An Expired Cure for the Health Reform

The Struggling Experience
of the Republic of Macedonia

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Bachelor Thesis: UTKV03, 15 hp
Spring Term 2013
Tutor: Axel Fredholm
Abstract

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Following the turbulent period of transition, starting in the early 90’s, many
Central and Eastern Europe (CEE) and Southeastern Europe (SEE) countries have
experienced painful domestic economic adjustments, and consequently huge political,
social and economic problems. The Republic of Macedonia belongs to the list of these
countries.

Since its independence in 1991, the country was in need of reforming the health
sector, but in accordance to the requirements and conditions set by international
organizations, and driven by the principles of the neoliberal ideology. However, up-to-
date the country is still struggling with these reforms.

The purpose of this thesis is to look into and reveal the main past and current socio-
political trends and further challenges the health system reform faces in the Republic of
Macedonia? For this purpose, the thesis seeks to determine how the health reform in
Macedonia is seen and understood and what obstacles and challenges the health reform
faces.

Keywords: Neoliberalism, health sector reform, beneficiaries, doctors, state
Acknowledgment

Special gratitude is dedicated to the tutor/supervisor, Axel Fredholm, for the assistance throughout this intellectual journey and for pointing the way out of the lagoon.
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1. Introduction

After the fall of the Berlin wall a “wind of change” blew from West towards the central, eastern and southeastern parts of the European continent. Many countries being previously behind the Iron curtain started to experience massive and tremendous political, economic and social changes. The changes in these countries were mainly driven by the neoliberal ideology and the need for structural adjustments in order to catch up with the other countries from the West. The transitional processes were focusing on shifting from the former planned/command economy structures and establishing liberal market economy structures, which should include deregulation, stabilization of inflation, marketisation, privatization and liberalization of international trade.

As many other transitional countries of Central and Eastern Europe (CEE) and Southeastern Europe (SEE), the Republic of Macedonia (hereinafter referred to as Macedonia), has experienced major transformation processes in both its economic and political systems. In light of the principles of neoliberalism and in accordance with the necessities for structural adjustments and reforms recommended and propounded by the international organisations, reforms of the health sector in the country were commenced (Milevska-Kostova, 2010). The focus of health reforms in Macedonia, since the 1990s, has been in accordance with the necessities for structural adjustments, and the conditionalities given by the international organisations, such as World Bank and IMF, on the promotion of private sector healthcare delivery. The country has started to incorporate market conditions for the health services provision and new funding allocation instruments (Marrée and Groenewegen, 1997; Cernic-Istenic, 1998). However, in a period of 22 years, Macedonia has failed to reform its health sector according to the requirements of the new political and economic order (Lazarevik et al., 2010: 8; Dimeski, 2011: 9; Apostolska et al., 2009: 3, 17).

1.1 Aim, purpose and research question

The intention of this thesis is to uncover and examine what social and political tendencies were associated with the reform of the health sector in Macedonia. It aims to look into and determine what the health reforms actually mean and represent, firstly to the beneficiaries/customers of the health services, secondly to the health workers, and consequently to the state. Its purpose is to find out how the health reform in Macedonia is
seen and understood, and what are the obstacles and challenges the health reform faces in Macedonia.

In order to successfully achieve the aim of this thesis the following research question has been addressed:

_What are the main past and current socio-political trends and further challenges the health system reform faces in the Republic of Macedonia?_

1.2 Structure of the thesis

The thesis is organised in the following way:

The next chapter deals with the research methods and approaches which were employed during the research process. It firstly describes the research design and methods that have been used in order to gain the most relevant and empirical data. Later on, it describes the process of data collection and data analysis. The third chapter provides background information, firstly about the characteristics of the process of transition from planned/command economy to market economy structures and later on, information about the form of health reform in Macedonia. This chapter supplies useful and necessary information that will help to have an overview on the three different periods of health system reform in Macedonia. The fourth chapter deals with relevant to the study’s theoretical and conceptual framework. It firstly discusses and provides an insight on the institutional monocropping concept and later on talks about the frequent donors’ inaccuracy. The fifth chapter analyses and discusses, at the beginning, the perceptions of the beneficiaries/customers on the health reform; later on, the perceptions of the health workers on the health reform; subsequently, it discusses and analyses how the reform of the health sector in Macedonia is seen, felt and understood; respectively, how the state struggle with the reform and what is the problem of political partitioning in Macedonia. The sixth (last) chapter recapitulates and concludes.
2. Research methods

2.1 Methods and design

The major goals and objectives of the research relevant to the study and this thesis were to grasp the meanings people in Macedonia attach to the health sector reforms in the country and their socio-political consequences. In order to grasp the insider's perspective and fully accomplish the initial and specific goals and objectives, qualitative methods and approaches have been employed and carried out throughout the study process. These methods and approaches are well able to deal with the complexity of social phenomena, can be used for a wider range of purposes and in a wider range of situations (Punch, 2005: 238). Additional reason for employing and carrying out these methods and approaches was the fact that they help the researcher to acquire a data which have a holism and richness (ibid.).

The research process proceeded through three subsequent research/study phases.

1. Desk study I – research/scientific literature overview
2. Short field study – 7 interviews (health sector staff) and 10 interviews (beneficiaries)
3. Desk study II – research/scientific literature overview, transcription and analysis

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<td>Desk study (II)</td>
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2.2 Data collection

During the desk study (I) phase, different library database browsing platforms and catalogues such as: LUBsearch and Lovisa at Lund University Library, but also Summon and (http://vega.bit.mah.se/) at Malmö University Library, and Google scholar (http://scholar.google.com/), were used, in order to search for useful research/scientific literature relevant to the study aims and objectives. Mostly literature data in English language was searched, but also available literature data in Macedonian, Serbian and Croatian language has been taken into consideration. The criterion for searching relevant and useful literature was based on several main topics: the relation between economy, health and development; health and development on a global level; the process of health sector reforms in Central Europe, Eastern Europe, South Eastern Europe and Macedonia; international assistance,
neoliberal policies and health policy creation and implementation in Macedonia; decentralization process and health sector reform in Macedonia.

During the short field study phase, semi-structured, in-depth interviews (Bryman, 2008: 196) were conducted in Kavadarci and Negotino (see Appendices 1 & 2). Seven of the interviews were conducted with personnel employed in healthcare facilities, four of which were conducted in Kavadarci, whereas three other were conducted in Negotino. Ten other semi-structured interviews were conducted with beneficiaries/customers of healthcare services, five of which were conducted in Kavadarci and five other in Negotino. The interviewees were randomly selected. Considering ethical issues, prior to the beginning of each interview the interviewees were provided with general information in regard to the research project aim, objectives as well as which methodology and approaches are planned to be used, the way the data will be handled and the purpose of using the accumulated data (Bryman, 2008: 201; Punch, 2005: 174-175). They were also assured that their anonymity in this study should be guaranteed. During some interviews, where agreeable, possible and applicable, audio recording, and/or note taking was included. Prior to the start of the interview, assuring that the data will be used only for purpose of the study, permission and approval for audio recording, and/or note taking was asked from the interviewee.

In order to collect in-dept information, representing independent and different views, perceptions, understandings and meanings attached to the health sector reform in Macedonia; during the entire process of data collection three different alternatives/angles were approached and consulted:

- Research/scientific literature
- Personnel employed in healthcare facilities in Kavadarci and Negotino
- Beneficiaries/customers of healthcare services in Kavadarci and Negotino

These three different alternatives/angles which are source of this set of information do not exclude each other but instead complement each other and add to the quality of data and by this make the data unique and specific.
During the desk study (II) phase, additional and supplemental research/scientific literature was researched and reviewed, and the data collected throughout this phase was cross-checked with the empirical data collected from the interviews during the short field study phase. Later on, the entire data collected throughout all three study phases was analysed.

2.3 Data analysis

In order to avoid biased interpretation and deal in productive and proper manner with the data which was collected throughout the semi-structured interviews, the Miles and Huberman framework has been used during the process of analyzing the data. The Miles and Huberman framework consists of three actions/components: data reduction, data display and drawing and verifying conclusions (Punch, 2005: 197). The data reduction component consists of coding, memoing and abstracting and comparing, and is almost always present during the analysis, but consequently is applied and used in different ways. Initially, data reduction is used through editing, segmenting and summarizing, but later on, it evolves through coding and memoing (Punch, 2005: 198). Coding has allowed to commence analyzing the collected data by putting names and tags i.e. during this process the collected data was broken down into small “pieces”. Memoing has been used simultaneously with coding in order to highlight the theoretical similarities between the common characters of the collected data and come up with ideas that may take place during the analyzing process.

In order to organize, compress and assemble the information, in a parallel to data reduction it was applied data display, which is the second component of the Miles and Huberman framework. Data display brought an overview of the current stage of analysis i.e. displayed the point the analysis came up so far, and provided with a foundation for additional analysis and categorizing (Punch, 2005: 198).

Through applying abstracting general picture has been withdrawn from the specific one and comparing has been used in order to make comparison between low and high priority concepts (Punch, 2005). The abstraction has helped to elevate from specific and develop more abstract understandings.

All three components of Miles and Huberman framework are interrelated and interconnected. Data reduction and data display are essential and joint parts of drawing and verifying conclusions (Punch, 2005: 199).
3. Background

3.1 From planned/command economy to market economy structures

After 45 years as part of the Socialist Federal Republic of Yugoslavia, in autumn 1991, Macedonia gained independence in a peaceful secession. After independence, the country moved towards developing parliamentary democracy and established its political system based on this political model (Gjorgjev et al., 2006: xiii; Lazarevik, et al., 2012: 176).

Since its independence, Macedonia has experienced major transformation processes in both its economic and political systems. In light of the principles of neoliberalism and the ideological framework of Washington Consensus policies, these transformation processes were focusing on fully establishing market economy structures, including deregulation, establishing private property ownership, creating a clear distinction between private and public sectors and the introduction of the necessary privatization trends in the public sector, liberalization of international trade, stabilization of inflation, and the development of small- and medium-scale enterprises (Gjorgjev et al., 2006: 5, Milevska-Kostova, 2010).

Inevitably and necessary at the same time, the country has commenced the reforming of the health sector (Milevska-Kostova, 2010). Health sector reforms were needed in Macedonia in order to overcome the problems associated with early phase of transition and changes in the social and economic situation, similar to those in other countries in transition (Ivanovska and Ljuma, 1999). The focus of health reforms in Macedonia as in many of the transition economies of Central and Eastern Europe (CEE) and Southeastern Europe (SEE), since the 1990s has been on the promotion of private sector healthcare delivery (Saltman and Figueras, 1997; Saltman et al., 1998). Governments of those countries (Czech Republic, Hungary, Slovenia, Slovak Republic, Poland, and Macedonia for example) have started to incorporate market conditions for the health services provision and new funding allocation instruments (Marrée and Groenewegen, 1997; Cernic-Istenic, 1998). One of the reforms of particular interest was the introduction of a stronger role of the primary healthcare (PHC) in the countries of CEE and SEE, which has been particularly challenging to implement as the rapid transition from command to market economy brought financial instability, decline in expenditures of social sectors, and inadequate organisational structures and financing systems (Atun, 2005; Shkolnikov et al., 2001). However, these challenges were justified with the rationale for improvement of efficiency and quality of healthcare services (Nordyke and Peabody, 2002).
3.2 The form of health reform in Macedonia

The priorities set in the agenda for reforming the healthcare system in Macedonia, supported by a World Bank credit, involved improvement of the quality, efficiency and effectiveness of the health services, with the primary healthcare (PHC) by strengthening the role of the market in healthcare provision (Nordyke and Peabody, 2002). Among the strongest reasons for reforms, besides the high inefficiency, has been that the health system did not appear to offer equitable access to basic health services, despite the social solidarity foundations (Milevska-Kostova, 2010).

Before the break up and dissolution of the Socialist Federal Republic of Yugoslavia, there was no private medical practice in the healthcare system. One of the specifics of the old Yugoslavian model of health system organization that left its mark in further development of the Macedonian health system was the notion of universal and free access of health services for all citizens regardless of their ability to pay (Saric & Rodwin, 1993). This means that all the citizens were included in the concept of national health or general health care in which the access to the health care services was available for everyone, medication was free of charge and health insurance was general and obligatory (Kamcev et al., 2010: 595).

The primary healthcare, which existed since the previous socialist system, has been transformed once together with the secondary and tertiary levels during the independence, by allowing the private initiative in the healthcare practice (Figure 1).

As a result of this transformation, the healthcare system in Macedonia is organized by public or private property health institutions divided on three levels: primary, secondary and tertiary healthcare (Figure 2).
The process of privatization of publicly-owned primary healthcare which started intensively in 2005, brought market rules into the healthcare sector in Macedonia. The transformation begun with the introduction of a capitation payment system for primary healthcare providers (Milevska-Kostova, 2010). The capitation payment model that was introduced is a patient-based capitation model, in which the physician receives a payment that is dependent on the number and type of patients registered (Chaix-Couturier et al., 2000). The primary healthcare providers that have been working in the public sector as general practitioners (GPs), paediatricians, dentists, gynaecologists, school medicine doctors and pharmacists (Gjorgiev, 2006) have been obliged to open private primary healthcare offices and sign a productivity-based capitation contract (for payment per registered patient) with the Health Insurance Fund (HIIF) (Milevska-Kostova, 2010). For further savings in the system, the Ministry of Health and the Health Insurance Fund have enabled the concession of public primary healthcare clinics to private groups or to newly privatized primary healthcare providers and pharmacists (Nordyke, 2000).
3.3 The three different periods of health system reform


<table>
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<tr>
<th>First period</th>
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<th>Third period</th>
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<tr>
<td>- Constitutional right to health protection</td>
<td>- Adoption of Health Insurance Law</td>
<td>- Political platform (manifesto) for health sector reforms</td>
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<td>- Adoption of the Health Care Law 1991</td>
<td>- Purchaser/provider split reform</td>
<td>- Health management – two directors in public health institutions</td>
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<td>- Development of health insurance system</td>
<td>- Separate Health Insurance Fund from the Ministry of Health</td>
<td>- Reorganization of the University Clinical Centre</td>
</tr>
<tr>
<td>- Transfer of ownership from social to public</td>
<td>- Development of the capitation model</td>
<td>- Strategic purchasing function of HIF</td>
</tr>
<tr>
<td>- Reestablishment of professional associations and medical chambers</td>
<td>- Continuous medical education</td>
<td>- Decentralized procurement</td>
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<tr>
<td>- Introduction of the system of referral and choice of doctor</td>
<td>- Purchasing equipment</td>
<td>- Advanced rights of patients</td>
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<td>- Introduction of co-payment for health services</td>
<td>- Strengthening perinatal care</td>
<td>- Reference and set-pricing of pharmaceuticals</td>
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<tr>
<td>- Promotion of private practice ownership</td>
<td>- Decentralization and new territorial organization</td>
<td>- Development of contracting process;</td>
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<tr>
<td>- Humanitarian and development assistance programmes</td>
<td>- Privatization (dentistry, pharmacies, primary clinics)</td>
<td>- Health insurance for all</td>
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<tr>
<td>- Maintaining features of the old system</td>
<td>- Opening of private hospitals</td>
<td>- Purchasing new equipment;</td>
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<td>- 1996 World Bank – Health Sector Transition Project #1</td>
<td>- World Bank- Health Sector Transition Project #2</td>
<td>- Renovating health facilities</td>
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(Source: Lazarevik et al., 2012: 182)

Table 1. - Three periods of health system reforms in the Republic of Macedonia 1991–2011

All these three periods of the health reforms in Macedonia (1991–2011) are determined by the shifts in political decision-making, change of governments and their influence over the health policy priorities and goals, as well as allocation of resources (Lazarevik et al., 2012: 178).

The first seven years after the independence of Macedonia, from 1991 to 1998, has been determined as a post-socialist period. The period that took place after the parliamentary elections in 1998 and which coincides with the first official shift in political power from left-
oriented former socialists to centre-right conservatives is referred as the pro-market period in healthcare reforms. The third period of health sector reforms in Macedonia, the manifesto period, came after the elections in 2006, as outcome and an integral part of the political manifesto of the upcoming government, which marked a turning-point in the promotion of new health system reforms in the country (ibid.).

The post-socialist period of health reforms occurred when the first transition of government from socialist democrats to Christian democrats took place. The post-socialist period was characterized by attempts to prevent the collapse of the health care system and to maintain some positive characteristics of the old socialist system such as “strong prevention, free access, and solidarity in financing” (ibid.). In this post-socialist period the government of Macedonia signed the first Loan Agreement with the World Bank for health sector reforms, and during this period the country received from many international donor agencies and countries which have good foreign relations with Macedonia, huge humanitarian assistance for the healthcare sector in pharmaceuticals, medical devices and equipment (Lazarevik et al., 2012: 178).

During the pro-market period very intensive health sector reforms occurred in Macedonia, mainly initiated and guided by the World Bank’s Health Sector Transition Project. The most crucial for designing of structural adjustments and financial reforms, as well as development of health policies in the healthcare sector in Macedonia were the influence and pressure of the international institutions such as the World Bank and International Monetary Fund (IMF) (Lazarevik et al., 2012: 179, 183).

Within this period, the Health Insurance Fund was formally separated from the direct control of the Ministry of Health. In 2000 a new Health Insurance Law was adopted and the Health Insurance Fund was established as a semi-autonomous health insurance agency, after which the Health Insurance Fund was to improve transparency and efficiency in financing and delivering health care services. The health reforms during the pro-market period continued with preparations for privatization of the primary health care clinics and implementation of the patient-based capitation model, in which the physician receives a payment that is dependent on the number and type of patients registered (ibid., Chaix-Couturier et al., 2000).

In 2001, Macedonia witnessed an internal armed conflict, which ended with the Ohrid Framework Agreement. During the following years the pace of the healthcare reforms declined to resume and as one of the tenets of the Ohrid Framework Agreement, decentralization of Macedonia emerged. A new law on local self-government was subsequently passed and basic healthcare was decentralized to municipalities. In 2004 with
the changes in the Health Care Law the Ministry of Health for the first time opened the possibility of privatization of parts of the public healthcare system including dental clinics and pharmacies. With the additional amendments adapted to this law in 2005 the privatization of the practice of primary health care doctors was to be initiated (Lazarevik et al., 2012: 179).

The private health care sector also felt the pro-market wave of the reforms. This pro-market period has been characterized with the development and opening of big private hospitals for cardio-surgery, gynecology and obstetrics, and one general hospital. The private health care sector was developing and working in parallel to the state hospital system. At that time the Health Insurance Fund signed contracts to cover the services provided in the cardio-surgery hospital but not with/in the other private health care providers. Thus, unavailability of insurance requires the patients/beneficiaries who choose private health care providers to pay out-of-pocket for the services provided (Lazarevik et al., 2012: 180).

The manifesto period, or the third period of health sector reforms in Macedonia, has been characterized as a turning-point in the promotion of new health system reforms. This promotion of new health system reforms was an integral part of the political manifesto of the government created after the elections in 2006. Key features of the government programme were to decrease out-of-pocket expenditure for health, to improve efficiency and transparency at the level of health care providers, to advance patients’ rights in all medical interventions, and to strengthen the position of the Health Insurance Fund as strategic purchaser of health care services (Lazarevik et al., 2012: 182). The manifesto period in healthcare reforms in the Macedonia will be remembered for its promising start, great enthusiasm, profusion of activities, and political promises to improve the health system delivery, but overall with limited success. The main objective of the manifesto period of the health reforms in Macedonia, which was to decrease the out-of-pocket expenditure, has not been accomplished (ibid.).
4. Theoretical and conceptual framework

4.1 Institutional monocropping

During the process of building institutions that will promote development in the countries of the global South, the prevalent method that has been usually practiced was to impose uniform institutional blueprints which are based on Anglo-American idealized models of institutions. Evans (2004: 31) started to call this process “institutional monocropping”, comparing and equating it with the old-fashioned models of agricultural monocropping (Evans, 2004: 33). The concept of institutional monocropping, as Evans (ibid.) argues, rests on both the general assumption that the effectiveness of the institutions does not depend on corresponding with the local sociocultural environment, and the more specific assumption that idealized versions of Anglo-American institutions are the best, most favourable or desirable developmental instruments, regardless of level of development in any country of the global South, or its position in the global economy (ibid.).

International organizations, regional and local policy makers, and private consultants, all together are often enforcing the presumption that the most advanced countries of the North have already found the best institutional blueprint for development and that this institutional blueprint is applicable everywhere, no matter different national cultures and circumstances. They are enforcing this presumption with increasing aggressiveness across a range of institutions – “from debt-to-equity ratios in private firms, to relationships between central banks and bank presidents, to the organization of public hospitals or pension systems” (Evans, 2004: 33). However, Evans (2004: 35), refers to Chang (2002), and mentions that the institutions that are currently imposed on the countries of the global South are not in fact those that characterized the now-developed countries during the period when they developed, and that the imposition of these idealized institutions will hinder, not facilitate, development in the countries of the global South. The governance-related conditionalities imposed by the international financial institutions (IFIs), such as World Bank and IMF, which usually do not “take”, and often fail to produce the expected results even when adopted, as Evans (2004: 35) argues, are the most obvious concrete examples of monocropping’s lack of efficacy.

Evans (2004: 31), refers to what Dani Rodrik and Amartya Sen have argued, that there should be an alternative to monocropping, where institutions that improve citizens’ ability to make their own choices will be fostered, instead of imposing a “one best way”, which is based on the supposed experience of now-developed countries. When there will be strong
institutions that improve citizens’ ability to make their own choices, the citizens will be able to participate in public discussion and exchange, where they can propose strategies and solutions, and by this will directly be involved into processes of governance. As Evans (2004: 36) suggests, this is a process of deliberation and planning with other participants, or as called “deliberative democracy” or “empowered participatory governance” (according to Fung and Wright (2003: 20)). The further development coming as a consequence out of this deliberative democracy process could be called “deliberative development” (Evans, 2004: 37).

4.2 The frequent donors’ inaccuracy

While questioning and criticizing the “quality” of development assistance, Birdsall (2004) identifies and puts forward “seven sins” that donors are responsible for, while being involved in conducting the “business of aid”.

Firstly she addresses the (i) impatience by the donors with institution building. The importance of good and strong institutions is often emphasized by many development theorists and the development “can be thought of as a process of creating and sustaining the economic and political institutions that support equitable and sustainable growth” (Birdsall, 2004: 4). But as Birdsall (ibid.) argues, the donors, in great majority of developing countries where political and economic institutions are weak, have not generally had patience for the long-term challenge of building new institutions. This impatience comes as a result of the fact that the foreign aid is budgeted annually in the donor countries, and the donors are impatient to disburse money and are pushing for “results” even in cases of post-conflict or failed states, where nation building requires many years of predictable and continuous support (ibid.).

The second donor sin according to Birdsall (2004: 8-10) is (ii) envy or collusion and coordination failure among donors. Donors are colluding by tending to operate in “many countries and in many sectors within countries” i.e. donors want to be everywhere. This creates “fragmentation” at the recipient country level what is seriously degrading the limited public sector capacity and institutions in the recipient country.

The failure to evaluate or (iii) ignorance has been recognized as third donor sin. The high suspicion in the donor countries that finance assistance about that much such assistance is wasted can influence on the political decision most likely to limit than to expand foreign aid budgets. Beside the fact that rigorous evaluation in costly, those who work in the developing countries and donor officials are often ignorant or do not invest in long-term evaluation of what they do in the recipient country because they are “careful” that if any long-term rigorous
evaluation results are negative and show that they failed in implementing successfully the previously planned program the foreign aid budget is to be limited by the donor countries that finance assistance and those who work in the developing countries and donor officials are most likely to be withdrawn from further program implementation (Birdsall, 2004: 11).

The forth deadly sin addressed by Birdsall (2004: 13-14) is (iv) pride donors have, or the failure and unwillingness to exit from programs and countries “where their aid is not helping” (Birdsall, 2004: 13). This donor sin is correlated with the first one – impatience. The impatience to spend money, and push for “results”, even if these results are negative is in strong correlation with an inability and unwillingness to stop large flows of assistance and big spending while remaining engaged (ibid.).

Donors are pretending that “participation” is sufficient for “ownership” and they even consider participation as an adequate substitute for ownership (Birdsall, 2004: 15-16). The participation approach demanded by donors claim that “participation” of citizens through civil society groups is sufficient to secure “ownership”. Here, Birdsall (2004: 15) founds the fifth donor sin: (v) sloth, and argues that the role of local governments and legislatures is undermined and many socially vulnerable groups are excluded from civil society participation. She further argues that not enforcement for participation and reforms implementation through loan conditions can help reforms instead the receiving/developing country should have “ownership” of a reform agenda in order to be able to implement desired reforms (ibid.).

The sixth and seventh donor sins* (vi) greed (unreliable as well as stingy transfers) and (vii) foolishness (underfunding of global and regional public goods) are intentionally left uncovered while presenting and formulating the theoretical framework of this paper, this due to the fact that only the first five sins presented above are going to be used as part of the theoretical framework and basis for later analysis within this paper.

* - If eager to get familiar with the last two sins please consult Birdsall (2004: 16-22).
5. Analysis and discussion

5.1 The perceptions of the beneficiaries/customers on the health reform

In a liberal socio-political environment, the perceptions, needs and interests of the citizens as beneficiaries of health care services have a crucial importance and should be taken into consideration during the reform process (Ljubljana Charter on Reforming Health Care, 1996). However, the role of the citizens in this process in Macedonia is negligible, i.e. they know insufficiently their patients’ rights and are not very initiative and active. This is obvious in the following two quotations:

‘Nobody ever asked my opinion about the changes the politicians are doing in the healthcare. They just change some laws and regulations and we, the citizens sometimes even do not have a clue about these changes, until we go to the doctor or pharmacy and realize it ourselves... We can not follow them and feel very tired from all these changes which are occurring in the healthcare sector.’

(Interview 7 [IB7], 04.03.2013)

‘The politicians are just coming to talk to us when they need our votes. And even that I feel very frustrated some days I do not know how and where I can complain and tell my needs and opinion about the healthcare sector in our country. I feel my voice will be never heard because I am not a politician but just an ordinary citizen.’

(Interview 3 [IB3], 26.02.2013)

Overall, it is apparent that citizens know insufficiently their patients’ rights and are not very initiative and active due to underdeveloped civic culture (ignorance of the civil rights, lack of knowledge in the forms of civil action and expression) (Patumen, 1980; Almond and Verba, 1989), and the lack of transparency of the system of health care services and, in general, the public sector. This can be seen through the following statements made by two interviewees:

‘There is not too much I can do in order to change the current situation. There are some others who are deciding about our own health and I can say even about our own life, because if we have a bad health we have a bad life too.’

(Interview 5 [IB5], 28.02.2013)

‘It is so difficult to find some clear information about the frequent changes they are doing. I learn about it when only being affected by these changes.’

(Interview 1 [IB1], 25.02.2013)
From these statements it is evident that there is dissatisfaction with the health care reform in Macedonia. Citizens expect health reform with improvements which will be centered on them. Here they look at the reform from two different aspects – when they are in a role of beneficiaries of health care services (patients) and when in a role of tax payers.

From the aspect of beneficiary there were several points of dissatisfaction stressed out.

Firstly, as it is apparent in the following three quotations, the difficult and unequal access to the health care services has been emphasized.

‘Last time when I needed to visit a doctor, I had to wait couple of weeks before I was able to get to there. But there are people who are in urgent need, as for example to go to surgical operation, and are put to wait really long time...this is extremely inhumane and irresponsible.’

(Interview 10 [IB10], 07.03.2013)

‘Few times when I was waiting in the corridor, before entering the doctor’s room I have experienced a situation when some other patient is taken into the room before me, even if this person was supposed to go in after me, only because of wearing better clothes or being friend or relative to the doctor or the nurse.’

(Interview 6 [IB6], 04.03.2013)

‘There are different doctors, some of them are expecting from us, the patients every time we visit them to bring some “presents” to them. This makes me really disappointed and irritated. There is even a saying here in Macedonia in a favor of this kind of doctors: “To the doctor you better never go with empty hands”.’

(Interview 5 [IB5], 28.02.2013)

According to the statements above the long waiting time (long queues) for getting to the doctor or surgical operation, discrimination on a social and ethnic basis, corruption in the health sector are just additionally increasing the dissatisfaction of the beneficiaries.

The behavior of the health staff and personnel is an additional issue that dissatisfies the beneficiaries (patients). This is evident in the following quotation:

‘Very often the nurses and doctors are not paying attention to my health problems. I go to them in a hope to receive there all the necessary care and medical treatment but several times I felt that they are focused on their private issues and ask me to come to them over and over again... It happened once to me, that during the medical examination someone called the doctor on his phone and he went out from the room... I waited there for a couple of hours.’

(Interview 8 [IB8], 05.03.2013)
General remarks are those that the health care staff is not interested/concerned about the patients, they are so slow in delivering the services, not responsible and in some cases even not human.

There are also significant problems with delivering the therapy and problems with the compliance, which are evident in the following three quotations:

‘With my low salary I can not afford to buy the medications which the doctor prescribed to me... they cost half of the salary I receive per month.’

(Interview 6 [IB6], 04.03.2013)

‘Last time when I visited a doctor, I got prescribed medicaments that I could not find in any pharmacy in the town... sometimes there are medicaments which are only available on the private list, this means I have to pay for them out of my own pocket.’

(Interview 2 [IB2], 26.02.2013)

‘I avoid going to the doctor until the moment I feel badly ill because few times I went there they told me that the medical equipment is out of order and I should come after a couple of days, when they will fix it.’

(Interview 1 [IB1], 25.02.2013)

From the quotations above, it is obvious that very often the medicaments/drugs are too expensive for the patients or there is a deficit/shortage of them, while the medical equipment needed for therapy is not working or is not used. The obstacles in the communication with the doctors together with the shortage of drugs are opening the question of compliance or patient’s noncompliance with the recommendations of therapy from the doctor. It seems that the patient often does not follow the recommendations of the doctor. The problem with shortage of drugs for serious illnesses/diseases is already a chronic problem in Macedonia and when the politicians want to show that they understand the need for health reform they talk about this problem (MOHRM, 2007; LBIHIR, 2008). However, it is clearly evident that the access to health care services, the behavior of the doctors and medical personnel towards the patients are still not open as serious political issues of rights, responsibilities and freedom.

Hence, during the process of health reform creation it should be taken into account what the perceptions and the needs of citizens are. It should constantly be measured how much the citizens are satisfied with the health care services. Beside the fact that accurate evaluation can be costly, there is often ignorance by the international organisations for investing in long-term evaluation (Birdsall, 2004: 11).
The citizens are also concerned with the financial aspect of the health care sector. There are few points to be emphasized. Firstly, as evident from the following two quotations, citizens have concerns about how the health care sector is going to be financed and about the quality of the public health care.

‘With the recent changes they are doing in the health care sector I am worried that I will have to pay from my salary for health insurance much more than I used to pay before.’ (Interview 4 [IB4], 28.02.2013)

‘Very often the money from the health insurance is not spent rationally and transparently... I suspect the government uses this money to cover some holes in their budget.’ (Interview 2 [IB2], 26.02.2013)

The citizens (tax payers) are interested to know about the percents that they should pay from their incomes for health insurance, the way money is spent, also about all forms of additional payment. Furthermore, they are also concerned about the quality of private health care and its place in relation to the public health care. This is obvious in the following quotation:

‘Every month I pay from my salary for health insurance... when I visit a doctor in the state-owned healthcare facility I expect that I will be able to receive all the necessary medical care and treatment, equipment that will be fully functional and will operate. But mostly I expect that the staff there will have friendly approach towards me. What I often find and experience there is completely opposite from what I am expecting. That is why I often choose to go to some private clinic.’ (Interview 9 [IB9], 06.03.2013)

In Macedonia it can be said that there is a financial parallelism between the private and public health care from the aspect of the citizen as beneficiary of the health care services. The citizen who regularly contributes in the public health care, very often uses the services of the private health care. In some cases the money that is spent on a yearly basis directly out of the pocket for the services delivered from the private doctors can amount more than the money that is spent for the public health care (internist and cardiology examinations, birth delivery etc., in private clinics) – and all this because of the better quality of services (easier access to health services, faster diagnosis, more organized therapy). It can be said that with the introduction of the private health care, the citizens spend more money for their own health while do not see any improvement in the public health care.
Big part of the costs for health in Macedonia is going for drugs/medicaments (Lazarevik, 2010). Hence, control of supply, price, distribution and release/prescriptions of drugs is an issue on which citizens have to be informed and for which they can demand accountability from public institutions (primarily the Ministries of Finance and Health) (ibid.).

The reform should take into account all these questions and concerns. Only with concrete/specific answers on these questions the health care system may be more efficient and more economical (i.e. not too much money to be spent).

The concerns of the citizens about the financial aspect make the health reform a big political question. Therefore, it is important how much the reform as political action is accepted by the citizenry. Do they understand it, do they believe in it, how much they are informed about the reform. The reform that will create gap between the policy and citizens is actually missing its aim. In any case, the aspect of concern of the citizens makes the reform more complex and politically sensitive. Economical requests are only one side of the reform. The other side is the requests of the citizenry. So, the big question is to what extent the reform can be pushed against the requests of the citizenry. Therefore the reform that is not accepted can not lead towards prosperity since it will not be possible to be implemented (Kooiman, 1993). Because of this the health reform can not ignore the perceptions and requests of the citizens. In a liberal democratic society the health reform must face also with the issue of fairness, equity and equality in terms of access to health services, and not only the efficiency of utilization and cost of services. Health reform in transitional countries did not see/take seriously these warnings (Daniels et al., 2005; Kruk and Freedman, 2008). But, it holds the fact that with such reforms which have emphasized liberalization and privatization came oppression of lower socioeconomic groups and the elderly (Solar and Irwin, 2010; BTI, 2012; Milevska-Kostova et al., 2011; Lazarevik et al., 2009; Gjorgiev et al., 2006). Therefore, it is not surprising that it is these groups who have a negative attitude towards (such) reforms.

From this, a general and a specific conclusion arise. Namely, that formulation of health reform goals should rely more on the rights of health service users and citizens' attitudes. In this regard, the World Health Organization (WHO) through its European regional office clearly demands this from those who are responsible for the reforms. The principles of health reform set by WHO strongly emphasize the rights of beneficiaries of health services and the requests by the citizens (Kickbusch and Gleicher, 2012; WHO, 2008). Also, Ljubljana Charter on Reforming Health Care from 1996 states that health reform must take into account the needs of citizens and their expectations.
5.2 The perceptions of the health workers on the health reform

Doctors and workers employed in the healthcare sector are not satisfied with their economic and social status. For more than 15 years they receive low wages which are founded largely by the state budget. This is obvious in the following quotations:

‘Since 1998 my monthly salary amounts more or less the same amount for every month. While the product prices in the shops and almost all the basic life expenses are incredibly rising year by year, our salary stays the same for all these years. The state does not really care about us the doctors if we have enough money to live on and how we can make ends meet at the end of each month.’

(Interview 4 [IMD4], 05.03.2013)

‘Both my husband and I are employed in a state medical facility. He works as a general practitioner and I work as a nurse at the same medical facility… we both think that the salaries we receive are very low for the work we are doing. Those in the government are thinking only about themselves and are getting good salaries while we are struggling with economical difficulties day after day.’

(Interview 7 [IMD7], 08.03.2013)

In a situation when privatisation is rapidly expanding and the importance is given to the market and market valuation of labour, doctors and workers employed in the healthcare sector are even more dissatisfied. This is evident in the following statements:

‘The government is pushing their privatization agenda without having any interest to hear about our concerns and everyday problems we are dealing with at our working places. They just want us to privatize out health care services but are not eager and able to help us to overcome all the financial and administrative obstacles in this process of intentionally imposed rapid privatization.’

(Interview 3 [IMD3], 01.03.2013)

‘All this we have built all together during few decades the state wants to sell out right here and right now. They do not want to sell out only the medical facilities and inventory but in a package, together with these they want to sell out also us, all the medical staff. They put a price on us, and want to value our work performance on an individual basis. With this we are becoming a commodity...’

(Interview 6 [IMD6], 07.03.2013)
However, as the following quotations indicate, what the doctors and the other medical and health personnel can do themselves and what they should expect from the state and reform are questions to which they can not clearly and unambiguously respond:

‘I am not quite certain that we as doctors have a strong voice and can do a lot to change this situation which is occurring nowadays in the health sector. The government together with the Ministry of Health is pushing the privatization and marketization process of the health sector and is keen to privatize the entire health sector, soon or later. We, the medical staff are not that strong to go against the will of the government.’  

(Interview 3 [IMD3], 01.03.2013)

‘I am very disappointed with the entire process of reform in the health sector but I cannot complain to anywhere because my voice is not going to be heard. I often talk with my colleagues and notice that they also do not like how the health reform and the privatization process of the health sector went and are still going on. Anyhow, we just keep on talking...and do not have power to change and improve anything.’  

(Interview 5 [IMD5], 06.03.2013)

Furthermore, the doctors and other personnel employed in the healthcare sector are in discrepancy between active participation as physicians and medical staff in changing the working conditions or passive indulgence when the state and political parties are to decide about their status. This is obvious in the following quotations:

‘We are not very coordinated and therefore do not have that much power to be able to influence the decisions about improving the working conditions at our working place. Most of the decisions that are made have a political character and are coming from above, either from the state or from the most influential political parties.’  

(Interview 3 [IMD3], 01.03.2013)

‘I am not sure if it is better to take an active initiative ourselves and push changes for better conditions at our working place...or to keep calm and wait to see if the decisions the government has made will be positive and productive. There are cases when if being too proactive, person can be fired from work.’  

(Interview 7 [IMD7], 08.03.2013)
As the quotations given below suggest, the undefined terms and relation between the public and private healthcare represents one of the actual and acute issues among the doctors in regard to their active participation for improving their status in Macedonia. This due to the fact that the entrepreneurial spirit of the doctor is increasingly developing and there is increased push for transformation from public to private healthcare. As is obvious from these statements below, despite the constant undermining of doctor’s status in public healthcare institutions, the uncertainty and risks inherent in the status of private doctor not each doctor can accept:

‘The government is pushing us to privatize and marketize our services but forgets or fails to bring us a clear picture of what private and public health care services means and what the difference should be between these two. I know many colleagues, who are working during the morning hours in our clinic, but during the afternoon hours they work in private owned clinics, or even some of them have opened their own private medical facilities even though they are still employed in the public health care sector.’ (Interview 1 [IMD1], 27.02.2013)

‘It would be impossible for me to privatize and establish my own private clinic even if I have to do that soon or later. First of all, I need a lot of money to do this, and the salary that I receive is extremely low for even starting to think about this. Even if I would be able to somehow do that, for example maybe to take a bank loan, the economy of the country and the health care services market is so unstable that the risk is too high and I will face a lot of problems and difficulties to continue running my own private facility/practice and giving back the money to the bank.’ (Interview 6 [IMD6], 07.03.2013)

The uncertainty which turbulent market brings, low paying ability (purchasing power) of potential patients, poor conditions for starting a private practice (inability to take a favourable loan, etc.), disorganization and lack of coordination of private medical practice, the unpersuasive reforms the government carries out are all demotivating factors when making a decision to start a private practice. Hence, the need for professional, existential and psychological security and certainty contributes toward decision of the doctors (and healthcare workers) to reconcile with poor working conditions (the "public/state job") by comparing it with the uncertain and precarious private practice.
The following quotations suggest that another actual issue among the doctors in regard to their participation for improving their status is a lack of systematic solutions proposed by professional association of doctors:

‘If we want to change something and improve the difficult situation we face with everyday we must unite and all together speak out about the problems we experience at our work for such a long time. The main question is how to unite when there are colleagues with completely different views and positions.’

(Interview 3 [IMD3], 01.03.2013)

‘There is a significant confrontation between different groups of doctors and other medical staff which are formed by different family members (relatives), different peer groups and sometimes groups which are formed by colleagues according to which political party they are affiliated with.’

(Interview 7 [IMD7], 08.03.2013)

The dissension based on different kinship and age/generation, as well as the high politicisation (Dimeski, 2011: 9) are to prevent most attempts to set strategies and projects aimed at reforming healthcare sector. An additional factor which negatively affects the doctors to professionally associate, as the quotations below indicate, is the gap between junior/younger doctors who are without much power and older, long-established (especially those who have the support of political and party elites, since the previous state system of the Socialist Republic of Macedonia):

‘I feel very frustrated when some of the older colleagues that I have, who have close ties with the political parties, and who hold the power, are putting and keeping us, the younger ones, on the margins and do not want to associate and cooperate with us in order to act together and to improve the situation for all our colleagues both younger and older.’

(Interview 1 [IMD1], 27.02.2013)

‘I appreciate my younger colleagues and think that we must all work together on bettering our working conditions, because they are the same for everyone who works here. However, there are colleagues from the “older generations” as I am but who do not think the same as I do. They do not agree that the younger colleagues should contribute into the process of decision making and improvement.’

(Interview 5 [IMD5], 06.03.2013)
The gap between junior/younger doctors and older doctors is manifested also in terms of management activities in the healthcare sector. Young doctors think that the older doctors are hindering the change, while the older doctors consider themselves still competent to manage. This is evident in the following quotations:

‘There are few older colleagues in this hospital who hold the ropes in their hands and do not let to the other colleagues, particularly to us, the younger ones, to come up with any creative and new idea about positive changes. They always consider the ideas coming from their younger colleagues not to be relevant and not worthy to be taken into consideration... All these circumstances create conflicting situation which have negative consequences.’

(Interview 4 [IMD4], 05.03.2013)

‘Our younger colleagues do not have the necessary experience, knowledge and skills to be able to make right decisions and to manage any changes in the health care sector. To be able to manage in the health care sector they should be competent and have relevant experience which can be gained during many years of work in this sector. They are young and do not have this relevant experience.’

(Interview 6 [IMD6], 07.03.2013)

The disunity together with the discontent not only makes doctors politically uncoordinated, but encourages corruption and nepotism in healthcare sector. The quotations below indicate that corruption is a major problem for doctors:

‘I consider taking money or any presents from the patients as an unethical attitude. However, there are some doctors, even though they have sworn the Hippocratic Oath to practice medicine honestly, they are asking money from patients who are severely ill.’

(Interview 4 [IMD4], 05.03.2013)

‘Some of the patients are giving money as gratitude to the doctor. And of course this is becoming a tradition also because of the fact that some colleagues are affirming and sustaining this patient-doctor approach.’

(Interview 2 [IMD2], 01.03.2013)

‘I have some colleagues who are famous and “well known” for asking money from the patients...They do not get suspended or expelled from work because they have close ties and are affiliated with the major political party in the government... Anyway, it is against my ethics to ask and take money from the patients. I am here to treat and cure illnesses of the patients.’

(Interview 5 [IMD5], 06.03.2013)
It is apparent from the quotations above that the corruption of the doctors goes hand in hand with the certainty that there will be no sanctions, because corruption, though publicly condemned, is considered normal and therefore socially acceptable. Corrupt doctor does not feel like a criminal. Close contacts with the government (political parties, police, and judiciary) and the media further provide that certainty. In this sense, it can be said that corruption is a phenomenon that makes dissension and disunity in the health professional association; it divides firstly, to those who are corrupt and those who are not, and secondly, to those who are not interested in change and those who are. These two divisions are reinforced by a third division between doctors who are close to the government and those who are not.

As the following quotation points out, nepotism is a phenomenon that goes along with the corruption and, as a rule, can be located in the same professional circles which are suspected to be corrupt:

‘Few doctors and managers in this hospital who are holding the top positions have many of their relatives employed here. There are two options for the recently graduated doctors to get employment here. Either to be a close relative of some of the doctors and managers who are holding the top positions, or to have a lot of money to pay in order to be able to get a job.’

(Interview 1 [IMD1], 27.02.2013)

The power provided by these phenomena (nepotism and corruption) is found in those who have higher and managerial functions in the healthcare sector. Compensating with this the unsatisfactory social and economic status, they are not ready or motivated to spend energy to work on changing the status through participation in professional association and action. This is evident in the following quotation:

‘I do not see any need for some changes of the working conditions and the doctor’s status. Everything is just fine. I am satisfied with the working conditions at my working place...there are of course some colleagues who are complaining about their working conditions, but I think that they are just exaggerating.’

(Interview 2 [IMD2], 01.03.2013)

This directly discourages those who are resistant on these, as they call them, "socially negative phenomena" (corruption and nepotism) for greater engagement in the field in terms of organization and management. As the quotation below reveals, this affects both the practice and professional careers of those who are outside the "dirty games":

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‘Only those colleagues who hold the power in their hands are against any changes. Because if there are any changes to occur these colleagues can potentially lose their power, and this is the main reason why they are against any changes. I personally think that changes are necessary, but as the colleagues who have the power oppose them I am not certain they are going to happen soon.’

(Interview 4 [IMD4], 05.03.2013)

The enthusiasm of the young doctors (or anyone who has enthusiasm for change) quickly falters as a reaction to feelings of helplessness and exploitation either specifically by the powerful ones from the healthcare sector, or generally by the state. This is reflected in the following quotations:

‘I am very eager for improvement of the working conditions and for making them better. There are also other young colleagues who are keen to see and experience changes. Anyhow, even if we would be able to organize ourselves and try to act together I do not think we will succeed in initiating any changes from which we will benefit...Some other colleagues which are against changes have more power than we do.’

(Interview 3 [IMD3], 01.03.2013)

‘I do not see anything promising in organizing ourselves in one professional association when I notice that there is disintegration and fragmentation of our professional interests, needs and perceptions for change.’

(Interview 1 [IMD1], 27.02.2013)

It is evident that in Macedonia, the doctors’ dissatisfaction goes hand in hand with the unwillingness to act in an organised manner and in accordance with long-term objectives, which are related to the healthcare as a system and to the medical profession as association. Furthermore, the discontent is not channelled into a more argumentative attitudes and demands of the medical profession. This opens a space where others, who have political power, are deciding about the medical profession. This is obvious in the following quotations:

‘Until the moment we are not going to coordinate and organize in one professional association through which will be able to speak up with one voice all our concerns, needs and demands, there will be the major political parties and the government who will be deciding about our profession and future.’

(Interview 3 [IMD3], 01.03.2013)
'The director of this medical facility has been assigned immediately after the last governmental elections by the major political party who won the elections...since then all the decisions are obediently made in accordance with the policy of this political party which is in the government.'

(Interview 2 [IMD2], 01.03.2013)

Hence, the political representatives of the doctors or the doctors who receive managerial positions with political/partisan appointments often make unsubstantiated decisions with arbitrary character, no matter that they are relating to the health care sector and its reorganization, and in that sense affects them too.

This situation when others decide about the health care sector does not encourages the need for reinforcement of the professional medical association, but strengthens the phenomenon of political engagement of doctors - a manoeuvre that some doctors make it out of the profession in order to improve things in the health care and the status of the medical profession. This is evident in the following quotation:

‘Many of my colleagues who were not politically active before, in the last couple of years became members of some of the major political parties. They did this in order to be politically active and to be in a position from which they will be able to influence the decisions about our profession and by this improve our working conditions. Because of these reasons I have also joined one of the major political parties recently.’

(Interview 4 [IMD4], 05.03.2013)

However, the exit out of this situation of dissatisfaction can be likely found in a more serious organizing of medical workers in an association which will be able (politically and professionally) in an argumentative manner to defend its positions. If aiming towards better conditions, the medical profession must be built as a centre of power and to establish itself as an equal partner in the strategic conflicts with the state (government).

5.3 How the reform is seen, felt and understood

The need for reform arises both from inside – the beneficiaries - and from the providers of health services. Both are, in their disorganization and ignorance, failing to initiate, offer and impose their own solutions, but constantly are in a position either to accept or not foreign solutions (Interviews [IB7, IB3, IB5, IB1, IB4, IMD3, IMD6, IMD05], 2013). From here, it is obvious that the reform in Macedonia is driven too much from the top and is burden with
political arbitrariness and ignorance. The way it was/is conceived and implemented reform inherits all the weaknesses of a hierarchical state (Menon, 2006). Thus, the reform is imposed and is alien to the concerned (Interviews [IB7, IB5, IB1, IMD3], 2013). By this it is achieved just the opposite, i.e. this creates a gap between the government, healthcare sector and the beneficiaries of health services (BTI, 2012; Apostolska et al., 2009, Apostolska and Tozija, 2010). It creates a situation of unpreparedness for cooperation between the government and healthcare sector and very little involvement of the citizens and the business sector. The concerned are not seeing the reform as something that is really for them, but as an obligation that the government takes just to satisfy the requirements for structural adjustments of the IMF, World Bank and other international financial institutions and instances (Hesse, 1997: 142). And therefore, the implementation of the reform faces criticism, comments and dissatisfaction from the beneficiaries' side and opposition from the doctors - because of the feeling that they are least asked about the reform (Interviews [IB7, IB3, IB5, IMD3, IMD5], 2013). In this sense, the reform is felt as imposed and alien. And yes, it should not be forgotten that the health reform is for the health of citizens. In this sense, it is an expression of political necessity in itself. However, in Macedonia the voice of those, before all others, who should benefit from this necessity the most (doctors and patients/beneficiaries), hardly is heard (Daskalovski, 2009: 269; EOHCS, 2000: 10; Interviews [IB7, IB3, IB5, IMD3, IMD6], 2013).

As already mentioned in the background chapter of this thesis, the public has already created an image that the reform is not imposed by the doctors and patients, but that health care in Macedonia is reforming because of the so-called "structural adjustments", for approaching EU standards, because of the demands of the World Bank and IMF (Lazarevik et al., 2012: 179, 183). As part of these "structural adjustments", the dominant method that has been usually used for reforming the healthcare sector in the country, as in many other developing countries, was the “institutional monocropping” or imposing uniform institutional blueprints based on Anglo-American idealized models of institutions (Evans, 2004: 31).

To remind about the policies of restructuring required of national economies in order to adjust to the changes in the world economy which, as already mentioned, are often referred to as the ideological framework of Washington Consensus policies: economic liberalization, rationalization, restructuring of the state sector, privatization, commercialization of the welfare state services in order for the services to become products that should be exchanged in the market (Gjorgjev et al., 2006: 5, Milevska-Kostova, 2010); creating a climate in which individual responsibility for health and education increases. As time passes, as more on the
horizon is the arrival of a new ideological paradigm - post-Washington consensus (Birdsall and Fukuyama, 2011; WHO, 2013), it becomes more and more important the question of how much longer Macedonia should rely on the policies of marketisation and privatization. After the dissolution of Socialist Federal Republic of Yugoslavia (SFRY), Macedonia inherited a relatively solid basic health care (Lazarevik et al., 2010: 6; Saric, 1993), which during the past 22 years has failed to reform according to the requirements of the new political and economic order (Lazarevik et al., 2010: 8; Dimeski, 2011: 9; Apostolska et al., 2009: 3, 17), i.e. according to the principles of the ideological framework of Washington Consensus policies.

One of the reason is perhaps that the Anglo-American idealized models of institutions are not the best institutional blueprints for development in Macedonia, when not being considered and taken into account the different national cultures and circumstances in the country (Evans, 2004: 33). The other reason is that the international financial institutions, such as the World Bank and IMF, have not generally had patience for the long-term challenge of building new institutions which will originate from inside (Birdsall, 2004: 4).

The dissatisfaction of the citizens with the quality of current health services puts in confrontation the current health care system, with the perception they have about the previous health system of how everything was good and ideal (Menon, 2006; Bartlett et al., 2010). This perception of citizens makes health reform to be seen more as ideologically imposed and alien, i.e. the citizens see the failed health reform as an inherent part of the failed reforms in the whole society which are imposed by the requirements of external international factors. This comes perhaps as a consequence of the insisted institutional monocropping which obviously not always fit with the local sociocultural environment (Evans, 2004: 33).

There is nothing disgraceful in the questions, whether international organizations know what they are doing (Deininger & Mpuga, 2005; Okuonzi, 2004), and whether international regulations actually hinder the development of poor countries (ILO, 2004). In fact, many times they themselves admit they were caught by the phenomenon called transition and that they often made ad hoc and empirically unverified solutions (Clarke & Pitelis, 1993: 6). The envy or collusion by tending to operate in many sectors and be everywhere, and the coordination failure among them creates “fragmentation”. This is seriously degrading the limited public sector capacity and undermining institutions in the country (Birdsall, 2004: 9).

The reform of the public sector in recent years has focused on efficiency, privatization and marketization (Nordyke, 2000; Nordyke and Peabody, 2002; Menon, 2006), which still remains the requirement for public spending to be economically meaningful and justified. However, the reform of the public sector is much more than the requirements and objectives
set by the deregulation, privatization, marketization (DPM) framework (Eliassen and Kooiman, 1993). Modern societies are much more complex than it was assumed by the creators of the DPM framework. They missed questions such as, the promotion of human rights and collective rights in a market economy (Lane, 1997: 6). In general, during the recent years the rights of citizens, justice, solidarity, and quality of life are increasingly emphasized (Den Exter, 2008; Gilbar and Bar-Mor, 2008). Thus, health reform in Macedonia will have to be guided corresponding to the demands of the citizens for quality of healthcare and equal access to health services. The citizens should be able to deliberatively participate in public discussion, planning and exchange with other participants, i.e. in “deliberative democracy” process, where they can propose strategies and solutions, and by this foster “deliberative development” (Evans, 2004: 36-37).

Health reform is a matter of knowledge, a serious health policy and involvement of many political actors, scholars, experts, health workers and citizens in the process of implementation. Without understanding the objectives, the health reform remains imposed and not accepted, which means implementation problems.

5.4 How the state struggle with the reform

The transitional policy in Macedonia, especially the economic policy, is managed in accordance to the demands for privatization, development of market economy, reducing the state's influence on the market and reduction of state administration (the principles of neoliberalism, respectively the ideological framework of Washington consensus policies) (Mojsovska, 2005; IMF, 2006).

From the position of these requirements the things are quite clear – to reduce the state's role in health care, which means to go for privatization and cut down the funding from the budget of Macedonia provided for the health care (including funds from the Health Fund) which, in light of the principles of neoliberalism, are excessive and are spent irrationally (Nordyke and Peabody, 2002). However, it is completely wrong if it is thought that this is about a complete salvation of the state from the healthcare sector. Therefore, it should be emphasized that this is not about abolition of the state, but to find a balance between the obligations of the state and regulatory capabilities of the market. The private property, individualism, market and competition do not abolish the public interest. The public sphere remains an obligation of the state. Although the public sphere constitutes by the citizens (civil associations, various forms of local governance) and the market, the state, as one of the
governing actors, in principle, have to care about the health of the citizens (ibid.). Even in the most liberal variant, the state should not be relieved of the obligation to take care about the health of the population.

The transition i.e. the shift from socialism to capitalism brought too big challenges for the Macedonian economic and health policy (Gjorgjev and Sedgley, 2009; Gjorgjev et al., 2006; Nordyke and Peabody, 2002; Atun, 2005; Shkolnikov et al., 2001, Saltman et al., 1998).

Without going deep into the transitional details, here is enough to say that in terms of the healthcare sector the state faces serious problems (Lazarevnik et al., 2010, 2012; Gjorgjev and Sedgley, 2009; Gjorgjev et al., 2006). The government which is representing the state and determines its activities is composed of people of political parties vying/competing for power and voters (Lazarevnik et al., 2010, 2012). And it is torn and stretched between the demands of citizens (potential voters) and requirements of doctors and health workers. And at the same time, it must also meet the conditions set by the external arbiters such as the IMF, World Bank, and EU (Mojsovska, 2005). On the one hand, the state does not want to comply with those requirements. The requirements of the neoliberal policy agenda and the ideological framework of Washington consensus policies amid weak economic growth, high unemployment, many social cases (Bartlett et al., 2010), constitute a certain threat to political parties vying for power. The fulfillment of these requirements is a threat to the popularity of the ruling party. The battle for the votes of citizens in a particular way is delaying the reforms which are supposed to be in accordance to the requirements of the neoliberal policy agenda and the ideological framework of Washington consensus policies, and thus keeps alive the welfare state which in Macedonia is for 22 years in somnolence and lethargy (Uzunov, 2011; Bornarova, 2011). On the other hand, however, it must comply with those requirements, because these foreign arbiters are politically very powerful. At the same time they are impatient to spend money, and push for “results”, even if these results are negative. They have a pride and are unwilling to exit from programs and countries even if their aid and assistance is not helping there (Birdsall, 2004: 13).

However, with the requirements for structural adjustments (primarily, the demands for privatization and reduction of administration) as a prerequisite for development and "Europeanization", they are valuing the work of the state (Mojsovska, 2005; IMF, 2006, 2012), thus the state, in turn, orients toward them as chief arbitrator for state’s own work. The ruling parties in Macedonia regularly refer to these external arbiters in order in front of the citizens to legitimize their policies (economic, social, educational policy), but at the same time they also think about the number of votes they would get or lose as a consequence of the
implementation of the policies suggested from outside (Dimeski, 2011a: 9; Lazarevik et al., 2010: 12; BTI, 2012). And finally, the citizens believe that external international institutions have higher weight of sovereignty in regard to the sovereignty of the Republic of Macedonia (Mojsovska, 2005), which is, however, simplified picture of the real international constellation in which the sovereignty of a nation state is placed today (Johnson, 2011: 54).

5.5 The problem of political partitioning

A big obstacle in the reform implementation in Macedonia is political partitioning and politicization of the public services, including the healthcare service (Lazarevik et al., 2010, 2012; Dimeski, 2011a, 2011b; Milevska-Kostova et al., 2011). The political parties in Macedonia, who are inclined towards autocracy, are oriented more toward ruling rather than governance and management, and implement the reforms from above and outside (Lazarevik et al., 2010, 2012). It is accepted that the politics primarily consists of winning the power in order to make decisions that apply to all members of the political community. But as indicates the 22-year-old democracy in Macedonia, the party interests, can often be put before the interests of the reform (ibid.). Those interests are often associated with acquired positions and relations in the economy, the monopolistic position in an activity and transactions from which the personal profits are great. It is clear that in such a political structure the medical profession is subordinated to political parties (which are in the government) (Lazarevik et al., 2010, 2012; Dimeski, 2011a, 2011b). In such a situation, the party's authority is over the authority of the doctor, and much more over the authority of the beneficiaries of health services.

The result of all this is politicized hierarchical inefficient state which does not know that the problem of unmanageability is inherent precisely to that kind of state. This politicized and hierarchical state is a problem for implementing any kind of reform. Without the involvement of relevant stakeholders (healthcare sector with the professionals cores, the citizenry, and the business sector) the health care reform in Macedonia will remain arbitrary. The one who will make decisions regarding the reform, and will not explain and elaborate in front of the beneficiaries, employers, doctors, and the public in general, will only face regulatory policies implementation problems related to the health care.
6. Conclusion

The intention of this thesis was to disclose and scrutinize the main past and current socio-political propensities which were colligated with the health sector reform in Macedonia. It also inclined to look into and determine the further challenges the health sector reform faces in the country.

The study learned that, in Macedonia, there is a lack of trust attitude toward the government and its policies. The country is a good example of what it means an implementation deficit or problem in terms of transition. It can be said that the transitional country of Macedonia is a "poorly regulated" liberal democracy, because it seems that the government is stretched between citizens as voters and duties which are received from international institutions.

The transition, which for the disgruntled and distressed citizens means only questionable privatization and dismissal from work, has contributed to build a general view that the state (government) is irresponsible and unready to act in the direction of "genuine" reforms from which the citizens would benefit too, and not only those who grab. Such an attitude, in turn, is a major obstacle in the implementation or realization of reforms.

The implementation of the policies (and reforms) is evaluated from both inside and outside. Thus, the international institutions are evaluating the policies (as good or bad). And that is a realistic situation which must be accepted. But in many cases, to the government is more important the assessment coming from the external/international institutions. This frustrates the state (state institutions) and the political parties who consider that the government, in particular, is accountable to the electorate. This frustrates the citizens too, because they believe that the government is accountable to them.

Equally, the electorate too can assess the government as bad because, among other things, the policy (health policy, for instance) is very poor and does not meet the expectations of the citizens. The people, both as citizens and as employees in public institutions, are not motivated to implement reforms, among other things, also because they do not know what they would benefit with from them.

Despite such views, the citizen who is dissatisfied with the health services, as a rule, still addresses the state, not the doctor or medical organization. This ambivalent attitude in which the state, on the one hand, is seen as incompetent, and, on the other hand, as the only one who can do something, is unproductive and further burden the state in terms of duties and responsibilities.
However, the past 22 years have demonstrated that the state is unready at any cost in healthcare sector to implement the neoliberal policies and the ideological framework of the Washington consensus policies. Privatization and marketization are far from completed processes in the healthcare sector. The imposition and misunderstanding of the reform and insufficient knowledge of the implementation process are located as major impediments. The reform deranges in both individual and in terms of the society. Sets new rules and require adjustments that frustrate. However, given how rapidly the political paradigms in the world are changing, it can happen that Macedonia as a state would have once again to decide in which direction will lead the health system reforms. In fact, with the emergence of the post-Washington consensus the principles of liberalization, privatization and marketization are criticized. In many countries that entered the "post-market era", i.e. the post-Washington consensus, health reform is orientated towards social effects, not only on economic ones.

Whether future reforms in the Macedonian health care sector will resort to these countries, it remains to be seen. In any case, in Macedonia there is an insight that the 22 years of emphasis on the economic policy, uncontrolled marketization and privatization has led to "reckless" forms of free and uncontrolled market. The social consequences of such market are unemployment, poverty and exploitation. These consequences are further undermining the already fragile political stability which basically was to be overcome exactly with the economic reform. This is a vicious circle in which the Macedonian state does not know to whom to turn – to citizens or to the international community.
References


Lazarev, Vladimir; Risteska, Marija and Simonovska, Valentina (2009). "The Impact of Social Assistance Programs on Reducing Inequities in Health Care Among Vulnerable Groups in the Republic of Macedonia (A Small Scale Descriptive Study)". *Macedonian Journal of Medical Sciences*. 2009 Mar 15; 2 (1);

Lazarev, Vladimir (2010). "Policy Interventions to Tackle Health Inequities in Macedonia: Patient Rights and Reference Pricing of Pharmaceuticals". *Macedonian Journal of Medical Sciences*. 2010 Mar 15; 3(1);


Appendices

Appendix 1 - Profile of the interviewees

Interviews with beneficiaries/customers of health services

[IB1] - Female interviewee - from Negotino
[IB2] - Male interviewee - from Negotino
[IB3] - Male interviewee - from Negotino
[IB4] - Female interviewee - from Negotino
[IB5] - Female interviewee - from Negotino
[IB6] - Male interviewee - from Kavadarci
[IB7] - Male interviewee - from Kavadarci
[IB8] - Female interviewee - from Kavadarci
[IB9] - Male interviewee - from Kavadarci
[IB10] - Female interviewee - from Kavadarci

Interviews with doctors and health workers

[IMD1] – Young physician - from Negotino
[IMD2] - General practitioner - from Negotino
[IMD3] - Medical Specialist - from Negotino
[IMD4] - Young General practitioner - from Kavadarci
[IMD5] - Older Specialist Surgeon - from Kavadarci
[IMD6] - Doctor Specialist ear-nose-and-throat - from Kavadarci
[IMD7] - Hospital Nurse (her husband is a doctor GP) - from Kavadarci
# Appendix 2 - Interviews timetable

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<th>Interviews with beneficiaries/customers of health services</th>
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