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RECOMMENDATIONS TO COMBAT CORRUPTION IN HEALTHCARE PUBLIC PROCUREMENT

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Editor: German Filkov

Authors: Sabina Fakic, German Filkov and Marko Mitevski

Proofreading: Tatjana B. Eftimoska

Translation from Macedonian into Albanian: Agon Ismaili

Translation from Macedonian into English: Magdalena Simionska

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FAKIC, Sabina
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CONTEXT

The public healthcare sector in the country is facing a continuous and growing gap between public funds spent and results delivered. In the last 10 years, healthcare costs incurred under public procurement have significantly increased; however, the scope of services, efficiency and accountability remain the same or are declining. Such discrepancy opens a series of dilemmas about the manner in which public funds in the healthcare sector are spent and controlled.

The three research analyses developed by the Center for Civil Communications in 2025 and 2026 provide detailed and comprehensive overview of these challenges and identified a series of weaknesses, corruption risks and possible abuses (PUBLIC HEALTHCARE SPENDS MORE, BUT PROVIDES LESS, KEY PLAYERS AND COMPETITION IN HEALTHCARE PUBLIC PROCUREMENT and CORRUPTION SCHEMES IN HEALTHCARE PUBLIC PROCUREMENT DETECTED THROUGH PUBLIC PROCUREMENT APPEALS).

Based on findings presented therein, this document outlines specific and practical recommendations for measures aimed at reducing corruption risks and abuses in healthcare public procurement.

One of the most significant findings concerns the enormous gap between funds spent and results achieved. While the value of healthcare public procurement has increased by almost two and half times, i.e. from 126 million EUR to 315 million EUR over a period of 10 years, the scope of public healthcare services decreased. For example, the number of general and specialist consultations, the number of inpatient days, etc., are all marked by sharp decline both at clinics and general hospitals. This means that growing costs have not yielded better delivery of services, which is indicative of inefficient allocation and spending of public funds.

Analysis of public procurements and procurement processes revealed significant risks relating to market competition and market concentration. In the last 5 years, only 10 companies accounted for a share of 49% on the healthcare public procurement market, while 55% of tender procedures were marked by participation of only one bidder. While the small market and nature of these procurements can be justified, reasons thereof are often found in specific and limiting technical specifications, pre-arrangements and market division among bidding companies. For example, tender procedures organized for procurement of reagents are often related to specific equipment received as donation or given under lease, thus limiting tender participation to only one supplier. Such practices do not only decrease competition, but also increase the risk of inflated prices, long-term dependence on particular suppliers, and potential arrangements made in advance.

The third analysis, focused on corruption schemes identified on the basis of appeals lodged by companies in healthcare public procurement, revealed the practical aspects behind the manner in which weaknesses identified in public procurements had been conducted. In particular, it revealed models for adjustment of tender specifications, criteria for tender participation, and other practices that could facilitate favouritism of certain bidders and abuse of public funds. These findings showed that corruption risks in healthcare public procurement are not isolated incidents, but are rather built into structural and procedural shortcomings.

Together, findings from all three analyses indicate to the critical need for reforms. The challenges are not limited only to individual cases showcasing poor performance of public procurement, but also

reflect much deeper problems relating to systemic weaknesses, poor management and operation, institutional capacity, market functioning, and data transparency.

Addressing these problems requires comprehensive and concerted approach, i.e. combination of legislative changes, improvements to enforcement of existing legal regulations, institutional capacity-building, greater transparency, and strategic use of data. A key precondition for that is, of course, political will.

Recommendations are grouped into several key areas: improvements to public procurement planning and assessment of procurement needs; strengthening competition and access to the market; improving transparency and accountability; strengthening control, audit and supervision; institutional and human capacity-building, and promoting legal protection.

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DETAILED OVERVIEW OF MEASURES

LINKING PUBLIC PROCUREMENT TO ACTUAL NEEDS AND SERVICES DELIVERED

MEASURE #1: Plan public procurement on the basis of objective indicators and actual projections

- An obligation should be created for planning public procurement on the basis of objective indicators relating to actual needs, in particular the expected number of patients, the planned number of services and inpatient days. When planning public procurement, the contracting authorities must take into consideration available human and physical capacity, existing stock of medicines, medical and laboratory supplies, as well as the medical equipment's general condition and functionality. The basis for these calculations should be data on previous consumption rates, expected scope of work, and contracts signed with the Health Insurance Fund which define the planned scope of services at the level of individual institutions. The Ministry of Health and the Health insurance Fund need to develop guidelines, standards or mandatory indicators to be used for needs assessment of particular categories of healthcare procurements, which PHIs would take into account when developing their annual public procurement plans, in compliance with public procurement regulations.

Rationale: The current practice on public procurement planning applied by most public healthcare institutions is generally based on historic data, i.e. public procurements are often based on the value and quantity from previous years, and not on projected needs and actual situation in respect to staff, space, stock and medical equipment. This creates space for the quantity needed to be "inflated" beyond the real scope of services, implies a risk of irrational public spending, and could led to expiration of the shelf life for portion of the quantity purchased. Contracts with HIF are the only formal document that quantifies the expected scope of work by any public healthcare institution. Hence, linking these documents to public procurement planning creates a measurable and verifiable basis instead of relying on discretionary estimates.

Guidelines and indicators should include references to types of data that need to be taken into consideration by PHIs when planning their public procurements (such as: the number of patients, the type and scope of services; inpatient days, previous consumption and stock levels), as well as indicators on deviations between procurements planned and the actual, i.e. contracted, scope of services.

MEASURE #2: Conduct annual analysis of proportionality between goods/services procured and services delivered to patients

- PHIs should be mandated to conduct annual analysis to examine alignment between the value and quantity of goods/service procured and the scope of healthcare services delivered, and submit these analyses as integral part of their work reports to the Ministry

of Health and HIF. In particular, the analysis should be developed per type of service, per department and, where applicable, by diagnostic group, not only at the level of overall average. Furthermore, it should be based on comparisons between data on public procurements, consumption levels, stock levels, and healthcare services performed, all for the purpose of establishing whether goods and services procured correspond to the actual scope and structure of services provided to patients. Another mandatory element of these analyses concerns elaboration on the status of significant stock levels that remain unconsumed, quantity of medicines destroyed after expiration of their shelf life, as well as cases where goods, services or equipment were procured but they cannot be adequately linked to actual healthcare services delivered

Failure to submit the proportionality analysis within a given deadline and/or submission of incomplete or inaccurate data should serve as basis for disciplinary and material liability of responsible persons at PHIs, to be stipulated by amending the relevant secondary legislation.

Rationale: The current practice is mainly cantered on budget execution and funds spent, without any systemic comparison against services performed. This allows significant quantity of purchased goods (medicines, reagents, sanitary supplies) to "disappear" in the system, i.e. cannot be clearly linked to the specific scope of services delivered or the number of patients receiving these services. An average indicator at the level of individual institutions could be defined in statistical terms, but actually conceal major anomalies at the level of individual departments. Hence, the analysis should facilitate timely detection of excessive or unconsumed stock levels, irrational spending, as well as procurements that lack straightforward and functional connection to actual healthcare services provided.

For efficient implementation of this measure, the institutions need to gradually ensure better linkage and alignment of data from PHI's internal system, "My Appointment" and HIF, and to promote the system for monitoring receipt, consumption and stock level of medicines and medical supplies.

MEASURE #3: Introduce an obligation for reporting disproportionality to competent bodies

- An obligation should be created for HIF to inform competent bodies in cases where proportionality analyses have established deviations, violations or possible criminal actions, within a period of 30 days the longest from the day when these were established, together with an analysis of possible reasons.

Rationale: The deadline of 30 days is realistic and measurable, and non-compliance therewith should automatically trigger liability.

MEASURE #4: Publish results of proportionality analyses

- Results of proportionality analyses, as well as key indicators, detected deviations and adequate elaborations thereof, should be published on official websites of MoH and HIF, in open-data format (not only as PDF), understandable for citizens and the media, within a period of 60 days the latest after expiration of the reporting year.

Rationale: Publication of results from proportionality analyses in an open format allows these data to be independently processed by researchers and NGOs, and creates media and civic pressure. If these data are not made publicly available, the analysis is confined with the institution and thereby fails to achieve its purpose in terms of transparency and external supervision.

REGULATION OF MEDICINE PRICES

MEASURE #5: Reform the methodology for setting cap prices

- The number of reference countries used to set cap prices of medicines should be expanded from 5 to 8-10 countries, selected on the basis of previously defined and publicly available criteria, with due consideration for inclusion of countries in the region with comparable markets and lower prices of medicines. Calculation of the average comparable price should be based on the average of the three lowest prices, instead the two lowest prices.

Rationale: The lower number of reference countries limits the scope of price competition. Expansion of the list of reference countries creates a much broader and more realistic basis for setting cap prices. Inclusion of countries in the region with lower prices pushes down the cap price and reduces procurement costs, and could contribute to more efficient limitation of cap prices, provided that the selection of reference countries is methodologically justified and transparent. Use of the average based on the three lowest, instead of the two lowest prices enables a stable calculation, while simultaneously maintaining the pressure for lower prices. The need for this measure arises from the high share of tender procedures presented with only one bid (55% in 2024), which allows economic operators to be awarded contracts at cap prices.

MEASURE #6: Introduce annual price revisions

- An obligation should be introduced for prices of medicines to be updated annually, thereby allowing timely alignment when reference prices are dropping.

Rationale: Having in mind the dynamics on the market for medicines, irregular updating of prices creates a period in which cap prices set in Macedonia remain higher than prices in reference country, causing direct damage to the public budget. Alignment of cap prices in cases of price drops eliminates any discretionary postponement of price alignment.

MEASURE #7: Create and regularly update a publicly available database on medicine prices

- Public, online database comprised of reference and cap prices should be established for all medicines and medical supplies, comparable according to international non-propriety names or equivalent standard designation when INN is not applicable. The database should be regularly updated, i.e. after any change to prices and at least once per year. It should be designed in open-data format and access thereto should be grated to all interested citizens, researchers and the media.

Rationale: Transparency of prices is basic precondition for competition in healthcare public procurement. Any database that is not updated or is made accessible in unreadable format is practically useless. The open-data format allows independent analyses and comparisons, as well as monitoring of price fluctuations in the course of time.

INCREASING COMPETITION IN PUBLIC PROCUREMENT

MEASURE #8: Eliminate discriminatory criteria for tender participation

- Tender documents and technical specifications need to be revised in order to eliminate selective, disproportional and discriminatory criteria for tender participation which unjustifiably limit the number of possible bidders. This process should be conducted by PHIs in coordination with BPP, by mapping and identifying criteria and conditions that most often lead to limited competition, followed by their removal or adequately limited and clearly justified use in public procurement.

Rationale: Tendentiously designed tender documents and technical specifications account for one of the simplest mechanisms for pre-selection of contract winners. Systemic revision of documents is the first step towards opening competition in public procurement, especially in tender procedures that have been historically presented with only one bid.

MEASURE #9: Mandate market analysis before each tender procedure that was previously marked with participation of only one bidder

- Contracting authorities should be mandated to conduct market analysis and take active measures to attract more bidders prior to organizing tender procedures that had been previously marked with participation of only one bidder. This process should be conducted by PHIs, especially when organizing tender procedures for complicated procurement subjects, and could include analysis of retail prices, internet-based research of technical specifications, as well as technical dialogue with economic operators. Activities related to market analysis should be an integral part of the public procurement dossier.

Rationale: On annual level, almost half of the total value of contracts is awarded under tender procedures marked by participation of only one bidder, accounting for 150 million EUR. The mandated analysis

would oblige contracting authorities to actively research reasons for absence of competition on their market segment and take measures before they announce the tender procedure.

MEASURE #10: Regulate the practice for donation/lease of medical apparatus

- All medical apparatus owned by PHIs or received donation/lease agreements should be subject of mandatory records-keeping and public registration, including designation for companies that supplied them and the agreement's terms and conditions. Such registration should prevent acceptance and use of donated, rented or leased apparatus in cases where this creates an obligation for procurement of reagents, tests, supplies or other goods which unjustifiably limits competition, except when technical links are objectively justified and adequately elaborated.

Rationale: Oftentimes, the so-called "free" apparatus is much more expensive than those purchased, given that supplies (tests, reagents, etc.) linked to that equipment are procured at higher prices and without competition for the next 10 years. In most cases, tender procedures for procurement of reagents and tests (worth up to 29 million EUR annually, and marked by growth of 81% over a period of 10 years) are organized as formality because technical specifications concern already existing apparats and the procurement's outcome is known before the procurement procedure is initiated. A register of such equipment would make these relations visible and would allow examination whether donation, rent or lease of apparatus creates a long-term linkage of PHIs to specific suppliers and organization of public procurements with limited competition.

MEASURE #11: Limit the use of technical specifications linked to specific apparatus

- Use of technical specifications for reagents and tests that are exclusively applicable to specific apparatus or brand should be limited, except in cases where PHIs have publicly and rationally proved there are no technology alternatives available. By rule, PHIs should focus on organizing public procurement of tests for particular medical examinations with an obligation for the economic operator whose bid is selected as the most advantageous one to secure compatible apparatus for performance of such tests for the contract's entire duration. Exceptions therefrom should be approved by the Ministry of Health.

Rationale: Equipment-tied specifications are the simplest mechanism to predetermine the contract winner: all is needed for the apparatus to be in place, after which all future procurements of reagents are automatically awarded to the same supplier. At the same time, favouritism is facilitated by use of technical specifications that include parameters that are exclusive to a particular manufacturer. Use of such technical specifications closes the market and prevents greater competition, while the mechanism for exceptions allows for flexibility whenever equipment-tied specifications are truly inevitable.

MEASURE #12 Introduce an obligation to estimate total costs when medical apparatus is procured

- When procuring or receiving any apparatus (including as donation), PHIs should be obliged to estimate the total costs generated by use of the apparatus in question, including expected costs for adequate supplies and maintenance costs during the apparatus' life-time cycle. Inclusion of life-time cycle costs as part of the bid-evaluation process is a standard principle for obtaining the best value for the money spent and prevents selection of equipment based solely on its price. This assessment should be made public and should be an integral part of the decision to accept equipment donation/lease.

Rationale: Cheap equipment with costly maintenance or when servicing is not available ends up costing much more in the long run. Estimate of total costs makes this hidden cost visible as early as the decision to accept equipment donation/lease and allows rational comparison against other alternatives. At the same time, this problem also implies costs linked to apparatus maintenance.

MEASURE #13: Improve centralized public procurement

- Clear rules should be defined for public procurements that are organized by the central body (Public Institution in the Field of Healthcare for the Needs of Public Healthcare Facilities, University Clinics, Burau and Emergency Centre – Skopje) and the Ministry of Health. Clear and measurable objectives should be established for centralized tender procedures aimed at reducing prices and improving contract performance conditions.

Rationale: The current model of centralized public procurement is not clearly distinguished, i.e. there are no precise rules on the categories of goods that must be secured under centralized or decentralized public procurements. Absence of clear framework that regulates this issue creates double procurements, inefficiency, and space for circumventing the centralized mechanism. Centralization of public procurements is an instrument, not an end in itself. Without defined objectives (e.g., reducing prices by a defined minimum percentage compared to the previous public procurement), it cannot be assessed whether the centralized model yields any returns and whether it should be kept, expanded or reformed.

TRANSPARENCY AND ACCOUNTABILITY

MEASURE #14: Regularly publish healthcare programmes and reports on programme performance

- An obligation should be created for MoH to publish annual performance reports for all healthcare programmes, within a period of 60 days the latest after the end of the reporting year. These reports should include budget planned and budget executed, number of patients covered, quantity of medicines and supplies delivered, and evaluation of therapeutic outcomes, when applicable. .

Rationale: The research found that performance reports for the insulin programme are not published regularly. Annual public procurements worth tens of millions of euros are not accompanied with public financial account, which is a structural non-transparency that prevents civic and institutional supervision.

MEASURE #15: Introduce an obligation for publishing data on services delivered

- Each PHI should be obliged to publish data on services delivered (medical consultations, scans and tests, surgical and other interventions).

Rationale: In the period 2015 – 2024, the number of medical consultations performed by 55 clinical hospitals has reduced by 14%, while the number of inpatient days has dropped by 24% - at the same time when the value of healthcare public procurement has tripled. In the absence of any public data on services provided, this discrepancy remains invisible.

MEASURE #16: Clearly distinguish costs incurred by additional activity

- Information on additional activity should be separated, clearly distinguishing between medicines and medical supplies spent for this purpose, as well as the number of patents that received healthcare services under regular appointments and as part of additional activity.

Rationale: Grouping costs for performance of primary and additional activity conceals the actual situation in terms of public spending and complicates control over the use of goods and services provided under public procurement contracts.

MEASURE #17: Evaluate therapeutic outcomes of medicines for rare diseases

- MoH should establish a system for monitoring therapeutic response for all rare disease medicines procured under the relevant programme, in compliance with the obligation already stipulated under the Programme for Treatment of Rare Diseases, which is currently grossly neglected. This evaluation is a precondition for programme funding to continue the next year.

Rationale: The State Audit Office has found that MoH does not dispose with complete data whether therapies administered for rare diseases actually improve the patients' health status. Linking finances with an evaluation is a standard practice in EU member-states and the only way to rationalize costs.

CONTROL, AUDIT AND SUPERVISION

MEASURE #18: Urgently establish the National System of Material and Financial Management at Public Healthcare Institutions

- The urgent need to establish the National System of Material and Financial Management at Public Healthcare Institutions (which is a legal obligation since 2015) is aimed at ensuring complete, timely and reliable monitoring of receipt, consumption, stock levels and financial flows at public healthcare institutions.

Rationale: This system is a legal obligation for more than 10 years, but has not been established to date. In its absence, there is no clear insight into actual financial flows at PHIs.

MEASURE #19: Fully operationalize the system for public internal financial control (PIFC) at MoH and PHIsY

- PIFC is the first line of defence against abuses at the institutions. Non-operation of this instrument means that PHIs do not have their own mechanism to detect irregularities before they escalate to the level of public damage. Also, this implies compliance with the obligation for annual assessment of corruption risks in public procurement, including definition of specific measures and deadlines to address them.

Rationale: Risk assessment is a standard tool to prevent and combat corruption. Mandatory performance of such assessments would oblige PHIs to engage in systemic identification of different vulnerable points and take measures to address them, instead of taking action only after specific problem is detected.

MEASURE #20: Use risk indicators to guide supervision of public procurement

- As part of their competences, MoH, HIF, BPP and other competent bodies should establish and apply a mechanism aimed at identifying PHIs marked by higher corruption risks in public procurement, based on objective indicators such as: share of tender procedures with participation of only one bidder; concentration of procurement contracts with small number of suppliers; value and frequency of signing annexes to contracts awarded; and repetitive deviations identified in proportionality analyses. Defined risk indicators should be used to guide control, supervision and audit activities at PHIs marked by prominent risks.

Rationale: The Bureau of Public Procurement already disposes with methodology and data that clearly identify high-risk institutions. For the measures to be applied, the Bureau needs to adopt secondary legislation on use of so-called red flags for corruption. According to their relevant competences, the other institutions could design indicators to identify high-risk institutions. The need for this focus arises from limited supervision and control resources.

MEASURE #21: Use the red flags for "collusion and pre-arrangements"

- An obligation should be created for the Bureau of Public Procurement to automatically submit reports to the State Commission for Prevention of Corruption on all PHIs which in the last two or more consecutive years have been categorized in the so-called "red zone" based on the indicator for collusion and pre-arrangements, together with the relevant trend analysis.

Rationale: The research showed that 9 of the 10 biggest PHIs are qualified in the so-called "red zone" according to the criterion on collusion and pre-arrangements used by the Bureau of Public Procurement. However, this finding does not automatically trigger enhanced supervision. Introduction of formal risk-based classification turns the existing indicator into operational supervision mechanism.

PROFESSIONALISM AND CAPACITY

MEASURE #22: Strengthen expert staff working on public procurement

- Activities should be taken to strengthen capacity at public procurement units by means of employments, continuous training, and adequate valuation of employees on the account of complexity and scope of their work tasks and duties. Furthermore misdemeanour liability should be anticipated for responsible persons at PHIs when they have failed to ensure employment of expert staff members, including in cases where they have not submitted a request for employment approval to competent bodies when the institution does not have such employees. Misdemeanour liability should not be sought in cases where PHIs have timely requested such approval, but the same was not issued by competent bodies. ла согласност, но согласноста не била дадена од надлежните институции.

Rationale: The research found that 23 of 110 public healthcare institutions do not have a single staff member with passed exam on public procurement, which is contrary to the Law on Public Procurement. Unqualified staff is a direct factor behind errors in technical specifications, bid-evaluation and bid-selection processes, and sometimes, intentional abuses.

MEASURE #23: Assess institutional capacity prior to procurement for medical equipment and monitor utilization thereof

- Prior to any procurement of medical equipment, PHIs are obliged to develop an analysis of available human and spatial capacity needed for its utilization. Such procurements can be organized only when the institution has proved availability or future availability of adequate conditions for operation of the equipment in question. After public procurements are completed, PHIs should regularly monitor and publicly report on the utilization rate of the equipment procured. Furthermore, sanctions should be introduced for failure to use expensive equipment.

Rationale: Expensive medical equipment procured without previous analysis of human and spatial capacity remains unutilized which, in turn, amounts to public damages that the State Audit Office has

confirmed in the case of several PHIs. This measure closes the gap between the public procurement and the institution's actual ability to use the equipment procured: human capacity must be in place; space should be secured and arranged. Regular monitoring and public reporting on utilization of medical equipment create responsibility for public procurements and reveal cases where the equipment has not achieved its purpose. .

LEGAL PROTECTION

MEASURE #24: Strengthen legal protection in public procurement procedures

- An analysis should be conducted to identify reasons behind the low number of appeals lodged before the State Commission on Public Procurement Appeals and systemic obstacles for use of legal protection. Based on the analysis findings, specific measures should be designed to overcome such barriers, including through better information for economic operators about their rights in public procurements and appeal mechanisms available.

Rationale: Appeals are the basic instrument of legal protection in public procurement, i.e. mechanism for detection of irregularities. Companies participating in tender procedures directly witness discriminatory specifications, pre-intended public procurements and irregular tender procedures, but legal protection is efficient only when it is available and known. The low number of appeals in healthcare public procurement does not imply absence of problems, but most probably it denotes lack of trust or information that appeals could yield any result.

MEASURE #25: Align criteria in tender documents with the Law on Medicines and Medical Supplies

- When setting tender participation criteria and requirements in tender procedures for procurement of medicines, contracting authorities should define these conditions in line with provisions from the Law on Medicines and Medical Supplies whereby bids offering medicines which, at the moment when the tender procedure is organized, do not fulfil law-stipulated conditions for market placement or sales could not be assessed as acceptable, except in cases explicitly allowed by the law.

Rationale: The Law on Medicines and Medical Supplies clearly regulates conditions under which certain medicine could be placed on the market or used. In the practice, however, cases are noted where bids offering medicines that, at the moment when the tender procedure is organized, were selected as the most advantageous one, although they do not fulfil these conditions. When these decisions are not appealed, there is a risk of the medicine in question being legally sold in spite of its disputable status. On that account, the criteria defined in tender documents must be aligned with the legislative framework, in order to prevent illegal selection of bids, annulment of tender procedures, and legal insecurity.