

North Macedonia

Health system summary 2025

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This Health System Summary is based on the *North Macedonia Health System Review (HiT)* published in 2025 in the *Health Systems in Transition (HiT) Series*. Health System Summaries use a concise format to communicate central features of country health systems and analyse available evidence on the organization, financing and delivery of health care. They also provide insights into key reforms and the varied challenges testing the performance of the health system.

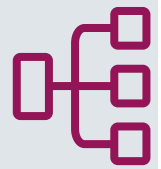
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How is the health system organized?



North Macedonia has a centralized health system based on social health insurance

Organization

North Macedonia has a centralized health system, with stewardship and policy processes vested at the national level and with little input from the municipalities. The Ministry of Health has a central role in the decision-making process in most health-related activities (Box 1). The health system is largely financed through a mandatory social health insurance scheme operated by the Health Insurance Fund (HIF), that acts as the main purchaser of publicly funded health services. The social health

insurance scheme is funded through contributions and government budget transfers pooled by the HIF. The Ministry of Finance determines the budget for the Ministry of Health and the HIF. The Law on Health Care regulates the organization, governance and management of the health system, establishes the social health insurance system and the purchaser–provider split, and regulates the rights and responsibilities arising from the social health insurance system.

Box 1 Capacity for policy development and implementation

Health policy is mainly developed and proposed for adoption by the Ministry of Health, with a growing role for professional societies and chambers as well as civil society. This shift has been supported by the EU Instrument for Pre-accession Assistance (IPA), which provides funding for civil society to support the authorities in implementing structural reforms. Although there is no formal mechanism for their involvement, both civil society and professional chambers are involved in the decision-making process in the governing bodies of the HIF and are regularly invited to join the working groups of the Ministry of Health. This cooperation is especially prominent in the implementation of preventive programmes on HIV/AIDS, the development and implementation of a programme for the treatment of rare diseases, and the policy dialogue on health system reform, strengthened in particular since the change of government in 2017.

Planning

The Ministry of Health oversees health policy, planning, evaluation and public health programmes, guided by the National Health Strategy (2021–2030). It regulates capital investments in the public domain and quality standards enforced by the Agency for Quality and Accreditation of Health Care Institutions (AKAZUM). Decision making and financing are fully

centralized, including management appointments and budget allocation. The Health Network, established in 2012, comprises certified public and private providers ensuring geographical access under the social health insurance system. The Ministry of Health determines the Network's scope and composition for the purpose of strategic resource planning.

Providers

The health system features a mix of public and private providers. While secondary and tertiary care remain predominantly publicly owned, private provision has expanded across specialist services, inpatient care, dental care and pharmaceuticals. Primary care is provided by private practices operating solely within social

health insurance under HIF contracts. Conversely, all public university hospital centres, university hospitals, general hospitals and health centres operate under direct Ministry of Health authority, with centralized management appointments, financing and staff recruitment.

How much is spent on health services?



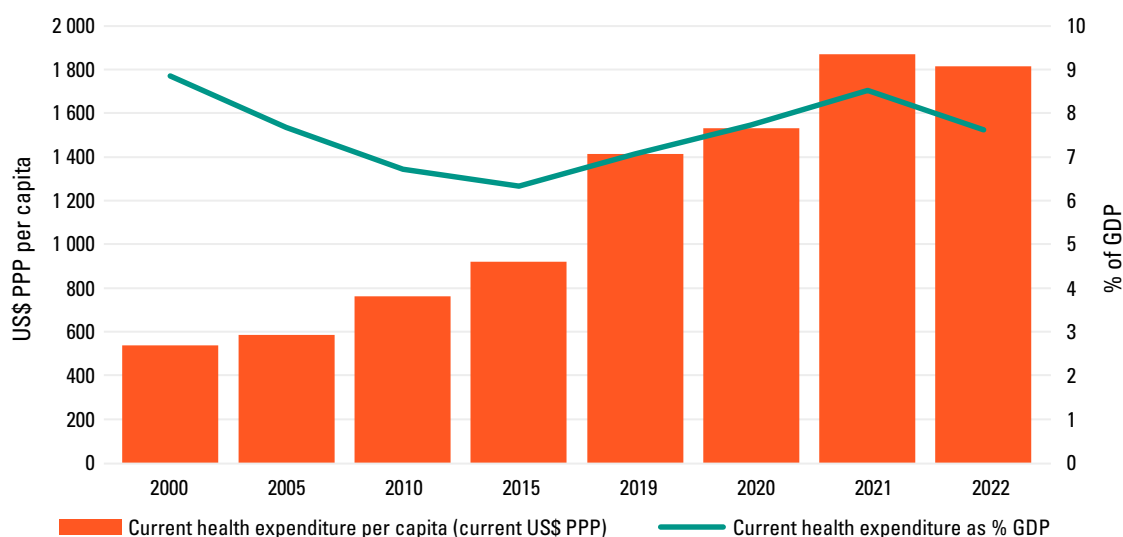
The share of public spending is low and private spending is substantial

Funding mechanisms

The health system is financed from mandatory (salary-based) social health insurance contributions, spending from the state budget (with revenues raised via general taxation) and other agencies, and out-of-pocket (OOP) expenditure directly paid by the population. Donors

and non-governmental organizations (NGOs) play a minor role, and while the share of voluntary health insurance (VHI) has increased, it represents a very small source of revenue.

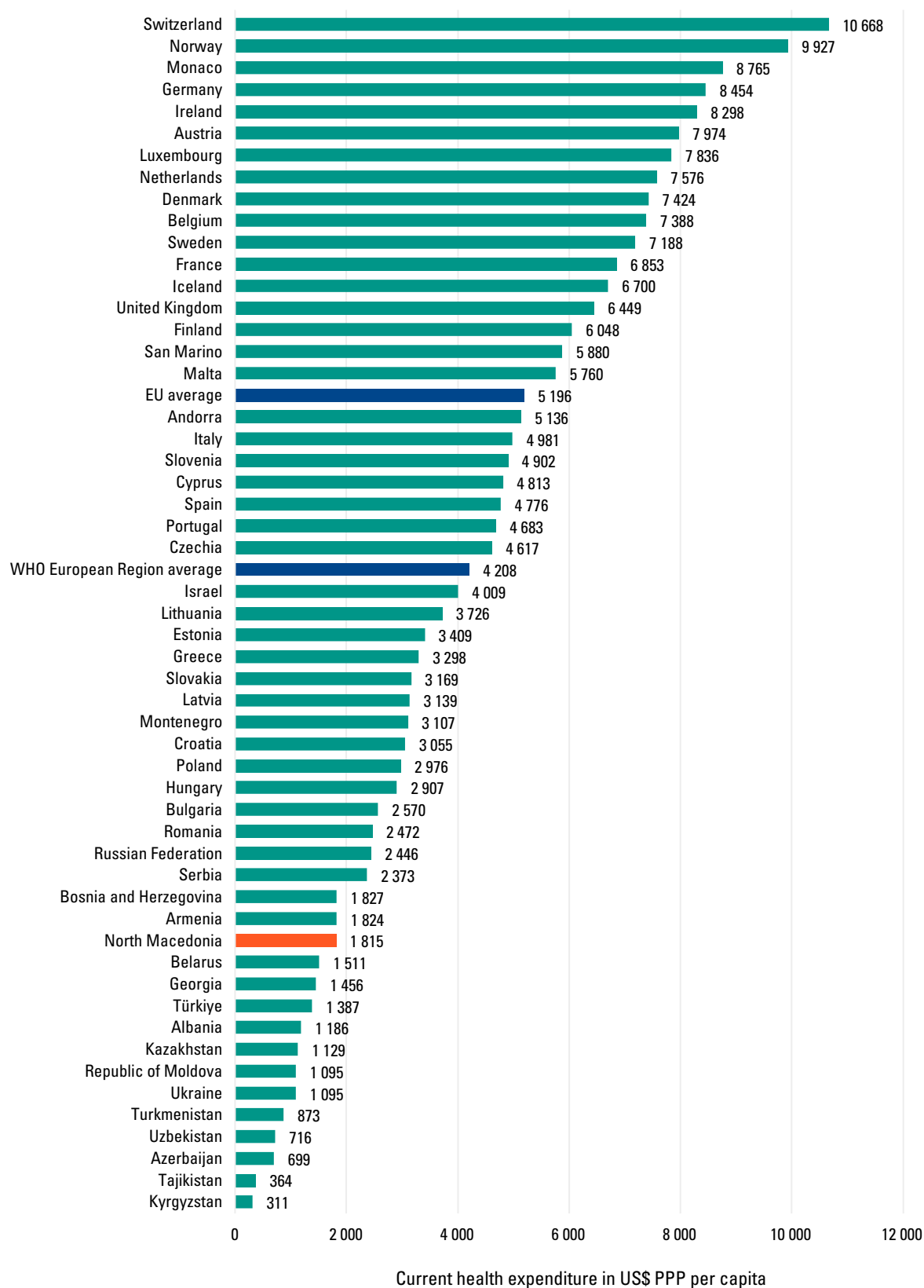
Fig. 1 Trends in health expenditure, 2000–2022 (selected years)



Notes: CHE: current health expenditure; GDP: gross domestic product; PPP: purchasing power parity.

Source: WHO, 2025a.

Fig. 2 Current health expenditure (US\$ PPP) per capita in the WHO European Region, 2022



Notes: CHE: current health expenditure; EU: European Union; PPP: purchasing power parity.

Source: WHO, 2025a.

Health expenditure

Health expenditure per capita was US\$ 1815 (adjusted for differences in purchasing power) and 7.6% as a share of gross domestic product (GDP) in 2022, placing the country at the lower end in the WHO European Region and below the European Union (EU) average. In absolute numbers health expenditure per capita has grown, but it has fluctuated as a percentage of GDP (Figs. 1 and 2). Social health insurance contributions

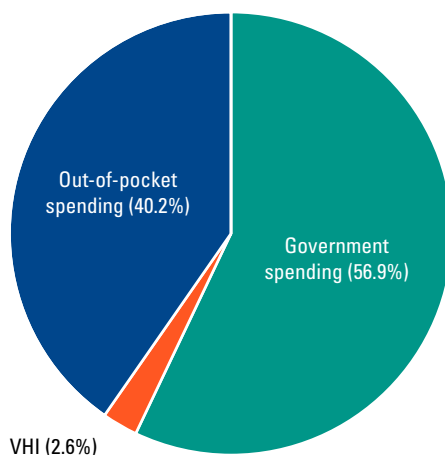
are the major source of funding for health, accounting in 2022 for 51.3% of current spending on health and 90.0% of public spending on health. OOP payments are the second source of funding for health, accounting for 40.2% in 2022. Although VHI has grown, especially in 2021, it still plays a minor role in health financing, accounting for 2.6% of current health spending in 2022.

Out-of-pocket payments

There is strong reliance on OOP payments, which accounted for 40.2% of health spending in 2022 (Fig. 3), one of the highest shares in South-eastern Europe. OOP spending mainly consists of co-payments for services partly covered by social health insurance and of direct payments for over-the-counter medicines and health services not covered by social health insurance. Medicines are the biggest driver of OOP spending, and one of the reasons for this is the outdated positive list of medicines (a long-awaited

update was introduced at the end of 2024, marking a first step towards more regular revisions). Informal payments are widespread in obstetric and gynaecological care as well as other service areas both in private and public facilities, and constitute an important portion of OOP spending. About 41% of respondents of a nationally representative survey in 2022 reported informal payments as a serious problem when accessing health care (WHO Regional Office for Europe, 2024).

Fig. 3 Sources of current health expenditure, 2022



Note: VHI: voluntary health insurance.

Sources: WHO, 2025a.

Coverage

The social health insurance system covers the entire population. Nevertheless, minor gaps in coverage may still occur, such as people without regular employment

who do not pay contributions, employees whose salary payment has been delayed for more than two months due to their employer's lack of liquidity, and Macedonian

citizens living abroad. The HIF provides a broad basic benefits package, covering emergency care, primary care, secondary and tertiary outpatient and inpatient care, and preventive and rehabilitation services. In

addition, the HIF covers dental and mental health care services, medical devices and prescribed medicines. Yet, access may be limited in practice, partly due to limited capacity in the public sector (Box 2).

Box 2 What are the key gaps in coverage?

The population receives a comprehensive benefits package covering dental care, sick leave, maternity benefits and child care. However, coverage gaps persist, particularly for innovative medicines. Many newer-generation drugs available in-country remain excluded from the positive medicines list, forcing patients to pay out of pocket and limiting access to more effective, cost-efficient treatments. The HIF is aiming to improve access to services that are not sufficiently available within the public sector (such as ophthalmic, cardiovascular and vascular surgery) by negotiating contracts to purchase such services from private providers. However, this is not the case for some of the services that are available in the public sector but for which there is insufficient capacity to meet population needs (such as mammography or obstetrics/gynaecology services), creating a demand for private OOP paid services to avoid long waiting times.

Paying providers

All services provided by public providers in health centres, hospitals and tertiary university clinics are subject to negotiations with the HIF and are financed by a mix of fee-for-service, episode payments and global budget (Fig. 4). Primary care providers are paid through capitation that has two payment categories: 70% of the total amount consists of a fixed capitation fee based on the number and age of registered

patients, and the remaining 30% is conditional on meeting the preventive health targets for primary care. For outpatient specialist services in health centres, hospitals and specialist practices, the HIF uses 'specialist care packages', which can be individual services or several services grouped into a package covering one episode of treatment.

Fig. 4 Provider payment mechanisms in North Macedonia

					
GPs	Specialists	Acute hospitals	Hospital outpatient services	Dentists	Pharmacies
Capitation + capped episode payment	Global budget/ capped episode payment	Global budget/ capped DRG + conditional budgets	Global budget/ capped episode payment	Fee-for-service	Reimbursement

Notes: DRG: diagnosis-related group; GP: General practitioners.

Source: Authors' compilation.

What resources are available for the health system?



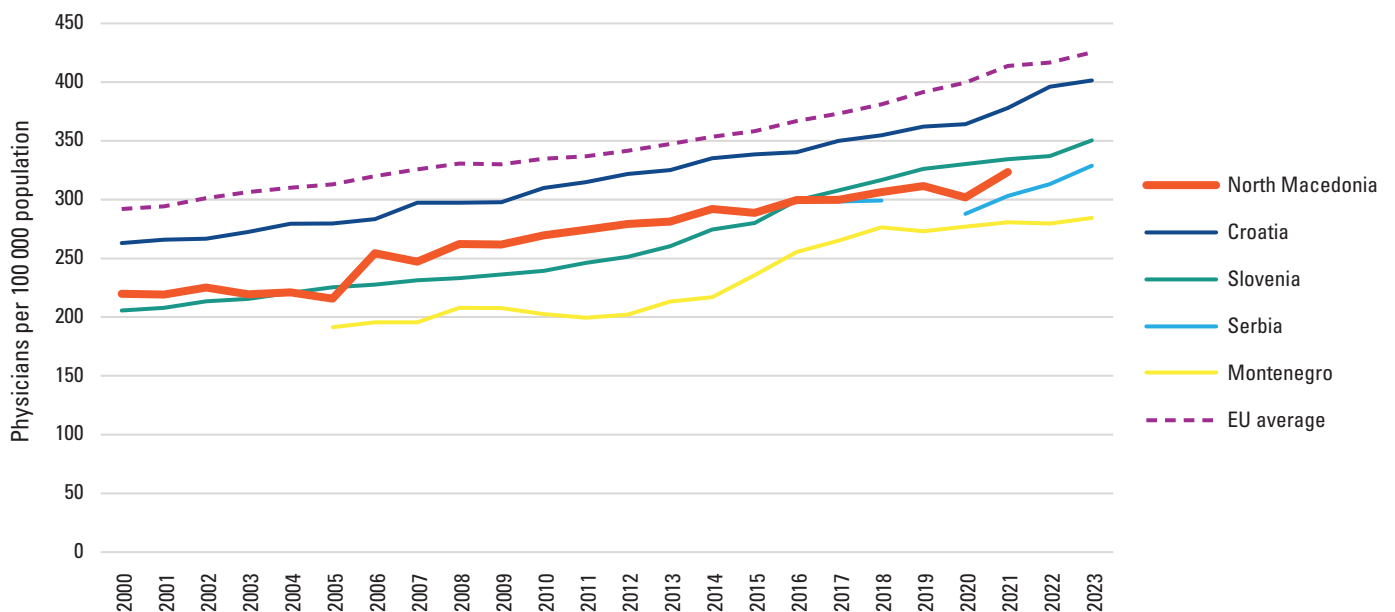
Numbers of health professionals have increased but human resources in health remain scarce

Health professionals

North Macedonia struggles with overall health workforce shortages, emigration and internal migration. The country's physician and nursing ratios are below the EU averages, but have increased between 2000 and 2021 (Figs. 5A and 5B). Health workforce emigration poses major sustainability challenges. To attract and

retain health professionals, the country introduced measures such as increased capitation rates for GPs and family doctors, higher salaries for public-sector specialists and nurses, remuneration and social insurance for private medical and dental residents, and substantial salary increases for other health professionals.

Fig. 5A Number of practising physicians per 100 000 population, 2000–2023



Notes: Professionally active doctors for North Macedonia, practising doctors for all others.

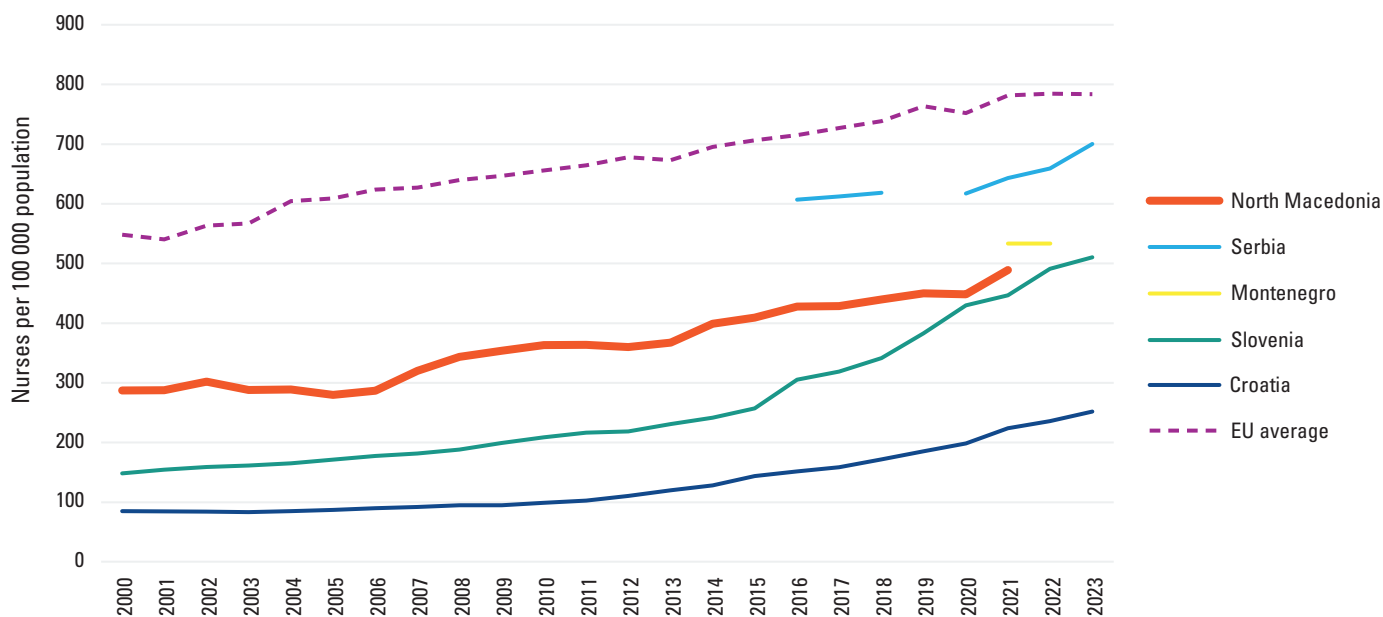
Source: Eurostat, 2025.

Health infrastructure

In 2021, the Health Network comprised 124 institutions, including 76 hospitals, out of which 53 were for acute care and 14 for chronic care. Hospital bed capacity declined from 506 to 449 per 100 000 population between 2000 and 2021, in line with the wider

European trend (Fig. 6). Despite increases during 2019–2021 due to the COVID-19 response, the ratio remained below the EU average of 484 in 2021. Of total beds in 2021, 71% served curative care, 17% long-term care, 4% rehabilitative care, and 7% other

Fig. 5B Number of practising nurses per 100 000 population, 2000–2023



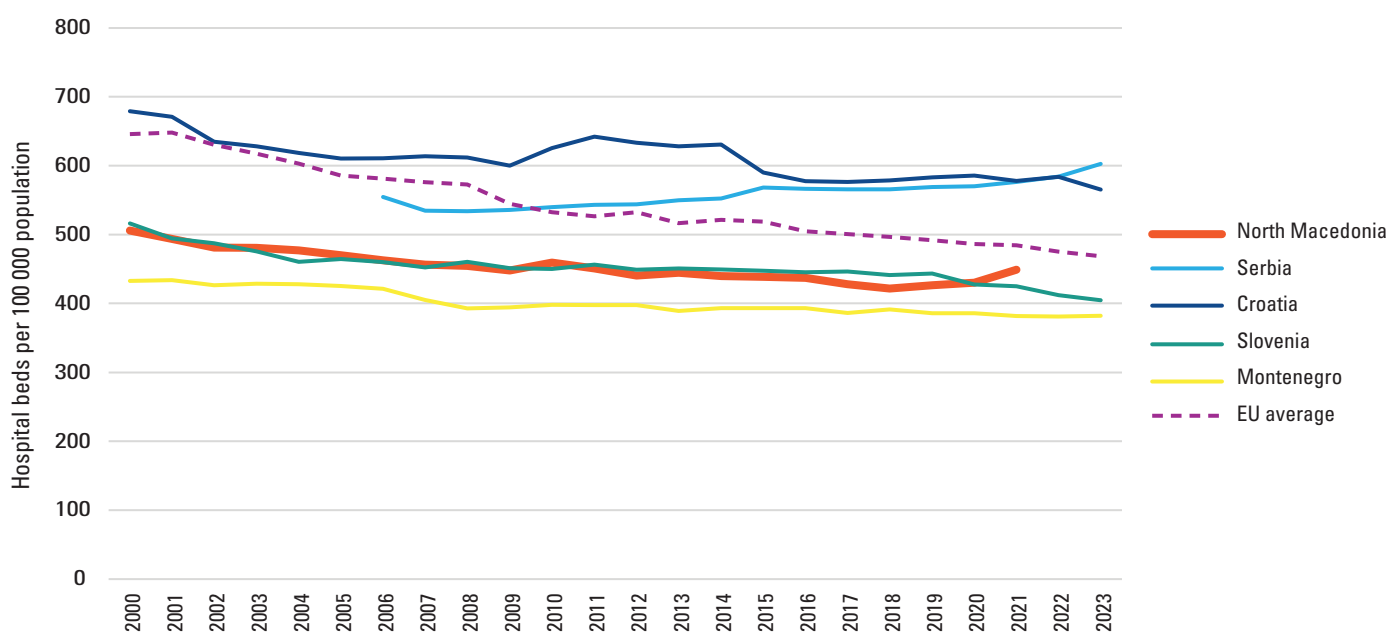
Notes: Professionally active nurses for Montenegro and North Macedonia; practising nurses for all others.

Source: Eurostat, 2025.

purposes. While private hospital beds have increased, approximately 95% of all hospital beds remain in publicly owned facilities. Despite investment in medical equipment, North Macedonia has limited capacity

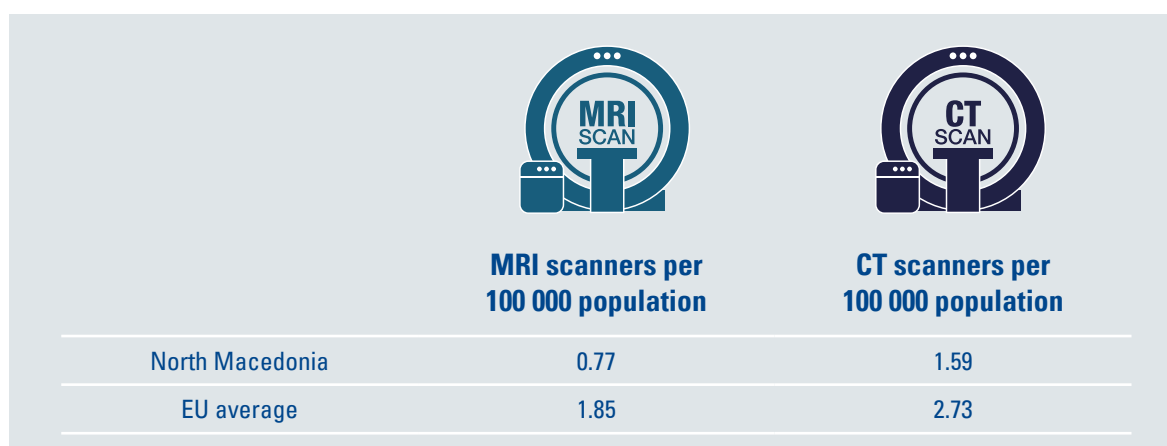
of imaging equipment and ranks below the average volume of magnetic resonance imaging (MRI) and computerized tomography (CT) units in the EU as a whole (Fig. 7).

Fig. 6 Total hospital beds per 100 000 population, 2000–2023



Source: Eurostat, 2025.

Fig. 7 MRI and CT scanners in North Macedonia and the EU



Notes: 2021 for North Macedonia, 2023 for EU average.

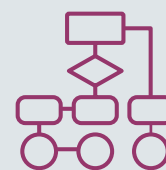
Sources: Eurostat, 2025; Ministry of Health, personal communication, 2024.

Distribution of health resources

To ensure equitable geographical access to health services, the Health Network of certified health care providers was introduced in 2012. However, inequities remain across regions due to the unequal distribution of human resources and discrepancies in the quality of care. Some specialized and tertiary services are accessible only at the university clinics in Skopje. Following the initial step of privatization

launched in the primary care reform of 2004–2007, primary care services are delivered by private GPs and family doctors, as well as in the 34 publicly owned health centres. Primary care availability varies, particularly in smaller municipalities and rural areas, with a poorly defined scope of services and limited usage of equipment affecting care availability and quality.

How are health services delivered?



Tobacco control policies are underdeveloped and the efficiency of hospital and inpatient care remains a challenge

Public health

The provision of public health services is organized through a network of public health institutions, with one national institute (the Institute of Public Health) and 10 regional Centres of Public Health operating through 21 local units, which are coordinated and supervised by the Institute of Public Health. The local units provide local-level services in public health and

epidemiology, as well as environmental health and microbiology laboratory services.

Most preventive services are provided through the 34 publicly owned health centres. These services include: immunization provided by specialized teams of a medical doctor and a nurse; health promotion and disease prevention provided by community (patronage)

nurses; and physical examinations of pre-school and school-aged children. Community nurses are also responsible for visiting pregnant women and mothers and newborns during the postpartum period. Preventive services for hypertension, diabetes, asthma, chronic obstructive pulmonary disease (COPD) and hypothyroidism are provided by GPs and family doctors.

Although some policies have been adopted (such

as nutrition standards for school children), intersectoral policies to address key determinants of ill health (such as smoking, physical inactivity and poor nutrition) remain absent or underdeveloped. In particular, a reversal of the anti-tobacco policy in 2018 permitting smoking in certain indoor public spaces and a lack of media campaigns against tobacco use have undone the modest progress achieved in the 2010s.

Primary and ambulatory care

Primary care physicians (GPs, family doctors, obstetricians/gynaecologists and dentists) are the first point of contact for patients and are meant to be gatekeepers to more complex medical care, but there are high rates of referral (Box 3). Primary care services are provided mainly in solo practices, although group practices are sporadically available. Challenges in

primary care are gaps in the availability of general practices in rural areas, and of obstetrics/gynaecology care in rural and some urban settings due to a historical lack of specialists. Specialist outpatient care is mainly delivered in publicly run health centres and public hospital outpatient departments as well as in private outpatient practices.

Box 3 What are the key strengths and weaknesses of primary care?

Primary care providers are directly accessible and well-distributed nationwide, yet equitable access to standardized, quality care remains challenging, particularly in rural areas. Large variations in the scope of practice and available services stem from undefined service standards and a lack of standardized clinical protocols. Primary care physicians face prescribing limitations (e.g. for insulin) and cannot order specific diagnostics (endoscopies, MRI, CT scans), requiring specialist referrals for chronic diseases and multi-morbidities.

These scope-of-practice restrictions contribute to high referral rates to secondary and tertiary care. Nurses have similarly limited roles, primarily performing administrative tasks due to heavy workloads. While primary care privatization in the mid-2000s was successfully implemented and accepted, failure to re-establish functional links between private primary care practices and public secondary/tertiary facilities, preventive and rehabilitative services has created care fragmentation. The dominance of solo practices exacerbates discontinuity across care levels. Additionally, private practices lack systematic integration with preventive and health promotion services, limiting cooperation with health centres.

Hospital care

Inpatient care is provided in public general, clinical and specialized hospitals, university clinics and private hospitals. Hospital services include specialized diagnostics and treatment of acute and complex cases, day care, and treatment of people with chronic conditions. The number of hospital beds and the average length of hospital stays have decreased, but efficiency remains a challenge, with very low utilization rates of hospital beds (on average 49% for curative care). Day

care is becoming more widely used, especially among mental health patients, and is considered preferable to prolonged hospital stays. In 2018, day care was piloted at the community level in a health centre to ensure that patients no longer need to travel to the nearest hospital but can receive the necessary care in their own community. Further efforts to improve integration of care across care levels are described in Box 4.

Box 4 Are efforts to improve integration of care working?

In North Macedonia, recent efforts within the broader health system development agenda have sought to enhance the integration of health services between different levels of care. Integrated protocols and pathways in primary care were established to simplify patient care, enhance treatment outcomes and mitigate the fragmentation of services across different care levels. Integrated care initiatives such as the integrated health and social care pilots in two municipalities aim to achieve horizontal integration of providers by comprehensively addressing health and social determinants. Moreover, the adoption of digital health solutions, such as the electronic health record (EHR), My Appointment, e-prescriptions and telemedicine, marks significant progress in integrating providers and treatments across care levels, enabling enhanced information sharing and an overall improvement in health care management. However, there is a lack of comprehensive data to assess the full impact of these integration efforts. Further evaluation and data collection are warranted to provide a comprehensive understanding of their effectiveness.

Pharmaceutical care

Pharmaceuticals are dispensed through 948 community facilities including pharmacies, pharmaceutical stations and mobile stations. Pharmacies require graduate pharmacists and technicians, while pharmaceutical stations (introduced in 2015) operate with technicians only. All HIF-contracted facilities connect to the HIF digital system, allowing the calculation of OOP payments and co-payments for reimbursable medicines. The use of medicines from the positive list has increased gradually, with prescribed

medicines increasing by 66% between 2009 and 2021. However, the positive list remains largely outdated despite a very modest update in 2024, which limits therapeutic coverage and alignment with national clinical guidelines. Weak monitoring of prescribing and dispensing practices, together with restrictions preventing family doctors from prescribing some medicines for chronic conditions, further contribute to inefficiencies in pharmaceutical spending and higher OOP payments.

Long-term care

The country's long-term care system is still underdeveloped, with little coordination between the social welfare and health systems, or between public and private (not-for-profit and for-profit) providers. There are five public residential facilities for older people, with a total of 624 beds, and 28 licensed private residential facilities, with a total of 1051 beds. Only about 0.4% of older people received any form of residential long-term care in 2020 (below the EU average of 2%), whereas it has been estimated that about 17% of persons above the age of 65 years require such care.

Long-term care is still mostly provided by informal carers (family members, relatives, etc.).

Although North Macedonia has embarked on efforts to improve long-term care for older people, for example by introducing a new subspecialization in geriatric medicine and palliative care for doctors in 2021 to respond to the shortage of qualified staff and meet the rising demand for geriatric and palliative care, more efforts are needed. So far, the quality of long-term care is neither measured nor ensured.

Dental care

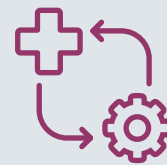
Dental care is provided in preventive, primary, secondary and tertiary settings. The Ministry of Health prioritizes strengthening preventive care for children and adolescents, including check-ups for all school

children and uninsured children. Paediatric, preventive and emergency dental care are delivered through 149 preventive teams in 34 health centres. Primary dental services are provided by HIF-contracted private

practices. Secondary and tertiary dental care operate through public hospital maxillofacial departments and university facilities in major cities. Most private

practices contract with the HIF, but patients can also access practices without an HIF contract and pay out of pocket.

What reforms are being pursued?



Integration pilots and primary care expansion aim to improve access and reduce unnecessary referrals

North Macedonia has not implemented major structural health system reforms since 2018, instead piloting targeted initiatives to identify effective models for future implementation. The COVID-19 pandemic delayed planned reforms, diverting resources towards pandemic response. However, the government introduced policy changes addressing system efficiency, quality improvement, primary care, access to medicines and digitalization (Box 5).

Initiated in 2018 to address low hospital utilization and high referral rates, two community-level integration models were piloted. The first tested 'one-stop-shop' services at Resen Health Centre, combining health and social outreach services. The second model created 'local hospitals' by integrating general hospitals with health centres, piloted in five facilities. Initial assessments demonstrated increased equity in accessing care and improved efficiency with the first model.

Building on the first phase of the primary care reforms (2004–2007), the second phase began in 2019 following the Primary Health Care Roadmap 2020–2030 and envisaged an integrated, patient-centred and multidisciplinary model of primary care.

Key achievements of this second phase include the introduction of e-prescription in 2020, extended prescription validity and enhanced nurse training. Clinical guidelines and protocols for ambulatory care-sensitive conditions were introduced in 2023, enabling primary care providers to diagnose and manage these conditions without specialist referrals.

Following increased neonatal mortality in 2015, perinatal care became the pilot for hospital reform. Six Perinatal Care Networks were established across administrative regions to improve coordination at regional level and ensure access to high-quality maternal and child care. This master plan also serves as the model for the hospital reform, which is one of the key priorities of the government up to 2030.

Recent investments in digitalization focused on data integration between civil registries and health records, real-time patient registries for diabetes and chronic kidney disease, and active workforce registries. Modules for monitoring vaccination and screening uptake were introduced in 2021–2022 and improved public health surveillance and linkages between curative and preventive services.

Box 5 Key health system reforms over the last 10 years

- 2018: Integration of social and health services at community level.
- 2019: Beginning of the second phase of the primary care reform.
- 2019: Regionalization of hospital services with pilots in perinatal care.
- 2019: Reintroducing comprehensive access to prescription medicines.
- 2020: Continued digitalization of health care.

How is the health system performing?



Improving the quality of care is an explicit policy aim, but premature mortality rates remain high

Health system performance monitoring and information systems

Despite some efforts to introduce this in the past, there is no mechanism for monitoring health system outcomes. Health system performance monitoring relies primarily on general morbidity and mortality data. There is a lack of internationally comparable data and data quality control mechanisms, and there is no systematic assessment of patient and provider satisfaction.

North Macedonia launched a nationwide e-health system in 2012, the My Appointment system (Moj Termin). Its functionality expanded from a scheduling system for clinical appointments and diagnostic tests to a fully-fledged e-health system for managing appointments and electronic health records. It is used by all institutions within the Health Network for electronic health records, referrals to higher levels of care for diagnostic tests and treatment, and electronic

discharge letters, as well as e-prescriptions for pharmaceuticals. In 2023, the My Health (Moe Zdravje) portal was developed to provide patients with access to their electronic health records, including appointments for specialist referrals, prescriptions and vaccination records.

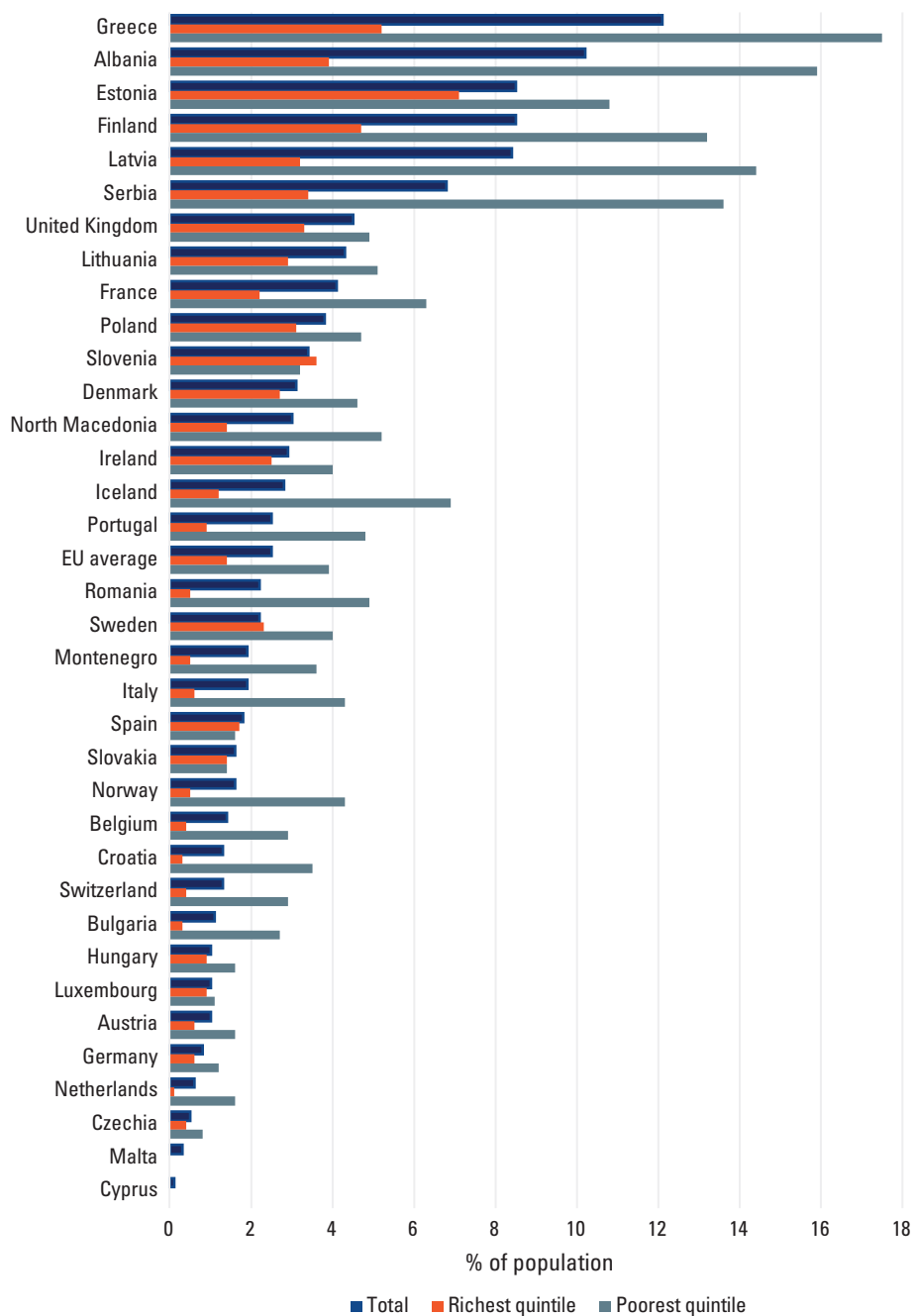
The My Appointment system aggregates data from more than 70 sources on communicable and noncommunicable diseases, and supports the creation of digital health registers. In addition, it now has an integrated real-time module for early detection of clusters and outbreaks of communicable diseases. It also collects robust data on financial protection, and National Health Accounts were successfully introduced in 2019, although their potential to inform policies is still underutilized.

Accessibility and financial protection

There is nearly universal population coverage and a wide range of services are covered by social health insurance. However, affordability is a concern, especially for poorer households, due to very high OOP expenditures, including co-payments for specialized and hospital care and for pharmaceuticals. In 2022, 3.0% of the population reported unmet needs for medical examination due to cost, waiting time or travel distance, which was slightly higher than the EU

average of 2.5%. The poorest quintile of the population was most affected, with 5.2% reporting unmet needs (Fig. 8). Affordability is particularly an issue for pharmaceuticals, which consumed up to half of OOP payments in 2021. Access to innovative and newer-generation medicines, and services for which there is limited capacity in the public domain (such as mammography and obstetric/gynaecological care) is particularly limited.

Fig. 8 Unmet needs for a medical examination (due to cost, waiting time or travel distance), by income quintile, EU/EEA countries, 2024



Notes: EEA: European Economic Area; EU: European Union. Data for Montenegro and Switzerland from 2023; for Albania and North Macedonia from 2022; for Iceland from 2020; for UK from 2018.

Source: Eurostat, 2025, based on EU-SILC.

Health care quality

Improving health care quality through standardizing care has been one of the key priorities of the country since its independence. However, North Macedonia still faces high rates of premature mortality and a disease burden that could be improved if public health policies were strengthened and health care provided more effectively in a timely manner, particularly in the treatment of noncommunicable diseases. Improving health care quality is an explicit policy aim of the National Health Strategy 2021–2030 and many stakeholders are interested in the establishment of a system for quality control and assurance, but so far a comprehensive quality improvement strategy with an action plan that defines priorities, performance

indicators and roles/responsibilities has not been developed. The Agency for Quality and Accreditation of Health Care Institutions (AKAZUM) is underfunded and only has a very weak role in the health system. The HIF undertakes a minimal role in ensuring quality of care through its payments for primary care, and to some extent for secondary specialist and inpatient care, although it is not mandated to perform this role. Despite the existence of a wealth of patient-level data in the system, many quality indicators are not easily available to policy- and decision-making processes, including avoidable hospital admissions for chronic conditions, in-hospital mortality rates and cancer survival rates.

Health system outcomes

Key health indicators show improvement in the last decades, particularly mortality from noncommunicable diseases. Since 2000, mortality from ischaemic heart disease has decreased threefold and mortality from stroke nearly twofold, while life expectancy showed steady improvements, except during the COVID-19 pandemic. However, cancer and diabetes trends remain concerning.

North Macedonia tends to lag behind EU averages, with unhealthy lifestyles (high blood pressure, tobacco use and poor diets) accounting for nearly three-quarters of deaths (Box 6). Premature mortality from four major noncommunicable diseases (cardiovascular diseases, cancer, diabetes and chronic

respiratory diseases) among people aged 30–69 years declined from 556 per 100 000 population in 2000 to 409 in 2021 but remained well above the EU average of 250 in 2021 (WHO Regional Office for Europe, 2025a). Internationally comparable data on treatable and preventable mortality are unavailable.

There is no national cancer plan, and current policies and programmes are mainly focused on measures such as screening and public awareness, while diagnosis tends to be late. Multidisciplinary approaches to cancer prevention and care are lacking. Similarly, no national strategies address diabetes, cardiovascular diseases, or related risk factors, with only opportunistic screening at primary care level.

Box 6 Are public health interventions making a difference?

Unhealthy lifestyles, including high smoking prevalence and poor dietary habits (excessive sugar, salt and fat consumption), drive more than half of all deaths in North Macedonia (Rechel et al., 2025). Fragmented and under-resourced public health institutions lack capacity to address these challenges effectively. North Macedonia ranks among the world's highest for smoking prevalence and cigarette consumption among adults and youth. Over one-third of adults (35%) smoked in 2017 (Analytica, 2018), exceeding South-eastern Europe (30%) and WHO European Region (24% in 2020) averages. Smoking rates declined from 40% in 2004, attributed to the 2010 public smoking ban, increased cigarette prices and enhanced public awareness campaigns. North Macedonia routinely records patients' tobacco use, yet smoking data are excluded from national statistics, limiting policy evaluation (Analytica, 2018). Conversely, per capita alcohol consumption (4.4 litres per year in 2020) remains well below the WHO European Region average (8.8 litres in 2020) (WHO Regional Office for Europe, 2025b).

Health system efficiency

While there is no systematic monitoring of health system efficiency, some improvements are evident. Average hospital stay decreased to 5.6 days in 2021, and health care digitalization enhanced access for patients and providers through e-prescriptions, telemedicine modules and electronic health records.

At the same time, the very low utilization rates of hospital beds (49.3% on average for curative care in 2019) suggest that there is room for significant improvements. Despite COVID-19 driving respiratory admissions in 2021, high cardiovascular episodes suggest a need for enhanced primary and secondary prevention.

Technical efficiency of primary care suffers from overutilization of emergency services, with patients preferring emergency calls (accounting for 98% of all such calls) over primary care providers. Many procedures available at primary and secondary levels are inappropriately referred to tertiary facilities, preventing university hospitals from focusing on complex cases. There is also considerable room for efficiency improvements in the use of pharmaceuticals, such as through the introduction of health technology assessment (HTA).

Summing up



North Macedonia has achieved health improvements but fragmentation of the health system and high mortality rates require sustained reform efforts

North Macedonia's health system has achieved population health improvements but faces substantial policy development and implementation challenges. High premature mortality rates, exacerbated during COVID-19, persist, with mortality from cancer, cardiovascular diseases, tobacco consumption and air pollution exceeding levels in most EU countries. Health promotion and disease prevention remain underdeveloped, with concerning reversals in anti-tobacco measures. The National Health Strategy 2021–2030 continues previous policy frameworks, but frequent leadership changes and disruptions from the pandemic have resulted in slow, fragmented reforms often dependent on international support from WHO, UNICEF and other UN organizations.

Nearly universal population coverage exists for publicly funded services, yet high OOP payments undermine financial protection. Geographical access barriers persist, although government initiatives include reforms to regionalize inpatient care and integrate health and social services.

Resource allocation challenges include a continued emphasis on hospital care and deficiencies in primary care, with technical inefficiencies across inpatient and outpatient settings. Primary care remains disconnected from preventive and rehabilitative services, and appears to be underutilized compared to specialist care. Primary care provision in rural areas and access to obstetric/gynaecological care are undermined by staff shortages. The My Appointment health information system reduced waiting times and continues expanding through digitalization modules. COVID-19 accelerated this process, which now incorporates e-prescriptions and telemedicine capabilities.

Equitable access to high-quality care represents a National Health Strategy priority, yet comprehensive quality improvement plans defining priorities, indicators and responsibilities remain absent. Future policy efforts could be developed to enhance continuity of care across the different levels of the health system to achieve better prevention, equitable access and improved financial protection.

Population health context

Key mortality and health indicators

Life expectancy (years)	2023
Life expectancy at birth, total	75.3 ^a
Life expectancy at birth, male	73.2 ^a
Life expectancy at birth, female	77.6 ^a
Mortality	2023
All causes (SDR per 100 000 population)	1 104.4 ^b
Circulatory diseases (SDR per 100 000 population)	427.2 ^b
Malignant neoplasms (SDR per 100 000 population)	204.5 ^b
Communicable diseases (SDR per 100 000 population)	1.4 ^b
External causes (SDR per 100 000 population)	22.4 ^b
Infant mortality rate (per 1 000 live births)	2.8 ^a
Maternal mortality per 100 000 live births (modelled estimates)	3.0 ^a

Note: SDR: standardized death rate.

Sources: ^aWorld Bank, 2025; ^bWHO, 2025b.

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