

**MINISTRY OF HEALTH OF THE REPUBLIC OF MACEDONIA
HEALTH SECTOR MANAGEMENT PROJECT
CONSULTANCY ON FUTURE ORGANIZATION, FUNCTION, AND
FINANCING OF PUBLIC HEALTH IN THE REPUBLIC OF MACEDONIA
INCEPTION REPORT, JUNE 28, 2007**

**Thomas E. Novotny, MD MPH
Public Health Consultant
Skopje/San Francisco, California
June 29, 2007
Contract No. 17-9050/1**

<u>Table of Contents</u>	<u>Page No.</u>
I. Introduction	1
Background	1
Aims and Objectives, Scope of Work	3
Some Key Definitions	4
II. Work Plan	5
III. Initial Findings	8
IV. Initial Recommendations	12
Annex. Letter of Invitation and Information Request	17

I. Introduction

Background

This consultancy responds to Component 1 (Policy and Implementation) of IBRD Loan No. 4733, Health Sector Management Project, specifically relating to overall health policy and strategy development for the Ministry of Health (MOH) in Macedonia. In the newly developed Health Strategy of the Republic of Macedonia 2020, a vision for public health upgrading and harmonization with international standards was presented in Chapter 13. This strategy calls for reorganised, modernized, and strengthened systems focusing on *core public health functions* for the needs of the State and local self-governments, as well as for other users of services. The public health network, representing the Regional of Institutes for Health Protection (IPH) and the Republic Institute for Health Protection (RIPH), along with other Ministries and Institutes with equity in public health in the Republic of Macedonia (RM), will be the focus of this strategy development. Improvements in data collection, processing, and analysis on health status are called for. These analyses should contribute to improved planning for both health care delivery and population health (infectious and noninfectious diseases as well as risk factor assessment). Health promotion programs and health policy development will be strengthened (Chapter 11). Particular attention will be paid to adolescents, who will be covered by health promotion activities to prevent drug abuse, tobacco use, and alcohol abuse (covered in Chapters 4 and 12). A strategy for adolescent health promotion will be developed.

Significant intersectoral public health activities are necessary to achieve the Priorities for Health Improvement described in Chapter 11, including targets for maternal and child health (MCH), school health education, eldercare, mental health, control of infectious diseases, blood safety, major non-communicable diseases (NCDs), kidney disease, and injury control.

The IPHs will be strengthened in monitoring, assessment, and control of risks from environmental pollution in cooperation with other sectors (Chapter 10). For example, the Ministry of Health will assure that health protection and risk assessments are performed when a new settlement or factory is built, when economic activities may create unacceptable noise or pollution levels, or when schools may be built in unsafe areas. An environmental health action plan has been drafted.

The food safety system will be developed into an integrated system for food safety and control, and the relationships between various agencies with competency in food safety will be harmonized.

Occupational medicine services will focus more on preventive and less on curative activities. The occupational medicine services and the Institute for Occupational Medicine will be organized as a national public health network according to the adopted Strategy on Health, Healthy Living, and Working Environment and Occupational Safety in the RM. A strategy for occupational safety and health in small and medium sized enterprises will be adopted, but all employees will be assured of protection and evaluation of health risks in the workplace.

In response to this Health Strategy Document, a DRAFT action plan for implementation has been presented to the MOH. The relevant public health-related actions from several of the draft action plan points can be found in the Progress Report of Dr. Kees Schaapfeld (available from PCU).

Aims and Objectives of the Consultancy

The *main aim* of this work is to provide policy advice and to propose public health network organization, function, and appropriate financing of public health activities,. This will lead to improvements in the health of the population and the performance of the health system in the RM.

The *Key Objectives* of this assignment are to:

1. Define the essential Public Health functions in the RM in line with international standards tailored to the country needs.
2. Assist in the development of the national Public Health Program for 2008;
3. Determine the optimal functional organization of the Public Health Services based upon proposed Public Health functions on national, regional and local levels;
4. Define the financial framework for the Public Health Program including available sources of financing of the proposed organizational and functional IPH structure. Recommend the best approach in presenting the proposal to the Government and or parliament.
5. Guide the development of business plans for the existing Public Health Institutes, including those focusing on target population groups.
6. Perform needs assessment on the current and future Public Health legislation and propose an outline of future PH legislation;

Scope of Work

The health system in RM is in transition, and a comprehensive set of health reforms are embodied in the Health Strategy. Among priority activities, actions are planned to revise the existing Basic Benefit Package (BBP) of services and integrate the preventive part of the current 13 MOH programs in the national public health program. The MOH has identified the need for a comprehensive annual Public Health program. This consultancy will help with the revision of essential public health functions based on the best international experience and re-organization of the structure and financing mechanisms of the public health system. This will assure optimal delivery of public health activities for the population of the RM and adequate cooperation and coordination with other sectors such as the HIF, the Food Directorate, and the Sanitary Directorate. Public health is the responsibility of government, yet also depends on active community involvement to accomplish its goals. Hence, recommendations will be made regarding communications strategies, community involvement (such as the existing Healthy Cities program in several Regions), and trans-sectoral involvement with agriculture, veterinary medicine, education, and the Ministry of Finance.

The analysis and proposals for the functional and structural reorganization of public health care in the country, including adequate financing mechanisms and financial

frameworks for public health will be submitted to the Ministry of Finance by mid 2007 in order to ensure sufficient funding of public health care and a national Public Health Program in 2008. An initial financial analysis is included in this inception report, but detailed financial analyses and recommendations are scheduled for the second mission in mid-July.

Some Key Definitions

The broad mission of public health, according to international standards, is “the fulfillment of society’s interest in assuring the conditions in which people can be healthy.” Public health practice is organized *community* efforts aimed at the prevention of disease and promotion of health. It links many disciplines and rests upon the scientific core of Epidemiology (the study of the distribution and determinants of diseases and injuries in human populations). There are three public health Core Functions described in modern public health literature, each associated with respective essential public health services:

- *Assessment*
 - Monitor health status to identify community health problems
 - Diagnose and investigate health problems and health hazards in the community
 - Evaluate effectiveness, accessibility, and quality of personal and population-based health services
- *Policy Development*
 - Develop policies and plans that support individual and community health efforts
 - Enforce laws and regulations that protect health and ensure safety.
 - Research for new insights and innovative solutions to health problems
- *Assurance*
 - Link people to needed personal health services and assure the provision of health care when otherwise unavailable
 - Assure a competent public health and personal health care workforce
 - Inform, educate, and empower people about health issues
 - Mobilize community partnerships to identify and solve health Problems

II. Work Plan for the Consultancy

Four missions and three workshops are planned for this consultancy.

1. The first mission was completed June 24-30, 2007, in Skopje, and is summarized in below. During this mission, a broad overview of the public health network in RM was obtained, including visits to the RIPH, four Regional IPHs, meetings with the Deputy Minister, the WHO country office, the Health Insurance Fund (HIF), the MCH program, and with working groups considering the action plan for the Health Strategy. Reviews of documents pertaining to the Health Law, the 13 public health programs of the MOH, the Health Strategy and draft action plan, the Health in Transition report, the Public Health Evaluation Report, etc., were reviewed. In addition, plans for the division of the 13 public health programs into curative and preventive care functions were reviewed. A broad set of options for public health reorganization and financing was developed for consideration by the MOH, RIPH, and IPHs.

Date	Institutions Visited	Persons met
June 25	RIPH and PCU	Vladimir Kendrovski Fimka Tozija Director Dragan Gjorgjev Health Strategy Working Group (Kees Schaapveld, Consultant) DM Vladimir Lazarevik
June 26	Skopje IPH Maternal and Child Health Institute WHO Office Social Medicine Division, RIPH	Director Sheval Memishi, Specialists of all units (Valentina Simonovska-social med) Directors of all sections, Deputy director Zoran Stojanovski, Skopje Health House Marija Kisman-Hristovska Vladimir Kendrovski Fimka Tozija
June 27	Regional IPH Kumnovo Regional IPH Veles Health Insurance Fund	Director, Vesna Stefanovska and various specialists Florentina Surbevaska, Director Director Georgi Trenkoski CFO Romela Popovic
June 28	PCU Tetovo Regional PH Institute	Health Reform Working Group DM Vladimir Lazarevik Director Radka Veterova and all program specialists
June 29	RIPH	Director Dragan Gjorgjev

	Ministry of Health	Minister Imer Selmani
--	--------------------	-----------------------

2. The second mission is now planned for July 9-15, with a workshop on July 12 for the 10 Regional IPHs, the RIPH, and other key individuals concerned with public health reform in RM. See attached draft letter for DM to IPHs inviting their participation. The purpose of this half-day workshop is to present options for reorganization of the public health network, including financing, oversight, monitoring and evaluation, and planning for the next five years. It is critical that the participants in the workshop assume ownership of the transition process and that their input is considering in the evolution of the public health program. The other main objective of the second mission is to develop a detailed plan for financial transition of the public health system for consideration in the 2008 budget. This financial planning activity will be linked to the redefinition of the public health core functions for the RIPH/IPH network as well as the associated other entities with equity in public health in RM (Food Authority, Occupational Medicine, etc.). A complete list of stakeholders will be developed during this mission to include in the development process. The first progress report will be completed at the end of this mission, and a working group will be established to review and contribute substantively to a draft plan to be discussed in the third mission. The working group will likely consist of RIPH leaders, several IPH directors, MOH representatives and representatives of the Food Authority, HIF, and others with equity in public health. Guidelines for development of individual IPH business plans will be distributed, and the Regional IPHs will be asked to begin work on these plans, showing financial transitions necessary for fulfillment of essential core functions specifically tailored to their communities.
1. The third mission is tentatively planned for the third or fourth week of September. Prior to this mission, inputs from the various stakeholders, both those attending the workshop in July and others, will be incorporated by the public health working group into a draft plan for reorganization and financing of the public health system in RM. This will be distributed widely for comment prior to the mission, and input will then be obtained during a set of visits with the HIF, MOH, RIPH, IPHS, and other stakeholders. Particular attention during this mission will be paid to drafting legislation to support the core functional changes of the public health network in RM. A workshop of stakeholders will be held at the end of this mission to further refine the draft plan and policy documents, particularly related to the revision of core functions of the RIPH. A second progress report will be submitted to the MOH at the end of this mission.
2. The fourth mission will be planned for the fourth week of November. The IPHs will be invited to another workshop during this mission to review draft business plans for the next five years. During this mission, the overall draft plan for the public health network and consultancy report will be finalized for consideration by the MOH. Key stakeholders will be asked to review this

document, and a final, small workshop conducted to review final recommendations for reorganization, financing, legal support for, and planning for the future of the public health system in RM. This workshop should include the MOH and the working group. A final report will be submitted after this mission is completed, approximately mid December.

III. Initial Findings

1. The public health network, centered in the RIPH, Regional IPHs, and the 13 core public health programs of the MOH, is struggling due to a lack of mission orientation and ownership of responsibilities, rooted in outdated concepts of public health practice and in the recent financial insecurity brought about by decentralization. Since 1993, decentralization has been implemented for the 10 Regional IPHs and associated local entities, but there is a lack of definition in the relationship between the RIPH and these decentralized authorities, as well as a clear set of responsibilities for implementation of priority public health programs throughout the system.
2. There is extensive data collection, albeit with antiquated methods, on infectious diseases, morbidity based on hospital data, and registries through the Regional IPHs. These data are provided to the RIPH for required reports, but it is unclear how the voluminous data are used for policy development, monitoring of health progress, monitoring of program outcomes, and planning future public health strategies. IT resources in RIPH and IPHs are lacking, and there is no electronic transfer of data between the IPHs and RIPH. Dedicated policy development activities, including economic analyses, are in early phases within the RIPH and essentially non-functional at the regional level.
3. There has been extensive program analysis, consultation, and data compilation regarding the public health system, but thusfar, these actions have not led to purposeful reorganization and re-direction of the public health network. Examples include a proposal to the Soros Foundation for improved analysis, management, and use of data for policy development and planning (this was not funded). There has been a proposal for an information technology system (IT), focusing on the clinical side of the health system, proposing five quality indicators for health care delivery. This system has not been implemented, and it is unclear as to its future.
4. Changes in the political environment periodically alter the leadership of Regional IPHs as well as the RIPH, with new directors in most Regions, and lack of strategic planning at the Regional level thusfar. There is variability in experience among the leaders, but these are key positions that should have a professional standing separate from the political process. Some are highly motivated to be accountable for the health of their populations. Continuity is essential to sustain leadership development. More support for ownership and responsibility for health outcomes based on evidence (as called for in the Health Law) for the IPH leaders should be built into the restructured program.
5. The financing system for the RIPH and Regional IPHs is based minimally on core MOH funding for the 13 programs, and depends primarily on funds from the HIF as well as complicated self-financing mechanisms at both the Regional and National levels to support salaries, discretionary funding, and investment in infrastructure. The HIF is now hesitant to continue salary supports for the provision of clinical services under the domain of the HIF, and is concerned as to what this financial support

provides in terms of impacts on the HIF efficiency (i.e., prevention effectiveness). . HIF has indicated a need to shift its salary support out of the IPHs in the near future.

6. The RIPH and the Regions support much of their salaries and infrastructure (but probably not new or non-MOH programs) through self-financing. This mainly means laboratory services to hospitals for clinical lab services, to individuals for required laboratory testing of products, to hospitals for hospital infection control, to water systems for environmental testing of water supplies, to food manufacturers and distributors for food safety assurance requirements of the Food Authority, and to various other agencies and individuals for other environmental testing. In addition, services to travelers for vaccinations and counseling are provided as fee-for-service outside the HIF. There is redundancy in all the IPH labs performing these testing services, mainly due to the need to raise funds at the Regional level (as well as national) to keep the institutions functioning. Drug testing is mainly done at RIPH, but this is on manufactured and imported drugs. No attention is paid to testing or accrediting the privatized pharmacies, and it is unknown if there is a counterfeit drug problem in RM. Accreditation is ‘pending’ in many of the labs, with a variety of international and national accreditation agencies involved. When asked about these lab services as a core institutional function, many IPH official agreed that IPH labs should be for reference, support for public health investigations, and other public health activities and not for revenue. These are a survival function in the face of lack of central governmental support for the IPHs.
7. Of the four IPHs visited, the distribution of revenue is roughly as follows:
 - 60% of revenue is from HIF, most of which provides salary support for the IPH staff
 - 30% of revenue is from self-financing
 - 10% of revenue is, or should be if fully funded, from the MOH 13 programs. This may be split off to provide some to the revenue HIF for clinical preventive services such as immunizations.
 - On a percapita basis, there is about 150 denars per person on average (range 111 to 180) spent by the IPH, but this is not necessarily for public health. This is the total budget expenditure for the lab outputs, administration, reporting, etc. Still, this is equivalent to about 2% of total health percapita health care expenditures (curative and preventive) in the current RM health system. If the lab and other nonessential activities were excluded, it would be likely that true public health expenditures would be less than 0.5% of percapita health expenditures. *This is an indicator of gross underfunding of core public health functions.* In general, it is thought that 5% of total health expenditures should be devoted to preventive, public health measures as a baseline. This is a very crude analysis, and specific expenditures and revenue distributions are needed for each IPH as a baseline for the analyses proposed for the second mission.

8. Health manpower is apparently sufficient at present, but with many specialists nearing retirement age and already some attrition at the Regional levels, there is likely to be a health manpower shortage in public health within the next five years unless purposeful training, recruitment, and professionalization of human resources accompanies the planned improvements in the public health system. An MPH program has been established in the Medical School, but there is minimal interaction between the academic program and the practice environment; it is discouraging to new public health professionals to seek jobs in the IPH system as these jobs are not evident. There does not appear to be a manpower planning process within the network, and incentives to enter the public health field are lacking. In particular, differentiation should be made about the sufficiency of health manpower for current functions, and manpower needs for improved functions. For example, less emphasis on laboratory, more emphasis on epidemiology, more emphasis on policy, and more emphasis on targeted health interventions, and less emphasis on data collection alone. A report on the current health manpower assignments and projected needs are necessary for the work planned in the second mission.
9. Core public health functions are not the main concern for the public health network leadership. Instead, there appears to be concern mainly to retain equipment, supplies, staff salaries, and infrastructure of the public health units, without a clear focus on mission. This mission is to serve the health needs of the Regional and local populations, but in questioning the leaders of the IPHs visited, there appears to be a fairly vague concept of population health, proactive approaches to solving problems, overconcern for data collection without analysis and linkage to policy development, and direction from the top down instead of the bottom up.
10. The MCH program is situated administratively under a local Health House in Skopje. It is not clear why this arrangement has been made, but the MCH program has a national mandate to assure the health of mothers and children. In particular, infant mortality, under five mortality, maternal health and mortality, and health screening of school age children are key functions of this program. Patronage nurses are affiliated with the MCH program (and the local municipalities?) to conduct home visits and monitoring. The effectiveness of the programs is seen in the reduction of infant mortality rates, under five mortality rates, high levels of immunizations, and fairly low maternal mortality. The key issue here is to consider how this program should remain relatively autonomous yet integrated into overall public health programming.
11. The IPHs all have essentially the same structure, with four main programs: epidemiology, social medicine, microbiology (laboratory), and hygiene, with additional administrative units to support these programs. There is apparent functional separation of the programs, with need of better communications among them and between the IPHs. Although the RIPH has a website with data, laws, and program descriptions, there is no active

communication mechanism among the IPHs. Sharing data between them is seldom done, and for some at least, the feedback of results from the RIPH is insufficient. Financial management and information availability is quite variable. Few could describe the revenue flows, expenditures, and program financing in any detail; improved transparency and budgeting processes are needed.

12. There is insufficient communications within the public health network. This begins with the previously mentioned intra-network communications problems, and extends to communications within the government—upwards to policy makers, and laterally across other concerned ministries. There is no regular public health briefing mechanism for the press, and no pro-active communications office within the RIPH. A model for this would include a weekly or biweekly morbidity and mortality report, website postings of new programs, public relations events, and coordinated communications strategies to support ministerial programs as well as multinational participatory events such as World Health Day.

IV. Initial Recommendations

1. Recruit the IPH directors and RIPH leadership staff into the redesign process. First step here is to present findings at a workshop on July 12 in Skopje. This workshop should be under the joint leadership of the MOH and the RIPH. In advance, IPH directors should be asked to provide a total budget estimate and distribution of revenue flows. In addition, they should supply a summary of staffing and vacancies. Finally, they should provide brief statements on
 - 1) main HEALTH problems for the their populations, especially those not addressed in MOH programs,
 - 2) ideas for improvement of relations between RIPH and IPHs, and
 - 3) Ideas for improving Regional IPH accountability for the *health outcomes* of their populations. At the conclusion of this workshop, RIPH and MOH will assemble a WG to include elected representatives of the IPHs (N=3) who will be responsible to the entire group for their role in the planning process. Other members include RIPH leadership, HIF, and MOH. An invitation letter is found in the Annex.
2. Develop short-term, medium-term, and long-term plans and measurable objectives for revision of the public health network according to the input of the WG, the RIPH, and the international consultant. These will be based on international best practices and the needs of the local environments. This will be the core content of the final consultative report.
3. Submit a very general budget request to the MOH for improving central financing for core public health budgets in the 2008 budget and following years. This will show a gradual shift from HIF and self-financing to a predominant central MOH budget support for the public health network over the next five years, including RIPH and IPHs. In this initial crude estimation procedure, several exclusions must be noted (the MOH Programs, Sanepidemiology Inspectorate, Food Agency, Occupational Medicine, Military health system) See Table 1 for initial projections for core public health funding. Table 2 shows the MOH budgets for the core public health programs as they currently exist. These are targeted to split between population and curative health programs, and initial estimates have been made on the split of these resources (There was insufficient time to analyze this split payment plan at present). Table 3 shows the distribution of payments to the Republic IPH and the 10 Regional IPHs. There are likely other distributions germane to public health the health through the curative health centers, etc. In the next mission, a detailed financial analysis will be conducted.
4. Reform managerial concepts and responsibilities to establish accountability at the IPH level for the *health* of regional and local populations. This requires a shift away from top-down planning and more regional, data-driven and rational responses to identified health problems as well as streamlined essential surveillance of key reportable diseases, cross-sectoral cooperation at the regional level, and support from the RIPH. Unnecessary data collection processes should be eliminated (these may include the extensive environmental assessments, food product testing, and reporting of laboratory procedures completed). An assessment of the surveillance system according

to best international practices should be conducted with the assistance of an international consultant (perhaps the US Centers for Disease Control and Prevention or WHO).

5. The RIPH should gradually shift away from the laboratory business to become more effective as a reference lab facility, policy development office, and technical support center for the IPH and local authorities. These functions should mostly be supported out of central funds. The RIPH should develop annual reports and intermediate action plans focusing on the reform, the assurance functions of the public health network, and leadership development among the IPH programs.
6. Financing options for the public health network may include local taxing authorities, external funding sources in the early stages of the reform process (further consideration should be given to a specific World Bank investment or grants from outside donors), and mainly the central MOH budget. The shift from self-financing and HIF to central budget should be gradual and should not begin until at least 2009.why?? It will take at least this long to get revenue estimates, manpower estimates, funding priorities, and program directions clearly defined.
7. Training of public health practitioners in various disciplines should begin immediately, with most training conducted in-country. The existing MPH program should include a required field assignment, and specialist vacancies should be identified at national and regional levels. The international consultant would like to review the curriculum of the new MPH program to ascertain content for public health practice. Job incentives should be developed (signing bonuses, moving expenses, housing allotments, etc) to support new hiring in key positions at the regional and national levels in response to initial manpower shortage analysis.
8. Set up and staff an office of communication at the RIPH level, with designated communications coordinators at the Regional levels. Develop a functional network communications system through a monthly Public Health report based on data, emerging diseases, news from abroad, and other key information of use to national, regional, and local experts. Begin developing regular electronic communications activities with the Regional IPHs; for example, a weekly electronic newsletter (one page only) sent to all Regional directors and communications officers for distribution throughout IPH staff.
9. Mentoring of the process of reform may be needed. External funding should be sought to support medium-term public health experts from the European environment (stability pact nations, UK, Finland?) to support training and advice to the IPHs and RIPH. The leadership in the MOH and RIPH will need some hands-on assistance to focus the reform process, and they should take a similar role with the Regional IPHs; this does not mean consultant reports but rather day-to-day management assistance and communication.

Table 1. Initial General Budget Projections for Public Health Network Financing, 2008***

Revenue Source	2007 allocation		2008 proposal		2009 proposal		2010 proposal		2011 proposal	
	RIPH	IPH	RIPH	IPH	RIPH	IPH	RIPH	IPH	RIPH	IPH
Central MOH										
HIF										
Self Financing										
External/other										
Estimated total health national expenditures (dinars)*	21 billion		22.05 billion		22.15 billion		23.21 billion		24.37 billion	
Percent funding (%) for prevention and public health**	0.5		1.0		2.0		4.0		5.0	
Estimated core MOH budget for IPH (denars)	150 million (needs to be verified with current data for 2007)		220.5 million		443 million		928.4 billion		1.22 billion	

* based on estimated 20 billion denars for 2006, both financed and out of pocket expenses, and estimated annual medical inflation rate of 5%.

**based on estimated regional percentage estimates for purely public health/preventive expenditures in 2007

***Excludes MOH Programs, Food Agency, Occupational Health Agency, Sanepidemiology Inspectorate, and Military systems

Table 2. Funds for public health programs provided by the state budget for 2006 and 2007.

No	DESCRIPTION	Total for the programs for 2006	Approved budget for 2006 per programs	Total for the programs for 2007	Approved budget for 2007 per programs
1	Systematic medical examinations of pupils and students	16.000.000	16.000.000	34.500.000	34.500.000
2	Organization and promotion of blood donation	37.080.000	8.700.000	30.000.000	30.000.000
3	Preventive health care	58.662.410	48.700.000	110.000.000	110.000.000
4	Obligatory immunization of the population	51.000.000	51.000.000	55.545.000	55.545.000
5	Research of occurrence, prevention and eradication of brucellosis with the population	7.100.000	7.100.000	8.000.000	8.000.000
6	Preventive measures for preventing of tuberculosis of the population	12.000.000	12.000.000	15.500.000	15.500.000
7	AIDS protection of population	7.440.000	7.440.000	8.200.000	8.200.000
8	Maternal and children health care	27.815.200	12.730.000	42.700.000	42.700.000
9	Early detection and prevention of diseases of women reproduction organs	11.500.000	8.500.000	8.500.000	8.500.000
10	Health protection of people with mental disorders	70.581.875	34.500.000	89.484.875	45.500.000
11	Health protection of addiction	63.549.890	18.500.000	96.374.000	43.600.000
12	Health protection of certain groups of population and certain disorders of population that is not covered with health insurance	158.935.400	21.200.000	105.390.000	105.390.000
13	Securing expenditure funds for patients treated with dialysis, securing medicines for transplantations and securing citostatics, insulin, growth hormone and treating patients with hemophilia	158.952.919	75.000.000	172.669.566	94.548.000
	TOTAL:	680.617.694	321.370.000	776.863.441	601.983.000
	The Budget also include the approved costs for participation.		40.880.000		103.548.000

Table 3. Distribution of State funds to the 10 Regional IPH, 2006

No.	PHI	Budget 2006	salaries	Total	Percent
74	Republic Institute for Health Protection - Skopje	19.115.000	9.950.000	9.950.000	52,05
75	Institute for Health Protection -Bitola	20.143.000	650.000	18.764.000	93,15
76	Institute for Health Protection -Veles	16.383.000	1.330.000	16.018.000	97,77
77	Institute for Health Protection -Kocani	8.362.000	895.000	8.362.000	100,00
78	Institute for Health Protection -Prilep	11.411.000	590.000	10.871.000	95,27
79	Institute for Health Protection -Kumanovo	12.723.000	830.000	12.212.000	95,98
80	Institute for Health Protection -Skopje	29.287.000	2.550.000	28.866.000	98,56
81	Institute for Health Protection -Strumica	9.008.000	680.000	8.759.000	97,24
82	Institute for Health Protection -Tetovo	14.962.600	1.800.000	14.175.600	94,74
83	Institute for Health Protection -Stip	10.110.000	670.000	9.727.000	96,21
84	Institute for Health Protection -Ohrid	11.462.000	360.000	10.641.000	92,84
	TOTAL			148,345,000	

Annex. Questions for the Regional Institutes of Public Health

- 1) What are the three main HEALTH problems for the population of your Region, (especially those that are not addressed in 13 Ministry of Health programs)?
- 2) What are three ideas you might have for improvement of communications and working relations between the Republic Institute of Public Health and the Regional Institutes of Public Health?
- 3) What are your ideas for improving the accountability of your Regional Institute of Public Health for the *health outcomes* of your population?

Data Needed for Workshop Discussions by Regional Institutes of Public Health

- 1) Please specify the quantities of your
 - a. Total budget with revenues from all sources
 - b. Revenues from the Health Insurance Fund
 - c. Revenues from Self-financing and general categories of sources
 - d. Revenues from the Ministry of Health
 - e. Other revenues
- 2) Please provide the total numbers of employees
 - a. By job category
 - b. By age
- 3) Please specify any unfilled vacancies at your Insitute by job category

**Proposed Agenda for the Workshop on Public Health Reform
July 12, 2007, 10:00-15:00**

<i>Time</i>	<i>Subject</i>	<i>Speaker</i>
10:00	Welcome and opening remarks	Dragan Gjorgjev
10:30	Review of public health system challenges	Thomas E. Novotny
11:30	Questions from the group	
12:00	Assignment of working groups/lunch WG 1. Public health financing WG 2. Public health communications WG 3. Relationship between Republic Institute And Regional Institutes WG 4. Accountability in public health	
1:00	Working group meetings	
2:30	Report Back from working groups	Dr. Novotny
3:00	Final Remarks	Vladimir Lazarevik Dragan Gjorgjev Nick Haazen
3:30	Adjourn	