ESPN Thematic Report on Inequalities in access to healthcare

former Yugoslav Republic of Macedonia

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Summary/Highlights

Unrestricted access to healthcare is the constitutionally guaranteed right of every citizen in the former Yugoslav Republic of Macedonia (fyr Macedonia). In addition, changes to the Health Insurance Law of 2009 have extended eligibility to compulsory health insurance coverage to all residents who have proof of citizenship, which has led to near-universal coverage of the population. However, such positive legislative solutions have not fully tackled the issues of administrative and financial barriers to healthcare among the most vulnerable groups.

This report provides evidence that the most problematic issue in relation to access to healthcare is the affordability of care. According to the World Health Organization, private household out-of-pocket expenditure represents 36.6% of total health expenditure in the country. Other sources (Health Consumer Powerhouse) also indicate that patients in fyr Macedonia are frequently expected to make unofficial payments for medical services.

Total health expenditure in the country amounted to 7.6% of GDP in 2016. Public healthcare amounted to 4.9% of GDP, and the government projects a negligible rise in healthcare financing to 5.0% by 2030. The composition of total health spending by type of care indicates that primary healthcare makes up only one third of overall health spending.

The majority of those covered by health insurance are employed persons – 49.1%, followed by pensioners (26.2%), the unemployed and those insured through the Ministry of Health (21.7%), farmers (1.8%) and others (1.2%). In terms of the structure of contributions by type of income, 83.7% came from actively employed people, 6% from farmers and 2.2% from the self-employed.

In terms of the availability of healthcare, FYROM has a well-dispersed network of primary healthcare at the municipal level. According to the Health Insurance Fund Annual Report, in 2017 the ratio of general practitioners to insured persons was 0.86 per 1,000. The Northeastern region of the country has the best ratio (0.97), while the lowest is in the Eastern region (0.73).

Despite 90.3% coverage by health insurance in 2016, EU Statistics on Income and Living Conditions (EU-SILC) data show that 20.5% of people in the country have great difficulty using the healthcare services. This figure is close to the official number of people at risk of poverty in 2016 (21.8%), suggesting that the majority of those who have difficulty in accessing healthcare may also be experiencing risk of poverty.

In addition, the EU-SILC indicator on self-reported unmet need in the country for 2016 stood at 2.9%. The main reason for unmet medical need was that it was 'too expensive to travel': this reason was mostly voiced by women (3.2%), the elderly aged 65+ (6.5%), the unemployed (4.1%) and retired people (3.8%), by those with less than primary, with primary or with lower-secondary education (5.1%) and by the bottom income quintile (5.2%).

The report shows that those categories facing major issues related to access to healthcare are undocumented or unregistered persons, as well as Roma people. Some of the reforms initiated relate to tackling those challenges, including: the Roma Health Mediators programme, the introduction of the 'rural doctor' institution/service and the introduction of pharmacy-stations in rural areas with a population of up to 3,500 residents. To sustain these reform initiatives, more viable financing is needed in the future.

1 Description of the functioning of the country's healthcare system for access

In terms of access, the main principles of the country's healthcare system include comprehensiveness, solidarity, equity and effective utilisation of funds (Article 2, Health Insurance Law). Financing of the system includes both contributions (from economically active persons) and state budget support, enabling necessary medical care for citizens. The system provides preventive, diagnostic and rehabilitation services. Voluntary supplementary insurance is available for non-standard medical services, i.e. services that fall outside the basic package of medical services determined by the compulsory system (MISSCEO, 2017). The Law on Voluntary Health Insurance provides regulations for supplementary health insurance or private voluntary insurance. The law does not allow individuals to opt out of compulsory health insurance. Voluntary health insurance plays a minor role in the insurance market.

According to the World Health Organization (WHO), total health expenditure amounted to 7.6% of GDP in 2016.[1] *Financing of public healthcare* has been fixed at 4.9% of GDP for the period 2016-2018. The government's Economic Reform Programme 2018-2020 (2018) projects a negligible rise in healthcare financing to 5.0% by 2030.

Public healthcare is funded exclusively by the Health Insurance Fund (HIF). There are different rates and bases of payment of the health insurance contribution. Actively employed persons pay 7.30% of their gross wage, while farmers pay 7.30% on 20% of the average gross wage. Retired persons pay 13% of their pension, while those unemployed and not covered by insurance from any other source pay 5.40% on 50% of the average paid national wage. Health insurance contributions are collected by the Public Revenue Office (PRO) and then allocated to the HIF. The HIF purchases services and devices from health providers on behalf of the insured, through a broadly defined basic benefits package.

In 2017, total health expenditure was 27.4 billion Macedonian denar (MKD). Of this, 87.4% went on health services. Analysis of total health spending by type of care indicates that the biggest share went on inpatient healthcare (34.9%), followed by specialist outpatient care (30.8%) and primary healthcare (30%). According to the WHO, in 2014 private household out-of-pocket expenditure represented 36.6% of total health expenditure.

The role of voluntary health insurance (supplementary) is underdeveloped.

1.1 Healthcare coverage

As of 2009, the Health Insurance Law designated all residents (with identification documents) eligible for compulsory insurance coverage. Article 5 of the Health Insurance Law (No. 142/2016) stipulates 15 different categories of insured persons (see Annex, Table 1). According to the Annual Report of the HIF (2017), at the end of 2017, there were 1,872,466 insured persons, representing 90.3% coverage of the population.

[1] World Health Organization, https://gateway.euro.who.int/en/country-profiles/the-former-yugoslav-republic-of-macedonia/#h2020_target[5]

Table 1 Number of people insured and covered by health insurance, 2017	
Employed	572,291
Farmers	21,028
Pensioners	304,657
Unemployed	6,649
Persons insured under the programme of the Ministry of Health (MoH)	246,611
Others	13,678
Total insured	**1,165,004**
Family members	707,462
Total covered	**1,872,466**

Source: Health Insurance Fund, 2017.

It should be borne in mind that aside from the 6,649 unemployed covered by health insurance, other unemployed persons are covered under the MoH programme.

Most of those who hold health insurance are employed persons (49.1%), followed by pensioners (26.2%), the unemployed and those insured under the MoH (21.7%), farmers (1.8%) and others (1.2%). Thus the ratio of those employed to those unemployed or on a pension is equal. In terms of structure of contributions by type of income, 83.7% was collected from actively employed people, 6% from farmers and 2.2% from the self-employed.

The public healthcare basket is broadly defined and includes services, devices and medicines in: a) primary healthcare, b) specialist outpatient care and c) inpatient healthcare. Dental and mental care services are also part of the public healthcare basket. Use of services not covered by the Law (i.e. not listed in Article 10) is funded directly by individuals. Also, if health services are purchased in institutions that have not signed an agreement with the HIF or that operate outside the procedures prescribed by the Law, those services will not be paid by the HIF.

In terms of *availability of healthcare*, the former Yugoslav Republic of Macedonia (FYROM) has a well-dispersed network of primary healthcare at the municipal level. According to the HIF Annual Report, in 2017 the ratio of general practitioners to insured persons was 0.86 per 1,000. The Northeastern region of the country has the best ratio (0.97 per 1,000), while the lowest is in the Eastern region (0.73).

The preventive healthcare network consists of 1 public healthcare institute, 10 centres for public health and 21 regional units, established as public healthcare institutions.

Primary healthcare protection is provided by 34 healthcare centres and 2 healthcare stations established as public health institutions, with the activities being carried out by 2,963 healthcare workers and 1,202 administrative/technical staff. Within the framework of these healthcare institutions, there are home-visit services, counselling centres for mothers and children, vaccination services and emergency medical aid services, organised in working teams. Within primary healthcare, there are also private health institutions with 3,183 doctor's offices, of which 1,405 are in the field of medicine, 1,290 are general dental offices and 133 are polyclinics. All these health institutions work within the network of healthcare facilities whose services are financed by the HIF of Macedonia.

Secondary healthcare protection consists of specialist consulting and hospital healthcare protection in 13 general hospitals, 3 clinical hospitals, 7 specialist hospitals, 7 health centres and 5 institutes established as public health institutions. In secondary healthcare, there are 8,715 health workers employed, of whom 6,468 (74%) are medical and 2,247 (26%) are non-medical staff. At the level of specialist consulting and hospital healthcare

protection, there are 264 specialist health offices that function as private health institutions in the field of medicine, 224 specialist health offices in the field of dentistry, 26 polyclinics, 190 diagnostic laboratories, 2 dialysis centres, 1 general hospital, 8 specialist hospitals, 1 clinical hospital.. Some of these health institutions have been included within the network of health institutions.

Tertiary healthcare protection consists of 28 university clinics and 1 university stomatology clinical centre, all of which operate as public health institutions; their work is conducted within the network of health institutions by a total of 3,875 employees, of whom 2,820 (72.7%) are medical and 1,055 (27.3%) are non-medical staff (Government of fyr Macedonia, Ministry of Labour and Social Policy, 2017).

1.2 Affordability of health expenditure

The Health Insurance Law provides for the possibility of co-payment exemptions. The annual maximum amount of co-payment for one insured person is set at 70% of the previous year's national average net wage. There are other – lower – limits of 40% and 20% for persons on a low income, children and persons above the age of 65. Additional co-payment exemptions include:

- insured persons for a medical check-up at the chosen general practitioner (GP), as well as emergency medical assistance on call;
- beneficiaries of permanent financial assistance, persons in public residential care and in foster care, according to the Law on Social Protection, except for prescription medicines issued under primary health protection and treatment abroad;
- persons in mental health residential care and persons with mental health issues who do not have parental care;
- children with special needs, according to the Law on Social Protection;
- participants in the programmes of the Ministry of Health (i.e. blood or tissue donors, children aged up to 1 year;
- war veterans and war disabled people and their families.

Also, insured persons have a right to a refund of certain defined medical costs. In 2017, the HIF paid out MKD 63.9 million (EUR 1.08 million) in refunds, which represents an increase of 21% over 2016.

However, according to the Health Consumer Powerhouse data for 2017, FYROM belongs in the group of countries where patients are frequently expected to make unofficial payments for medical services (Health Consumer Powerhouse, 2018: 84).

2 Analysis of the challenges in inequalities in access to healthcare in the country and the way they are tackled

Although the law provides for universal healthcare coverage, the evidence suggests that there are specific groups excluded in various ways and for various reasons from health insurance and healthcare.

According to Eurostat data on people experiencing difficulty in using the healthcare services, in 2016 31.1% of the population indicated that they had some difficulty, 25.6% said they had moderate difficulty and 20.5% of people in the country had great difficulty in using healthcare services. Of those experiencing great difficulty, 37.9% were households with three or more dependent children and 31.5% were single persons with dependent children. According to income group, 40.3% of those households with great

difficulty had income below 60% of the median equivalised income and 14.8% had income above 60% of the median equivalised income.[2]

In addition, according to the EU Statistics on Income and Living Conditions (EU-SILC) indicator on unmet need for medical examination or treatment, the proportion of people who self-reported unmet need in FYROM in 2016 stood at 2.9%, which is an improvement on 2010, when 11.4% of people self-reported unmet need. In comparative terms, unmet need in the country is slightly higher than the EU-28 average of 2.5%; it is similar to the situation in neighbouring Bulgaria (2.8%), but is lower than Greece (13.1%) and Serbia (4.5%). Of the three main reasons, 'too expensive to travel' was indicated by 2.0% of the population. The other two reasons were less significant: only 0.7% mentioned the waiting list and 0.2% the distance involved as reasons for the unmet need. The unmet need for medical care was more pronounced among women (3.2%), the elderly aged 65+ (6.5%), the unemployed (4.1%) and retired people (3.8%), as well as among those with less than primary, with primary or with lower-secondary education (5.1%) and those in the bottom income quintile (5.2%).[3]

A UNICEF survey on barriers to accessing health insurance among Roma in the country (2016) found that 9% of the representatives of surveyed households did not have any form of health insurance. Nearly half (45.6%) of all those Roma without health insurance cited lack of identification documents as the main reason. Poor health literacy and scarcity of information were other reasons cited. Approximately 26% of Roma women surveyed said they did not need a family doctor, while another 12% said they did not know how to choose a doctor. The location of the health centre and doctor was an additional contributory factor (UNICEF, 2016: 2-3).

Another recent study assessing implementation of the government project Health Insurance for All indicated that the following categories lacked access to healthcare: 'individuals without documents (identity cards), estimated to be around 500 people in the country, as well as individuals who do not have formal employment'. The latter category was not seen as problematic, as 'the system would immediately provide health insurance the first day they register with the Fund' (Parnadjieva-Zmjekova and Dimkovski, 2017: 14).

According to the latest World Health Organization Health in Transition report on FYROM (WHO, 2017: 129) the 'major portion of out-of-pocket payments are the result of direct payments for privately purchased health care services and informal payments'. Somewhat older data – from the World Bank Life in Transition Survey – indicated that over 40% of the population made informal payments to receive health services (World Bank, 2015). The household consumption survey of 2016 shows that on average 3.4% of total household income is spent on health (State Statistical Office, 2017).

Some of the previously existing challenges in relation to accessibility due to waiting times were resolved with the introduction of the real-time e-booking system 'My Appointment/Moj Termin'. Thanks to this, in 2014 the country moved up in the Euro Health Consumer Index from 27th to 16th place. Since July 2013, any GP can call up the booking situation of any specialist or heavy diagnostic equipment in the country in real time, with the patient still sitting in the consulting room, and can book anywhere in the country with a few mouse clicks. This has essentially eliminated waiting times, provided the patient is willing to travel a short distance (Health Consumer Powerhouse, 2018).

Also, the Roma Health Mediators (RHM) programme, which was introduced in 2012, has increased the number of Roma who have access to the health system and has increased the number of families using RHM services (European Commission, 2017). This is an example of good practice for access to healthcare among vulnerable groups in the country, and should be supported further.

[2] http://appsso.eurostat.ec.europa.eu/nui/show.do?dataset=ilc_ats12&lang=en

[3] http://ec.europa.eu/eurostat/tgm/table.do?tab=table&init=1&language=en&pcode=sdg_03_60&plugin=1

The government's Employment and Social Reform Programme (2017) acknowledges some of the challenges related to access to healthcare. Some of the initiatives planned and currently being undertaken in relation to access include: introduction of the 'rural doctor' institution/service; the opening of pharmacy-stations in rural areas with a population of up to 3,500 residents; home visits to people with disabilities or with chronic illness; and the introduction of additional incentives by the Health Insurance Fund for doctors who provide healthcare services in rural settlements (Government of FYROM, 2017: 65).

With regard to activities aimed at improving the healthcare situation and access to healthcare services for the Roma population of Macedonia, the planned initiatives include: 'increasing the usage and scope of the healthcare services defined within the preventive programmes, such as the programmes for mothers and children, systematic physical examination of children, vaccination, health for everyone, furthermore continuation of the implementation of the project for Roma health mediators, etc.' (Government of FYROM, 2017: 66). However, the document does not fully operationalise the initiatives or provide planned budget costs for them.

It may be concluded that in terms of access to the healthcare system in FYROM, the main the main weaknesses include:

- lack of integration of unregistered/undocumented persons within health insurance and care (mostly affecting Roma people);
- difficulty of using healthcare experienced by specific households and income groups, such as households with three or more dependent children and single persons with dependent children, as well as households with income below 60% of the median equivalised income; and
- a high share of out-of-pocket payments (mostly private and informal) that increase the overall health expenditure of households.

3 Discussion of the measurement of inequalities in access to healthcare in the country

Measurement of access to healthcare in the official statistics is only available through the EU-SILC data in relation to self-reported unmet need for medical care. A source of administrative data providing additional information on access is the Annual Report of the Health Insurance Fund, which details the health insurance coverage of different employment statuses and other insured groups. The same report also provides data on public health expenditure by structure. In addition, the Ministry of Finance provides evidence related to forecasts on health expenditure as a percentage of GDP, while the Ministry of Labour and Social Policy provides reports on programmes supporting access to health by Roma people. However, the administrative data are neither systematic nor synchronised, and thus do not provide a complete picture in the domains analysed.

In relation to access to healthcare, the main contribution is made by Eurostat data and Eurostat ad-hoc modules, which provide disaggregated data on different income groups, gender, education and household types. These contribute to evidence-based policy measures.

In addition, the country needs a systematic measurement of out-of-pocket payments that will provide information about the real picture of overall household health expenditure.

References

European Commission (2017) Roma Health Mediators in Macedonia: A successful model under threat? ESPN Flash Report 2017/37

Government of fyr Macedonia, Ministry of Labor and Social Policy (2017) Employment and Social Reform Programme 2020, Skopje: Government of fyr Macedonia

Health Insurance Fund (2017) Annual Report for 2017, Skopje: HIF.

Healthcare Law (Official Gazette No. 43/2012), as amended on several occasions Health Consumer Powerhouse (2018) Euro Health Consumer Index 2018, https://healthpowerhouse.com/publications/euro-health-consumer-index-2017

Law on Health Insurance (Official Gazette No. 142/2016)

Law on Obligatory Social Insurance Contributions (Official Gazette No. 142/2008)

Milevska Kostova, N., Chichevalieva, S., Ponce, N.A., van Ginneken, E. and Winkelmann, J. (2017) The former Yugoslav Republic of Macedonia: Health system review, Health Systems in Transition, 19(3): 1–160.

Ministry of Finance (2018) Economic and Reform programme 2018-2020, Skopje: Ministry of Finance.

Mutual Information System on Social Protection of the Council of Europe – MISSCEO (2017) Comparative tables of social protection systems in 12 member states of the Council of Europe, https://rm.coe.int/table-2-missceo-summary-2017/168077f665

Parnadjieva-Zmjekova, M. and Dimkovski, V. (2017) Policy Study: *Universal Health Insurance in the Republic of Macedonia and Effects from the Implementation of the Project "Health Insurance for All,* Finance Think: Skopje.

State Statistical Office (2017) Household Consumption in the Republic of Macedonia, 2016, Skopje: SSO.

UNICEF (2016) Assessment of Barriers to Health Insurance Access for Roma, Skopje: UNICEF.

World Bank (2015) FYR Macedonia Public Expenditure Review, Fiscal Policy for Growth, Washington DC: World Bank

World Health Organization (WHO) (2017) The former Yugoslav Republic of Macedonia: Health system review, http://www.euro.who.int/__data/assets/pdf_file/0006/338955/Macedonia-HiT-web.pdf?ua=1

Annex

Table 1: Categories of insured persons by eligibility
1. Employed persons and their dependants
2. Persons holding citizenship of the former Yugoslav Republic of Macedonia employed on the territory of the country in international and foreign institutions or diplomatic missions
3. Self-employed persons
4. Individual farmers
5. Religious officials
6. Temporarily unemployed persons receiving unemployment benefits
7. Persons holding citizenship of the former Yugoslav Republic of Macedonia who work abroad that are not insured in the country of employment
8. Pensioners and 9. Beneficiaries of financial benefits under the pension and disability regulation
10. Persons receiving permanent social assistance; refugees; persons under subsidiary protection; persons accommodated in shelter homes and social protection facilities (nursing homes); persons who had status of parentless children until age of 18 years; persons who are victims of family violence; etc.
11. Persons holding foreign citizenship employed on the territory of the country in foreign or international institutions and diplomatic missions; and 12. Foreign students studying in the country
13. Persons in detention or prison and minors in correction facilities
14. Persons that participated in the Second World War and war veterans; family members of the war veterans; civilian victims of the Second World War; exiled persons, and other similar categories defined by law
15. Persons holding citizenship who are not insured under any of the categories 1 to 14 above

Source: Health Insurance Law, Official Gazette No. 142/2016.