership can be both formal and informal, and can explicate on the policy-making, decision-making and implementation levels.

Leadership as a function of the government requires the vision, policy directions, technical leadership and influence primarily provided by the central level health authorities, but also leadership and political authority of local governments in terms of their role in the delivery of healthcare services; leadership is also a responsibility of other stakeholders outside of the public sector in their role as purchasers and providers of healthcare services who must ensure that as much improvement as possible in health status of the population result from their efforts.

In the health sector, as already mentioned, centralization of competences and authorities is still dominant, thus the leadership is located likewise.

The Law on Local-Self Government⁴⁰, however, stipulates that one of the transferred competencies from central to local level is the healthcare: “- management with the network of public healthcare institutions and facilities in primary healthcare that should enable participation of the local self-government in all boards of publicly owned healthcare institutions; health education and promotion; preventive healthcare services; protection of the employees’ health and occupational safety; health surveillance of the environment; surveillance of communicable diseases; assistance of patients with special needs (for example: mental health, child abuse, etc) and other areas that might be additionally defined by law.”⁴¹

Under this Law, municipalities in collaboration with the regional institutes for public health are being transferred the competency to develop and implement following components of the preventive healthcare:

- Social care services and health insurance to socially vulnerable groups, including alcohol and drug abusers;
- Management of local health intuitions, at primary and secondary health care level;

³⁹ Chemers, M. M. (2002). Meta-cognitive, social, and emotional intelligence of transformational leadership: Efficacy and Effectiveness. In R. E. Riggio, S. E. Murphy, F. J. Pirozzolo (Eds.), *Multiple Intelligences and Leadership*.

⁴⁰ Official Gazette of the Republic of Macedonia no. 5/02

⁴¹ Art. 22, Law on Local-Self Government, Official Gazette of the Republic of Macedonia no. 5/02

- Development, financing and implementation of local health promotion programmes, including preventive activities, surveillance of communicable diseases and health care services.

The new Law on Public Health⁴² also stipulates that the units of the local self-government can deliver public health activities for their own territory for which purpose they have self-generated funds. The units of the local self-government within the inter-municipal cooperation can establish a joint workgroup, committee, coordinative or other expert authority for the purpose of exchange of information, experience and coordination of the public health cooperation for the territory of their municipality, in accordance with the Law.⁴³

3. Performance

Performance in the health sector is very difficult to be measured for various reasons; as in many areas, health sector represents a point in which multiple stakeholders represent their interest, but the main difference is that in this arena of stakes, someone's (i.e. patients) stake is very high (i.e. their health and ultimately their life). Being defined as measuring the achievement of a task against preset standards, performance indicators in health are still very vague and usually population-based, rather than patient-based; further, presetting of standards has been an eternal task of many epidemiologists and health economists, as both the emerge of new health issues and the development of medical technology happen very rapidly and multidimensionally.

Nevertheless, if we make the assumption of the current state in the health sector in the country being rather unchanged in terms of technology excellence and disease pattern of the population, the performance of the health sector can be judged against the effectiveness of care and efficiency of public spending on provision of optimal care. In the focus groups held in the municipalities of Shtip, Strumica and Kichevo a similar theme emerged – changes of the “payment to hospitals’ system to the diagnosis-related groups (DRG) as a model for improvement of efficiency of use of health resources has been prematurely introduced, for what the hospitals with current organizational and physical structure are unprepared, which can lead to further depletion of services or to the other end - endangering the hospitals to enter further into the spiral coil of indebteding.

⁴² Official Gazette of the Republic of Macedonia no. 22/10

⁴³ Art. 19, Law on Public Health, Official Gazette of the Republic of Macedonia no. 22/10

In this sense, in one of the focus groups, it was suggested that the decentralization of healthcare could contribute to improvement of the fund management and service delivery on local level, especially if public-private partnerships are enabled and encouraged.⁴⁴ CSOs and local government representatives from Strumica have also presented the idea of Strumica becoming a regional healthcare center, since over 250,000 inhabitants from the region are seeking healthcare in the hospital located in this municipality.

Yet, in another focus group it was suggested that the decentralization would be very complex and slow process, and this was illustrated by the fact that the budget of the hospital is almost half of the total municipal budget.⁴⁵

4. Accountability

According to Mary McNeil and Takawira Mumvuma “accountability takes two forms: horizontal accountability and vertical accountability. Horizontal accountability refers to the capacity of state institutions to check on abuses by other public agencies and branches of government, whereas vertical accountability refers to the means whereby ordinary citizens, mass media, and civil society actors seek to enforce standards of good behavior and performance by public officials and service providers.⁴⁶

Another challenge for the good governance in the health sector is in ensuring reliability and integrity in decision-making and public transactions were opportunistic behaviors, inefficiencies and unresponsiveness to patients’ and end-users needs, especially the socially excluded (most-at-risk) and vulnerable groups might be particularly tempting and rewarding. Thus, good governance entails setting up the policies and the systems for transparency and accountability, while at the same time gathering the political will to enforce the rules, and providing the right incentives to ensure positive behaviors of key players and stakeholders in the health system.

⁴⁴ Focus group discussions in Strumica, September 21, 2010

⁴⁵ Focus group discussions in Stip, September 15, 2010

⁴⁶ For more details on the distinction between horizontal and vertical accountability and on accountability mechanisms see: Cavill, S., and M. Sahai: “Strengthening Accountability for Urban Services” in, *Environment & Urbanization* 16(1), 2004; Malena, C., R. Foster, and J. Singh: “Social Accountability: An Introduction to the Concept and Emerging Practice” in, *Social Development Papers, Participation and Civic Engagement*, World Bank, Paper No.76, 2004

4.1. Horizontal accountability

4.1.1. State Audit Office

All public entities and state institutions are subjected by law to the State audit⁴⁷ performed by the State Audit Office. The annual auditing plan of the State Audit Office (SAO) is adopted by the Parliament, same as SAO Annual reports. The annual reports, which usually cover at least several healthcare facilities in the public domain, contains detailed accounts on the proper spending of public resources, as well as recommendations for improvement and correction of activities that were not performed in accordance with the regulation. Unfortunately, despite these reports being very objective and precise in determining the failures of public spending, they do not get the sufficient attention by the elected officials, and no actions are taken thereof. In other words, the accountability mechanism is set, but dysfunctional in practice. This leaves the space for continued and unpunished mismanagement of funds by the management of healthcare settings.

In a layer below the SAO, Health Insurance Fund is also responsible for observing the accountability of operations by the healthcare institutions. In the case of HIF, however, the control mechanisms are more tangible, as the HIF is the payer of the services provided by the healthcare facilities, however, HIF is not an independent institution as SAO is, therefore, the accountability control mechanisms are subjective and often times politicized.

4.1.2. Management and inspectorates

Ministry of Health has its own established mechanisms of monitoring the accountability of healthcare institutions, more so from the aspect of provided quality of services and spending of resources provided through the preventive programs, as well as control of quality of collected epidemiological data.

The State Sanitary and Health Inspectorate (SSHI) has the authority to make regular supervision, invited supervision or instructed supervision to healthcare facilities, in which normative and operational standards are checked.

The Institute for Public Health (IPH) is the research and advice institution in the healthcare system, directly responsible to the Ministry of Health. IPH has the responsibility and authority to collect and process epidemiological data from all 10 regional Centers for Public Health

⁴⁷ Law on State Audit, Official Gazette of the Republic of Macedonia no. 66/10.

(CPH), which collect their data from local healthcare institutions. The accuracy of the collected data is confirmed by IPH through field visits, funded through the preventive programs. In one of the focus groups was mentioned that the system of data collection is functional and it does not need confirmation of accuracy, despite funding being set aside for this particular activity.⁴⁸ Yet, a much bigger issue lies with the inadequate reporting, for which additional trainings, manuals and even stricter controls of the quality of data should be performed.

4.2. Vertical accountability

Vertical accountability of public health spending and performance of health institutions is rarely on the agenda, compared to other daily-political issues. Most often, this is in a form of media presentation of cases of fraudulent activities within health sector, often nailing the public spending by HIF or MoH. In this sense, the accountability by these institutions is in a reactive rather than proactive manner. There are not many CSOs that work in the field of health, and even less in the area of accountability and performance measurement of the health spending. Some recent initiatives of budget monitoring and accountability have been made, but all are on national level. On local level, since there is no budget allocated to the municipalities for healthcare, there are no accountability activities accordingly.

5. Transparency

Transparency, and fiscal transparency as a particular interest of this research, is defined as the public disclosure of all relevant fiscal information on a systematic and timely basis. Fiscal transparency is ensured through providing to the beneficiaries or end users: regular financial reports, access to financial records, open discussion and debate on decisions involving the use of public funds, etc.⁴⁹

Unlike the municipalities, the healthcare facilities on local level have no obligation to publish or publicly disclose in any form (printed or electronic) their financial reports or operation plans. Most of the focus groups participants have confirmed that their financial data is solely communicated with the HIF and/or MoH, where it becomes aggregated and published in

⁴⁸ From the focus group discussions in Municipality of Veles, 21 September, 2010.

⁴⁹ Massachusetts Nurses Association Glossary of Terms, <http://www.massnurses.org/labor-action/labor-education-resources/union-finances/glossary#f> (last accessed: September 13, 2010)

annual reports of these institutions.⁵⁰ Thus, fiscal transparency of the healthcare facilities can only be observed and monitored through the State Audit Office reports, which are not auditing all institutions every year, thus the process of monitoring of transparency of operations is non-linear, and other sources have to be used, such as providing information under the Law for free access to public information.

Participants in all focus group discussions have declared that they are not aware that the financial reports are information of public nature, and they are not aware that such information should be put at the disposal of the citizens and CSOs.

6. Fairness

On a long run, the general principles and values of the healthcare system in the country are:

- Equity – the whole population is entitled to financially and geographically guaranteed access to healthcare services, through a single basic benefits package;
- Accountability – everyone is responsible for their own health and health of others: citizens, the Government, all healthcare providers and settings, public and private enterprises, as well as CSOs;
- Solidarity – in the respect of the human rights, the health insurance is provided to all, based on the principles of interdependence and solidarity between the healthy and the ill; the wealthy and the poor; and between the needy and the non-needy.

This entails health policy that will put the patient and the citizen in the centre of the care, providing implementation of their rights as guaranteed by the Constitution, the national legislation and the signed and ratified international instruments, which on a long-run will contribute to better health and socio-economic status, and thus sustainability and enhancement of the healthcare system for the next generations.

⁵⁰ From the focus group discussions held in municipalities of Shtip, Veles, Kichevo, Strumica

6.1. How health governance affects social inclusion in Macedonia

6.1.1. Respect of the culture of non-majority communities

The mentioned Strategy for Poverty Reduction and Social Inclusion in the sector analysis and recommendations of health includes specific points and activities targeting the needs of specific non-majority communities. Namely, the Strategy envisages the implementation of the new Law for medical records, according to which the medical data will be disaggregated, based on ethnicity and confession, which will enable identification of the culture-specific needs of the target groups.

6.1.2. Providing health services and support for persons with special needs

Additionally, the Strategy is proposing implementation of the basic human rights in healthcare that are already regulated by law, but have not been properly implemented. Those include provision of services in native language, in cases when the patient does not speak the official language or the language of the majority; provision of health information to deaf, blind and mute person, as well as provision of health information on adjusted language for person with reduced mental capabilities.

In the focus groups discussions, these issues emerged as not yet complied with by the law, as the healthcare institutions neither have the finances to employ staff skilled for assistance of persons with special needs (deafness, blindness, language barriers, etc.), nor have the funding to cover the costs of such person being occasionally engaged if necessary.⁵¹ One of the propositions of the focus group attendants was that specialized associations of citizens dealing with such issues can be engaged, but this form of cooperation has never been established, due to financial reasons and no serious need emerging to date.

⁵¹ Focus group discussions in municipalities of Veles, Bitola, Shtip

6.1.3. Healthcare services for vulnerable groups

The socially excluded and vulnerable groups have been identified and defined in a number of strategic and legal health-related documents. Those include the Law on protection of patients' rights, Law on healthcare, Law on health insurance, National Health Strategy up to 2020, National Strategy for Fight against HIV/AIDS 2007-2011, and recently prepared draft-National Strategy for Poverty Reduction and Social Inclusion.

Nevertheless, these legal and strategic frameworks are only a segment of the proper implementation of the right to health and other human rights in healthcare for these groups; implementation and monitoring policies need to be in place as well – a process that is usually hindered by financial reasons, or lack of communication and cooperation with stakeholders and their representing organizations (CSOs, self-help groups, etc).

In the focus group discussions in Strumica, Stip and Kichevo, the participants have mentioned that more attention is needed for addressing the health needs of particular vulnerable groups, and not only the Roma minority; among the ones that should be more in the focus are the rural communities⁵², farmers, older people and users of narcotic substances.⁵³

6.2. Implementation of the social inclusion policies

As mentioned earlier, in the recent years, there is an increasing practice of health authorities to endorse strategies which address issues and propose mechanisms of interest to the general or particular population group, but such strategies usually have either no precise fiscal implications, or no clear vision of the potential sources of funding for their implementation. This directly risks the implementation and encourages decreased accountability.

Besides the funding issue, in most cases, there are no clearly set mechanisms for data collection and monitoring of the implementation of these strategies, through a set of predefined indicators; even where indicators are in place, or special health registries are gathered, the data is not always gathered fully or properly, as there are no precise guidelines or control mechanisms.

Thus, this implies that the implementation of social inclusion policies is usually dependant on the availability of funding – more ad hoc than strategically planned; interest of the donor

⁵² Focus group discussions in Strumica, September 21, 2010

⁵³ Focus group discussions in Kicevo, and Strumica

community; or motivation and power of particular population groups within the society – alone or represented through international community, EU accession mechanisms etc.

Ensuring proper, fair, transparent and outcome-oriented implementation of the social inclusion policies requires first of all sincere commitment and not only a declarative statement of intentions for diminishing the social gap; continuity of the vision and improvement of technical, human and financial capacity to implement this vision, and establishing just mechanisms for monitoring, evaluation and if necessary unbending the path towards achievement of the social inclusion goals and objectives.

On the other hand, for example, in the focus group in Strumica, where minorities are Roma and Roma that declare as Turks, it has been stated that the majority population, i.e. ethnic Macedonians are in less favourable situation, as a result of the over-implementation of the social inclusion policies.⁵⁴ Some disadvantages of the majority population were mentioned, as the privilege of the socially marginalized groups to be tolerated if not paying their co-payments, although, this in the broader sense has been understood as the critique to the government for not setting the exact rules on who and on what grounds can be waived the co-payment fees.⁵⁵

⁵⁴ Focus group discussions in Strumica, September 21, 2010

⁵⁵ Focus group discussions in Strumica, September 21, 2010

IV. Conclusions and Recommendations

The legislative review has shown that in the Republic of Macedonia there is a solid regulative framework for providing exercise and protection of the human rights in healthcare to all citizens, including vulnerable groups and population with special needs. The legislation, further strengthened with the signed and ratified international instruments, is continuously changing and adapting to the most contemporary regulative developments, especially in the light of the strategic determination of the country for EU integration and legislative harmonization therefore. Yet, the legislative efforts are to be accompanied with sets of strategies and implementation policies of these rights, converting the paper-based norms into daily-life practice.

As could be concluded from the above research, this in practice is rarely the case, for various reasons. If compared with other segments of the society, it can be argued that the start-up of the fiscal decentralization in the health sector might improve the implementation of these rights, especially the right to health, through increased accountability and transparency of the public health spending and provision of high quality services to all citizens. However, since the decentralization in health is yet to wait for better days and stronger fiscal solvency/creditworthiness of the municipalities, the recommendations given below are divided into two: those that refer to the present situation of the system, and those that are referring to the future timeline of implemented decentralization of the health sector.

Better health sector performance requires improving management support systems in health, particularly in the public sector. The devolution of health services creates opportunities for shifting from the highly centralized and more complex policy and decision making at the national level to a more focused and community-responsive action at the local level. Consequently, it also creates new challenges for the government in overseeing that local actions are in accordance with overall national health policies and goals.

1. First line recommendations

The first-line recommendations refer to the current situation of the healthcare system, i.e. centralized organization of services and financial management of public funding.

1.1. Recommendations to the state actors

- Improve the system of monitoring of public spending by healthcare institutions, provided directly through the central budget (preventive programs). The process should ensure participation of broad range of relevant stakeholders;
- Enforce mechanism for accountability for public spending from the preventive programs on national level, such as reviews on the impact of the programme and endorsing the recommendations for change at the level of planning and funding;
- Improve transparency and accountability of budgeting in health by introducing participatory budgeting for some public health spending, initially for the preventive programs. One such possibility might be the public-private partnership, but this should be further explored;
- Improve transparency and accountability of the healthcare institutions through introduction and enforcement of obligation to publish/make publicly available the financial plans and reports;
- Increase cooperation with CSOs and citizens, for improvement of citizens' participation in policy making and decision making. Recognizing CSOs as equal implementing partners and involving them more comprehensively in the processes will enable better outreach in the community and ultimately improved results on community level.

1.2. Recommendations to the CSOs and citizens

- Strengthening the capacity for monitoring of transparency and accountability of the public spending or healthcare on national and local level;
- Establishment of closer cooperation with healthcare institutions, for enabling the regular monitoring of the public spending, equitable delivery and satisfactory level of quality of care;
- Awareness-raising campaigns for the rights and responsibilities of both patients and healthcare providers and opening dialogue between them for discussing the problems and disparities.

2. Second line recommendations

The second-line recommendations refer to the future timeline of decentralized healthcare system, in which the local actors will assume more responsibilities for provision of healthcare to their community, and will be held accountable for the public spending in healthcare on local level.

2.1. Recommendations to the state and local government actors:

- Improve the system of monitoring of public spending by healthcare institutions, provided directly through the central budget (preventive programs). If the preventive programs are also fiscally decentralized, the system of monitoring of public spending will be directed towards the municipalities;
- Enforce mechanism for accountability for public spending from the preventive programs on local level, such as broad planing and monitoring procedures;
- Improve transparency and accountability of budgeting in health by introducing participatory budgeting for some public health spending, initially for the preventive programs;
- Define, prepare, and implement annual, medium-term and long-term work plans for the implementation of public health activities, including health promotion, screening of the population, and monitoring and control of communicable and non-communicable diseases on local level, by regional centers for public health. as defined under the Law of Public Health;
- Improve transparency and accountability of the healthcare institutions through introduction and enforcement of obligation to publish/make publicly available the financial plans and reports;
- Establish councils for public health on local level (by the local-self government units) that will consist of representatives from the municipality, regional centers for public health, CSOs and other stakeholders. The role of the council for public health, as defined in the law, is to develop policies and recommend actions pertinent to the public health to the municipality councils;
- Increase cooperation with CSOs and citizens, for improvement of citizens' participation in policy making and decision making.

2.2. Recommendations to the CSOs and citizens

- Strengthening the capacity for monitoring of transparency and accountability of the public spending or healthcare on local level;
- Establishment of closer cooperation with healthcare institutions and local government for enabling the regular monitoring of the public spending and quality of care;
- Awareness-raising campaigns for the rights and responsibilities of both patients and healthcare providers on local level and opening dialogue between them for discussing the problems and disparities.

Bibliography

- UNDP Report (2007) Human Development Report Bosnia and Herzegovina
- World Bank, „World Development Report 1993: Investing in Health”, World Bank 1993.
- Universal Declaration of Human Rights, General Assembly of the United Nations, adopted December 10, 1948.
Available at: <http://www.un.org/en/documents/udhr/index.shtml> (last accessed: September 2010).
- National nomenclature for territorial units of statistics (NTES-3), Official Gazette of the Republic of Macedonia no. 158/07
- Нацрт-Национална стратегија за намалување на сиромаштијата и социјалната исклученост [Draft-National Strategy for Poverty Reduction and Social Inclusion], Ministry of Labor and Social Policy website: http://www.mtsp.gov.mk/WBStorage/Files/strategija_socijalna.pdf (last accessed: October 1, 2010)
- Nordyke R.J., Peabody J.W. 2002. Market reforms and public incentives: finding a balance in the Republic of Macedonia. *Social Science & Medicine* 54:939-953.
- World Health Statistics 2009, WHO http://www.who.int/whosis/whostat/EN_WHS09_Table7.pdf
- National Development Plan 2008-2013, The Government of the Republic of Macedonia
- Law for changing and amending the law on health insurance, Official Gazette of the Republic of Macedonia, 67/09
- Law on medical records, Official Gazette of the Republic of Macedonia no. 20/09
- Law on health protection, Official Gazette of the Republic of Macedonia no. 38/91, 46/93, 55/95, 10/04, 84/05, 111/05, 65/06, 5/07, 77/08, 67/09
- Health Strategy of the Republic of Macedonia up to 2020
- The Constitution of the Republic of Macedonia, Official Gazette of the Republic of Macedonia, no. 52/91, 1/92, 31/98, 91/01, 84/03, 107/05, 3/09
- International Covenant on Economic, Social and Cultural Rights, Office of the UN High Commissioner for Human Rights: <http://www2.ohchr.org/english/law/cescr.htm> (last accessed: September 14, 2010)
- Law on health insurance, Official Gazette of the Republic of Macedonia no. 52/91, 1/92, 31/98, 91/01, 84/03, 107/05, 3/09
- Law on Mental Health, Official Gazette of the Republic of Macedonia no. 71/06
- Law on Occupational Safety and Health, Official Gazette of the Republic of Macedonia, no. 92/07
- Law on Biomedically Assisted Reproduction, Official Gazette of the Republic of Macedonia, no. 37/08
- Poverty Reduction Dictionary, <http://www.srds.co.uk/mdg/participation.htm> (last accessed: September 14, 2010)

Steering Committee for Advancement of the Healthcare was established in 2009, in a form of one central committee and 5 subcommittees on: organization of healthcare, healthcare management, financing of healthcare, patients' rights

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WHO/MOH Project on Good Governance of Medicines, UNICEF/MOH Project on Improvement of National Immunization Plan, etc.

Foundation Open Society Institute Macedonia (FOSIM) Project on Budget Monitoring of Immunization Activities among Roma population in the Republic of Macedonia, 2008-2010.

OECD/World Bank. "Beyond Public Scrutiny: Stocktaking of Social Accountability in OECD Countries, OECD/World Bank Institute Working Paper" 2006
http://www.oecd.org/LongAbstract/0,3425,en_2649_34129_38983243_119666_1_1_37405,0
0.html (last accessed September 2010)

Chemers, M. M. (2002). Meta-cognitive, social, and emotional intelligence of transformational leadership: Efficacy and Effectiveness. In R. E. Riggio, S. E. Murphy, F. J. Pirozzolo (Eds.), *Multiple Intelligences and Leadership*.

For more details on the distinction between horizontal and vertical accountability and on accountability mechanisms see: Cavill, S., and M. Sahail: "Strengthening Accountability for Urban Services" in, *Environment & Urbanization* 16(1), 2004; Malena, C., R. Foster, and J. Singh: "Social Accountability: An Introduction to the Concept and Emerging Practice" in, *Social Development Papers, Participation and Civic Engagement*, World Bank, Paper No.76, 2004

Law on State Audit, Official Gazette of the Republic of Macedonia no. 66/10.

Massachusetts Nurses Association Glossary of Terms, <http://www.massnurses.org/labor-action/labor-education-resources/union-finances/glossary#f> (last accessed: September 13, 2010)