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**PRISTOPMK**



**MINISTRY OF HEALTH**  
**Project Coordination Unit**

**GRADES AND OPINIONS OF CITIZENS ON HEALTH  
-CARE REFORMS IN THE REPUBLIC OF MACEDONIA**

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## INTRODUCTION

The Ministry of health of the Republic of Macedonia, for its own use ordered a sociological research on actual conditions in healthcare, in order to determine the factual condition. The public opinion research of citizens was necessary in order to investigate certain actual conditions in healthcare in 2006. The realization of the research was envisioned as part and in service of preparations for a complete communications strategy on healthcare reforms.

The basic population mass in this research were citizens of age in the Republic of Macedonia, divided according to place of residence and certain socio-demographic characteristics. The research was carried out in Macedonia, towards the end of November, 2006. The participants were positive about partaking in the research, and accordingly to this attitude contributed to its successful realization with their answers. The main emphasis in the research was placed on their awareness on healthcare reforms, satisfaction from healthcare services, personal perception of conditions and problems in healthcare on a local and national level, as well as their expectations for the period following the reforms.

Of particular interest are the personal opinions of the participants on reforms, i.e. on expected changes in healthcare and the road they believe must be taken to achieve a greater awareness of them among citizens. In this respect, the medical staff (doctors and nurses) were a separate category in the sample in order to probe the opinion of people professionally involved in healthcare.

The realized poll sets the basis for realizing certain conditions and dominant tendencies in the opinions of citizens on healthcare. Based on received data, the research team, along with the conclusions, offers suggested activities and measures in order to improve healthcare conditions through the creation of a communication strategy which would inform the citizens. The Ministry of health, aware of the challenge it faces - the realization of a thorough reform of the healthcare sector in the spirit of European standards, is faced with conditions resulting from long years of taking inappropriate solutions or making decisions which according to their character and scope did not lead to essential changes in healthcare. For the first time, according to initial announcements, healthcare in Macedonia is expected to be in the eye of the expert and entire Macedonian public. The citizens, first of all as beneficiaries of healthcare services, feel that our healthcare needs radical changes in order to get closer to the patient. A common topic today are the rights of patients and legal regulations (specific laws) for relations in this area. The primary public healthcare in the past period was an obligation of the state. This character and status, despite the many positive experiences in the past, will be changed, i.e. for the most part it will be privatized. The intent corresponds with the spirit of modern conditions in the healthcare area, where it is expected for the quality of healthcare services, prices and patient relations to be in the foreground.

## I. BASIC CHARACTERISTICS OF HEALTHCARE IN THE REPUBLIC OF MACEDONIA

### 1. SHORT RETROSPECTIVE ON HEALTHCARE IN THE COMMUNITY

One of the key areas in everyday life of the people is healthcare, i.e. the need for good health. Healthcare is a basis of every society, and Macedonia as a democratic and social state<sup>1</sup> devotes special attention in this area. As an activity, it was completely organized by the state, i.e. there were no possibilities for privatization. The healthcare system is obligated to provide public-healthcare services for individuals, to be efficient in organizing and managing the healthcare sector and to create human and financial resources<sup>2</sup> enabling a regular realization of planned tasks.

Macedonian healthcare today is organized in privately and publicly owned healthcare facilities. According to the factual condition, healthcare beneficiaries have the right to healthcare on three levels: primary, secondary and tertiary healthcare. **The first level** of healthcare may be used through the primary healthcare organizations (general practices) distributed according to the place of residence of healthcare beneficiaries in villages, towns and cities. The primary healthcare services are available in 293 villages. **The second level** of healthcare entails a specialized form of healthcare, carried out in medical facilities (general hospitals and clinics) in urban centres in the state. **The third level** is carried out by the medical staff in the clinics at the Skopje Clinic Centre.

According to the data of the State Healthcare Institute (RZZZ), from the Health Map of the Republic of Macedonia, citizens may receive healthcare services in 137 publicly owned medical facilities (50 on primary, 39 on the secondary and 48 on the tertiary level). In 2005 the right to healthcare on a primary level could be realized in a total of 50 healthcare organizations (6 health stations, 18 general practices, 10 hospices and 16 medical centres). These medical centres were transformed at the beginning of 2006 in general hospitals and general practices.

On the secondary level, beneficiaries of healthcare services can go to one of 39 healthcare organizations (16 general hospitals, 10 healthcare institutes, 7 healing, rehabilitation and bath centres, 2 special hospitals for pulmonary diseases and tuberculosis, 2 specialized mental institutions and 2 other specialized hospitals).

In the Republic of Macedonia, according to RZZZ data, from 2005, there are 4392 doctors, 939 general practitioners, 706 dentists, 205 pharmacists and 3052 specialists. For every medical personnel there are a different number of patients, so for one doctor there are 463,8 patients; one dentist for 2885,1 and one pharmacist for 9935,9.

Healthcare in the Republic of Macedonia is available to the population according to geographic, economic and temporal factors. According to certain analysis of healthcare organizations on the territory of Macedonia, it can be concluded that most Macedonian citizens (around 90% of the population in less than 30 minutes) have access to healthcare institutions for primary healthcare and can receive healthcare services.

Today, the largest number of private practices is dentist offices, while a large number of doctors<sup>3</sup> have opened private practices as well. In the following period the last of the activities with which the primary healthcare can be privatized, i.e. the current medical staff can carry it out privately are expected to be finalized.

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<sup>1</sup> The Constitution of the Republic of Macedonia, in article 39 states that „Every citizen is guaranteed the right to healthcare. The citizens has the right and obligation to maintain and improve their own health and the health of others“.

<sup>2</sup> This entails financing the healthcare sector (collecting and combining finances, purchasing effective and quality healthcare services from healthcare providers and appropriate payment methods).

<sup>3</sup> See Healthcare Strategy of the Republic of Macedonia 2006 - 2015, March 2006, p. 17, which mentions the Ministry of Health's data where 607 out of 1722 doctors (most of which are general practitioners, pediatricists and gynaecologists) are in primary healthcare private practices.

Based on the total capacity of private practices and the needs of healthcare beneficiaries, as well as information from the field, private practitioners of primary healthcare do not carry out an all-encompassing primary healthcare which would encompass all preventive and emergency services during office hours. In reality they cannot provide a continued healthcare which is of essential importance for a healthcare system. The privatization includes not only changing of the status of healthcare staff in accordance with the activity, but also with its realization a better quality for healthcare services must be provided. During the privatization of the primary healthcare there must be no impression of insecurity, uncertainty and a feeling of being left on their own. The medical staff must not have the feeling that a good primary healthcare system is being torn down on account of individual, private practices and the needs of the “few”.

The realization of the privatization in 2005, as a process defining the structure of employees, at the end of 2006, according to the Ministry of Health's data, it can be concluded that 2542 employees from the public healthcare have gained the status of private practitioners. After the end of the transformation of primary healthcare and dentistry, there is a total of 3680 employees in public healthcare, of which 1692 in primary healthcare, 653 in secondary, while 1335 are in the administrative and technical sector. In primary preventive dentistry, there is a total of 216 dentists.

Citizens which are beneficiaries of compulsory health insurance have the right to choose a personal doctor, personal dentist and personal gynaecologist in the primary healthcare from a public or private healthcare organization. This right actually means that the citizens as beneficiaries of healthcare services have the right to change their personal doctor, dentist or gynaecologist for different reasons.

The privatization of general dentistry is complete, while at the moment the privatization of specialized dentistry is being carried out as well. According to the data of the RZZZ, in 2005<sup>4</sup> in the Chamber of Dentists there are 2254 dentists and 1205 dental technicians registered in the country. Dental healthcare is carried out in public and private healthcare organizations: general and specialized practices, healthcare institutes and the Dental Clinical Centre.

## 2. ACTUAL CONDITIONS AND CURRENT PROCESSES

The citizens of the Republic of Macedonia despite the daily complaints that may be seen in the media on the quality of healthcare services which may give the wrong impression that the conditions are far from good, based on measurable parameters and indicators, the grade of the health of the citizens is no different than that of most other countries in south-east Europe. The condition is even less favourable if we apply the standards of European Union member countries. It is a fact that Macedonian healthcare faces numerous problems (*see table no. 25*) of an objective and subjective nature, which influence healthcare quality and have a direct impact on the interests of healthcare beneficiaries.

These reasons alone show the need for reform<sup>5</sup> in healthcare as an imperative in time. By delaying it, the chances for improving the condition in a short time are drastically lowered. Which is why healthcare, as an activity and area has faced numerous challenges in the past. One of the key challenges is the need for reform according to the standards of European Union member countries. Undoubtedly in this area reforms are a decision of the state in order to fulfil the obligations arising from the status candidate country for European Union membership on one hand, and a realistic and specific need of the citizens of the Republic of Macedonia in order to improve healthcare, on the other. This, above all else, means securing a basic package of healthcare services, public health, planning, managing and development of

<sup>4</sup> See Healthcare Strategy of the Republic of Macedonia 2006 - 2015, March 2006, p. 19,

<sup>5</sup> By reform we mean carrying out a partial or complete change of the current social condition in the legal area by changing or amending existing legal solutions, regulations and decisions. By carrying out such activities in healthcare one carries out reforms in healthcare.

human resources, securing quality healthcare services, financing of healthcare, as well as securing development of the healthcare system. Intending to reach a better quality for the population's health, it is necessary to put the main emphasis on improving health and prevention, as well as the population's health culture through education and regular information. Primary healthcare should be the source where healthcare beneficiaries will realize their rights. The principles of solidarity, righteousness and equality should be completely incorporated in the system through providing healthcare services to the citizens on the primary level by eliminating the inequalities in this area. The modernization of various equipment and tools, and the application of new working methods, as well as relations with beneficiaries are necessary as never before in order to reach a higher quality for the population's health. In lieu of this, it is also necessary to carry out a financial improvement of the healthcare sector, planning and managing human resources in healthcare and reorganizing the secondary and tertiary healthcare.

Dissatisfaction from the current processes and conditions in healthcare are exhibited by both employees, mostly the medical staff, and healthcare beneficiaries (*see Table no. 14*). The doctors exhibit dissatisfaction from their own status in valuing their efforts, working conditions and possibilities given to them to advance in their career. The beneficiaries are dissatisfied with “under the counter” tactics while realizing their right to healthcare, the conditions offered during hospital care, and the lack of medicines. The healthcare system reform, of which the privatization of primary healthcare is an essential and most important part, must provide efficiency, effectiveness and quality of healthcare for both the beneficiaries and the medical staff. This way the level of responsibility can be raised in both healthcare providers and beneficiaries and a system will be built which is supposed and expected to function for all involved subjects. The realisation of this supposition will strengthen the guidelines for righteousness and solidarity in the healthcare system.

For the citizens of the Republic of Macedonia, the Ministry of health is directly responsible for their introduction and information on the contents of the reforms (*see Annex 1, table no. 6*). At the same time it increases and strengthens its position in society in view of the responsibility for providing quality healthcare for the population. Exhibiting dissatisfaction from bad conditions in public healthcare is mainly due to the management which is mostly recruited from the medical staff (doctors). This staff cannot always achieve top results in organizing work, financial dealings and inter-human relations<sup>6</sup>, human resources<sup>7</sup>, like they can individually in the medical profession and specific specialization. One estimate is that results of top doctors should not always coincide with their results as managers of certain

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<sup>6</sup> By inter-human relations we mean the relations among colleagues at the work place. Of special note is the regular cooperation of colleagues from different sectors on two levels: for the working needs (functional cooperation) and personal needs (emotional cooperation). The Ministry of Health cannot be successful only through positive economic results, if the inter-human relations are not satisfactory. On the contrary, success implies that the Ministry has a high degree of cooperation among colleagues. Such cooperation contributes to homogeneous inter-human relations despite the division (special and functional) and makes them compact (by creating a whole). The ultimate result is the building of a working environment where employees feel friendly to each other, and belong to a collective which they can identify with.

<sup>7</sup> It is of utmost importance for the Ministry of Health to create an atmosphere and surroundings which will secure the link between the personal goals of the individual and the goals of the ministry. Care for employees and managing human resources is a key element to success, efficiency and professionalism of the ministry in carrying out its mission. Employment has an extremely important role, where the real challenge lies in employing capable, adjustable and persons loyal to their profession. In the past the phrase human resources (HR) meant personnel, industrial relations and staffing. The contemporary understanding of human resources means four wholes: employment, education and development, motivation and improvement and strategy and leadership. The employment process is an integral and important part in managing human resources. As special processes and functions within human resources there are: analysis of position, planning, winning the hearts of employees, selection, introduction to the job and career development, education of employees, professional orientation, advancement, termination, motivation, rating of success, discovering management talent and information.

clinics. These are mostly results far below the average of top managers in other areas. One intent is that the management of hospitals in the time to come to be realistically a job for professional managers, while increasing the degree of their autonomy (executive) in reaching decisions and the degree of responsibility in management.

Achieved results, above all in the domain of financial dealings, in improving the quality of healthcare, in inter-human relations of employees in medical facilities, and in building a healthcare system with developing components, will be the criteria for grading the level of success of each of the selected managers in healthcare. Their success is expected to be measurable through solving actual and specific problems which directly influence the behaviour of healthcare beneficiaries and their image and perception of healthcare in general. It is a fact that the inappropriate distribution of medicine on the territory of Macedonia and the common lack of certain prescription drugs in public pharmacies, as well as the price and quality creates anxiety and revolt with the citizens. Solutions abound, and one of them may be changing of the monopoly position, i.e. creating possibilities and conditions for other companies to engage on the Macedonian medical market.

Then solving the problem with lack of finances (and lack of payments) in a procedure which involves a complete system with protective mechanisms for the providers and beneficiaries of healthcare is a priority question of the reform and a specific task for healthcare managers. Undoubtedly the lack of finances in the Health Insurance Fund (FZO) is due to the incomplete payment of health insurance contributions for employees (the employer does not pay the contribution) as well as from the unemployed budget, retired persons, beneficiaries of social care, etc. Namely, there are other planned activities within the Healthcare Law which are not completely financed by the state budget, which really contributes to creating a larger difference between income and expenditure in healthcare. Rarely is equipment and maintenance of objects invested in, and no special funds are being filled for the purpose of equipment deterioration, which would be purposefully used by healthcare facilities.

Financial managers in healthcare facilities are not expert enough and exhibit weak results due to inappropriate training in this field. Finalizing obligations in the work place by all subjects in the healthcare system should be imperative for these managers in their day to day work. In reality, due to current social circumstance (low legal employment, lack of contribution payment) is very difficult in a healthcare system which is ordered as such. However, if the content of the reform is taken into consideration, their success will be measured according to exact criteria in battling such problems, because if it is not carried out, it can be seen that the existing healthcare system has no development capacity in the time to come.

Healthcare corruption is seen as a cancer and on the level of perception it is off the scale compared to other areas of society, according to the scope it is believed to be within the healthcare system. Also, there is a difference according to the readiness of each employee in the healthcare and the beneficiaries to openly discuss it. The persons in white coats, due to the nature of their work - caring for the health of the people - in comparison to other professions are "privileged" when speaking of corruption, i.e. the number of those willing to talk is almost insignificant. When speaking of the scope of this ailment in society, especially in healthcare, mainly it is the perception created as a result of the attitude of the media towards certain specific cases.

No one denies the existence of corruption in healthcare, however there are no determined criminal activities which may imply towards a high level of corruption, and no one has undertaken or can undertake responsibility for it until it can be specifically determined. Separate cases abound, and have always been present, but the grade of corrupt healthcare must be extrapolated from the real facts. One of the ways for its prevention is the application of penal policy for persons breaking the law. This condition of undefined existence of healthcare corruption can be solved by implementing a set of measures from the legal, financial and educational sectors. It can be presupposed that according to their behaviour it

can easily be determined breaking of the laws, applying an appropriate penal policy and informing the public about the consequences for such persons.

A special segment in the everyday work of healthcare facilities, and with it of their management, are the legally regulated rights of healthcare beneficiaries (*see Annex 1 Table no. 9*). In this context, the cooperation of healthcare management with certain citizen groups concerned with the protection of the rights of the beneficiaries, mostly by improving the legal structure, is highly important. The existing problems within healthcare are reflected, in a direct manner, on the health of healthcare beneficiaries. In order to reform public healthcare, it is necessary to solve specific problems in step (lack of drugs, payment of healthcare services, and improving their quality, improving hospital care, etc.) and build a communication strategy for better awareness of the medical staff and the citizens of the reforms with which, as it is evident, they are not well informed of, as well as their rights of which they have really no knowledge of.

### 3. COMMUNICATION WITH THE PUBLIC A FACTOR FOR SUCCESSFUL HEALTHCARE REFORMS

The Ministry of Health (and the Government) as the most significant organ, as well as the other institutions (Health Insurance Fund and the Republic Institute for Healthcare), compared to other organizations (the Union of Professional Medical Associations, and citizen associations) are directly called on to inform citizens of reforms. Realistically they are the policy makers in the healthcare sector and carriers of the reform, and it is up to them how large of a burden of responsibility will they bear, and what number of institutions will be included in the realisation of the reforms. Realistically, it is impossible to realise a solid government reform in any segment if there is no good communication policy in place first. Every decision made in order to be successfully implemented must be communicated to the public. This way the declared policy is confirmed, it checks its own value and is realised before the public. For every policy, the public opinion is key, because what is good for the policy may not be good for the citizen. During the public address, it is better to start from the citizen's aspect because the good policy is not a guaranteed success unless it is presented as a good policy for the citizen.

According to certain analysis made by the Ministry of Health, the reform process is being carried out not publicly enough and not a lot of citizen categories are included in it, especially the medical staff. The media barely mention the healthcare reform, and if something is talked about then it is mostly negative and brought out of context which creates additional anxiety and negative energy with healthcare beneficiaries. The communication<sup>8</sup> within healthcare is closed within tight circles and a small number of individuals create the reform in this sector. Also, the communication is weak, not enough and does not satisfy the needs of the public, especially healthcare beneficiaries, and a good part of the medical staff is displeased as well. This puts additional strain on the chances to improve the degree of awareness of the public.<sup>9</sup>

It is a fact that without completely including healthcare beneficiaries, medical staff, citizens associations and the media, as well as the citizens, a quality healthcare reform can not be expected. Certain solutions prepared by the creators of the reform are not getting the appropriate media support on one hand, and others are continually pointed out as bad, thus characterising the entire reform as such, on the other. Most of the citizens are aware that they are not informed about the reform, but also exhibit a high level of individual awareness of the degree and specific problems within the healthcare. The several national electronic

<sup>8</sup> By communication we mean receiving (hearing and watching) information (pictures and words) through the public electronic and printed media, as well as a direct and indirect communication among the people (verbal and nonverbal) aimed at exchanging information. When the exchange of information is in the healthcare context then we are talking about healthcare communication.

<sup>9</sup> See chapter III section Awareness of citizens a precondition for a successful healthcare reform.

media and daily newspapers report on the conditions and problems in healthcare, and are the main sources of information for the citizens. The so called “journalist story” is quickly becoming the only truth for the reforms in healthcare. The truth of the healthcare beneficiaries and the medical staff is either not noted or superficially presented, and an even worse treatment is reserved for the truth of the Ministry of Health. Namely, what the media publish about the healthcare reforms, according to the way it is presented, from the Ministry's aspect, it is better if it is not presented at all.

For the most part, and in the long term, according to the media's way of informing, one can talk about presenting incomplete information, disinformation, and speculation on the reform which adds to the confusion which is difficult to remove. A lot more time and information is necessary to correct the conditions generated by the unprofessional (bad) informing. Much more time, resources and knowledge is needed to realise expert crisis communication which is dictated by the actions of the creators of the reform, compared to the preprepared communication strategy which plans the activities of the creators of the reform in the public. A key argument for good public communication is not telling it that someone is good and has good ideas, but the dedication to announce to it what is being done and why.

The forms and content of communication (crisis and strategic) can be similar, but they are different from the aspect of the subject which enforces either. Namely in crisis communication, as well as in strategic, there can be an address of a certain person in the public through the medium, but with crisis communication this address is extorted, imposed and seen with a large amount of negative energy from the public. With strategic communication the person plans the event, defines clear messages towards certain categories and expects the public to be positive about the presentation of the content. The story told is not disputed by anyone because they are not forced to “answer the questions” but to “give answers to the questions”.

Social changes, what is being introduced as a novelty and which concerns most citizens, the public would like to hear from a relevant source (institution and person) and based on this to build an opinion and attitude. This is why it is necessary to timely inform the public in a quality manner, because it only serves the plan, which in this case is the reform. Direct communication (open or immediate) is desired in cases when various “informants” present themselves as competent to inform the public on the content of the reform. Parallel with the direct communication (meetings with citizens), a maximum use of the media is desired as powerful and influential means for informing the public. In this respect, a regular and direct communication is needed with the journalists in order to introduce them with the details of the reform and the planned activities.

As forms which would contribute to a better inner awareness in healthcare and the public, a service for informing can be set up with a professional team which would perform this task regularly. The purpose of this service is to create a strategy of integral information. On the inner level it can create an informational system, and on the outer a database for tracking activities in health activities of the population on a local level. Part of the activities of this service could be put into informing certain institutions and organs on an international level of the policy of the Ministry of Health.

The existence of a toll-free phone line in the Ministry of Health in order to present information of interest for the citizens is a good way to keep in touch with their needs and requests. Those who want to call the toll-free line are supposed to be more comfortable with such a means of communication and receiving the necessary information. The content of this line can be sufficiently spread from giving general information to giving expert advice, depending on the staff potential.

The main advantage of the toll-free phone line may not be measurable and apparent on first glance, as with the other forms of communication, except by the number of phone calls. Namely, in all forms of communication the ratings can be seen (measured), but the

effects of the toll-free line must be recognized through the immediate verbal communication carried out by the people who called with the people who did not.

A necessary, but not sufficient condition for the healthcare reform to be supported is for all relevant institutions, organs and citizens associations to be included in its preparation and realisation. The communication on the inner and outer level is the key to success of the reform in Macedonian society. Realistically, there are different target groups for communication: healthcare employees (medical and nonmedical staff), patients which will feel the reforms personally, part of the public which may benefit from the reform, journalists, representatives of citizens associations, as well as other categories of the population (such as: retired persons, handicapped, unemployed, blood donors, etc.) according to the specifics of the need to be communicated with.

In this context, communication means cooperation with the other ministries and institutions from the healthcare sector (such as the Health Insurance Fund, the Republic Institute for Healthcare, the Doctor's Chamber, the Healthcare Union, public healthcare institutions, and private practices), the producers and distributors of drugs, citizens associations, international donors, as well as media in order to strengthen the credibility of the reform carriers.

The efficient communication starts with a well conceived policy, continues with making the messages and specifying the target groups, and ends with following and measuring the effects. Of special note in placing the messages within the frame of the healthcare reform is the timely informing of the public and helping it understand that its essential mark is the knowledge that the reform influences everyone and must be transparent. When faced with resistance to the reform, which can be expected, the best way to lessen and prevent is the regular communication on all levels. Only through open communication can one's own dedication be imposed as just and in step with the times. People like to hear that what is being done is for their own benefit and it will make things better for them. Which is why there is a need for maximum readiness by the carriers of the reform to present it through numerous competent persons from the healthcare sector and outside of it.

#### **4. BASIC CHARACTERISTICS OF POPULATION STRUCTURE**

There are 1753 inhabited places in the Republic of Macedonia and 84 municipalities, inhabited by 79,21 persons per square meter. According to recent data, there are 2.036.855 inhabitants on the territory of the Republic of Macedonia. 1.021.772 are men, and 1.015.083 are women.

The data from 2005 show that from the total number of inhabitants, 1.215 live in a city, and 821.715 in a village.

20,1% are up to 14 years of age, of which 213.486 are male, and 199.127 female. Of the total number of citizens, 68,9% are ages between 15 and 64, out of which 711.853 are male, while 701,042 are female. 11% of the total number of citizens are above 65 years of age, of which 98.618 are male, and 126.428 female.

The Republic of Macedonia, as a multi-national state, is comprised of 64,2% Macedonians as the majority population, 25,2% Albanians, 3,9% Turks, 2,7% Roma, 1,8% Serbs and others.

According to the religious affiliation, there are 64,7% orthodox and 0,37% other Christians, 33,3% Muslims and others, as well as an undetermined 1,63%.

According to latest statistical data, 566 293 persons are employed, or 63, 9%, 319 316 or 36,1% are unemployed, while the average pay per employee is 13.306 denars.

## **II. BASIC FRAME OF RESEARCH**

### **1. INTRODUCTION**

This research is the first of its kind and the main aspects in it are concentrated around the healthcare reforms and the way the citizens are being informed of it. The received results should form the basis on which the communication strategy of the Ministry of Health will be built, whence the reform will be promoted as well as the novelties it brings. The research was carried out on the territory of the Republic of Macedonia in rural and urban areas, where the initial basis for determining the sample was the electoral unit, and afterwards the specific municipalities within it.

### **2. RESEARCH SUBJECT**

The subject of the research was actual conditions in healthcare with a personal explication from employees in healthcare facilities and citizens of age, as well as the dominant tendency in thought. The basic object of the research was determining the grades and attitudes of citizens on the healthcare reform, followed by the place of they use for healthcare, a grade for the kind and degree of problems and the incidence of forms through which they inform themselves on actual healthcare matters.

### **3. GOALS OF THE RESEARCH**

- determine the influence of certain socio-demographic<sup>10</sup> characteristics on processes and occurrences in the healthcare reform;
- determine the degree of awareness of the public about the changes in healthcare, as well as the forms they usually use to inform themselves;
- determine the manner of keeping informed of the rights as a beneficiary of healthcare services;
- determine the scope and kind of basic problems in healthcare, i.e. the most sensitive issues from the aspect of the medical staff and the beneficiaries of healthcare services;
- determine the quality of healthcare services of the personal doctor and hospital care, and determine the satisfaction from the service offered in the public and private healthcare;
- determine the appropriate forms and ways of communication with the public in order to popularize healthcare reforms.

### **4. SUPPOSITIONS**

In the healthcare sector there is an inappropriate legal regulation in the spirit of the needs of healthcare beneficiaries and the medical staff. The current social condition generates displeasure in citizens from the healthcare as it is being practised, and there is also displeasure in medical staff concerning the status and a number of unsolved issues.

The economic condition in society, characterised by a high degree of poverty and unemployment can be graded as bad, and thus directly reflecting on the conditions in healthcare. This area suffers numerous problems whose common denominator is the lack of finances. With the way healthcare is being carried out, realistically the social peace is kept, as well as the health of the population. Healthcare realistically, on the inside, is faced with

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<sup>10</sup> By socio-demographic factors we mean all indicators characterising one person and the surroundings, at the same time taking them as independant variables in order to determine the development of certain processes and occurrences. They are the measure for all other data for extrapolating health indicators. Demographic indicators include: total population divided by sex, age and place of residence (rural and urban). Socio-economic factors include: education, family income, social status, working place and population by ethnic and religious affiliation.

numerous problems with its own (lack of) organisation and, on the outside, the relations with healthcare beneficiaries. The perception of the problems in healthcare is especially sharpened with the citizens as a result of the way the media inform them, which does not necessarily have to correspond with the factual condition. The public is especially sensitive to corruption within the society, and is especially aggravated if this is done in medical circles.

One of the main reasons for the slow reform process, except for the lack of funding, is the lack of awareness which creates fear and produces uncertainty in both healthcare beneficiaries and medical staff as to what is the content of the healthcare reform. In general, the reform is supported, but it is necessary for it to be explained in immediate meetings with the citizens or in direct debates on the electronic media by the carriers of the reform. The expressed will for reform by all subjects involved is a necessary condition, but not enough for it to succeed in the time to come. The public is aware that in the future, in healthcare, things cannot continue to be as they used to, and also sees that there is no new model for contemporary healthcare.

One of the key factors influencing the attitude of the public towards the reform is the medium. The way they report, mostly the electronic media and daily newspapers, determines the perception, attitudes and values of citizens concerning the healthcare reform. The public is not informed of the reform. The media have the largest influence on citizens, but other forms of communication can be used in order to explain the reform to the public.

By forming an appropriate system for information within healthcare aimed at tracking, classifying and analysing the data and exchange of information, a higher degree of awareness is built on the real conditions and raises the level of healthcare culture within the society. By increasing the degree of awareness of the beneficiaries of healthcare services their rights are being protected as well, providing for a healthier society.

## 5. BASIC STRUCTURE OF PARTICIPANTS

The total number of participants (1.200), enabled the research (in technical, temporal and financial terms) to be carried out according to the planned dynamic and the poll to be voluntarily filled out by the citizens of age. With this research we get a complete image of the opinion of healthcare employees (medical staff) on certain issues.

As a result of the successful training of the interviewers, we achieved a complete fulfilment of the planned sample in the research. Based on the experience so far, it can be supposed that the participants were honest, which guarantees the accuracy of the conclusions.

*Table no. 1 Electoral unit*

Electoral unit	P	%
First	200	16,7
Second	200	16,7
Third	200	16,7
Fourth	200	16,7
Fifth	200	16,7
Sixth	200	16,7
TOTAL	1200	100,0

*Table no. 2 Place of residence*

Place of residence	P	%
Village	611	50,9
Small town	120	10,0
Town	230	19,2
City	239	19,9
TOTAL	1200	100,0

*Table no. 3 Sex*

Sex	P	%
Male	558	46,5
Female	642	53,5
TOTAL	1200	100,0

*Table no. 4 Age*

Age	P	%
18-28	228	19,0
29-39	286	23,8
40-50	387	32,3
51-61	214	17,8
over 62	85	7,1
TOTAL	1200	100,0

*Table no. 5 Education*

Education	P	%
Primary	190	15,8
Secondary	624	52,0
High	122	10,2
Higher	264	22,0
TOTAL	1200	100,0

*Table no. 6 Nationality*

<b>Nationality</b>	<b>P</b>	<b>%</b>
Macedonian	876	73,0
Albanian	182	15,2
Turkish	19	1,6
Serbian	51	4,3
Vlach	13	1,1
Roma	42	3,5
Other	17	1,4
TOTAL	1200	100,0

*Table no. 7 Religious affiliation*

<b>Religious affiliation</b>	<b>P</b>	<b>%</b>
Orthodox Christian	926	77,2
Muslim	256	21,3
Catholic	10	0,8
Protestant	1	0,1
Other	7	0,6
TOTAL	1200	100,0

*Table no. 8 Social status*

<b>Social status</b>	<b>P</b>	<b>%</b>
Worker	512	42,7
Clerk	161	13,4
Private entrepreneur	147	12,3
Student	51	4,3
Unemployed	162	13,5
Retired	102	8,5
Farmer	18	1,5
Housewife	47	3,9
TOTAL	1200	100,0

*Table no.9 Working place*

<b>Working place</b>	<b>P</b>	<b>%</b>
medical facility	242	20,2
other	635	52,9
unemployed	323	26,9
TOTAL	1200	100,0

*Table no. 10 Monthly family income in denars*

<b>Monthly income</b>	<b>P</b>	<b>%</b>
up to 6000	225	18,8
6001 - 12000	389	32,4
12001 - 18000	310	25,8
18001 - 24000	146	12,2
above 24001	130	10,8
<b>TOTAL</b>	<b>1200</b>	<b>100,0</b>

### III. ANALYSIS OF THE RESULTS OF THE RESEARCH

#### 1. THE INFLUENCE OF SOCIO-DEMOGRAPHIC CHARACTERISTICS ON DECISIONS OF PARTICIPANTS ON HEALTHCARE

While analysing the data on the influence of the age of participants and the need to go see a doctor (*see table no. 11*) it can be said that there is an influence, according to which the older age groups (51 - 61 and above 62 ) *regularly* see a doctor out of 25,2%. And 34,1%. The young on the other hand see a doctor *regularly* и *often* around 10 %, while most go *sometimes* (37,7%).

Table no. 11 Influence of age on going to a doctor

AGE 4/11	Goes to a doctor during the year					
	Regularly	Often	Sometimes	Rarely	Very rarely	TOTAL
18-28	21 9.2	23 10.1	86 37.7	53 23.3	45 19.7	228 100
29-39	31 10.9	29 10.1	91 31.8	75 26.3	60 20.9	286 100
40-50	42 10.8	37 9.7	136 35.1	98 25.3	74 19.1	387 100
51-61	54 25.2	24 11.2	63 29.4	38 17.7	35 16.5	214 100
above 62	29 34.1	21 24.7	19 22.4	8 9.4	8 9.4	85 100
TOTAL	177 14.8	134 11.2	395 32.9	272 22.6	222 18.5	1200 100

Based on the received data, it can be concluded that the older generations are more common in the medical facilities. Having in mind their health condition and needs, it is understandable. At the same time, it is confirmed by the data received on the younger generations, where the number of those going to the doctor's *rarely* и *very rarely* is 19,7% and 20,9%. Younger participants, as their personal motive to see a doctor (*see Annex 1 Table no. 1*) listed that (more than 2/3) do it due to *poor health*, while the elder believe that the *specific illness* is their true motive.

When it comes to grading the quality of healthcare services offered in the past 12 months by the personal doctor, while keeping in mind the social status of the participants, (*see table no.12*), the following can be concluded: services offered by the personal doctor are mostly *bad* with the largest percentage of answers compared to other groups by unemployed persons, or 14,8%. But at the same time 35,1% of this category claim the service they were offered from their personal doctor is *good*. Healthcare services from the personal doctor was graded by 42,6% of workers as *good* i.e. *very good*, while less than 1/3 of them believe it is *excellent*. For 26,7% of clerks, i.e. 29,4% of private entrepreneurs it is *good* and *very good*, while 1/3 of both categories rated the healthcare service provided by their personal doctor as *excellent*.

Table no. 12 Influence of social status on the grade of the quality of healthcare services in the past 12 months offered by the personal doctor

SOCIAL STATUS 8/17	Grade for the quality of healthcare services offered by the personal doctor in the past 12 months					
	Bad	Poor	Good	Very good	Excellent	TOTAL
worker	51 9.9	87 16.9	150 29.4	67 13.2	157 30.6	512 100
clerk	8 4.9	22 13.6	43 26.7	36 22.6	52 32.2	161 100
Private business	9 6.1	24 16.3	43 29.4	24 16.3	47 31.9	147 100
Student	5 9.8	6 11.7	16 31.5	10 19.6	14 27.4	51 100
unemployed	24 14.8	24 14.8	57 35.1	21 12.9	36 22.4	162 100
retired	7 6.8	8 7.8	37 36.2	23 22.5	27 26.7	102 100
farmer	0	2 11.7	8 44.7	3 16.6	5 27	18 100
housewife	3 6.4	1 2.1	21 44.6	8 17.1	14 29.8	47 100
TOTAL	107 8.9	174 14.5	375 31.3	192 16	352 29.3	1200 100

The personal doctor is a personal choice of each patient, and so it is expected of the participants to rate the services offered in the past 12 months more positively.

The grade for the quality of services received (*see table no.13*) in the past 12 months in hospitals varies in participants in accordance with their social status. Namely, 38,9% of the unemployed give the lowest grade (*bad*). The unemployed are most critical when compared to the clerks, workers and private business owners, of which more than ½ rate the services of hospital care *good*, i.e. *poor*. Of these categories 1/3 of them have rated hospital care as *bad*.

Table no. 13 Influence of the social status on the grade for the quality of healthcare services in the past 12 months in hospitals

SOCIAL STATUS 8/18	Grade for the quality of healthcare services in the past 12 months in hospitals					
	bad	poor	good	very good	excellent	TOTAL
worker	157 30.6	141 27.7	143 28	43 8.3	28 5.4	512 100
clerk	43 26.7	40 24.9	48 29.9	16 9.8	14 8.7	161 100
private businessman	48 32.7	38 25.9	41 27.9	9 6.1	11 7.4	147 100
student	16 31.3	10 19.6	19 37.4	5 9.8	1 1.9	51 100
unemployed	63 38.9	40 24.7	47 29	5 3.1	7 4.3	162 100
retired	29 28.4	30 29.4	32 31.4	8 7.9	3 2.9	102 100
farmer	8 44.4	3 16.7	5 27.7	1 5.7	1 5.5	18 100
housewife	18 38.3	14 29.8	11 23.5	2 4.2	2 4.2	47 100
TOTAL	382 31.8	316 26.3	346 28.8	89 7.5	67 5.6	1200 100

Table no. 14 Working place and rating quality of healthcare services from personal doctor in the past 12 months

PLACE OF WORK 9/17	Rating the quality of healthcare services by personal doctor in the past 12 months					
	bad	poor	good	very good	excellent	TOTAL
medical facility	15 6.2	41 17	52 21.4	36 14.9	98 40.5	242 100
other	56 8.9	96 15.2	206 32.4	106 16.6	171 26.9	635 100
unemployed	36 11.2	37 11.5	117 36.1	50 15.5	83 25.7	323 100
TOTAL	107 31.8	174 26.3	375 28.8	192 7.5	352 5.6	1200 100

The research showed that the citizens have a relatively different perception of healthcare services rendered by the personal doctor in accordance to whether they work in or out of a medical facility (see table no.14) Employees of medical facilities rated the services rendered by the personal doctor in the past 12 months as positive: 40,5% of them as *excellent*, while 35,3% believe they are *good* or *very good*. Unlike them, 22,7% of unemployed participants consider the services to be *bad* or *poor*. According to 36,1% of the unemployed, the healthcare services of the personal doctor are *good*, while 25,7% said it was *excellent*. For participants working at some other place instead of a medical facility, 32,4% consider the services rendered by the personal doctor to be *good*.

The influence of the place of work of participants (medical facility / other) is visible when it comes to rating hospital care (*види Табела бр. 15*). Namely, most critical are the unemployed, of which 60,8% believe that it is *bad*, i.e. *poor*. For ½ of medical facility employees the rating of hospital care is *bad* or *poor*, while 12,4% of them consider it to be *very good*. More than ½ of employees working in other places 31.8% consider that hospital care is *bad* i.e. 28,2% rate it as *poor* and *good*.

*Table no. 15 Place of work and rating of quality of healthcare services in the past 12 months in hospitals*

PLACE OF WORK 9/18	Rating of quality of healthcare services in past 12 months in hospitals					
	bad	poor	good	very good	excellent	TOTAL
medical facility	62 25.6	59 24.4	70 28.9	30 12.4	21 8.7	242 100
other	202 31.8	179 28.2	178 28.1	42 6.6	34 5.3	635 100
unemployed	118 36.5	78 24.3	98 30.3	17 5.2	12 3.7	323 100
TOTAL	382 31.8	316 26.3	346 28.8	89 7.5	67 5.6	1200 100

*Table no. 16 Influence of place of residence with the rating of healthcare services in the past 12 months in hospitals*

PLACE OF RESIDENCE 2/18	Rating of the quality of healthcare services in the past 12 months in hospitals					
	bad	poor	good	very good	excellent	TOTAL
village	199 32,6	167 27,3	168 27,5	47 7,7	30 4,9	611 100
small town	33 27,5	31 25,8	37 30,8	10 8,4	9 7,5	120 100
town	77 33,5	48 20,9	67 29,1	20 8,7	18 7,8	230 100
city	73 29,3	70 28,2	74 30,1	12 9,1	10 3,3	239 100
TOTAL	382 31,8	316 26,4	346 28,8	89 7,4	67 5,6	1200 100

The place of residence of participants does not determine their rating for services rendered from their personal doctor, i.e. from hospital care (*see Table no. 16*). Namely, both those that live in a village and those that live in a town are happy with their personal doctor (*see Annex 1, Table no. 3*), or 56% of the city participants rate their personal doctor as *very good* and *excellent*. Of those who live in a village, 1/3 consider their personal doctor to be *very good* and *excellent*. Independantly of their place of residence, a large percentage of participants has built a negative attitude towards the quality of hospital care. Of the total number, 60% of participants living in a village claim that hospital care is *bad*, i.e. *poor*. 1/3 of participants living in towns consider they receive *bad* hospital care. It can be concluded that independently of the place of residence, participants receive hospital care in the town in

conditions which are equal for all. On the other hand, it can be supposed that the level of general culture is improved on account of participants in villages, i.e. on their level of perception they see mistakes more easily (poor food, lack of hygiene, bad conditions, unkindness, etc.) which speaks towards lessening the meaning of this factor among participants.

*Table no.17 Influence of education on following news, texts, shows dedicated to healthcare on average during a month*

EDUCATION 5/23	Following news, texts and shows dedicated to healthcare on average durin a month					
	regularly	often	sometimes	rarely	very rarely	TOTAL
primary	39 20.3	24 12.1	52 27.2	40 22.2	35 18.2	190 100
secondary	112 17.9	102 16.3	236 37.8	109 17.5	65 10.5	624 100
2 year college	30 24.5	33 27.5	41 33.1	12 10.1	6 4.8	122 100
higher	88 33.3	64 24.2	82 31.3	19 7.1	11 4.1	264 100
TOTAL	269 22.4	223 18.5	411 34.3	180 15	117 9.8	1200 100

The degree of education has an influence on following news, articles and shows on healthcare (*see table no. 17*). This type of shows during a month is *regularly* followed by participants which have completed their higher education (33,3%). Of participants with secondary education and a 2 year college above 1/3 *sometimes* follow such shows, news and articles. The participants with only a primary education it is noticeable that they are least inclined to follow such shows (compared to other categories, 2/5 of them stated that they *rarely* or *very rarely* follow them) so it may be concluded that the main reason for the attitude towards these shows is the degree of education.

## 2. CITIZENS ON THE REFORM AND ACTUAL CONDITIONS AND OCCURRENCES IN THE HEALTHARE SECTOR

It was shown that the degree of education of participants influences the rating of the journalists informing on healthcare conditions (*see Table no. 18*). It can be noticed that those with a lower level of education are less critical, i.e. 40% of those with a primary education consider that the information is objective and truthful. On the other hand, 20% of participants with a 2 year college education believe they are receiving objective and truthful information from the journalists. On the other hand, 28% of participants with a higher education have stated that the information is sensationalist, as opposed to 4,7% of those with primary education.

Table no. 18 Influence of education on the rating of journalist information on conditions in healthcare

EDUCATION 5/56	Journalist informing on conditions in healthcare									
	objective	superficial	negative	truthful	sensationalistic	affirmative	wrong	I do not know	other	TOTAL
primary	37 19,5	40 21,0	10 5,3	41 21,6	9 4,7	0 0,0	13 6,8	35 18,4	5 2,6	190 100
secondary	113 18,1	219 35,1	33 5,3	75 12,0	53 8,5	5 0,8	18 2,9	98 15,7	10 1,6	624 100
2 year college	33 27,0	42 34,4	5 4,1	5 4,1	15 12,3	4 3,3	3 2,5	10 8,2	5 4,1	122 100
higher	42 15,9	74 28,0	23 8,7	13 4,9	74 28,0	4 1,5	6 2,3	22 8,4	6 2,3	264 100
TOTAL	225 18,7	375 31,2	71 5,9	134 11,2	151 15,6	13 1,1	40 3,4	165 13,7	26 2,2	1200 100

It can be concluded that participants with higher education are more critically inclined compared to the rest, while those with secondary education are holding the middle ground with their ratings, between those with primary and higher education.

The difference between certain categories according to the level of education is insignificant, (see table no. 19), i.e. Participants with 2 years of college, when compared to those with primary education show a mild tendency to prefer *debates and interviews* with managers rather than *directly meet* them. Namely, around 50% of all groups of participants, with a different degree of education, claim that citizen awareness could be improved through *direct meetings*.

Table no. 19 Influence of education on attitude towards the need for managers to take steps to improve citizen awareness for the reforms

EDUCATION 5/45	Managers in the Ministry of Health should do in order to improve citizen awareness about the reforms					
	Participate in seminars	Direct meetings	Interviews and statements	Debate shows	other	TOTAL
primary	7 3.6	111 58.4	26 13.6	39 20.8	7 3.6	190 100
secondary	55 8.8	302 48.3	97 15.5	157 25.3	13 2.1	624 100
2 year college	9 7.3	63 51.8	18 14.7	27 22.1	5 4.1	122 100
higher	25 9.4	108 40.9	58 21.9	65 24.8	8 3	264 100
TOTAL	96 8	584 48.7	199 16.5	288 24	33 2.8	1200 100

Around 1/4 of participants consider the need for *debates*, while an insignificant percentage believes there is a need for *seminars*. Based on the realised research, it can be concluded that the degree of education, to some extent, has an influence towards extreme population categories about what should managers in the Ministry of Health do in order to improve citizen awareness about the reforms. The direct meeting or face-to-face communication has the best influence on the public, although it requires the greatest effort, time and resources. Word of mouth information seems to be relevant in local areas with the greatest effect on those that are listening. Direct contact with the citizens enables verbal communication and creates possibilities for an easy distribution of printed material and contact with local media.

The need of large reforms in healthcare in the next 12 months is required by a large percentage of participants, independent of the level of education (*see Table no. 20*). Namely, participants with a completed primary education in 80% of the cases *agreed*, i.e. *completely agreed* with the statement that there is a need for large reforms. Participants with secondary education agree with the same attitude in similar numbers. Over 80% of participants with 2 years of college and higher education *agree*, i.e. *completely agree* with the need for large reforms in healthcare.

It may be concluded that according to the level of education there is no difference for the need for reforms in healthcare, i.e. the percentage of those who disagree is statistically insignificant.

*Table no. 20 Influence of education on the attitude that our healthcare needs large reforms in the next 12 months*

EDUCATION 5/72	Our healthcare needs large reforms in the next 12 months					TOTAL
	completely agree	agree	disagree	do not agree at all	no opinion	
primary	87 45.7	77 40.7	9 4.7	2 1.1	16 7.8	190 100
secondary	316 50.8	213 34.1	26 4.1	7 1.1	62 9.9	624 100
2 year college	69 56.5	39 31.9	8 6.7	0 0	6 4.9	122 100
higher	130 49.2	107 40.5	6 2.2	7 2.6	14 5.5	264 100
TOTAL	602 50.2	436 36.3	49 4.1	16 1.3	97 8.1	1200 100

Expectations of the participants for the conditions in healthcare in the following 12 months after the reform is realised are huge. Namely, it may be concluded that the participants are optimistic (*see table no. 21*) when it comes to the success of the reform. Of the participants which labelled themselves as *badly* informed on healthcare reforms 23,2% cannot estimate what the condition in healthcare will be after the reform is carried out. The greatest optimists are those who consider themselves *excellent* i.e. *very well* informed, of which over ½ - 42.8% claim that the condition in healthcare after the reform is carried out will be *much better*. The participants labelling themselves as *well* informed, 39,1% said that the condition will be *a little better*.

Table no. 21 Rate of awareness and expectations for the conditions in the first 12 months after the healthcare reform is carried out

RATE OF AWARENESS 19/73	Expectation for the condition in healthcare 12 months after the reform is carried out						TOTAL
	much better	a little better	the same	a little worse	much worse	cannot say	
bad	129 27	167 35	33 6.9	11 2.5	26 5.4	111 23.2	477 100
poor	118 34.5	139 40.5	24 6.9	5 1.1	14 4	45 13	345 100
good	90 33	105 39.1	21 7.9	4 1.5	11 4	44 14.5	275 100
very good	24 42.8	18 32.4	2 3.5	1 1.7	0 0	11 19.6	56 100
excellent	24 51.6	14 29.4	1 2.1	1 2.1	1 2.1	6 12.7	47 100
TOTAL	385 32.1	443 36.9	81 6.8	22 1.8	52 4.3	217 18.1	1200 100

Table no.22 employment and rate of communication between healthcare workers and beneficiaries

EMPLOYMENT 9/22	Rate the communication between healthcare workers and beneficiaries					
	bad	poor	good	very good	excellent	TOTAL
Health	35 14,5	47 19,4	87 36,0	42 17,4	31 12,8	242 100
other	195 30,7	189 29,8	191 30,1	39 6,1	21 3,3	635 100
unemployed	85 26,3	88 27,2	105 32,5	29 9,0	16 4,9	323 100
TOTAL	315 26,3	324 27,0	383 31,9	110 9,2	68 5,6	1200 100

The place of employment influences the perception of participants on their communication with healthcare workers (see Table no. 22). Namely, those who work in healthcare institutions will, logically, be less critical in their grades, i.e. 30.2% rate the communication as very good and excellent, opposite the 9% of the other or the 11% of the unemployed. On the other hand, 1/3 of healthcare employees consider the communication to be bad, while 1/2 of the unemployed chose bad to rate the communication.

How much participants go to the doctor influences their perception on the quality of the services rendered (see table no. 23). It may be concluded that those who visit the doctor more often are more satisfied from the healthcare services. Namely, 1/2 of participants which visit the doctor regularly or often, rate the services of their personal doctor as very good and excellent. On the other hand, of those who visit the doctor very rarely and rarely, 1/4 believe that the services are bad.

Hospital care, (See Annex 1 table no. 5) for 1/3 of participants that visit the doctor regularly and often, believe that the services are bad. The percentage of those who visit the doctor rarely and claim that hospital care is bad is not that greater (36,8%). Of those who visit the doctor sometimes, 1/3 consider the hospital care to be good.

Table no. 23 Influence of visits to the doctor and the rate of services rendered in the past 12 months from the personal doctor

VISITS DOCTOR 11/17	Rate the quality of services rendered by personal doctor in the past 12 months					
	bad	poor	good	very good	excellent	TOTAL
regularly	15 8,5	17 9,6	53 29,9	32 18,1	60 33,9	177 100
often	12 8,9	20 14,9	40 29,8	19 14,2	43 32,1	134 100
sometimes	26 6,6	57 14,4	127 32,1	72 18,2	113 28,6	395 100
rarely	28 10,3	43 15,8	88 32,3	41 15,1	72 26,4	272 100
very rarely	26 11,8	37 16,8	67 30,4	28 12,7	64 29,1	222 100
TOTAL	107 8,9	174 14,5	375 31,3	192 16,0	352 29,4	1200 100

Participants, independently of which services they use, whether public or private practices, have similar opinions on hospital care (*see table no. 24*). Of participants attending public practices 57,2% consider hospital care to be *bad* and *poor*, while 28,6% believe it is good.

Of the participants that are patients in private practices, 61,9% believe that the hospital care is *bad* or *poor*. Of those that use the services of both public and private practices, 36,6% think that the hospital care is *good*, while 54,6% think it is *bad* or *poor*. The percentage of those participants that said hospital care was *excellent* is insignificant.

Table no. 24 Most common place for check-ups and rating the quality of healthcare services of hospitals

PLACE FOR CHECK-UP 12/18	Rating of quality for healthcare services in hospitals					
	bad	poor	good	very good	excellent	TOTAL
Only in public practices	211 29.6	195 27.6	204 28.6	60 8.4	42 5.8	712 100
Private practices with money	31 36.9	21 25	22 26.5	5 5.9	5 5.7	84 100
Private practices with blue cards	38 30.9	28 22.7	44 35.7	8 6.5	5 4.2	123 100
Public and private practices with money	30 29.7	25 24.9	37 36.6	3 2.9	6 5.9	101 100
Public and private practices with blue cards	64 39.3	44 26.9	36 22.1	12 7.4	7 4.3	163 100
other	8 47.1	3 17.7	3 17.7	1 5.8	2 11.7	17 100
TOTAL	382 31.8	316 26.3	346 28.8	89 7.5	67 5.6	1200 100

The working place of participants contributes to different expectations considering the success of reforms in the 12 months following the implementation (*see Annex 1 table no. 14*). Those who work outside medical facilities are greater optimists, and over 70% of them believe that the condition will be much and a little better. Approximately the same percentage, 69% of the unemployed give the same prognosis. Of those employed in medical facilities, ½ consider that it will be much better. 10 % of health workers claimed that the condition will be much worse.

Participants made special note of the Ministry of Health as directly responsible to inform the citizens of the reforms and their rights. Of the total number of participants only 15,5% did not name the Ministry as significant (*see Annex 1, Table no. 6*). The greatest part (48,8%) rates the Ministry of Health first and it is convincingly the highest percentage compared to other institutions and organs. The government is pointed out by ¼ of participants as most important, while all of the others on this level do not have more than 10%, which statistically speaking is insignificant. The Health Insurance Fund with 20,8% and 21,2% is ranked second and third according to the importance, making it the third institution in line responsible for informing citizens on the reforms in healthcare and their rights. Public health institutions receive the public's "trust" as fourth in line with 14,4% and 16,4% in the second and third place. Other institutions are barely perceived in the role of promoting the reform in the eyes of the participants. Namely, in this respect the participants have such opinion of citizens associations in the healthcare sector and private practices, which with 91,1% and 90,3% are declared irrelevant for healthcare reforms. It was shown that the participants are mainly informed of their rights as healthcare beneficiaries through their personal doctor and the media (*see Annex 1, Table no. 9*). Participants living in villages pay more significance to recommendations from their personal doctor when compared to those from towns who are chiefly media oriented. In context of age, the younger participants prefer their personal doctor, while the older are equally divided between their personal doctor and the media. According to the data received through the research, it may be concluded that the other forms of informing the citizens of their rights (such as the internet and public campaigns) are almost unperceived.

Of the activities practised during a month, the participants were mainly for watching the TV news segment (*see Annex 1, Table no. 8*) through which they keep in touch with current processes. Of the total number, 31, 3% rank this type of shows in first place, which is almost twice as much as the second in line (watching TV, film, music). Reading daily newspapers with 24,2% in the second level is before watching healthcare shows, and almost 1/5 of the third level choice of the participants was walks through the city. It is evident that the electronic media have a significant advantage compared to printed media when it comes to following content by the citizens. Probably the entire circulation of the newspapers, especially the weekly ones, cannot cover a large part of the public's interest. This space is given to the electronic media.

### 3. CURRENT PROBLEMS - AN ACUTE CONDITION

When it comes to setting the level of the problems (*see table no.25*), the largest part were marked as a *big problem* and a *very big problem*. The number of participants that marked healthcare problems as *small* or consider them *not to be a problem*, are almost statistically insignificant. A particularly large problem, separated from the rest is corruption in healthcare, followed closely by the *poor conditions in public healthcare*. According to the number of participants marking these two problems (above 84%), it may be concluded that they constitute the first group according to the degree of importance of healthcare problems. The second group of healthcare problems includes *the lack of medications* (very big 47% and big 39,4%), *inefficiency and lack of organization* (very big 47,7% and big 37,1%) and the *lack of funding in healthcare and debts in the healthcare sector* which over 73% rate as a very big

and big problem. In the third group of problems ranging from 1/3 to 1/5 and where, most of all, the degree of meaning is lowered from very big to big, the participants point out the existence of *poor management, low salaries, and disrespect of Healthcare laws*. The fourth group of problems, according to the participants are *lack of awareness of healthcare staff, lack of awareness of healthcare beneficiaries, issuing of fake sick-leaves*, as well as the *lack of employees in public healthcare*, and rate these as bigger or problems without much significance.

The working place of the participants when evaluating certain problems which occur and exist within the healthcare system has proven to be an especially significant factor (see *Annex 1, Table no.10* ), depending on the contents of the problem. Healthcare employees (medical staff) see the poor conditions in public healthcare as a very big problem, totaling to 30,6% of them, while 38,0% see it as only a big problem. Of the participants employed at *other working places*, or are unemployed, less than 1/5 and less than 1/3 see a very big or big problem in the poor conditions in public healthcare. According to received results it may be concluded that the medical staff, which faces the reality of the healthcare institutions daily, is more critical of the conditions in the public healthcare, rating it as a very big and big problem. Participants that are not exposed daily to the conditions in the healthcare facilities display a milder criticism, however they are aware that the poor conditions in the public healthcare present a big problem.

*Table no. 25 Degree of problems in healthcare*

Problems	Degree of meaning					
	No problem	Small	Big	Very big	I do not know	Total
Lack of medicine	2,6	8,2	39,4	47,0	2,8	100,0
Low salaries	3,5	11,1	35,5	39,3	10,7	100,0
Over-employment in public healthcare	15,8	20,3	26,2	13,4	24,3	100,0
Disregard for healthcare legislation	4,1	10,8	31,4	34,0	19,8	100,0
Debts in healthcare	1,2	3,4	30,8	43,8	20,9	100,0
corruption	1,7	2,9	18,9	70,1	6,4	100,0
Lack of funds for healthcare	3,9	4,3	31,7	48,4	11,7	100,0
Issuing of fake sick-leaves	10,3	18,2	27,5	21,6	22,4	100,0
Poor conditions in public healthcare	2,0	8,3	34,9	50,7	4,2	100,0
Lack of awareness on the part of the medical staff	6,1	19,5	31,7	20,7	22,1	100,0
Lack of awareness on the part of beneficiaries	2,4	17,4	41,4	27,5	11,3	100,0
Poor management	3,7	11,1	35,7	37,6	12,0	100,0
Inefficiency and lack of organisation	1,9	6,2	37,1	47,7	7,2	100,0

The existence of poor management in healthcare facilities, as a problem, was pointed out in the third group (see *Annex 1 Table no.11* ), which goes to show that the participants do not feel the problem directly and do not pay special attention to it. However, keeping in mind the place of employment of the participants, it is especially significant that the medical staff values it as a *very big problem* above 1/5 and 18,9% as a *big problem*. Of the unemployed participants, less than 1/3 believe that the poor management in healthcare facilities is a *very big problem*, while over 2/5 believe it is a *big problem*. Based on the acquired data, it can be concluded that persons not working in healthcare see the problem with poor management

indirectly, unlike the medical staff which is faced daily and immediately with it. Due to this, there is large criticism against the management by healthcare employees.

The place of employment where the participants work did not show significant differences when rating the inefficiency and lack of organization in healthcare facilities as a problem (*see Annex 1, Table no.12*). Namely, this occurrence was mostly rated as a *very big problem* (47,7%), and there were no differences in opinion between participants who do not work in healthcare and those that do. A similar tendency occurs when rating this occurrence as a *big problem*, where 1/3 to 2/5 of participants who work in healthcare and those that do not have answered similarly.

*Table no. 26 Place of employment and opinion on the degree of problems in healthcare*

PLACE OF EMPLOYMENT 9/71	Degree of problems in healthcare					
	Small	Big	Very big	No problems	I do not know	TOTAL
medical facility	1 0.4	81 34.5	158 64.3	0 0	2 0.8	242 100
other	28 4.4	272 42.8	309 48.7	4 0.6	22 3.5	635 100
unemployed	17 5.2	142 44.6	142 44.6	4 0.1	18 5.5	323 100
TOTAL	46 3.8	495 41.3	609 50.7	8 0.7	42 3.5	1200 100

The research has shown that the place of employment (*see Table no. 26*) has no influence on the perception of participants on the degree of problems in healthcare. Namely, healthcare employees are pretty critical, and 64,3 % think that the problems are very big and 34,5% believe they are big. Almost ½ of the participants employed outside healthcare and the unemployed believe that the problems are very big.

Almost no one answered that there are no problems in healthcare.

Healthcare services from the personal doctor are rated relatively high by participants, regardless of whose services they employ (*see table no. 27*). Of those who go only to public healthcare practices, 49,1% rate the services of their private doctor as *good* or *very good*, while 29,1% rate them as *excellent*. Of the participants who use private healthcare practices by paying, 1/3 think that the services rendered are *good*, while 27,4% say the services are *excellent*. For 41,7% of the participants who use services from both public and private healthcare practices the services are *good* and *very good*.

Table no. 27 Usual doctor visits and rating the quality of healthcare services provided by personal doctor

PLACE FOR CHECK-UPS 12/17	Rating of quality of healthcare services in the last 12 months from the personal doctor					
	bad	poor	good	very good	excellent	TOTAL
Only in public healthcare facilities	61 8.6	99 13.2	225 31.6	123 17.5	204 29.1	712 100
Private practices with money	9 10.7	16 19	27 32.2	9 10.7	23 27.4	84 100
Private practices with blue cards	11 8.9	11 8.9	39 31.7	21 17.2	41 33.3	123 100
Public and private practices with money	8 7.9	18 17.8	38 37.8	12 11.8	25 24.7	101 100
Public and private practices with blue cards	15 9.2	26 15.9	43 26.4	25 15.3	54 33.2	163 100
other	3 17.6	4 23.5	3 17.6	2 11.8	5 29.4	17 100
TOTAL	107 31.8	174 26.3	375 28.8	192 7.5	352 5.6	1200 100

#### 4. AWARENESS OF CITIZENS - A CONDITION FOR SUCCESSFUL REFORM IN HEALTHCARE

Participants believe that citizen awareness on the occurrences and processes in healthcare may be increased through several activities (*see table no. 28*), while more than 2/5 believe that it can be done successfully by organising campaigns.

Table no. 28 The influence of education for better awareness - campaigning

LEVEL OF EDUCATION 5/35	Organising campaigns				
	Zero	First	Second	Third	TOTAL
primary	97 51,0	52 27,4	17 8,9	24 12,6	190 100
secondary	388 62,7	132 21,1	36 5,8	68 10,9	624 100
2 year college	69 56,6	39 31,9	9 7,4	5 4,1	122 100
higher	162 61,4	59 22,3	13 4,9	30 11,4	264 100
TOTAL	716 59,7	282 23,5	75 6,3	127 10,6	1200 100

Of the participants with primary education only, 27.4% rate the organization of campaigns as most important to keep citizens aware. Of the other categories (secondary and higher education) 1/5 believe that campaigns should be organized. It can be concluded that the degree of education creates an insignificant difference among participants when deciding that campaigns ought to be used as forms of information, where participants with lower education pay more attention to them.

The practice of various campaigns (see table no.29<sup>11</sup>) shows to be a particularly acceptable way compared to other activities. Namely, according to occurrence, campaigns are in fourth place with 40.3%, while ahead of them are *opening of a toll-free phone line for citizens*, with 56.1%, *creating an information service* 54.2% and 51.2% for *radio and television shows*.

The participants gave the least „votes“, as forms through which they may be informed, to *increasing the number of websites* (5.7%) and *press conferences* (15.2%).

Table no.29 Activities necessary for improving citizen awareness on healthcare

Activity	Degree of importance				
	0	1	2	3	%
campaigns	59,7	23,5	6,3	10,6	100,0
Increase number of websites	94,3	1,8	2,3	1,8	100,0
Publishing of propaganda materials	72,5	7,0	11,1	9,4	100,0
Buying ad-space in newspapers	72,3	5,6	11,5	10,6	100,0
Creating an information service	55,8	19,0	15,4	9,8	100,0
Toll-free phone line for citizens	43,9	43,9	24,2	13,1	100,0
Radio and television shows	48,8	13,7	18,7	18,8	100,0
Press conferences	84,8	2,8	4,3	8,1	100,0
Mailing materials to beneficiaries	69,1	7,1	6,5	17,3	100,0

Compared to how participants rated the communication between the medical staff and the healthcare beneficiaries (see Annex 1, table no. 2), adult groups give very varying answers. Of the total number of participants in the age group of 18 to 28 years of age, around 1/3 consider the communication is *bad*. Participants aged 51 to 61, as well as those above 62 years of age, in more than 30% of cases believe that the communications is *good* and *poor*. In the age group 29 to 39, the number of answers who consider the communication is *bad* and those who claim it is *good* is equal (31,7 % and 31,8%). It may be concluded that the younger generation rates the communication between medical staff and healthcare beneficiaries with more criticism, and one of the factors which influences this is the frequency of visits to the doctor, where the younger population shows it is less frequent.

Namely, it was shown that the elder generations realistically visit the doctor more often than the younger ones, and this may be one of the the suppositions for creating a better communication with healthcare beneficiaries.

To the question of whether the social status has any influence over the personal awareness on healthcare reforms, the research showed the following answers (see table no. 30): 77,9% of the unemployed claim they are *badly* or *poorly* informed on healthcare reforms. The workers and clerks have rated their own awareness with *bad* and *poor* by 69,4% and 64,1%, respectively. The highest degree of lack of awareness is noted in the housewives and farmers group, while the percentage of those who are *excellently* informed is insignificant.

<sup>11</sup> Presented were data on certain activities that the participants may believe ought to be undertaken in order to improve their awareness on healthcare reforms. The participants were given the possibility to circle three activities ranking them from 1 to 3, according to the degree of importance. The presented table shows the total frequencies according to rank of acceptance or degree of importance.

Table no.30 Influence of social status on personal awareness on healthcare reforms

SOCIAL STATUS 8/19	Rating of personal awareness on healthcare reforms					
	bad	poor	good	very good	excellent	TOTAL
worker	215 41.9	140 27.5	111 21.7	28 5.4	18 3.5	512 100
clerk	54 33.5	49 30.6	42 26.1	8 4.9	8 4.9	161 100
private businessman	49 33.4	39 26.5	35 23.9	12 8.1	12 8.1	147 100
student	13 25.4	17 33.4	17 33.4	2 3.9	2 3.9	51 100
unemployed	74 45.7	52 32.2	30 18.5	2 1.2	4 2.4	162 100
retired	40 39.2	27 26.2	30 29.4	3 3.3	2 1.9	102 100
farmer	10 55.6	4 22.2	4 22.2	0 0	0 0	18 100
housewife	22 46.8	17 36.2	6 12.8	1 2.1	1 2.1	47 100
TOTAL	477 39.8	345 28.8	275 22.9	56 4.6	47 3.9	1200 100

Regardless of their social status, (see Table no. 31) most of the participants gave similar answers. Which is to say that around ½ the participants think that direct meetings with the citizens are best. 23,5% of the workers and students believe that in order to improve citizen awareness there ought to be *debates*. 27,3% of the private businessmen stated that debates are best, while 1/5 of the clerks think that the debates and the interviews are the best way to improve citizen awareness on healthcare reform. It may be concluded that the categories with a lower income (less rich) on average look for direct meetings with the carriers of the reform. On the other hand, the clerks and private businessmen are more for television shows as forms where the management of the Ministry of Health should appear.

Table no. 31 The influence of the social status and what must be done by the Ministry's management in order to improve citizen awareness of healthcare reforms

SOCIAL STATUS 8/45	The ministry's management should do what in order to improve citizen awareness of healthcare reforms					
	Participate in seminars	Direct meetings	Interviews and statements	Debate TV shows	other	TOTAL
worker	49 9.6	235 45.9	93 18.2	121 23.5	14 2.7	512 100
clerk	18 11.2	66 40.9	35 21.7	36 22.4	6 3.8	161 100
private businessman	9 6.1	70 47.6	27 18.3	40 27.3	1 0.7	147 100
student	3 5.9	28 54.9	7 13.8	12 23.5	1 1.9	51 100
unemployed	12 7.3	94 58.6	19 11.4	34 21	3 1.7	162 100
retired	3 2.9	59 58.5	10 9.5	26 25.2	4 3.9	102 100
farmer	0 0	9 50	3 16.7	4 22.2	2 11.1	18 100
housewife	2 4.2	23 48.9	5 10.7	15 32	2 4.2	47 100
TOTAL	96 8	584 48.7	199 16.5	288 24	33 2.8	1200 100

When it comes to the personal awareness of the participants which are employed in medical facilities or out of them (*see table no. 32*) it may be concluded that the medical staff is insufficiently informed of the reforms. Namely, up to 65,7% of them consider to be *badly* or *poorly* informed. Of the unemployed, 1/3 considers themselves to be well informed, while 60,8% are *badly* or *poorly* informed. Of those participants not working in medical facilities, 60% say they are *badly* or *poorly* informed. It is a fact that the subjective grade on what one might consider excellent and bad awareness is a relative category, and in as much this method can give an answer it ought to be taken with a grain of salt when the percentages of the participants have very small values. However, in cases when the number of participants answering a certain way goes beyond a third of the total number of answers, while an insignificant number settled for another answer, then the grade that awareness on healthcare reforms is bad gains weight and cannot be ignored.

According to the acquired results, the higher degree of criticism of the medical staff towards their own awareness makes them suitable to give the grade which speaks of how uninformed they are, that is to say that they demand more information because they are directly affected by the reform.

Table no. 32 Place of employment and rate of personal awareness on healthcare reforms

PLACE OF EMPLOYMENT 9/19	Rate of personal awareness on reforms in healthcare					
	bad	poor	good	very good	excellent	TOTAL
medical facility	107 44.2	52 21.5	43 17.8	24 9.9	16 6.6	242 100
other	233 36.7	188 29.7	168 26.4	24 3.8	22 3.4	635 100
unemployed	137 42.4	105 32.5	64 9.8	8 2.5	9 2.8	323 100
TOTAL	477 39.8	345 28.8	275 22.9	56 4.6	47 3.9	1200 100

The place of residence of participants seems to be especially important for the rate of how the journalists report on the conditions in healthcare (see table no. 33). According to village inhabitants, the journalists are more positive, contrary to the opinion of those living in cities. Of the total number of participants living in villages, around 1/3 rate the journalists positively. Of the participants living in cities, around 2/3 rate the writing of the journalists on the topic of healthcare as: superficial, negative, sensationalistic and wrong. Of them, only 14,2% and 7,1% consider the journalists to be objective and truthful.

It may be concluded that the participants in urban areas display a high degree of criticism towards the journalists. Within the groups themselves two groups stand on opposite ends, which rate the writing as positive and negative, considering that the participants from rural areas have superficial as the worst grade for the writing of the journalists (32,7%).

Table no. 33 The influence of the place of residence on the rating of the writing of the journalists on healthcare topics

PLACE OF RESIDENCE 2/56	Reporting of journalists on healthcare reforms									
	objective	superficial	negative	truthful	sensationalistic	Affirmative	wrong	I do not know	other	TOTAL
village	126 20,6	200 32,7	32 5,2	82 13,4	49 8,1	5 0,8	21 3,4	82 13,4	14 2,3	611 100
small town	23 19,2	41 34,2	2 1,7	14 11,6	9 7,5	1 0,8	5 4,1	18 15	7 5,8	120 100
Town	42 18,3	76 33,0	10 4,3	21 9,1	32 13,9	4 1,8	7 3,1	36 15,7	2 0,8	230 100
city	34 14,2	58 24,3	27 11,3	17 7,1	61 25,5	3 1,3	7 2,9	29 12,1	3 1,3	239 100
TOTAL	225 18,8	375 31,2	71 5,9	134 11,2	151 12,6	13 1,1	40 3,4	165 13,8	26 2,2	1200 100

On what ought the managers at the Ministry of Health do in order to improve the awareness of citizens on healthcare reforms (see Annex 1, table no. 7) the largest percentage of participants employed in medical facilities (39,8%) consider that the best way to do this is

by *direct meetings*. For 14,8% of healthcare employees, *participating in seminars* seems to be the best solution, while ¼ of them think that there ought to be more *debates*. The largest percentage those employed outside medical facilities, are either for direct meetings (49,1%), or debates (23,9%). ½ of the unemployed support direct meetings.

It is evident that the medical staff prefers direct meetings which would serve the function of keeping them informed of the healthcare reform, realised through seminars - a form rarely seen in the answers of other participants. The direct meetings with managers and carriers of the reform is mostly sought by unemployed participants, followed by those who are employed outside the healthcare facilities, which speaks of the need to communicate face to face, where questions may be raised and personal opinions be given on what the content of the reform is.

*Table no. 34 Place for check-ups and rating of communication between medical staff and healthcare beneficiaries*

PLACE FOR CHECK-UPS 12/22	Rating for the communication between medical staff and healthcare beneficiaries					
	bad	poor	good	very good	excellent	TOTAL
Only in public healthcare practices	154 21.6	200 28.1	237 33.3	73 10.3	48 6.7	712 100
Private practices with money	31 36.9	28 33.3	16 19.1	7 8.3	2 2.4	84 100
Private practices with blue cards	38 30.9	30 24.4	40 32.5	10 8.1	5 4.1	123 100
Public and private practices with money	32 31.7	29 28.7	33 32.8	5 4.9	2 1.9	101 100
Public and private practices with blue cards	55 33.7	33 20.3	52 31.9	14 8.6	9 5.5	163 100
other	5 29.4	4 23.5	5 29.5	1 5.9	2 11.7	17 100
TOTAL	315 26.3	324 27	383 31.9	110 9.2	68 5.6	1200 100

The participants that mainly use public or private practices rate the communication between medical employees and healthcare beneficiaries (*see table no. 34*) the following way: 33,3% of public practice users believe the communication is good, while ½ think it is bad or poor. For 36,9% of patients of private practices, the communication is bad. Those who use both public and private practices believe the communication to be good (32,8%).

## IV. SUGGESTIONS

### For improving inter-communicational flow:

- **Publicizing**  
the Strategy of the Ministry of Health,  
Basics of the reform,  
the One-year Plan of work to be distributed to all employees (medical staff); and  
Internal magazines, brochures, etc.
- **Regular communication (daily meetings)**  
of the management with the collaborators, attended by the public relations advisor  
and  
of the managers with healthcare employees on various levels
- **Regular meetings on a local level**  
a method to reach the citizens  
explain the content of the reform and  
hear out new and different suggestions;
- **Increase degree of working culture**  
improve communication and increase trust of employees that the changes are for the  
good of all,  
choosing of Most Valuable Employee and  
awarding the best suggestions;
- **Forming of an information service on Ministry level**  
run by a sector manager,  
employees from the service partake in television and radio shows,  
affirms the reform and the positive changes in healthcare,  
informs employees and healthcare beneficiaries and collaborates with appropriate  
persons of the Government and other institutions;
- **Employing a specific person - communications director**  
messages from the Ministry of Health (or the Government) to be professionally  
presented in the media;  
the public to be informed from the source,  
complete logistic support from all other institutions and individuals engaged in the  
system;
- **Holding press conferences and briefings**  
on a specific topic (and) popularisation of specific solutions  
promotion of persons and ideas  
organization of events and activities

### Suggested suggestions from the Ministry of Health to the public:

- Macedonian citizens deserve a better healthcare system and they can have it
- The current system is inefficient and is not financially viable;
- Prevention is the basis for our health;
- Let us leave like Europeans with European healthcare standards;
- If we sincerely wish to change, then it is not difficult to follow through the healthcare reform.
- If we sincerely wish to change healthcare, then it is not difficult to go through with healthcare reform.
- It is not difficult to go through with the reform if we sincerely wish to change;
- It is not difficult to go through with the reform if we sincerely wish to change the healthcare

## V. CONCLUSIONS

The research of public opinion in the Republic of Macedonia on healthcare reforms with a main emphasis on the degree of awareness of the reforms and the perception of the problems in healthcare has shown that this important segment of everyday life preoccupies most citizens.

The field research, the collation of the data and its analysis has given certain conclusions on the occurrence within the framework of the set goals of the research.

### - Influence of socio-demographic characteristics

Based on certain socio-demographic characteristics of the participants, like age, it can be concluded that the older categories are more frequent visitors of healthcare facilities than the young ones. The older structure of the population claims that their personal motive for visiting a doctor is a specific illness, while the younger claim it is poor health. Very little attention is given to prevention as a form of behaviour towards personal health by the citizens.

The social status of participants influences their rating of the quality of the services rendered by their personal doctor, where those who are unemployed have a higher degree of criticism towards healthcare services and hospital care. Other categories, like the workers, clerks and private businessmen, rate the work of their personal doctors in a positive manner, however they do exhibit negative attitudes towards hospital care.

The place of employment of participants (medical staff, those who do not work within the healthcare system and those who are unemployed) has shown an influence in regards to the rating of the quality of the work exhibited by the personal doctor, whereas the medical staff has given their personal doctors very high ratings compared to the other two categories.

The place of residence does not determine any differences in regards to the rating of the work and satisfaction of healthcare beneficiaries from their personal doctors. Participants living in villages, compared to those living in towns, have no differences when reporting on the quality of the work of their personal doctors, which was rated positively in both categories. However, it may be concluded that regardless of the place of residence, all participants have rated the hospital care received in the cities, under the same, equal circumstances, as negative.

The place to see a doctor regardless of whether they use public healthcare facilities or private practices, participants give similar grades for hospital care, which is to say very negatively (*bad* or *poor*). The percentage of those who rated hospital care as *excellent* is insignificant.

Participants who frequently visit their doctor are more happier with healthcare services than those who do this rarely. They are more satisfied by the services rendered by personal doctors. In regards to hospital care, the rating of those who visit the doctor more frequently is negative, i.e. they rate the conditions of hospital care as bad.

### - Awareness of participants conditions, activities and forms and subjects in the context of information

The degree of education of participants influences the rating of the way journalists report the conditions in healthcare. Those with a lower degree of education have less criticism, i.e. those with primary and secondary education consider the reporting to be objective and truthful, opposite participants with a higher education which consider the journalists reporting to be superficial and sensationalistic.

The place of employment of participants and their rating of the personal awareness of healthcare reforms generates differences in the participants. Namely, those who work in healthcare facilities are not sufficiently informed of the reforms, and a larger percentage chose the grades *bad* or *poor*. According to acquired results the higher degree of criticism of the medical staff towards their own personal lack of awareness makes them perfect for rating

what truly is bad awareness of the reforms, i.e. in reality it means they would like to see more information because they are directly influenced by the reforms.

In the context of preferred **forms** for gaining more information on healthcare reforms there is little difference between the various educational groups. The direct meetings are accepted by most participants, as well as the television debates, however participants with a higher education prefer debates and interviews with managers rather than directly meeting them.

Participants believe that **citizen awareness** of the occurrences and processes in healthcare may be improved by organising campaigns. It may be concluded that the degree of education creates an insignificant difference among participants wherein those with a lower degree of education give more meaning to the campaigns. Especially favoured forms by the citizens are the toll-free phone line and the information service. Participants believe that press conferences and an increase in the number of websites will not achieve the desired effect and positive result on the popularisation of the reforms.

**Subjects** obligated to **inform the citizens** on the reforms and their rights, according to the participants in the research, are firstly the Ministry of Health and then the Government. They are directly responsible for the activities in the healthcare reforms, while all other organs and institutions are not perceived by participants as important in this respect. Namely, in this respect such an opinion is shown for citizens associations and private practices. The participants are mainly informed of their rights as healthcare beneficiaries from their personal doctor and the media. Those who live in villages pay more attention to the recommendations of the personal doctor when compared to those living in cities, who are mainly media oriented. In respect to age, the younger prefer their personal doctor, while the older are equally in favour of the personal doctor and the media. According to the data acquired in this research, it may be concluded that the other forms of informing the citizens of their rights (such as the internet and campaigns) are almost unnoticed.

**Of the activities** practised during a month, most of the participants watch news on the TV through which they keep in touch with current processes. It is evident that the electronic media have a significant advantage compared to printed media when speaking of following the content by the citizens. Probably the entire daily circulation cannot cover a large interest of the public. Watching shows with healthcare topics when compared to other activities, is somewhere in the middle, and these shows are more preferred by participants with a higher education.

Participants working in medical facilities rate the communication with the medical staff as *very good* and *excellent*, compared to the other two groups who have a higher degree of criticism, and rate it as *bad* and *poor*.

#### - **Problems in healthcare**

The degree of problems in healthcare, regardless of whether it is public or private healthcare, is seen by participants as big, and very big. The number of those who rate problems in healthcare as small is statistically insignificant. Of particular note, the problems in the **first group** include: corruption, followed closely by poor conditions in healthcare.

In **the second group** of problems in healthcare, participants selected lack of medicine, inefficiency and lack of organisation, lack of funds in healthcare and debts in healthcare as those that are big or very big problems.

In the **third group** the problems are poor management, low salaries and disregard for healthcare laws and are with a degree of significance from very big to big.

The **fourth group** of problems, according to participants, includes lack of awareness on the part of the medical staff, lack of awareness on the part of the healthcare beneficiaries, issuing fake sick-leaves, as well as the surplus of employed people in the public healthcare sector and are rated as big or problems with a smaller significance.

**The place of employment** of participants in the rating of certain types of problems occurring and existing in healthcare, has shown to be an especially important factor

depending on the content of the problem. Healthcare employees (medical staff) see the poor conditions as a very big problem. Participants working in other places, or those who are unemployed have much less criticism for the poor conditions in healthcare. According to the acquired data, it may be concluded that the medical staff which is faced with the reality of the healthcare facilities daily, has a higher degree of criticism towards the conditions in public healthcare, rating it as bad and a very big problem. Participants which are not exposed daily to the conditions in the healthcare facilities exhibit milder criticism, however they are aware that the poor conditions present a big problem as well.

The existence of poor management in medical facilities is of particular importance for participants in regards to the place of employment. The medical staff rates this as a very big problem. Compared to participants who do not work in the healthcare system. Based on the acquired data, it can be concluded that persons who do not work in healthcare see the problem of poor management indirectly, contrary to the medical staff which is daily and immediately faced with it. Thus the higher degree of criticism towards the management by the healthcare employees.

The place of employment did not exhibit particular differences among the participants when rating the inefficiency and lack of organisation of healthcare facilities as a problem.

- **Changes in healthcare**

The need for big healthcare reforms in the following 12 months is required by a large percentage of the participants in this research, regardless of their socio-demographic characteristics. The percentage of those who disagree with the attitude that the healthcare needs big reforms is statistically insignificant.

At the same time, the participants, regardless of their social status, expect the conditions in healthcare in 12 months following the reforms to be significantly improved. Namely, it may be concluded that the participants are optimistic in terms of the success of the reform, and those that think otherwise do not represent a relevant majority. Only the place of employment exhibited certain discrepancies from this conclusion, where healthcare employees showed a lower optimism than those who belong to the other two groups.

It is evident that after this research there need to be corrections in certain attitudes gained by inertia and stereotyping the conditions in healthcare and the healthcare reform. The research has simultaneously given answers and opened new questions in terms of the attitude of the medical staff in the following period, especially through the content of the reform which directly influences them the most.

## ANNEX 1

Table no. 1 Age and personal motive to visit a doctor

AGE 4/13	Most common personal motive to visit a doctor						TOTAL
	Poor health	Specific illness	Regular check-up	Prevention	Drug prescription	other	
18-28	159 69.7	15 6.8	25 10.9	17 7.4	10 4.4	2 0.8	228 100
29-39	171 59.9	41 14.3	27 9.4	24 8.3	17 6	6 2.1	286 100
40-50	196 50.6	54 13.9	47 12.1	41 10.6	36 9.3	13 3.5	387 100
51-61	93 43.4	53 24.7	23 10.7	16 7.3	24 11.6	5 2.3	214 100
Above 62	27 31.8	46 54.1	5 5.9	2 2.3	4 4.7	1 1.2	85 100
TOTAL	646 53.8	209 17.4	127 10.6	100 8.3	91 7.6	27 2.3	1200 100

Table no. 2 Influence of age on rating the communication between healthcare staff and healthcare beneficiaries

AGE 4/22	Rating of communication between healthcare staff and healthcare beneficiaries					TOTAL
	bad	poor	good	very good	excellent	
18-28	72 31.5	68 29.8	66 28.9	13 5.9	9 3.9	228 100
29-39	91 31.8	68 23.7	90 31.7	24 8.3	13 4.5	286 100
40-50	95 24.6	96 24.8	127 32.8	39 10.1	30 7.7	387 100
51-61	46 21.4	65 30.4	69 32.4	22 10.2	12 5.6	214 100
Above 62	11 12.9	27 31.7	31 36.4	12 14.1	4 4.9	85 100
TOTAL	315 26.3	324 27	383 31.9	110 9.2	68 5.6	1200 100

*Table no. 3 Influence of place of residence on rating quality of service of personal doctor in past 12 months*

PLACE OF RESIDENCE 2/17	Rating of quality of service of personal doctor in past 12 months					
	bad	poor	good	very good	excellent	TOTAL
village	49 8,1	87 14,2	217 35,5	96 15,7	162 26,5	611 100
small town	8 4,1	14 11,9	32 26,7	21 17,6	45 37,9	120 100
town	34 14,8	38 16,5	72 31,3	23 10	63 27,4	230 100
city	16 6,7	35 14,7	54 22,6	52 21,7	82 34,3	239 100
TOTAL	107 8,9	174 14,5	375 31,3	192 16,0	352 29,3	1200 100

*Table no. 4 Age and degree of awareness on conditions in healthcare*

AGE 4/20	Degree of awareness on conditions in healthcare				
	Completely	Well	superficial	Uninformed	TOTAL
18-28	15 6.8	57 25	85 37.1	71 31.1	228 100
29-39	35 12.2	65 22.7	111 38.8	75 26.3	286 100
40-50	57 14.8	90 23.2	162 41.8	78 20.2	387 100
51-61	26 12.3	62 28.9	79 36.9	47 21.9	214 100
above 62	6 7.1	23 27.3	32 37.4	24 28.2	85 100
TOTAL	139 11.5	297 24.8	469 39.2	295 24.5	1200 100

Table no. 5 Influence of frequency of doctor visits on rating the quality of hospital care in the past 12 months

FREQUENCY OF DOCTOR VISITS 11/18	Rating of quality of hospital care in the past 12 months					
	bad	poor	good	very good	excellent	TOTAL
regularly	52 29,4	48 27,1	49 27,7	13 7,3	15 8,5	177 100
often	45 33,6	34 25,4	34 25,4	14 10,4	7 5,2	134 100
sometimes	101 25,6	111 28,1	133 33,7	29 7,3	21 5,3	395 100
rarely	103 37,9	64 23,5	74 27,2	20 3,3	11 4,0	272 100
very rarely	81 36,8	59 26,8	56 25,4	13 5,9	13 5,9	222 100
TOTAL	382 31,8	316 26,4	346 28,8	86 7,4	67 5,6	1200 100

Table no. 6 Obligation of organs and institutions for informing citizens on changes in healthcare

Institutions	Degree of importance				
	0	1	2	3	%
government	55,7	25,0	11,2	8,2	100,0
Medical chamber	72,8	6,9	10,5	9,8	100,0
Private practices	90,3	1,7	2,3	5,8	100,0
Healthcare union	75,3	5,4	9,9	9,4	100,0
Ministry of Health	15,5	48,8	26,3	9,5	100,0
Public healthcare facilities	63,5	5,7	14,4	16,4	100,0
Health insurance fund	54,0	4,0	20,8	21,2	100,0
State healthcare institute	83,8	0,8	2,7	12,8	100,0
Citizen associations in the healthcare sector	91,1	0,8	2,2	5,9	100,0
others	98,2	0,8	0,3	0,8	100,0

Table no.7 The influence of place of employment on what ought the management at the Ministry of Health do in order to improve citizen awareness on reforms

PLACE OF EMPLOYMENT 9/45	Actions of management at the Ministry of Health in order to improve citizen awareness on reforms					
	Participate in seminars	Direct meetings	Interviews and statements	Debate shows	other	TOTAL
medical facility	37 14.8	96 39.8	47 19.7	58 23.9	4 1.8	242 100
other	40 6.3	312 49.1	113 17.9	152 23.9	18 2.8	635 100
unemployed	19 5.9	176 54.4	39 12.1	78 24.2	11 3.4	323 100
TOTAL	96 8	584 48.7	199 16.5	288 24	33 2.8	1200 100

Table no. 8 Activities most engaged in during one month

Activity	Degree of importance				
	0	1	2	3	%
Watching news on TV	31,3	31,3	12,8	12,8	100,0
Watching TV, films, music	54,9	16,0	18,7	10,4	100,0
Watching shows with healthcare topics	73,5	5,6	11,4	9,5	100,0
Reading daily newspapers	50,8	9,8	24,2	15,3	100,0
Reading weekly newspapers	89,4	1,5	4,3	4,8	100,0
Listening to the radio - music	74,3	4,5	9,3	11,8	100,0
Radio and television shows	82,9	2,6	6,3	8,3	100,0
Watching, listening, reading adverts	89,8	1,0	2,1	7,1	100,0
Surfing the internet	91,5	2,1	2,4	4,0	100,0
Walks through the town	61,8	9,0	8,3	21,0	100,0

Table no. 9 Way of keeping themselves informed of the rights of healthcare beneficiaries

Way of keeping informed	P	%
Friends	136	11,3
Personal doctor	437	36,4
Over the internet	19	1,6
Campaigns designed for the very purpose	17	1,4
Through media	380	31,7
Healthcare employees	140	11,7
Not really interested	59	4,9
other	12	1,0
TOTAL	1200	100,0

Table no.10 Influence of place of employment and degree of problems in healthcare - poor conditions in public healthcare

PLACE OF EMPLOYMENT 9/65	Poor conditions in public healthcare					TOTAL
	No problem	Small	Big	Very big	I do not know	
Medical facilities	21 8,7	43 17,8	92 38,0	74 30,6	12 0,8	242 100
other	34 5,3	130 20,5	209 32,9	110 17,3	152 23,9	635 100
unemployed	18 5,6	61 18,8	79 24,4	64 19,8	101 31,3	323 100
TOTAL	73 6,1	234 19,5	380 31,7	248 20,7	265 22,1	1200 100

Table no. 11 Influence of place of employment and degree of problems in healthcare - poor management

PLACE OF EMPLOYMENT 9/68	Poor management					TOTAL
	No problem	Small	Big	Very big	I do not know	
Medical facilities	13 5,4	32 13,2	70 28,9	101 41,7	26 10,7	242 100
other	23 3,6	69 10,8	217 34,2	247 38,9	79 12,4	635 100
unemployed	8 2,5	32 9,9	141 43,6	103 31,9	39 12,1	323 100
TOTAL	44 3,7	133 11,1	428 35,7	451 37,6	144 12	1200 100

Table no. 12 Influence of place of employment and degree of problems in healthcare - inefficiency and lack of organisation

PLACE OF EMPLOYMENT 9/69	Inefficiency and lack of organisation					TOTAL
	No problem	Small	Big	Very big	I do not know	
Medical facilities	9 3,7	22 9,1	84 34,7	116 47,9	11 4,5	242 100
other	11 1,7	32 5,0	232 36,5	309 48,7	51 8,0	635 100
unemployed	3 0,9	20 6,2	129 39,9	14 45,5	24 7,4	323 100
TOTAL	23 1,9	74 6,2	445 37,1	572 47,7	86 7,2	1200 100

Table no. 13 Influence of place of employment and the attitude that our healthcare needs big reforms in the following 12 months

PLACE OF EMPLOYMENT 9/72	Our healthcare needs big reforms in the following 12 months					TOTAL
	completely agree	agree	disagree	do not agree at all	no opinion	
Medical facilities	103 42.4	78 32.2	22 9.1	12 5.2	27 11.1	242 100
other	342 53.9	236 37.2	16 2.5	2 0.3	39 6.1	635 100
unemployed	157 48.6	122 37.8	11 3.4	2 0.6	31 9.6	323 100
TOTAL	602 50.2	436 36.3	49 4.1	16 1.3	97 8.1	1200 100

*Table no. 14 Place of employment and expectations from healthcare in the 12 months following the reforms*

PLACE OF EMPLOYMENT 9/73	Expectations from healthcare in the 12 months following the reforms						TOTAL
	much better	a little better	the same	A little worse	Much worse	Cannot make an estimate	
medical facility	70 28.9	60 24.8	10 4.3	12 4.9	26 10.7	64 26.4	242 100
other	212 33.4	260 40.9	41 6.6	5 0.7	17 2.7	100 15.7	635 100
unemployed	103 31.9	123 38.1	30 9.3	5 1.5	9 2.8	53 16.4	323 100
<b>TOTAL</b>	<b>385</b> <b>32.1</b>	<b>443</b> <b>36.9</b>	<b>81</b> <b>6.8</b>	<b>22</b> <b>1.8</b>	<b>52</b> <b>4.3</b>	<b>217</b> <b>18.1</b>	<b>1200</b> <b>100</b>

## ANNEX 2

Table no. 1 Influence of age on rating personal awareness on healthcare reforms

AGE 4/19	Rating of awareness on healthcare reforms					
	bad	poor	good	very good	excellent	TOTAL
18-28	90 39.5	72 31.8	54 23.7	8 3.3	4 1.7	228 100
29-39	124 43.3	74 25.9	63 22	10 3.6	15 5.2	286 100
40-50	145 37.4	112 28.9	84 21.9	26 6.7	20 5.1	387 100
51-61	86 40.1	60 28.3	52 24.2	9 4.2	7 3.2	214 100
Above 62	32 37.6	27 31.9	22 25.8	3 3.5	1 1.2	85 100
TOTAL	477 39.8	345 28.8	275 22.9	56 4.6	47 3.9	1200 100

Table no.2 Social status and monthly family income

SOCIAL STATUS 8/10	Monthly family income					
	Up to 6000	6001-12000	12001-18000	18001-24000	Above 24001	TOTAL
worker	59 11.5	182 35.5	150 29.3	62 12.2	59 11.5	512 100
clerk	3 1.9	35 21.7	58 36	36 22.4	29 18	161 100
private businessman	16 10.8	45 30.1	39 26.5	21 14.3	27 18.3	147 100
student	9 17.6	18 35.3	12 23.5	8 15.7	4 7.9	51 100
unemployed	81 50	45 27.8	24 14.8	11 6.7	1 0.7	162 100
retired	32 50	39 27.6	20 12.6	3 3	8 6.8	102 100
farmer	9 51.2	6 32.3	1 5.4	2 11.1	0 0	18 100
housewife	16 49.1	20 30.1	6 5.5	3 11.1	2 4.2	47 100
TOTAL	225 18.8	389 32.4	310 25.8	146 12.2	130 10.8	1200 100

*Table no.3 Influence of education and the need for improved awareness - setting up a toll-free phone line*

EDUCATION 5/40	Setting up a toll-free phone line				
	0	1	2	3	TOTAL
primary	62 32,6	52 27,4	48 25,3	28 14,7	190 100
secondary	265 42,5	114 18,3	163 26,1	82 13,1	624 100
2 year college	56 45,9	27 22,1	27 22,1	12 9,8	122 100
higher	144 54,5	33 12,5	52 19,7	35 13,2	264 100
TOTAL	527 43,9	226 18,8	290 24,2	157 13,1	1200 100

*Table no. 4 Influence of monthly family income and visits to the doctor in past 12 months*

MONTHLY INCOME 10/12	Place for check-up						TOTAL
	Only in public practices	Private with money	Private with blue cards	Public and private with money	Public and private with blue cards	Other	
Up to 6000	150 66.7	13 5.8	22 9.8	11 4.9	23 10.2	6 2.6	225 100
6001-12000	247 63.5	24 6.1	37 9.5	29 7.5	48 12.4	4 1	389 100
12001-18000	177 57	23 7.2	32 10.1	27 9.5	47 15.1	4 1.1	310 100
18001-24000	84 57.5	8 5.4	20 13.7	15 10.5	18 12.3	1 0.6	146 100
above 24001	54 41.5	16 12.3	12 9.4	19 14.5	27 20.8	2 1.5	130 100
TOTAL	712 59.3	84 7	123 10.3	101 8.4	163 13.6	17 1.4	1200 100

*Table no.5 Influence of monthly income on personal motive for doctor visit*

MONTHLY INCOME 10/13	Personal motive for visiting doctor						
	Poor health	Specific illness	Regular check-up	Prevention	Drug prescription	other	TOTAL
Up to 6000	104 46.2	53 23.6	24 10.7	10 4.4	23 10.2	11 4.9	225 100
6001-12000	222 57	65 16.7	39 10	27 7.4	26 6.4	10 2.5	389 100
12001-18000	173 55.8	50 16.1	29 9.3	31 10.1	23 7.4	4 1.3	310 100
18001-24000	89 60.9	21 14.4	15 10.3	14 9.6	6 4.2	1 0.6	146 100
above 24001	58 44.6	20 15.4	20 15.4	18 13.8	13 10.1	1 0.7	130 100
TOTAL	646 53.8	209 17.4	127 10.6	100 8.3	91 7.6	27 2.3	1200 100

*Table no.6 Religious affiliation and having a personal gynaecologist*

Religious affiliation 7/18	Has a personal gynaecologist		
	Yes	No	TOTAL
Orthodox Christian	343 37.1	583 62.9	926 100
Muslim	73 28.5	183 71.5	256 100
Catholic Christian	5 50	5 50	10 100
Protestant Christian	0	1 100	1 100
Other	3 42.8	4 57.2	7 100
TOTAL	424 35.3	776 64.7	1200 100

*Table no. 7 Influence of place of employment and following news, articles and shows on healthcare during one month*

PLACE OF EMPLOYMENT 9/23	Follows news, articles and shows on healthcare during one month					
	regularly	often	sometimes	rarely	very rarely	TOTAL
Medical facilities	82 33,9	68 28,1	71 29,3	14 5,8	7 2,9	242 100
other	126 19,8	105 16,5	228 35,9	110 17,3	66 10,4	635 100
unemployed	61 18,9	50 15,5	112 34,7	56 17,3	44 13,6	323 100
TOTAL	269 22,4	223 18,6	411 34,3	180 55,7	117 9,8	1200 100

*Table no. 8 Influence of frequency of going to the doctor on attitude that our healthcare needs reforms in the following 12 months*

FREQUENCY OF VISITS TO THE DOCTOR 11/72	Our healthcare needs big reforms in the following 12 months					
	completely agree	agree	disagree	do not agree at all	no opinion	TOTAL
regularly	88 49.7	67 37.8	7 3.9	3 1.9	12 6.7	177 100
often	63 47	51 38	6 4.5	3 2.2	11 8.3	134 100
sometimes	190 48.1	148 37.5	17 4.4	5 1.2	35 8.8	395 100
rarely	149 54.8	96 35.4	8 2.9	3 1.1	16 5.8	272 100
very rarely	112 50.4	74 33.3	11 4.9	2 0.9	23 10.5	222 100
TOTAL	602 50.2	436 36.3	49 4.1	16 1.3	97 8.1	1200 100

*Table no. 9 Influence of personal awareness on reforms on improved awareness of citizens on healthcare - campaigning*

AWARENESS 19/35	Degree				
	0	1	2	3	TOTAL
bad	290 60,8	116 24,3	28 5,9	43 9,0	477 100
poor	197 57,1	85 24,6	24 6,9	39 11,3	345 100
good	167 60,7	60 21,8	16 5,8	32 11,6	275 100
very good	30 53,6	10 17,8	5 8,9	11 19,6	56 100
excellent	32 68,1	11 23,4	2 4,3	2 4,3	47 100
TOTAL	716 59,7	282 23,5	75 6,3	127 10,6	1200 100

*Table no. 10 Influence of personal awareness on reforms on improved awareness of citizens on healthcare - creation of information service*

AWARENESS 19/39	Degree				
	0	1	2	3	TOTAL
bad	193 40,5	96 20,1	123 25,8	65 13,6	477 100
poor	146 42,3	73 21,2	84 24,3	42 12,2	345 100
good	132 48,0	46 16,7	63 22,9	34 12,4	275 100
very good	32 57,1	4 7,1	9 16,1	11 19,6	56 100
excellent	24 59,1	7 14,9	11 23,4	5 10,6	47 100
TOTAL	527 43,9	226 18,8	290 24,2	157 13,1	1200 100

Table no.11 Influence of personal awareness on monthly activity - watching news on TV

AWARENESS 19/46	Degree				
	0	1	2	3	TOTAL
bad	163 34,2	208 43,6	66 13,8	40 8,4	477 100
poor	103 29,8	177 51,3	44 12,7	21 6,1	345 100
good	86 31,3	134 48,7	32 11,6	23 8,4	275 100
very good	16 28,6	28 50,0	7 12,5	5 8,9	56 100
excellent	8 17,0	30 63,8	5 10,6	4 8,5	47 100
TOTAL	376 31,4	577 48,1	154 12,8	93 7,8	1200 100

Table no. 12 Influence of personal awareness and journalists' reports on conditions in healthcare

AWARENESS 19/56	Journalist reporting on conditions in healthcare									TOTAL
	objective	superficial	negative	truthful	sensationalistic	affirmative	wrong	I do not know	other	
bad	84 17,3	142 29,8	30 6,3	59 12,4	54 11,3	5 1,0	25 5,2	68 14,2	10 2,1	477 100
poor	69 20,0	117 33,9	12 3,5	37 10,7	46 13,3	1 0,3	7 2,0	48 12,9	8 2,3	345 100
good	50 18,2	91 33,1	19 6,9	28 10,2	36 13,1	5 1,8	6 2,2	34 12,4	6 2,2	275 100
very good	7 12,5	15 26,8	3 5,3	5 8,9	10 17,8	2 3,6	1 1,7	11 19,6	2 3,6	56 100
excellent	15 31,9	10 21,3	7 14,8	5 10,6	5 10,6	0 0,0	1 2,1	4 8,5	0 0,0	47 100
TOTAL	225 18,7	375 31,2	71 5,9	134 11,2	151 12,6	13 1,1	40 3,4	165 13,7	26 2,2	1200 100

Table no. 13 Influence of place of employment on rating reporting of journalists on healthcare conditions

PLACE OF EMPLOYMENT NT 9/56	Journalist reporting on conditions in healthcare									
	objective	superficial	negative	truthful	sensationalistic	affirmative	wrong	I do not know	other	TOTAL
Medical facilities	30 12,4	72 29,7	29 11,9	10 11,9	61 25,2	2 0,8	9 3,7	26 10,7	3 1,2	242 100
other	127 20,0	199 31,3	30 4,7	75 11,8	71 11,2	11 1,7	20 3,1	89 14,0	13 2,0	635 100
unemployed	68 21,1	104 32,2	12 3,7	49 15,2	19 5,9	0 0	11 3,4	50 15,5	10 3,1	323 100
TOTAL	225 18,8	375 31,3	71 5,9	134 11,2	151 12,6	13 1,1	40 3,3	165 13,7	26 2,2	1200 100

Table no. 14 Influence of place for check-up on rating of degree of problems in healthcare

PLACE FOR CHECK-UPS 12/71	Degree of problems in healthcare					
	Small	Big	Very big	No problems	I do not know	TOTAL
Public practices	25 3.5	287 40.3	372 52.3	6 0.8	22 3.1	712 100
Private with money	7 8.3	40 47.6	33 39.4	1 1.2	3 3.5	84 100
Private with blue cards	2 1.5	53 43.3	61 49.5	0 0	7 5.7	123 100
Public and private with money	7 6.9	40 39.6	50 49.6	0 0	4 3.9	101 100
Public and private with blue cards	4 2.4	68 41.7	86 52.9	1 0.6	4 2.4	163 100
other	1 5.9	7 41.2	7 41.2	0 0	2 11.7	17 100
TOTAL	46 3.8	495 41.3	609 50.7	8 0.7	42 3.5	1200 100