Annual National Report 2009

Pensions, Health and Long-term Care

Former Yugoslav Republic of Macedonia

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1 Executive Summary

In the past years, the pension system in the Former Yugoslav Republic of Macedonia underwent increased fiscal pressure. Ageing of the population, a continuously increasing unemployment rate, as well as the evasion of contributions are the factors that aggravate the increased number of pensioners which, consequently, decreased the contributors/pensioners ratio, and produced the deficit of the state pension fund. Therefore, the pension system was submitted to thorough reformation in order to provide for the system's financial sustainability in the long run, adequate pensions, equal social security for the current as well as for the future generations of pensioners, and to achieve a higher level of information and transparency of the system.

The reformed pension system has the following structure: A mandatory rationalised PAYG system (first pillar); a mandatory funded system (second pillar); and a voluntary funded system (third pillar). The second pillar was implemented in 2006 and the implementation of the voluntary funded pension insurance (third pillar) is planned for 2009.

The introduction of the fully funded component of the pension system led to a reduction of the scope of the state-run (PAYG) pension system, where the obligations of the state, in the long-term, will decrease and result in lower public expenditures on pension benefit payouts.

This report highlights system characteristics, recent reforms and political discourses as well as current challenges using the available official statistical data, data from annotated scientific papers and policy documents.

The health system in Macedonia is set up as an insurance-based system, providing almost universal coverage and a comprehensive health care package for the population. Average spending per capita on health care is around USD 200, or 7.8% of GDP. Several mechanisms are in place to improve access to care. Special programmes for preventive and curative care funded by the central budget have been set up to provide free care to both insured and even uninsured persons.

An initial assessment of health outcomes and service utilisation does not suggest significant barriers in access to health care, including preventive care services. Significant progress has been made in improving mother & child health indicators, primarily reducing neonatal and infant mortality, which has put the country on track for achieving the health-related Millennium Development Goals by 2015. Health indicators are relatively good and comparable with indicators in the region. However, there is still work to be done, particularly as some of the indicators show certain inequities. Inequalities in health outcomes in terms of location, wealth status and ethnicity highlight that despite a universal access policy and overall positive performance of the health system, utilisation of health care is unequal and is failing to reach specific population groups: low-income groups, children who do not attend school, street urchins, homeless individuals, the unemployed, socially vulnerable individuals, Roma, the elderly, and farmers. Despite the generally positive picture and the major reforms that have already been undertaken, the health system is stil in transition, improving health outcomes, financial sustainability and efficiency.

The Government has reaffirmed the commitment to ensure universal access to high quality and affordable long-term care. Challenges concerning accessible and sustainable long-term care are de-institutionalisation of Macedonia's health care system, which will enable dispersion of palliative and mental health care on community level; enhance home care throughout the country. Much can be achieved enhancing the role of the public health services: strengthening of health promotion, intersectoral cooperation and care coordination between health and social care, public and private provision, involvement of local authorities in public health.

2 Current Status, Reforms as well as the Political and Scientific Discourse during the Previous Year

2.1 Pensions

2.1.1 Overview of the system's characteristics and reforms

Macedonia's pension system is regulated by the following legislation: Law on Pension and Disability Insurance; Law on Mandatory Fully Funded Pension Insurance; Law on Voluntary Fully Funded Pension Insurance; and Law on Contributions for Mandatory Social Insurance.

The Macedonian pension system, as part of the social sector, has been existing for more than 50 years; and throughout the entire period, the system has been improving and developing in line with the social and economic environment of the country. In the past years, under the pressure of demographic and economic factors, the pension system has undergone changes, especially when the Former Yugoslav Republic of Macedonia entered the transition period as a country heading towards market economy. All these changes have caused imbalances of the pension system, between expenditures and revenues, problems in the regular payouts of pension benefits, which implied the urgent need to reform the pension system. In order to reach financial sustainability of the system, both in the long run and in the short run, in the period from 1994 to 2000, many important parametric reforms were implemented. Interventions in the system included an increase in the retirement age, the calculation of pensions based on wages from the entire career, the indexation of pensions, decreasing of the replacement rate etc. All these parametric reforms meant rationalisation of the PAYG system and at the same time preparation for supplementing the PAYG system with the funded component in order to provide for a long-term sustainability of the pension system. In 2000, the legal framework was adopted with which the new structure of the pension system in Macedonia was introduced. So, the reformed pension system represents a multipillar pension model that covers pension insurance based on the generational solidarity PAYG (first pillar), and fully funded pension insurance-DC (second and third pillar). In 2002, the Law on Mandatory Fully Funded Pension Insurance (second pillar) was adopted followed by a period of preparations of the institutional infrastructure, provision of minimum investment conditions / development of the capital market (issuance of public debt) and putting in place of a custodian of pension funds assets. After meeting these preconditions, in May 2005, the first licenses were granted to two pensions companies for managing mandatory pension funds. Consequently, from January 2006, the second pillar become operational with the first payments of contributions on the individual accounts and their investment.

In the Former Yugoslav Republic of Macedonia pension insurance has a rather high coverage of the labour force, and the insured parties under the mandatory pension and disability insurance are: 1) employees of enterprises and other legal entities engaged in business activities; of institutions and legal entities, or employed in public services, in state organs, as well as in units of the local self-government and in domestic and foreign legal entities; 2) private farmers – persons paying tax on income from agricultural activities who are engaged solely in an agricultural profession; 3) self-employed persons; 4) unemployed individuals receiving allowances in money, etc.

As far as the participation of insured persons in the mandatory fully funded pension insurance is concerned all contributors employed before 1 January 2003 were given the option to decide whether to enter the second pillar, and all newly employed contributors who entered the labour market after 1 January 2003 were mandatorily required to join the second pillar. The reformed pension system is mainly designed for young employees and employees who had

worked only few years before entering the two-pillar pension system. For older employees and employees with many years of service, there were strong reasons to remain in the mono-pillar system, given that in the new system they would have less time to accumulate assets in their accounts before retirement. (see Table 1 in Annex I; Report on the Developments of Fully Funded Pension Insurance in 2008, MAPAS 2009)

Rights which can be acquired from the pension scheme are the rights to an old-age pension, disability pension, survivors' pension, minimum pension etc. The basic principles stipulated in the laws which regulate the field of pensions are: pension and disability insurance is mandatory for all employees; the right to receive pension benefits depends on the number of career years and the amount of assets paid as contributions; the pension system shall comprise a fully funded component and be socially fair and involve solidarity between generations.

Eligibility criteria for retirement: 64 years of age for men, 62 years of age for women; a minimum of 15 years of career. These retirement conditions are equally valid for the insured persons in the mandatory pension system (first and second pillar).

Calculation of the pension benefit (pension formula) from the first pillar: the old-age pension benefit is determined on the basis of the average of all adjusted monthly wages of the contributor during his/her total years of service (pension base), but no earlier than 1 January 1970; the percentage is determined according to the length of pensionable service. As far as disability and survivors' pensions are concerned contributors who will join the mandatory two-pillar system shall receive the full amount of disability and survivors' pension benefit from the first pillar only if the assets accumulated on their individual accounts in the second pillar will be transferred to the first pillar. In case the accumulated assets are higher than the amount needed for the payment of the disability or survivors' pension benefit, a second-pillar member can choose to purchase a pension annuity from the second pillar or request a programmed withdrawal. In the second pillar, which functions as a defined contribution (DC), the pension benefits depend on the accumulated assets on the individual accounts, on the investment performance and on the operational costs of the system.

Pension benefits from the second pillar shall be paid out in the form chosen by the member: as a life-time pension annuity from the entire amount of assets accumulated on the member's individual account, or in the form of programmed withdrawals provided by the Pension Company managing the pension fund in which the contributor was a member on the retirement date. The provision of pension annuities and programmed withdrawals shall be regulated by a separate Law that the Government is supposed to prepare in 2009.

The indexation formula for the pension benefits from the first pillar is composed of 50% from the development of the living costs index, and 50% of the development of the average net wage paid in the Former Yugoslav Republic of Macedonia (Swiss formula).

The main source of financing of the system is made up by contributions: the total contribution rate until January 2009 was 21.2% of the gross wage, of which 65% (13.78% of the gross wage) go to the first pillar and 35% (7.42% of the gross wage) to the second pillar. Financing of the pension system also involves Macedonia's state budget; in 2008, this share was 27.1% of the total revenues, so these state transfers were aimed at covering the transitional costs for the second pillar, for benefits realised under favourable criteria, for minimum farmers and for military personnel pensions. (Macedonian Pension and Disability Insurance Fund: Report on the pension system in RM for 2008, April 2009)

The Former Yugoslav Republic of Macedonia does not have the legal preconditions for premature retirement except for disability retirement, which can be acquired prior to the legally prescribed retirement age for old-age pension. In the overall retirement structure in 2008 the share of disability pension benefits was 17.7%, and in the past several years, the

number of disability benefits has been decreasing due to the strict conditions for acquiring the right to a disability pension and the additional medical exams. (see Table 1 in Annex I; Macedonian Pension and Disability Insurance Fund: Report on the pension system in RM for 2008, April 2009).

The reformed pension system offers a greater level of transparency, which is an advantage in respect of the mono-pillar system which existed until 2006. This characteristic is very important and useful to the members of the private pension funds when making choices during their period of pension insurance (choosing a pension fund, transfer, fees, return, etc). The Macedonian pension system, by employing various mechanisms of information, should be regarded as generally transparent. Twice per year the members of the second pillar receive a notification from the pension companies including data on contributions, pension fund investments, fees, and returns on investments. Additionally, in terms of transparency, MAPAS publishes on its website information about the value of the accounting unit of pension funds on a daily basis, an Annual Report on the Developments in the Mandatory Fully Funded Pension Insurance, an Annual Statistical Report, as well as Quarterly Statistical Reports and Monthly Bulletins. The State Pension Fund also prepares and publishes Annual reports including data on the number of pensioners (old age, disability, and survivors), the indexation of pensions, the use of rights to old age, disability and survivors' pension, the revenues and expenditures of the pension system etc.

Macedonia's pension system is regulated by the following legislation: Law on Pension and Disability Insurance; Law on Mandatory Fully Funded Pension Insurance; Law on Voluntary Fully Funded Pension Insurance and Law on Contributions for Mandatory Social Insurance.

Reforms

In 2007, the Law on Voluntary Fully Funded Pension Insurance was prepared and it was adopted in 2008 and published in the Official Gazette of RM No.7 of 15 January 2008. The voluntary fully funded component of the pension system (the third pillar) is part of the multi-pillar structure of the pension system, where all citizens aged between 18 and 70 can become members on a voluntary basis. Each third-pillar member can have two accounts, where his/her assets shall be accumulated, one is an individual account and the other one an occupational account. The assets accumulated on the third-pillar accounts can be withdrawn, at the earliest at the age of 52 years for women and 54 years for men in the form of lump sum withdrawals, programmed withdrawals or pension annuities. The third pillar is characterised with EET tax treatment (tax exemption for contributions and investments and taxation of withdrawals). The objectives of the pillar III reform are: 1) to provide higher income, sustainable pensions and better living standard after retirement to individuals covered by the first and second pillars and to those who are willing and able to set aside additional assets for the sake of higher material security; 2) to provide higher retirement benefits to persons not covered by the mandatory fully funded pension insurance, including unemployed spouses, long-term unemployed persons, and those employed on projects, in foreign missions, and 3) to provide the preconditions for the establishment of an occupational plan in the process of harmonisation of the Macedonian social security system with that of the European Union.

The Government's intention, according to its action plan, envisaged the implementation of the voluntary pension pillar for mid-2008. Therefore, in the spring of 2008 the Government started a public educational campaign on the voluntary funded pension insurance and organised a road show in order to promote the voluntary pension system to foreign investors in Bulgaria and Slovenia. The Minister of Labour and Social Policy and other local experts made presentations in front of a number of Bulgarian and Slovenian banks, insurance and pension companies in order to attract potential founders of pension funds in Macedonia. As

part of the presentations the participants were informed on the characteristics, conditions, and tax exemptions, projections for expected numbers of members and assets and the licensing process in the third pillar. All activities after this period, as a consequence of the early parliamentary elections in June 2008, were put to rest and the implementation of the voluntary funded pension insurance was postponed.

The members of the second pillar have the right, from the very moment of entering the funded pension insurance scheme, to choose in which private pension fund they would like their contributions to be paid in. The right to transfer from one pension fund to another was not allowed in the first two years of the scheme's operation in order for the second pillar membership to become stabilised and for the members to acquire the needed education in order to be able to make the right decision. As from January 2008 the transfer of members within the second pillar was allowed, where one member could change the private pension fund if not satisfied with the management or the rates of return. So, for the members who stayed more than 24 months in one private pension fund, the transfer to another pension fund is free of charge, however for the members who stayed less than 24 months in one private pension fund, there is an administrative fee to be paid to the pension fund they are leaving. According to official statistics, this right to transfer to another private pension fund has not been exploited significantly and it has been noted that the number of members who have changed pension funds within the second pillar is small. The reason for this situation is the very similar performance (fees and return) of the pension funds within the second pillar, and the lack of knowledge on the part of the pension funds' members about the right to transfer.

In June 2008, the Government decided to make an additional reform geared towards the second pillar and therefore prepared and adopted an amendment to the Law on Mandatory Fully Funded Pension Insurance. The most important provision in this amendment is the liberalisation of the pension market allowing the entrance of new pension companies/founders. This allows for a significant extension of market competition, especially because the previous versions of the law allowed for the existence of only two pension companies (despite the amendment still only two companies exist on the Macedonian market). The other significant change is related to the introduction of the category of a maximum fee from contributions to be charged by the pension companies. The past solution had not prescribed any limits in this regard, and thus pension companies used this legal opportunity to keep the fees on a high level. So, this amendment was adopted for the purpose of protecting the interests of the pension funds' members and for providing adequate and sustainable pension benefits. (Amendment to the Law on Mandatory Fully Funded Pension Insurance; published in the Official Gazette No. 88 of 16 July 2008).

Currently, the "Central Bank of the Former Yugoslav Republic of Macedonia" acts as custodian of the private pension funds assets, which is stipulated as a transitional solution with the intention that in the future commercial banks shall take over this role. In this context the Agency for Supervision of Fully Funded Pension Insurance (MAPAS) and the Ministry of Labour and Social Policy (MLSP) organised a Round Table with a leading Croatian expert (Dubravko Shtimac) and representatives from Macedonian banks. At the Round Table as well as in his report, produced after the visit to Macedonia, the expert recommends that all obstacles should be removed for the smooth transition from the custodian role of the Central Bank to commercial banks, since this is a precondition for the implementation of the voluntary pension system. Therefore, at the end of 2008, based on the expert's proposals and the adequate preparation of the banking sector, the Government submitted a draft amendment of the Law on Mandatory Fully Funded Pension Insurance ? to the Parliament for the transition of the custodian role to the commercial banks. In addition, the amendments to the law include an article based on the proposal from the capital market expert, Klaus Schmidt-Hebbel, hired by the World Bank, to increase the percentage of allowed foreign investments

of the mandatory pension funds from 20% to 30%. The adoption of the amendment should contribute to a higher diversification of pension funds assets between domestic and foreign investments. These amendments have been adopted and published in Official Gazette No. 48 of 13 April, 2009.

In 2008, the Government undertook a significant reform by adopting the Law on Contributions for Mandatory Social Insurance, published in the Official Gazette No.142/2008. With this reform, the collection of all social contributions was integrated in one common law. The relevant solution of this law is that starting from January 2009 for the next three years, the social contributions for pensions, health and unemployment will be reduced. Moreover, the role of a sole collector of contributions was awarded to the Public Revenue Office therefore replacing the social funds as contribution collectors. One of the most important provisions of this law is that it introduces the calculation of gross wage as the sole possibility for payment of employees, and the abolishment of the previous concept of net wage (as from January 2009). As a result of this law, the Government expects an increase in the employment rate due to an enhanced flow of contributions and by attracting more foreign investments. Still, it should be pointed out that the reduction of the overall pension contribution would affect and will reduce the contribution portion of the second pillar (Law on Contributions for Mandatory Social Insurance; published in the Official Gazette No.142/2008, Foundation "Friedrich Ebert" -Skopje: Review for Social Policy No.2).

Table 1: Reduction of the pension contribution by years

Until year	Total pension contribution	Portion of the contribution to the first pillar	Portion of the contribution to the second pillar
2008	21.2%	13.78%	**7.42%**
2009	19%	12.35%	**6.65%**
2010	16.5%	10.73%	**5.78%**
2011	15%	9.75%	**5.25%**

The indexation of the pensions in 2008 was higher than the regular percentage stipulated in the law (9.78%) in the first place – based on the Government's decision to add on the indexation for pension and disability insurance (10.8%) in order to increase the pensions and improve the living standard of the pensioners. The total indexation in the first half of 2008 was 13.08% and in the second half of the year 7.58%. The indexation uses a digressive method and is categorised into four groups, by different amounts of pensions. The first group of lowest pensions was indexed with 17% in the first half of the year and with 8% in the second half; and the group of highest pensions (the forth group) was indexed with 7% in the first half of the year and 5% in the second. Using different percentages for the indexation of different categories of pension benefit amounts (higher indexation percentage for lower pensions and lower indexation percentage for higher pension) will, in the long run, lead to an approximation of the pension benefits from the different categories, regardless of the contributions paid during the working career. The total indexation of pensions in 2008 was 21.66%, which is higher than the increase of wages (amounting to 10% in the same period). Such proceeding will have an impact on the long-term sustainability of the pension system, since it will create obligations to pay higher pensions than those prescribed by the law. On the other hand, the revenues that finance the pension benefits' payout will see a slower growth rate due to the lower wage increase (Government decisions: Official Gazette No.16/08 and 99/08).

In July 2008, the director of the Agency for Supervision of Fully Funded Pension Insurance (MAPAS) was dismissed after the early parliamentary elections, which was a similar situation to the one in 2006. MAPAS is a public institution with a regulatory and supervisory role, established to supervise the operations of the pension companies and the pension funds, to protect the interests of pension fund members, and to stimulate the development of funded pension insurance schemes. For its operations MAPAS reports to the Government which, in turn, is in charge of appointing the members of the management board. In practice, the degree of independence of MAPAS is not satisfactory, given that after the parliamentary elections of 2006 and 2008 the new Government dismissed the directors and the members of the management board. On the other hand, MAPAS has been a member of the International Organisation of Pension Supervisors since 2007, and it has agreed to follow the principles of private pension supervision the second of which relates to the independence of supervisors: "2.1 The pension supervisory authority should have operational independence from both political authorities and commercial interference in the exercise of its functions and powers. 2.2 To ensure independence, stability and autonomy are particularly required at the senior director level of the pension supervisory authority. The nomination, appointment and removal of the head of the pension supervisory authority should be done via explicit procedures and transparent mechanisms".(see Table 4 in Annex I; Prof. Borce Davitkovski: Comparative Report with recommendations on the necessary independence of the Agency for Supervision of Fully Funded Pension Insurance – World Bank; International Organisation of Pension Supervision (IOPS): Principles for supervision of private pension funds, August 2006; and http://www.oecd.org/dataoecd/14/46/33619987.pdf).

Due to previous parametric reforms of the pension system, positive trends can be noticed in 2008: The ratio between contributors and pensioners was stabilised at 1.5 contributors to one pensioner, the dependency ratio between pensions and wages is 55.5%, and the pension expenditure as percent of GDP was reduced to 9.6% in 2008.

The introduction of the fully funded component as a supplement to the existing PAYG system helped towards the rationalisation of the expenditures in the first pillar, therefore decreasing, in the long run, the State's obligations for pension benefit payout. This can be seen in the share of the pensions in the GDP (e.g. in the 1993 the portion of GDP was 15.9%, while in 2008 after the reforms it dropped to 9.6%). The reform leads to a long-term financial sustainability of the pension system and ensures adequate pension benefits not only for the current but also for future generations of pensioners (see Tables 2, 3, and 4 of Annex I; Macedonian Pension and Disability Insurance Fund: Report on the pension system in RM for 2008, April 2009).

2.1.2 Overview of debates and the political discourse

In 2008, the pension sector was characterised by many activities that resulted in open expert debates, public and media discourses. Additionally, 2008 was an election year and many political parties used pension issues for political purposes and criticism. In this context, three main issues should be mentioned: 1) the reduction of the social contributions and the introduction of the new system of gross wage calculation; 2) the fees charged by Pension Companies; 3) the economic crisis and its impact the pension system.

1) The reduction of social contributions and the introduction of the new system of gross wage calculation with the adoption of the Law on Contributions for Mandatory Social Insurance provoked discussions by different groups including opposition political parties. The Government justified the reform as very positive for improving the business climate since it

would lead to reduced labour costs. As a result of the reform, the Government expects to increase the employment rate due to the lower contribution rate and enhance attractiveness for foreign investments. Whilst the Trade Union appreciated the introduction of a model of gross wage calculation and the reduction of the mandatory social contributions, it was pointed out that more discussion among the social partners was needed. The Trade Union blamed the Government that the Union's participation in this project, as a one of the social partners, was marginalised. The new system of gross wage calculation including the reduction of the social contributions and potential implications on the living standard were thoroughly examined by university professor Vanco Uzunov. He concluded that the benefits from the gross wage reform with the reduction of the social contributions did indeed result in savings for the labour force, but how this will impact on their living standard depended on the employers and not on the employees. Professor Uzunov prognoses that the savings from the reduced contributions could be used by some employers for increasing the wages of their employees, some could hire new employees or use the savings for company growth and development, while others might simply save them as profit (Foundation Friedrich Ebert – Skopje: Review for Social Policy No.2).

The ex-minister for Economy and Labour Stevco Jakimovski (he is a member of a political party of the opposition) perceives the reforms as a "trick" of the Government. He expressed his concerns that such a reform, as a consequence of the reduced social contributions, will create a deficit in the social funds and may, in particular, lead to a potential decrease of pensions and their adequacy in the second pension pillar. According to some economists and pension fund managers, the decrease of the pension contribution will have an impact on the income for accumulation in the private pension funds in the second pillar and on the pension benefits in future. In this context, at the end of 2008, the oppositional New Social Democracy Party submitted to the Parliament an amendment to the Law on Contributions for Mandatory Social Insurance. One of the most important proposals in the amendment was that the portion from the pension contribution for the second pillar (which will be 5% as from January 2011) should be changed to the previous amount (7.42%), in order to protect the future pensioners and to provide adequate pensions from the second pillar. In respect of this amendment a debate was embarked on in Parliament in which, eventually, the Government rejected the proposal stating that they do not expect a reduction of pensions since with the introduction of the gross wage calculation the basis for calculation of all contributions is increased, which should make up for the loss from reduced contributions.

2) One of the more important issues that were debated publicly in 2008 were the fees from contributions charged by Pension Companies for managing Pension Funds. It is common knowledge that the start-up costs for pension companies are very high, therefore it was expected that the companies would charge higher fees from contributions (8.9%) since they would be generating losses in the first years of operation. However, the first two years were more successful than expected, which created grounds for reduction of the fee from contributions. So, the Agency for Supervision of Fully Funded Pension Insurance and the Ministry of Labour and Social Policy entered discussions with the pension companies for their voluntary reduction of the fee to the real costs of operation. The result from these discussions was an insignificant reduction of the fee and in the beginning of 2008, the Pension Companies decreased their fee to the level of 6.8% from contributions. So, this low and insufficient actual decrease was an additional motive for the Government to decide to maximise the contribution by amending the Law on Mandatory Fully Funded Pension Insurance. The adoption of the Amendment on the Law on Mandatory Fully Funded Pension Insurance includes the category of a maximum fee from contributions for the pension companies, which the Government shall define every year, based on the calculations of real revenues and expenditures of pension companies, number of pension fund members, paid

contributions etc. Immediately after the adoption of this amendment, Alenka Znidarsic Kranjc, the president of the supervisory board of one of the pension companies responded publicly to oppose the Government's decision on maximum fees by commenting that the best way to determine the real/optimal fee from contributions was the market's movement and competition. She blames the Government for state interventionism and in her opinion these types of action are unfavourable in terms of attracting foreign investments in the future since this decision changes the conditions under which the pension companies shall operate. The Government is positive that this amendment to the Law is in the best interest of the members of the private pension funds and therefore cannot be seen as state interventionism since pension companies are still competitive and they are still free to determine the amount of the fee they will charge but within a given ceiling. Even with the introduction of this ceiling, the pension companies still have the possibility to compete on the market and can have their own fee policy.

3) In February 2009, Macedonian media were awash in public debates between the Minister for Finance, the Minister for Labour and Social Policy and public opinion makers on the subject of the economic crisis and its impact on the pension system, especially the fully funded pension component. The Minister for Finance opened this question by giving personal comments (as opposed to official standings of the Government), provoked by the discussions in Croatia on the same issue. Namely, in Croatia for 300 persons (women) who had retired in 2008 the value of their pensions had decreased as a result from the impact of the economic crisis on the value of the account units on their individual accounts. So, in his opinion the Former Yugoslav Republic of Macedonia should undertake a solid analysis of the people who entered the mandatory fully funded pension system (second pillar) and allow them, on a voluntary basis, to return to the first pillar, as a better solution for more adequate pensions than the one from the second pillar. On the other hand, the Minister for Labour and Social Policy, the Director of MAPAS, and some experts were firmly assuring that there was no reason to change the current structure of the multi-pillar pension system based on short-term occurrences in the economy and the pension sector. According to them the reformed pension system was still young and as such designed to function in a very long run. Its advantages will be seen after certain years of accumulation of assets in the private pension funds and their reinvestment. The Minister for Labour and Social Policy made quite clear the key argument in this debate, saying that fortunately the funded component of the Macedonian pension system is not mature enough to have the first pensioners who in these times of crisis would feel its impact when withdrawing the assets from the individual accounts in the private pension funds. Pension systems should always be considered on a long-term basis. Thus, the funded pillar may suffer periodical losses which can be compensated when financial and capital markets regain their strength and return to positive trends. The managers of pension insurance companies also joined this debate stating that they favour the reformed pension system and its structure. They were ready to follow the movements of the capital and financial markets and accordingly adjust the pension investment portfolio to the financial and economic crisis.

Other pension-related debates in the course of 2008 included e.g. additional indexation of pension benefits exceeding the one stipulated in the law. However, these discussions were not led with the same intensity or mass criticism as the ones on the three subjects mentioned above.

2.1.3 Impact assessment

Financial stability

The social and economic changes in the Former Yugoslav Republic of Macedonia in the beginning of the 1990s were unfavourable for the pension system and gave rise to financial difficulties in operations of the state-run pension fund, particularly as regards the regular payment of pensions. In order to assess the long-term status of the pension system, actuarial projections were made to show the future revenues and expenditures of the system, which depend on numerous demographic and economic factors and can be seen in the following diagrams:

Diagram 1

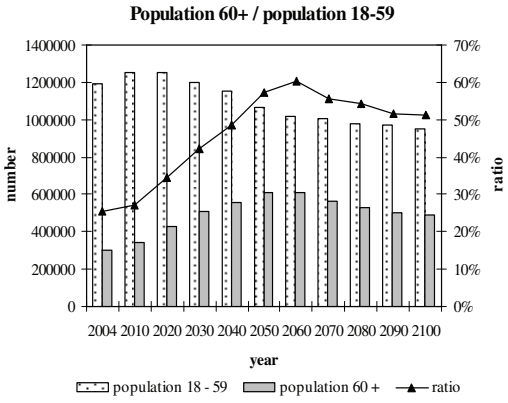
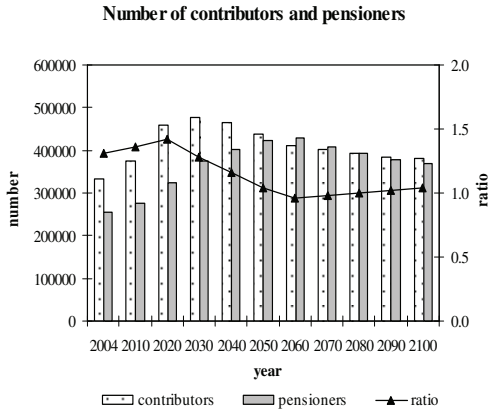


Diagram 2



The dependency ratio of the groups of population shown in Diagram 1 will increase from currently 25.5% to 60.6% in 2060 and decrease to 51.2% in 2100. That means that in the future around one third of the population over 18 years will belong to old population.

It is expected that the number of pensioners will increase continuously in the coming 60 years and then start to decrease, as shown in Diagram 2. In the long run, the ratio between contributors and pensioners will decrease from the current 1.3 contributors per one pensioner to 1.0 contributor per one pensioner. This trend means that a decreasing number of contributors will pay for an increasing number of retirees (Macedonian Pension and Disability Insurance Fund, 2005).

In the past ten years, the country has been undergoing a process of preparation and implementation of pension reforms. To the end of overcoming the expected problems of solvency of the PAYG pension system, a “true” reform was implemented and a multi-pillar pension system established. First, parametric reforms were implemented on the PAYG system to reduce its liabilities and to facilitate the transition towards the implementation of the fully funded component.

The pension system model implemented in Macedonia (a combination of PAYG and funded components) now, after a few years of operation, which were in favour of improving the overall system’s sustainability, shows the first short-term results. The actuarial projections show that the system will be financially stable in the long run, which is very important for the safety of the current and the future generations of pensioners. This can be seen in the decreased share of pension expenditures in public expenditures, in the GDP (more details on the annual movements are given in Table 2 of Annex I), as well as in the decrease of the dependency ratio (for more details see Tables 1 and 2 in Annex I, all data taken from the Annual Report for PDIF Activities in 2008). The expected long-term advantages for the individuals include greater safety, risk diversification, and enhanced transparency. Broader

benefits will include solvency of the pension system, increased national savings, increased investment and future economic growth, and a more efficient labour market (Apostolska, 2009; Apostolska, 2008).

An activity that much attention was paid to in 2008, not in the sense of financial stability of the pension system, but on the development of the funded pension insurance, was the improvement of the existing custodian role. Experts' assessments and recommendations in this respect can be qualified as unanimous, saying that in Macedonia the conditions are fit for abandoning the previous, temporary solution where the Central Bank was the custodian of the pension funds. By doing so, the custodian role shall be established with the commercial banks as a future systemic solution, commonly seen in banks throughout the world. At the end of 2008, based on the expert's proposals the Government submitted a draft amendment of the Law on Mandatory Fully Funded Pension System to the Parliament for the transmission of the custodian role to the commercial banks. (Dubravko 2008; the amendment to the law was adopted and published in the Official Gazette No. 48, 13 April 2008).

In 2008, the Government decided to introduce a system for the calculation of gross wages and, at the same time, to decrease the mandatory social contributions that resulted from the Law on Mandatory Social Contributions. According to the Government this reform will help create a better business climate with smaller costs for the labour force and an increased rate of employment, which may also attract foreign investors. In respect of this project, some experts and trade union representatives find that this reform, i.e. the introduction of the gross wage concept, is indeed useful, but they have doubts that the decreased social contributions will have a positive impact on the living standard of the employees and the future pensioners on the one hand, and the overall stability of the pension system on the other. For the purposes of this reform the Government did not publish in depth analyses or research which would demonstrate the long-term effects of the reform. (Friedrich-Ebert-Stiftung 2008; Law on Mandatory Social Contribution, Official Gazette No. 142/2008).

According to the Law on Pension and Disability Insurance, the pensions in the Former Yugoslav Republic of Macedonia are indexed by the Swiss formula, as explained in the part on Overview of the system's characteristics and reforms. In 2008, the Government decided to increase the pensions by additional indexation stipulated in two separate official decisions. As a result of indexation of pensions prescribed by the Law and additionally determined in the Government decisions, the pensions in 2008 were increased for 21.66 %, which is higher than the increase of wages (amounted to 10% in the same period of time).The Government explained its decision by stating that this measure will help in improving the living standard of the pensioners especially of those groups that receive minimum retirement incomes. (Annual Report for PDIF Activities 2008; Law on Pension and Disability Insurance; Government Decisions Official Gazette No.16/08 and 99/08).

2.1.4 Critical assessment of the reforms

Financial sustainability

The reduction of social contributions and the introduction of the new system of the gross wage calculation, according to some experts and Trade Union representatives, is expected to have an impact on the entire pension system and particularly on the second pillar, including second pillar pensions, because the members of the second pillar with the decreased pension contribution will have less assets on their accounts which may result in lower than expected pension benefits. The Government should prepare an analysis with actuarial projections on the long-term impacts of this reform over the pension system as a whole, as well as over the individual accounts in regards of adequate pension, since prior to the implementation of the

reform no analyses were publicly demonstrated. Such analysis would be helpful to undertake corrective measures in a timely manner, and to provide the long-term financial stability of the pension system and adequate pensions, if necessary.

As was elaborated in the impact assessment chapter, due to the additional indexation, specifically for 2008, the pensions were increased by more than the average wage growth, which was identified by some political opponents as a voting present. This solution might have an impact on the long-term sustainability of the pension system, since it might create obligations to pay higher pensions than those prescribed by the law. On the other hand, the revenues that are used to finance pension benefits payout might have a slower growth rate due to the lower wage increase. Nevertheless, this reform requires an analysis on how the additional pension indexation will influence the usage of different percentages for the indexation of different categories of pension benefit amounts (higher indexation percentage for lower pensions and lower indexation percentage for higher pension). In particular, the analysis should elaborate whether this will lead to an approximation of the pension benefits of the different categories in the long run, regardless of the contributions paid during the working career.

Building up public awareness

Considering that the voluntary funded pension insurance (third pillar) is a novelty in the pension sector in Macedonia, it is of crucial importance that the public be educated and informed on its characteristics so that this will help the citizens when making their decision for or against entering a voluntary pension scheme. Also, in the context of building public awareness there is a need that the members of the second pillar be informed about the rights to change from one private pension fund to another. The insufficient public campaign was noticed for both cases, mostly because of the election campaigns, which were most dominant throughout 2008. The creation of public awareness on these issues needs to be enhanced and more attention should be paid to the public campaign by the respective institutions in the forthcoming period.

2.2 Health

2.2.1 Overview of the system's characteristics and reforms

Access

The health system in Macedonia is set up as an insurance-based system aiming to provide universal coverage and a comprehensive health care to the population. The Ministry of Health (MOH) provides the legal and regulatory framework for system operation and stewardship, while the Health Insurance Fund (HIF) pools health insurance contributions from the payrolls (7.5% of gross wage), transfers from the state budget (for the unemployed and beneficiaries of social welfare), and co-payments.

Average spending on health care per capita is around USD 200. Relative to GDP, public spending for health care was 4.8 % in 2008 compared to 5% in the new EU Member States. Out-of-pocket payments, both formal and informal, reported in the household survey indicate that people contribute about 3% of GDP bringing the total health care spending to 7.8% of GDP (World Bank 2008).

The HIF is the single payer which contracts public and private providers to deliver health services defined in the basic benefit package which is currently under revision. Patients pay

co-payments for services, drugs and supplies, with a number of exemptions stipulated in the Health Insurance Law or in respective Government's decrees (HIF 2009).

In addition to the HIF, there are 16 national vertical programmes funded by the Government, which are free of charge and thus accessible to all population, insured or not, including the poorest and most vulnerable groups, which makes them pro-poor and equitable. In particular, the programme covering health costs of the uninsured, which are often (not always) the poorest, is a way of ensuring that children living in poor households have at least a greater chance to access preventive and curative health services (Pereznieto P.& Uzunov V. 2009). The responsibility and funds for the 16 national programmes has been discussed for several years. There are typical community-oriented public health programmes (e.g. AIDS or brucellosis), typical medical care programmes for individual patients (e.g. dialysis and uninsured patients), and mixed programmes (e.g. tuberculosis and mother & child care) (Novotny T. 2008, Schaapveld K.& Trajanovski M. 2009).

Even though the services in the national programme for active health protection of mothers and children are free of charge a certain number of pregnant women do not participate in the pre-natal health care programme, and a number of children do not participate in the post-natal visits and scheduled vaccinations due to cultural reasons or the effective costs for 16 visits to the health care facilities for poor mothers, especially for those who live in remote communities.

Basic benefit package

The current benefit package is considered very comprehensive and very costly. It seems that there are no sufficient funds for a broader list of services which the public expects to be in the package (Manu A. 2008). The designing of one universal type of package is being considered: an essential package for all citizens (including preventive check-ups, immunisation, coverage of part of the positive list of drugs and treatment of a range of communicable diseases). This already has been done in March 2009. (MOH 2009, www.moh.gov.mk; accessed on 8 April 2009)

The process of changes and rationalisations in the co-payment policy which contributes to the financial sustainability of the basic benefits package should be realised without endangering the accessibility to benefits for the vulnerable population groups. It seems that imposing a flat co-payment per services and prescription and including a safety-net for the poor, or a lower co-payment rate for the poor, could be a proper solution for this type of exclusion (Karol K. 2007).

Rational prescription of drugs but also an adequate access to the essential drugs (especially those from the positive list) is among crucial conditions that can impact the proper access especially by the socially excluded (Gjorgjev D. 2008).

Health care delivery

The health care is delivered through health care institutions (HCI) with relatively even territorial distribution, even though there are settlements with inadequately equipped facilities (poor physical conditions, insufficient medical personnel, lack of drugs and basic medical equipment etc.).

Primary care is delivered by general practitioners contracted by the HIF and paid on a capitation basis. The capitation formula is risk-adjusted by age, gender, and region and includes a performance component bound to compliance with selected preventive and curative care indicators (including preventive prenatal visits, postnatal check up of newborns, etc.). The GPs still do not provide all preventive services and emergency care after office hours. Reasons are that the family medicine model of public health care has not yet been

implemented, the infrastructure for service provision is inadequate, while PHC physicians tend to resort to selective (cherry-picking) practices when it comes to poor or uninsured patients. Special programmes for preventive and curative care funded by the state budget have been set up to provide free care both to insured and uninsured persons. However, the reimbursement procedures seem to be too cumbersome for many PHC physicians due to which there is a tendency to avoid such situations. This, in turn, has a negative effect on access to care. The distinction between public and private provision of preventive care, which took place as part of a vast PHC privatisation in 2007 (between the preventive teams kept on public payroll and privatised PHC physicians on capitation contract with the HIF), has created gaps in access, coverage and quality of preventive services, particularly in cases of emergency situations, pregnancies and delivery.

Specialist outpatient care is delivered publicly to about 70%, while patients pay a small co-payment for services. There is a reform plan for further expansion of private provision of specialist care services.

Inpatient care in hospitals is publicly provided and financed though historic budgets bound to a list of performance indicators based on which hospitals report to the HIF on a quarterly basis. The current and the next stage of the hospital payment reforms aim to introduce and upgrade case-based payment such as DRGs. Hospitals will be reimbursed based on outputs, and managing with them will change fundamentally along with rationalisation measures, proper modernisation and the provision of adequate information systems which are missing (Karol Consulting, 2008).

An integrated approach to service delivery with close cooperation between primary, secondary, and tertiary level services is also missing (proper disease management). The functional division between the different health care levels is not working well. On the other hand, all reform efforts focus mainly on the primary health care level. None of the reforms have addressed rationalisation of the health care services and their equal distribution on regional level (EU Progress Report, 2008).

Reforms

Macedonia's Government has identified a number of higher level objectives including economic development, poverty reduction, and the promotion of social stability and harmony. The Health Sector Management Project (HSMP) will contribute to these higher level objectives by addressing the important issue of cost-containment while improving quality and access to health services. The Health Sector Management Project financed through a Specific Investment Loan (SIL) of USD 10 million and by a Government contribution of USD 1.34 million, had satisfactory progress in 2008 (World Bank 2009).

HSMP Component 1 supported policy formulation and implementation, specifically public relations and communications and improvement of the Ministry of Health's management and business process. The National Health Strategy as well as the development of the Basic Benefit Package has been completed and the required legislative amendments were being prepared. Co-payment policy development has also been completed. A public health system strategy plan has been prepared (Novotny, 2008) as well as related legislation. A new Public Health Law that integrates relevant EU directives) is under discussion among the stakeholders (Schaapveld K.; Trajanovski M., 2009).

Component 2 strengthened the governance and management of the Health Insurance Fund, establishing eligibility criteria and a revenue collection system, and strengthening management processes, as well as improving the design and implementation of payment models and contracts, building staff capacity in areas relevant to purchasing, improving the

management of drugs, and ensuring better tendering processes. Training and other activities to support the HIF and hospitals in the introduction of DRG's will be undertaken.

With regard to the pharmaceutical strategy changes were made in the relevant legislation and the following activities are planned: technical assistance and advice ranging from the establishment of a drug regulatory authority, legal aspects of the regulation on pricing policy for pharmaceuticals, all the way through to a pricing and reimbursement policy of pharmaceuticals in Macedonia.

The Project supports the institutionalisation of family medicine: development of a PHC strategy, development of curricula for retraining of PHC physicians. Under the non-competitive "grant phase", reconstruction in 14 hospitals was financed. The establishment of a Hospital Management Training Centre is underway. The Ministry of Health toghether with the School of Public Health have developed an extensive Health Management and Leadership Training Programme, completed with the help of over 650 doctors and economists (World Bank, 2009).

Provider payment

Provider payment reforms set incentives to health care providers to increase the number of services and provide treatment for more patients. Special incentives have been introduced for the work in rural areas, preventive and promotion activities as well as rational prescription of drugs and referrals. The combined model of payment through capitation and fee for services could create more incentives for improved efficiency on this level, which is very important especially for vulnerable groups. It is impossible to give a comprehensive overview of documents or publications on impact assesment of these reforms due to the fact that there is no systematic monitoring and evaluation of the health policy interventions (HIF, 2009).

Funding for public health institutions is provided by the HIF through a defined annual limited budget upon decision of the HIF Management Board. The practical implementation of the DRG system as a payment mechanism of the hospital health care services started on 1 January 2009. According to this there are new reference prices for the health care services in the hospital care.

There are different initiatives in the country and an overall strategic plan for capacity building and modernisation of public health services has been prepared (Novotny T. 2008). The evaluation of public health services was completed and gaps identified: public health functions are grossly under-funded and fail to provide a number of essential services. Particular emphasis was placed on the lack of an effective system for data management, which leaves the MoH unable to monitor neither health nor health programme outcomes or provide the information necessary to support the process of policy making (Gjorgjev D. 2009).

Different initiatives in the country in the area of public health complement and support each other for a successful and sustainable outcome. Also initiatives to network in the Balkan Region in order to share knowledge and tasks are likely to attract external funding (designation of the Republic Institute for Health Protection (RIHP) as a member of the IANPHI in October 2008 and ongoing process of designation as a Regional Centre of Public Health Services). The new draft-Law on Public Health would encompass the role of the state in providing public health services as public "goods" based on: an analysis of public health legislation in EU and non-EU countries; current international health regulations, and inventory of relevant existing Macedonian legislation; reflecting the aspirations of public health in Macedonia and the goals of public health reform. (Schaapveld K., Trajanovski M. 2009)

The general idea is that paying for public health activities is a (national or local) government

responsibility, contrary to paying for medical care which is mostly an insurance matter (Novotny T. 2008; Schaapveld K., Trajanovski M. 2009).

2.2.2 Overview of debates/political discourses

A number of the strategies reviewed do not include clearly defined indicators or monitoring systems or clear implementation mechanisms (Rosenberg JD 2008).

A country's progress in its accession to the EU is a driver for change and regarded as a great opportunity. The EU has highlighted the fulfilment of children's rights, the reduction of child poverty and children's social inclusion as necessary elements in the EU accession process and political agenda (Pereznieto P., Uzunov V. 2009).

A lot of international Strategic documents such as UN Millennium Development Goals 2015, Decade for Roma Inclusion 2015, Adoption of Conventions and Declarations etc. have been reflected in Macedonia's national policy: National Strategy for EU Integration; National Poverty Reduction Strategy; National Employment Strategy until 2010; National Development Plan 2007-2009; National Strategy for Roma; Strategy for Equitable and Just Representation; Programme for Decentralisation; and the Action Plan for the Implementation of the Programme for Decentralisation 2008-2010; Strategy for the Demographic Development of the Republic of Macedonia 2008-2015; National Action Plan for Children (2006-2015); National Strategy for Deinstitutionalisation of Social Care Services; Programme for Social Protection

More national public health policies have been endorsed and implemented: Health Care Strategy of the Republic of Macedonia until 2020; National Strategy for HIV/AIDS 2007-2011; Strategy for TB Control in the Republic of Macedonia 2008-2012; Strategy for Mental Health Promotion in the Republic of Macedonia 2005-2012; 16 National Vertical Programmes; Health Care Law (amendments); Health Insurance Law (amendments); Law on Patient Rights (2008); Law on Evidences in Health (2009); Law on Social Protection (see Annex).

By signing the UNGASS Declaration of Commitment on HIV/AIDS in 2001, the Government of Macedonia committed to ensuring the development and implementation of the multi-sectoral national strategies and plans for funding the fight against HIV (coming along with two Global Fund grants of USD 5.9 million (2004–2008), and EUR 6.7 million for (2008–2013) (Burrows D. 2008)). Macedonia has also received a grant from the Global Fund of USD 3.07 million (2006-2011) to implement the project Improving the Efficiency and Impact of the Tuberculosis Control Programme within the scope of the decentralisation of the health care services in the Former Yugoslav Republic of Macedonia.

The proceeding within the Third Programmatic Development Policy Loan was a top priority of the Macedonian Government in 2008. Several measures to strengthen the transparency, governance and management of the Health Insurance Fund (HIF) were undertaken. Amendments to the Health Insurance Law (HIL) were adopted to improve the accountability and structure of the HIF Board. The first phase of the HIF Action Plan was implemented (supported by the PSMAL) to strengthen the financial management and internal controls within the HIF, including the staffing of a senior financial executive to implement the HIF Action Plan, the development of HIF and HCI staff competencies in budget formulation, execution, monitoring and control (Government RM. 2008).

The National Health Strategy 2008-2020 has been adopted to build a safe, efficient and just health care system, based on wide consultation with stakeholders. The strategy focuses on a

stronger role of primary health care with family medicine, effective preventive care, and a financially sustainable health benefits package. (MOH 2008)

Amendments to the Health Care Law have been adopted to introduce health management in all HCI in order to improve the access to health services allowing changes of the status of the health organisations that meet the population's needs, defining standards and normatives for organisational units of public health services that could not be privatised: emergency services and home treatment; emergency dental services; preventive health services for pre-school and school children up to 18 years; polyvalent patronage service. Furthermore, the quality of services of University clinics was defined, determining criteria for licensing and the role of chambers of health workers as well as for efficiency, effectiveness of health care services (HCL Official Gazette 77/08) (see Annex II with annotated documents).

The revised by-law for hospital payment defines the criteria for contracts and payment of health care services provided at inpatient health institutions to insured patients covered by compulsory health insurance. With the introduction of diagnosis-related groups – DRG payment system introduced 1 July 2008 the whole payment to the health institution will be increased or reduced by 20%, depending on the index of efficiency calculated by DRG, which reflects the real price of the health services in a given institution compared to all health institutions in the country. The intention of this efficiency index, which will be published monthly for each health institution, is to have comparable prices of health services in all health institutions (HIF 2008).

The Health Insurance Fund informs about the latest changes in the contracts for 2009 agreed with the stomatologists in primary health services. They aim at improving the access to services by 24-hour coverage for primary dental services; child services will remain at primary level; the capitation rate will remain the same (negotiations with stomatologists are still in process); the payment period for 2009 has been reduced from 90 to 60 days. The following measures have been implemented to improve the quality of dental services: introduction of modern materials, drugs and therapy with better quality. New drugs that can be prescribed by dentists are added in the positive list (HIF 2009, www.fzo.org.mk, accessed on 28 March 2009).

The latest innovations in primary health care that HIF agreed with medical associations include the following: improved access and quality by introducing receipts for 90 days for patients with chronic diseases (December 2008); increased quota for prescription to MKD 550 per capitation point (drugs for chronic diseases excluded); capitation point increased from MKD 45 to MKD 50; increased number of points for gynaecologists from 2000 to 3000; introduced weighted incentives for PHC doctors (up to 7%); primary health care remains free of charge; private health organisations will provide 24-hour coverage for emergency cases under mutual agreement until these services are organised by MOH.

2.2.3 Overview of impact assessment

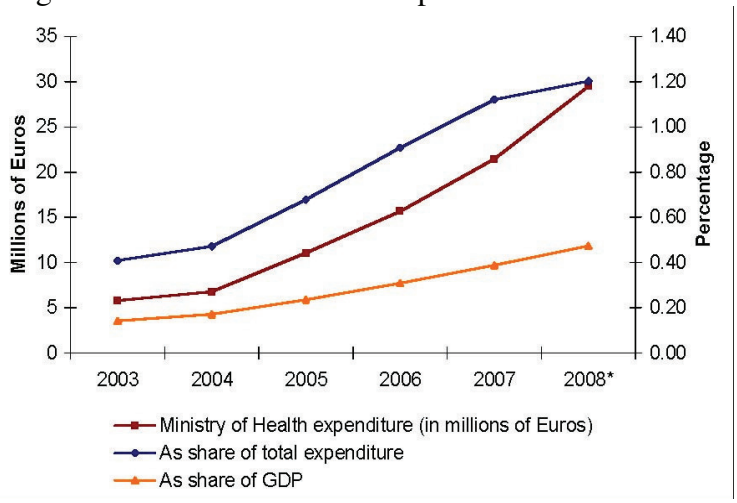
Although there are no data availale for 2008 and there has been no encompassing and systematic monitoring and evaluation of the health policy, a sound overview of the published health impact assessment is provided in this chapter, reflecting the access to, quality, equity, and sustainability of health care.

The main goal of the fiscal policy pursued by the Government at the end of 2007 and in the first half of 2008 was the creation of a greater economic growth potential, through stimulating both aggregate supply and demand. Macedonia has been showing positive economic growth rates, averaging 3.5% per year over the period 2003-2006 (IMF, 2008), growing to 5.1% in

2007, and showing a positive performance in the first half of 2008, with GDP increasing by 5.2%, which is in line with expectations. Thus, from a growth perspective, this period was quite positive as it saw increased employment opportunities. Nonetheless, unemployment remains an important challenge (Pereznieto P.& Uzunov V. 2009).

Expenditure trends for the health sector have been eye-catching, particularly as of 2006. Nominal expenditure by the MoH has risen from EUR 5.77 million in 2003 to EUR 29.45 million in the budget for 2008, an almost 4-fold increase. Resources of the MoH have also grown as a share of the total government budget, going from 0.42% to 1.2% (Pereznieto P., Uzunov V. 2009, World Bank 2008).

Diagram 3: Trends in MoH expenditure between 2003 and 2008:



Figures for 2003-2007 are for expenditure (budget execution). Figure for 2008 is budget allocation. Figures converted from Macedonian Denars, at the rate published by the National Bank, 61.4 Denar/Euro.
Source: Ministry of Finance data; author's calculations, Pereznieto P. & Uzunov V. 2009

The increase in budget allocations to the health sector is an important progress in ensuring more and better preventive health actions, particularly those reaching vulnerable populations (MOF 2009). However, this increase in resources should be accompanied by the development of capacities to plan for and monitor the use of these resources, which is not currently the case. Effective planning in the sector requires capacity building within the Ministry and also with those involved in health planning at the local level (Pereznieto P., Uzunov V. 2009).

In the case of social protection, although overall allocations to the sector are decreasing as a share of GDP and of total expenditure, most of the reductions result from the streamlining of allowances and payments of social funds (through better targeting and better management of resources as part of the ongoing reforms in the sector). This has actually increased the share of resources allocated to social protection programmes (Pereznieto P., Uzunov V. 2009).

As compared to OECD countries, Macedonia has a much lower income per capita, a much larger informal sector, a much higher unemployment rate, and a much lower employment rate. These features restrict the potential of the social insurance and social assistance schemes and make Macedonia a very special case in Europe. Macedonia aims at European Union standards while having an economy that is closer to emerging economies typically characterised by simpler social security systems (Verme PA 2008).

Access and health profile

Initial assessment of health outcomes and service utilisation at the same time do not suggest significant barriers in access to health care, including preventive care services. Utilisation levels in PHC centres and hospitals are low, and Macedonia has a relatively higher tuberculosis incidence and infant mortality rate compared to the region (RIHP 2009). Poor

and rural populations are more likely to seek emergency care than going to the PHC providers, due to transport costs, distance to facility, staff behavior, price of service or medicines, informal payments, or trust in providers. The poor may prefer hospital care because they are more severely ill once they seek care (Tozija F. 2008).

Demographic development combined with migrations (internal and external) has led to significant changes in population spatial distribution and age structure, which had impact on decreased natality and fertility, increased mortality and ageing. In fact, life expectancy for both men and women remained relatively stable, and has continued to improve (Tozija F. et al 2008, RIHP 2009).

Significant progress has been made in improving mother and child health indicators during the past 10 years, primarily reducing infant mortality to 10.3 in 2007 and under five mortality to 11.1, which has put the country on track for achieving the health related MDGs by 2015 (Tozija F. et al 2008, UNDP 2008). Health indicators are relatively good and comparable with indicators in the region. However, there is still work to be done, particularly as some of the indicators show certain inequities, related to location, ethnicity and wealth (UNDP 2008).

Maternal deaths have decreased from 11.5 per 100,000 live births in 1991 to 4.4 in 2006, whilst in 2007 no cases were reported. The percentage of births attended by skilled medical personnel is generally high, having increased from 89.9% in 1990 to 99% in 2004 and 99.6% in 2007, which is particularly important for keeping the maternal mortality at a low level. Registered abortions have been decreasing steadily, dropping from 52 per 100 births in 1995 to 27.05 in 2006 and 26.5 in 2007 (Tozija et al. 2008).

The prevalence of tuberculosis in Macedonia has been halved from 81 per 100,000 population in 1990 to 45 per 100,000, with the incidence rate declining from 35.4 per 100,000 population in 1990 to 27.5 per 100,000 in 2007. The incidence rate has been oscillating between 27 and 40 per 100,000 over the analysed period. It has been higher than the EU average, but lower than compared to Central and Eastern European countries. The tuberculosis mortality rate decreased gradually from 4.9 per 100,000 population in 1990 to 3.8 in 2003 and 2.7 in 2007, but remains twice as high as the EU average of 1.2 in 2005 (UNDP 2008).

Despite improvements in the quality of neonatal and infant health care services, the perinatal mortality trend, although decreasing, is very slow (Zahorka M. 2008). In addition, the data on perinatal mortality are likely to be underestimated due to incomplete registration of births. The birth certificate, as a requirement for most of the basic social services (except for preventive health care), represents a major barrier to access and represents a risk factor for social and economic exclusion and vulnerability of specific population groups, especially Roma (Tozija F. 2008).

Equity

Inequalities in health outcomes in terms of location, wealth status and ethnicity highlight that despite a universal access policy and overall positive performance of the health system, utilisation of health care is unequal and is failing to reach specific population groups. The groups most at risk to be excluded from health care are low income groups, children not attending school and street children, homeless individuals, the unemployed, socially vulnerable individuals, Roma, the elderly, and farmers (UNDP 2008).

One of the main premises to consider, however, is the high unemployment rate of 34.8%, and poverty at 29.4%. The problem is particularly bad for children, with 58.9% of households in poverty having children (State Statistical Office 2008, Pereznieto P.& Uzunov V. 2009). An increasing and high concentration of poverty amongst households with children is an alarming indication that not all children have equal opportunities which subsequently compromises the future competitiveness of the country (Unterhofen F. et al. 2008). The 2008 EU progress

report points out that there are still 17% of children who are not covered by public health insurance (EC, 2008).

In the poorest quintiles 24.5% of children aged 18-29 months have missed out on at least one of the eight recommended vaccinations. These children come predominantly from rural areas and from Roma and Albanian ethnic communities. The three poorest quintiles have a 1.5 times higher probability of dying before the age of five compared to the national average. In rural areas the under-five mortality rate is almost 2.6 times higher than in urban areas. Only 1 in 10 children aged 36-59 months attends preschool. Total primary school attendance is as high as 95.2% however only 86.3% among children in the poorest quintile. As many as 39% of Roma children do not attend primary school. 37% of all children at secondary school age do not attend secondary school. This rate is higher among the poorest quintile with 66.7% in comparison to 10.4% for the richest quintile. Insufficient public investment in health, education and social protection is strongly divided between rural and urban areas in terms of access to basic services (Gancheva, Y. et al. 2008).

Those most affected from child poverty are children in large households of over 6 members, households with no income or education or with primary education only, where the rate of relative poverty is higher (Spence, K. 2008). The safety level of housing also affects the health of children; particularly exposed to risk are the Roma children living without adequate infrastructure and with high unemployment and crime rates (Tozija, F. 2008).

The nutrition status is an indicator of the children's health condition, the households' socio-economic status and to a lesser degree of the access to primary health care (Cattaneo A. et al. 2008). Malnutrition is not a serious problem among children in Macedonia, but 2% of the children aged under five are moderately underweight and 0.5% are seriously underweight. Children whose mothers have no education are exposed to a higher risk of malnutrition. Among the Roma children this risk is twice higher (MICS, 2007).

Young people may be particularly vulnerable to the health-impairing effects of inequity as they are unlikely to possess or control much of the wealth or power held by society. Adolescents in Macedonia face a number of health problems related to risk behaviours as reported in the 2008 Global Student Health Survey: tobacco use (10.5%); use of alcohol (39.4%); sexual behaviour (11.9%); 31.3% seriously injured; 10.0% bullied; 8.6% seriously considered attempting suicide; drug use of 3.0% (Tozija F. et al. 2008, Candace C. et al 2008).

Roma

For the first time, there are earmarked resources for Roma education in the MES's budget, which is a positive first step, however, resources allocated for this purpose are minimal (EUR 100,000) and the plans for the use of resources was not yet clear (EU 2008).

Roma woman are the most marginalised entity being exposed to: lack of personal identification documents (76,5%); illiteracy (52%); lack of education; unemployment and social exclusion. The predominant age ranges from 15-18 for the first pregnancy and the age of fifteen for their first sexual relation. Out of the interviewed 51.2% has had one, two, three, or more abortions. Of the total number of persons interviewed, 6.3% do not have health insurance, while 56% have insurance in their name (National Roma Centrum 2008) (www.nationalromacentrum.org). Mothers from the Roma community are oftentimes uninsured and cannot afford to co-fund or pay for the informal costs of regular antenatal examinations, childbirth or postnatal visits even in the health care services that are free and subsidised under the vertical preventive programmes (Pavlovski B. 2008). The behavior of women in terms of their health depends on their socio-economic status and ethnic background. Poor women, women and girls from the Albanian community and women from the Roma community have

the lowest level of knowledge concerning sexual and reproductive health, transmission of HIV/AIDS and other sexually transmitted diseases (Tozija F. et al. 2008).

Two new public health programmes were promoted. The funding for all 16 public health programmes is progressively increasing; yet resources allocated to the hospital sector are still higher than those allocated to public health and primary health care. Institutional care for socially vulnerable and disabled people has not improved. To help decrease the number of deaths from cancer, annual screening for breast and cervical cancer is provided for all women above a certain age (EU 2008).

The data indicate that resources allocated for health programmes targeting specific groups, including vulnerable or socially excluded groups, are in a constant flux. This suggests that the Government determines budget allocation on the basis of the availability of funds rather than in terms of established goals and priorities, or the human rights that underpin them (Gancheva Y. et al. 2008).

Resources need to be invested in identifying how to best reach vulnerable populations and then deploy resources to address the problem to ensure full and equitable health care coverage (Pereznieto P. & Uzunov V. 2009). The medical map that has just been finalised can be used for geographical targeting as a planning tool to modernise and rationalise the health sector in identified municipalities with relatively high unemployment, illiteracy, infant mortality rates, tuberculosis incidence and low access values, etc. Targeting CCT programmes specifically to the poor and those excluded from service use could help the Government in meeting important equity objectives.

Quality

A recent patient survey shows that patient satisfaction in terms of access, quality and efficiency of the services is, in general, higher compared with findings from the previous survey (MOH 2006). Patients are mostly satisfied with the reforms: 50% assessed them as good, 14% as very good, and 10.4% as excellent. The quality of services is assessed as excellent by 53% of the interviewed, 22% very good, 19% good, and less than 1% bad. Payment for doctor examination: 90.6% have not paid, 9.4% did pay (the average is MKD 117). 92.0% received referrals to specialists, while 90.8% received drug prescriptions. After each visit to a PHC doctor the interviewed spent an average MKD 440 to 586 out of their pocket. Average travel time to the clinic is 16.5 min, 14.8 min; 92.8% of those interviewed had a blue card. The average waiting time in a PHC clinic is 14.6 min to 20.4 min (Tozija F. & Nikovska Gudeva D. 2008).

New equipment was provided for health care institutions, which will increase the quality of health care services (www.moh.gov.mk, accessed 18 March 2009).

Further improvement of the quality of health services is needed applying evidence-based medicine, continuous medical training and professional development of medical staff, as well as licensing and accreditation (Kocankoska L. 2008).

Sustainability

For the first time in the history of the Macedonian health care system in 2009 all public health institutions will start with zero debts. For this purpose EUR 13 million from the state budget have been allocated for covering losses of each hospital. It is the intention of this measure to cover all old debts and not generate new ones in the future. Additional EUR 6.5 million will be used for clearing the debts between the public health care institutions and the retailers (MOH 2009, www.moh.gov.mk, accessed on 10 April 2009).

2.2.4 Critical assessment of reforms, discussions and research carried out

Despite this generally positive picture and the major reforms already undertaken, the health system is still in transition.

Health insurance in Macedonia is a categorical right linked to various categories of people including employees, self-employed, pensioners and their relatives. Because of this, most people find a way to fit into one of the categories just to claim health insurance, even if they do not formally belong to that category. The result is that health insurance is almost universal. Also, most of those who are not covered should, in principle, be covered. This includes people such as employees who work for enterprises that fail to pay health insurance, children of young parents who are covered under their own parents and cannot cover their own children, or relatives of people working abroad (Verme PA 2008). There is evidence from various beneficiary assessments that the availability and the quality of health care is inadequate for a certain number of people who cannot be insured under any category (around 35,000 individuals) and those who cannot afford to pay for drugs, make out-of-pocket payments, or are unable to afford private doctors' fees. Some of the more vulnerable groups in terms of their access and benefits from the health care system include: long-term care patients, elderly, Roma, population from rural areas and uninsured and redundant workers whose companies are not paying contributions (Gjorgjev D. 2008).

Health insurance coverage is reportedly close to 100%, the indicators of physical access are impressive, and the basic benefit package is quite broad covering practically all health services. This generosity of the publicly financed system is hardly affordable and creates significant inefficiencies, ridden by corruption and balanced by expenditure cuts that are affecting the primary health care system and the maintenance of facilities which are important for the poor. The quality of health care has also deteriorated due to outdated equipment at bad facilities, lack of materials with wages and salaries absorbing most of the health budget.

The key areas of action over the next months that require particular attention, both in terms of dimension and importance in supporting the overall health sector reform, include the development of the health management information system, support to DRG implementation, completion of the public health system strategic plan and related legislation, pharmaceutical policy and support to the institutionalisation of family medicine and establishment of the Policy analysis unit in the Ministry of health (MOH 2008; World Bank; 2009).

There is a need for enhancing capacities (both on central and local level) in planning and monitoring of the relevant vertical programmes; alternative mechanisms should be sought to address the problems that result in poor absorptive capacity of budget allocations: strengthening of institutions including monitoring and evaluation and dissemination of information (Pereznieto P., Uzunov V., 2009).

To keep pace with these ambitious reforms and support the implementation of the CCT programme, data collection in health facilities needs strengthening and capacities should be built in a central unit for data analysis, monitoring, and timely evaluation. Results should be reported back to providers and used for the facilities' management. Public awareness about the variations in quality and satisfaction results will support consumers in making better choices, including seeking services under the CCT programme.

At present, the system is facing a number of challenges including the need to overcome the legacies of the health system that was previously in place. This includes: strengthening of human resources planning and training; the rationalisation of health care facilities to redistribute limited resources more effectively and thereby significantly improve the infrastructure of facilities as well as the quality in particular of primary care services.

Emphasis on the enhancement of the primary health care services, which still represent the best-affordable level of services compared to a comprehensive disease management level, will bring adequate health care services closer to vulnerable groups. Due to the limited resources rationalisation within health care facilities and proper geographical redistribution still needs to become more efficient.

Some services, such as emergency medical and dental care, emergency home treatment, preventive check-ups of preschool and school children as well as some patronage services should remain in the public domain, especially since those services are much more often used by the groups at risk.

The comprehensive benefits package needs to be evaluated using cost-effectiveness and allocative efficiency criteria. There is an overlap and duplication of benefits. In addition to the coverage under the compulsory health insurance, certain groups are eligible for free care under "special programmes" financed through general budget revenues. The "special programmes" also cover some of the most expensive drugs and medical devices such as renal dialysis, cytostatic medicines (for cancer treatment) (World Bank 2009).

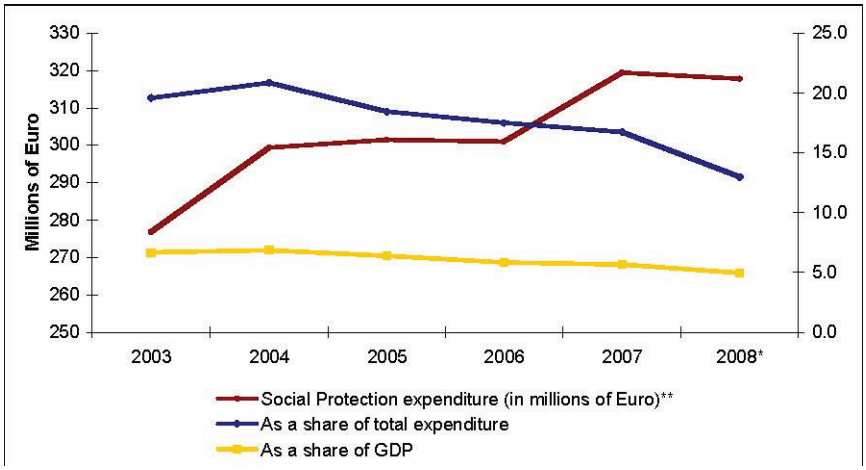
Public pharmaceutical expenditures are a key cost driver of health care, standing at 15% of HIF expenditures. In Macedonia, as in other EU countries, outpatient pharmaceuticals consume the bulk of resources, while inpatient drugs only consume 10-15% of expenditures. Macedonia is also likely to face continued growth in pharmaceutical expenditures in the short or medium term (World Bank, 2009).

2. 3 Long-term care

2.3.1 Overview of system characteristics and reforms

The Government's social protection activities are performed under the budget of the Ministry of Labour and Social Policy (MLSP) in accordance with the Social Protection Programme for 2008 (MLSP 2008). As illustrated in Diagram 4, although the nominal budget for social protection as a whole has increased, it has been decreasing over time both as a share of the total budget and as a share of GDP.

Diagram 4: Trends in social protection expenditure, 2003-2008



Figures for 2003-2007 are for expenditure (budget execution). Figure for 2008 is budget allocation.
Source: Ministry of Finance data, authors' calculations, Pereznieto P. et al 2009

According to the provisions of the Law on Social Protection (LSP), the state (both central and local government) is responsible for providing social protection. State-provided social care services include: measures for the prevention of social risks (social prevention); non-institutional social care and protection; social care and protection within social institutions; social assistance (MLSP 2008).

There are several types of social assistance targeted at different users according to their needs.

Non-institutional social protection includes: the right to individual help, including counselling and appropriate information services that empower people to make good decisions and develop their social potential; home care and help specifically targeted at elderly people and people with physical or intellectual disabilities; daily and temporary care including counselling, educational and entertainment activities, as well as feeding and hygiene maintenance. Day and temporary care services are also provided to children with disabilities, orphans, street urchins, substance abusers, homeless people and victims of domestic violence, foster families who care for elderly people etc. This falls under the responsibility of the CSW and the day centres (MLSP 2008).

Institutional care: Among other beneficiaries entitled to care and protection within state institutions are people with physical and intellectual disabilities who need permanent care; elderly people with physical disabilities; people with intellectual disabilities that are not able to take care of themselves; and those whose housing facilities do not allow the provision of home care (MLSP 2008).

The recent trend in the social care has been to reduce as much as possible social care provided within institutions and give priority to home care (Pereznieto P. et al 2009).

Traditionally, care of the elderly is provided by their families at home. There are cases, however, where the family is not able to provide such care, especially in certain periods of the year. The needs for long-term care are addressed in different ways. The smaller part of those needs can be satisfied by means of health care services in the form of treatment at home or an extension of hospital days in specialised hospitals providing beds for elderly patients. Special homes for the elderly and other social institutions that offer institutionalised security for individuals cover most of the needs arising in long-term care. These homes do not fall under health care but under social assistance (Gerovska Mitev et al. 2007).

So far, a small number of homes for elderly exist. There are four public foster homes for elderly with 567 beds (three in urban and one in rural area), and one gerontology centre. Geographical coverage of the country with this kind of facilities is unequal, e.g. there are no public foster homes for elderly in Eastern Macedonia. There are no categorisations of the services for the elderly persons that are accommodated in such public facilities and the services are equal for everybody. According to this, the number and the capacities of these facilities are not enough for the fulfillment of the existing needs. This situation has influenced the establishment of the private foster homes for elderly that are registered as trade companies (Friscic et al, 2008). Currently, only two private foster homes (both in the capital of Skopje, with 25 beds), have been licensed by the Ministry of Labor and Social Policy and one in Kavadarci is currently undergoing the process of registering and licensing. Until 2006, the institutions for elderly were under the Ministry of Labor and Social Policy, but with the decentralisation three were transferred under the local government. Financing of these services is provided both from the central and local budget, as well as from co-payments by the beneficiaries or their relatives (MLSP, 2009).

There is also a specialised institution for palliative care, which provides services in two specialised institutions for palliative care; two specialised daily hospitals; two specialised ambulatory services; two specialised units for home palliative care; two daily hospitals within

the university clinic hospitals (oncology; haematology; paediatric; geriatric; centre for pain treatment). Home palliative care includes two specialised units, which have taken up work in February 2005 (Gerovska Mitev et al. 2007).

Long-term care is provided in 15 general hospitals, seven treatment and rehabilitation centres, six special hospitals (for treatment of pulmonary diseases and tuberculosis, mental disorders and other diseases), tertiary university clinics and institutes in Skopje (RIHP, 2009). There is a surplus of health personnel and non-medical staff, contributing to high fixed costs. Given the size of the country and the fact that population in some regions have access to multiple general hospitals, there is scope for rationalisation of service delivery through a combination of planning and the use of output-based payment mechanisms (case-based payments) (Karol Consulting, 2008; World Bank 2009).

2.3.2 Overview of debates/the political discourse

In the past few years, there has been a move towards the de-institutionalisation of social care in accordance with the goals of the Strategy for Deinstitutionalisation of Social Care Services in the Former Yugoslav Republic of Macedonia in the period 2007-2014 as the most adequate mechanism for improving the quality of care for elderly and disabled people (MLSP, 2007). For this purpose, the MLSP has recognised the Centers for Social Work (CSW) as key actors in the deinstitutionalisation process and as the main providers of social protection, for which they have been given multiple responsibilities, including the coordination of a range of organisational units (MLSP, 2008).

Current budget allocations of 4.3% of the total budget for social protection programmes have been identified as insufficient to adequately operate the CSWs, particularly given the multiple responsibilities they are in charge of. The 2008 budget to CSW was 24% higher than expenditure on CSW in 2007. Efficiency gains in the MLSP through reforms in the social protection sector could be seen as an opportunity to provide additional funds to these centers (Pereznieto P. et al 2009).

Devolution of social protection resources has remained low, only about 1% of the budget in this sector has been devolved, corresponding mainly to resources for institutions for the elderly, which means that despite one of the aims of deinstitutionalisation – which is the promotion of local participation and decision making – most expenditure decisions are still made centrally or based upon inter-municipal coordination. No comprehensive policy framework has been developed to precede or to inform about the devolution of social protection resources and programmes. Therefore, according to the Law of Local Self-Governments (LSG) a range of social protection functions were to be devolved to municipalities entering phase two, while in reality the only two devolved functions have been childcare facilities (ECD) and homes for the elderly. It is necessary to develop a clear and coherent decentralisation strategy that defines roles, functions, and funding responsibilities, municipal cooperation and participation of local governments. This would facilitate the devolution responsibilities to LSG units, ensuring that the transfer of block grants corresponds with the effective delivery of services (Pereznieto P. et al 2009).

The main causes of morbidity and mortality especially among elderly are chronic non-communicable diseases, which require a shift in focus of public health professionals towards health promotion and health education for health problems such as cardiovascular disease, cancer, diabetes, obesity, and for lifestyle issues. Improved health promotion and other public health interventions and programmes in the country supported by the central and local community's budgets as well as by some international agencies could definitely improve the access to proper health care services to the populations at risk, and especially in regard of the

specific diseases prevention linked to the low economic status or insufficient access to health care services. In this regard, few national strategic documents have been developed: Health Strategy 2020; Strategy for demographic development etc. (see Annex II with annotated documents)

The state has not enacted a separate strategic document for the protection and support of the elderly, nor is there an appropriate legal framework to regulate financing and stimulation of daily centres for senior citizens in municipalities and settlements where the elder population represents the majority (Friscic J. et al, 2008).

There is a National Programme for the treatment of people with mental disorders (Law on Mental Health and Strategy for Mental Health Promotion in the Former Yugoslav Republic of Macedonia 2005-2012). Care of people with psychiatric illnesses is provided mainly in state-owned psychiatric departments, with a total number of 1,109 hospital beds in three special hospitals (RIHP, 2009). There are also uninsured people among these patients. Even though there are improvements in the existing facilities, the situation is still very bad. The ongoing intensive process of implementation of the National Mental Health Strategy (Ministry of Health, 2005) offers the possibility for improvement of the situation and decentralisation of mental health care through establishing Mental Health Centres in the community. The Ministry of Health, supported by the WHO's Mental Health Programme, has introduced community mental health centres distributed in various parts of the country (currently there are 8 centres). The main aim is the re-socialisation of the mentally ill patients, as well as their re-integration into society instead of long-term and inefficient treatment in hospitals. In addition to establishing new facilities, the present units of the psychiatry hospitals located outside of the hospitals have been used for this purpose. The organisation of the services provided in these community centres is effected by the daily hospitals, by shelter homes as temporary homes, by social clubs, as well as by a mobile team for home treatment.

2.3.3 Overview of impact assessment

Social protection, employment, health care and rehabilitation, social services, housing and de-institutionalisation are identified as priority issues for policy intervention (Friscic J. et al, 2008). There are many challenges with respect to strengthening the Government's institutional capacities to fight the poverty and social exclusion of the identified priority groups: single elderly, especially in rural or remote areas; uninsured elderly; older Roma; disabled people without access to institutionalised care as needed – residential, respite, in-home support (especially in rural or remote areas).

Policy formulation does not appear to follow a standard process across Ministries, and due to the scarcity of robust, disaggregated social statistics, planning may proceed in the absence of solid data on the needs, locations and numbers of target beneficiaries or consultation with the intended target groups, or indeed with other Ministries or units which may be involved in serving the same groups (Rosenberg 2008).

There is a need to strengthen data collection and analysis, within the integrated public health information system implementing the new Law for Evidence in Health (MOH, 2009) and the new public health law (Schaapveld 2009).

The majority of the elderly people do not have sufficient funds for proper health care according to their needs. There are cases also where the family is not able to provide such care, especially in certain periods of the year. Care is then provided in specialised hospitals providing beds for prolonged stays to elderly patients (Gjorgjev 2008).

The current system also creates some shortages for the long-term health care services and homes for elderly. Taking into account the size of the demand, there should be public-private-partnerships in the investment of such facilities and services, as well as proper conversion of the surplus of the beds in the hospitals to these specific long-term services. The situation is still very bad, especially in the mental health facilities where amongst others there is a problem of proper responsibility coordination between the health and social policy sector.

These processes should be accelerated. The state should increase the empowerment of community groups, deliver services that promote social inclusion of vulnerable groups and thus improve the capacity and efficiency of the primary health care level, and reduce the costs of treatment in hospitals. From another perspective, local communities should show more interest in possibilities to invest (jointly with the central Government) in health care facilities especially on the primary level for the benefit of the citizens (Rosenberg JD 2008).

Elderly people are facing a specific problem regarding social protection – which should be located at the place of residence: There are simply no daily centres for elderly where they can spend the day in the institution with organised contents and programmes in their surrounding. Only one daily center for elderly exists in the country. The need for the establishment of this kind of centres in Skopje, in municipalities with dominant elder population, is evident (Friscic J. et al 2008).

Persons over 65 years are entitled to free primary health care. Yet, they encounter many problems when trying to achieve their right to medical care. Elderly have to pay their share of the costs for the services they get in the secondary and tertiary health care centres, and they have to pay for the drugs that are not on the Health Insurance Fund's positive list. Together with the absence of care services, of patronage, of a nursing system for elder people, and insufficient sensitivity for their needs on the part of the local communities this deteriorates both their health and financial condition. Home medical care in rural areas is not well organised, with additional costs for the doctor's trip to the old person's home since these health centres do not dispose of vehicles. The disabled in all regions face even more problems in connection with health care: individuals with intellectual disabilities over 26 have to pay deductibles when using medical services. There is a shortage of medicaments from the positive list (Friscic J. et al, 2008).

2.3.4 Critical assessment of reforms, discussions and research carried out

Access

No clear distinction is made between health care services (which are supposed to be covered by compulsory health insurance) and other services for long-term care (which do not make part of the benefits to be provided by health insurance).

Another problem concerning long-term care is insufficient and underdeveloped provisions for home-care. This, in turn, exacerbates the gap between institutional long-term care capacities and the number of those who need this kind of care. The coordination of long-term care services with other health care services, in particular rehabilitation programmes, is very poor.

Quality

Another problem is the lack of capacities in institutional care. The lack of capacity is mainly due to the insufficient development of home care. Community nurses and personal doctors perform home care; this is partially done by special institutes and a variety of non-health care services. These services do not coordinate their work in organisational, professional and financial terms. There are differences regarding the quality, rights, and access to long-term

care services between individuals who require institutional care and those who receive care at home.

In public opinion surveys performed in Macedonia the majority of people has a negative impression of the quality of the hospital services. This is much more common in rural areas or smaller cities (60 % of the respondents) (Gjorgjev 2008).

The Law on Patient Rights (MOH, 2008) and a patient-centred approach should enhance the patients' free choice and increase awareness of the long-term advantages that good quality of care may bring. It is not acknowledged that free choice is related to increased costs of care (MOH 2008).

Financial sustainability

A good half of the expenditure for social services of long-term care is financed through public sources (national and local budgets) while the remaining almost-half is covered by private funds. Private funds comprise, for the most part, extra payments for food and lodging in homes for the elderly and other types of institutional care.

Effective health and preventive care services are of particular importance when the economy and the income declines and unemployment rises, but there is a significant risk that investment in health and long-term care will suffer (EC 2009). Postponement of plans to modernise and develop local health care and long-term care infrastructure can be expected in those municipalities that have under-resourced the health sector.

Challenges concerning accessible, high-quality and sustainable long-term care include: de-institutionalisation of Macedonia's health care system, which will enable dispersion of the palliative and mental health care on community level; enhancement of home care throughout the country; establishment of daily hospitals and centres for palliative and mental health care; to address the expected workforce shortages in the long-term care sector (formal care), as well as devise ways to support family or informal carers; to adequately recruit, (re)train, and maintain long-term care workers.

Much can be achieved by enhancing the role of the public health services: strengthening health promotion, intersectoral cooperation and care coordination between levels of Government, health care and social care, types of medical care, public and private provision; improved data collection; adequate reporting; involvement of local authorities in public health. The challenges of an enhanced transparency with regard to health care and long-term care expenditure remain to be tackled.

3 Impact of the Financial and Economic Crisis

3.1 Pensions

Most countries share the opinion that the negative effects of the crises are still fairly limited given the long-term nature of pension funds, and that it is still too early to predict the precise impacts based only on the short-term performance and the current situation. Pay-as-you-go pensions are statutory, state-run schemes paid from current contributions of workers. A serious economic downturn and larger national debt may increase the need for policy adjustments to secure the long-term sustainability. But, in the shorter term, retirees would like to get their pensions and they will expect any necessary adjustments for the longer term sustainability of the system to be maintained.

In general, the financial sustainability of the pension system in Macedonia depends on the contribution flow in both pillars. According to the official data of the Pension and Disability Insurance Fund (PDIF – central collector of the contributions) in 2008, the revenues were 3% smaller than the expenditures. In January and February 2009, the actual contribution payment was within the planned framework for the period and thus within the planned budget. The total revenues of the pension budget were realised with 99.5% and the total expenditures with 98.1% (PDIF – annual and quarterly reports 2008/2009). Contrary to these figures in the past two months of this year, Macedonia is facing a slow, but continuous reduction in the number of workers in the real sector (textile, construction, transportation, etc.), which respectfully will influence the reduction of the contribution payment and will have an impact on the expected future sustainability of the pension system.

Additionally, within the context of decreased revenues the Government decided to reduce the percentage of all social contributions (including pension contribution) and to reduce also the basis for the pension calculation from 65% to 50% as from January 2009. Both measures taken by the Government can positively contribute to the economy, but on the other hand it is expected that they will decrease the revenues of the pension sector (Law on Contributions for Mandatory Social Insurance; Official Gazette No. 142/2008.).

The reduction of the percentage of the contributions can have an impact on the long-run sustainability of the pension system and the adequacy of the pensions, accumulated on the individual accounts. It should be noted that the Macedonian reformed (funded) pension system is a very young one, at the beginning of its implementation (it has existed for only three years), with a huge majority of members of the second pillar belonging to the young population (the average age of the second pillar members is around 31 years), where the pension benefits are not expected to be paid out for quite some years (see Table 1 and Table 6 of Annex I).

The investment limits are regulated by law and the secondary regulation, and the investment policy portfolio is very conservative (around 40% of the investment in deposits, 40-50% in bonds of domestic issuers, 3-5% in short-term securities of domestic issuers, 6-7% in shares, 2-3% in shares and investment funds of foreign issuers).

The investment performance of the Macedonian pension funds in 2008 demonstrated an average downfall of 10% in the value of the pension funds (MAPAS 2009). In comparison with the countries in the region (Bulgaria, Croatia, Hungary) and OECD countries (average decrease 15-25%), Macedonian pension funds performed with a lower average decrease for 2008. The current picture is not too pessimistic, since the pension funds' investment performance should be considered on a long-term basis and not through the prism of one or two-year performance results.

The institutions included in the pension system, i.e. the Ministry of Labour and Social Policy, as the creator of the pension policy; the Ministry of Finance; the Agency for Supervision of Fully Funded Pension Insurance, as supervisory and regulatory body; the Pension and Disability Insurance Fund; and the private pension companies are in the process of following the developments and performance of the pension system in this period of crisis. All potential risks mentioned above are too early to be predicted and forecasted, since the final, deeper an more profound calculations and projections on the effects from the increasing unemployment rate, gross wage and reduced percentage of contributions are not completed yet. All of the above should be inputs for preparing and presenting short and long-term projections, which shall serve as bases for the recovery plans if necessary, to ensure the long-term strength of the pension system and adequacy of the pensions.

Based on the opinion of several international financial institutions (World Bank), findings of OECD and EU experts and the practical experience, one can learn valuable lessons from the economic crisis and its influence on pensions and come to the following conclusions.1

Pension systems are designed to function over very long periods. Short-term responses to relatively rare circumstances can potentially have negative long-term consequences on the capacity of pension systems to reliably provide adequate levels of retirement income. Pension systems should always be considered on a long-term basis and therefore the mandatory fully funded pillar may suffer periodical losses, which can be compensated when financial and capital markets regain their strength and return to positive trends.

The Macedonian pension system is a multi-pillar system with a balanced mix of pension pillars: public and private; pay-as-you-go, and funded; collective and individual. This continues to be the right approach for sustainable financing of pensions as our society is ageing and is the best model that offers the diversification between the demographic and economic risks. Macedonia's pension system is relatively young, and the pension benefits from the second pillar are not expected to be paid out for several years.

It is necessary to prepare and present short-term and long-term recovery plans in the next couple of months to ensure the long-term sustainability of the pension system.

3.2 Health and long-term care

Macroeconomic trends and social inclusion

The population of Macedonia has experienced multiple internal and external social, economic and political shocks, declining living standards, and a high level of social and economic insecurity and exposure to risk. Over the same period, Macedonia has experienced a sharp increase in inequality, from a Gini coefficient of 0.295 in 1997 to 0.391 in 2005[2] and 2006, and 0.37 in 2007 (Gancheva et al, 2008), which is quite significant and high for the region (Rosenberg, 2008), according to the latest available data (UNDP 2008).

Macro-economic measurements show that Macedonia achieved the very respectable level of 5% to 6% growth for 2007 and the first half of 2008. Economic growth in Macedonia that has been accelerating over the past few years is now likely to feel the repercussions of the global crisis. Real GDP grew at an average rate of 5.6%.

While job creation increased, the unemployment rate remained high. Throughout the recovery period, the labour force participation rate (employed or actively seeking work as percentage of the working-age population) has been very low, remaining below 45%. The labour force in the Former Yugoslav Republic of Macedonia numbers 920,512 persons, out of which 33.5% are unemployed (Statistical Office, 2008). Among older workers (45-65) approximately 80% have been without work for more than one year, 67% for more than two years and 44% for more than five years (Kjosev, 2007). Younger workers (15-24) experience unemployment rates 1.5 times higher than the national average, currently 54.6%. Women have a far lower

[1] These lessons learnt and findings were inspired from: 1) Mark Dorfman, Richard Hinz and David Robalino under the direction of Robert Holzmann, in consultation with regional staff; Pension Reform Primer Note; World Bank – Human Development Network; 2) OECD, Davos (Industry Partners Session): Strategic options to finance pensions, 30 January 2009. 3) OECD (Newsletter, Issue 5): Pension Markets in Focus, December 2008.

[2] UNICEF TransMONEE also shows a ten point increase in the Gini coefficient from 0.223 in 1990 to 0.320 in 2006, based on a different calculation method, but a very similar level of magnitude increase in inequality.

labour force participation rate at 28.4%, compared to 44.1% for men. As a result, despite recovery, Macedonia continues to experience the emigration of skilled and highly educated workers (Mojsoska-Blazevski et al, 2008).

Employment opportunities are geographically concentrated in urban areas, with an additional burden for some vulnerable groups including Roma, members of other ethnic minorities, people with disabilities, the long-term unemployed, people with little education, residents of small rural communities, and women of all ages (UNDP, 2008; Rosenberg, 2008).

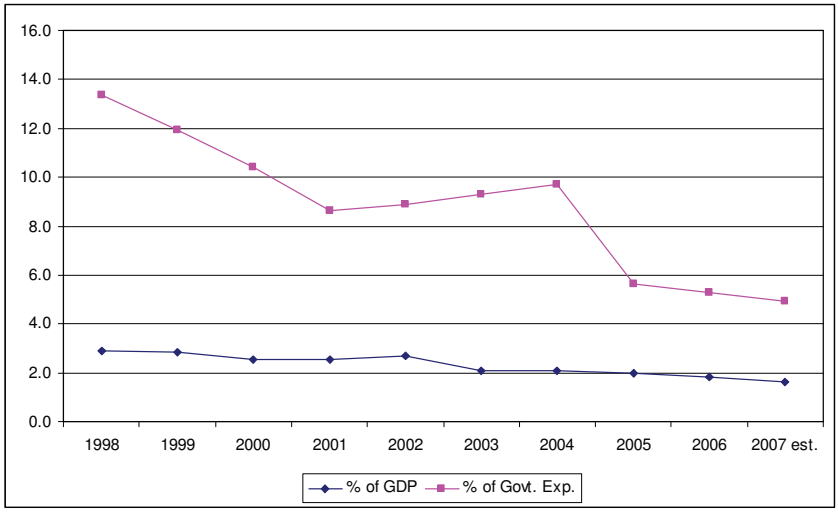
Despite growth, poverty has remained high and is likely to increase due to the impact of the global crisis. It has become entrenched among roughly 30% of the population, with a similar proportion of the population just above the poverty line. Moreover, the poverty gap has deepened (Rosenberg JD 2008).[3] There has been no substantial change in the poverty profile, indicating that multimember households, households with no employed members, households whose members have a low level of education, and households with children are at the highest risk of poverty and of being affected by the impact of the financial crisis (World Bank, 2009).

The nature and profile of vulnerability is not homogeneous. The disparities in poverty rates are found among groups defined by ethnicity, gender, age and educational attainment (Ivanov et al, 2008).

Financial crisis and Health care

The number of beneficiaries and total expenditure on cash benefits has greatly decreased to less than 5% in 2007. The total cost of cash benefits (excluding pensions and health insurance and including war veterans' benefits) was equivalent to approximately 1.4% of GDP and 4.3% of Government expenditure. Considering the levels of GDP per capita and unemployment in Macedonia the further decreasing of expenditures on cash benefits may jeopardise the very objectives of benefits. However, with the current level of expenditure, it is possible to greatly improve targeting, effectiveness and efficiency of benefits (Verme, 2008).

Diagram 5: Expenditure on Cash Benefits 1998-2007



Source: Verme PA 2008

[3] World Bank (2002-2003) estimates consumption poverty at 21%, with an additional 30% poor if non-monetary dimensions are included. World Bank (2005) estimates that 20% of the poor are working poor; Gancheva, Y. et al (2008) and State Statistics Office (various years) are using a relative poverty line, 19% of the population had income below 70% of the median equivalent expenditure, with a poverty gap index of 4.6. In 2007, by this measurement, the headcount poverty rate increased to 29.4% and the poverty gap index to 9.7.

The financing mechanisms of the health care system have also an impact on the social inequities in health care, particularly among the vulnerable groups. In Macedonia the health system is financed by compulsory social contributions. The health contributions from public and private sector employees represented 8.6% of their gross salary before June 2001 when the contribution rate was formally increased to 9.2%. However, the existing health financing system faces serious challenges due to the high official unemployment rate, resulting in a permanent lack of resources. This impacts directly on the access of patients to health care. In order to reduce the burden of contributions in the formal economy and to reduce the unemployment rate, the Government has proposed an ambitious plan to decrease all social contributions, including those for health, from 9.2% to 7.5% in 2009, to 6% by 2011 (Official Gazette No 142. 2008, MOF 2009). However, there are big concerns that the plan will have a negative financial impact on the health system, based on the fiscal parameters: decreased health contributions for 2009 will be MKD 10,570 million compared to MKD 11,150 in 2008 and decreased proportion for health from the central budget for 2009 of 1.62% compared to 1.94% in 2008 (Bedzeti 2009).

Encouraged by the successful implementation of the flat tax, the Government decided in 2009 to undertake over the next two years an overall reform of the financing system in the areas of social insurance and personal tax. Envisaged measures are: decrease the social contributions for health and pensions; introduce calculation based on gross salary; complete harmonisation of the basis for contribution estimation for compulsory insurance; decrease the minimal basis for contributions for compulsory social insurance from 65% to 50%; integrated payment of social contributions and personal income tax to the Public Revenue Office. The Government expects that these reforms will result in a further improvement in the area of social affairs, with a further increase of wages and salaries, a further decrease of the unemployment rate to 32%, and an increase of employment by 4% (MOF 2009).

This may generate an increase of the already high out-of-pocket expenditures for the patients, widening the social inequities in the access to health care services. The Hhousehold Expenditure Survey 2008 (Statistical Yearbook, 2008) shows that 68.5% of personal expenditures on health are spent on drugs and medical devices, 28.1% on outpatient services and 3.4% on hospital services (Lazarevik et al 2009).

Some vulnerable groups such as homeless people and beneficiaries of the social assistance programmes and others as presented before are mostly at risk to be affected by the lack of resources of the health care system and the wide-spread poverty in the country.

Financial crisis in Europe and it's impact in Macedonia

The impact of the economic crisis on previously healthy labour markets is now visible: the EU unemployment rate reached 7.6% in 2009 (17% for the young) from a recent low of 6.8% in April 2008. The GDP is estimated to be about 0.75 percentage points lower this year (SCP EC, 2009).

Some categories of workers are on the front line of the crisis, thus likely to be most affected by the economic downturn, including the young, the low-skilled, employees holding temporary contracts, mobile workers, migrants, ethnic minorities and the elderly. The number of job vacancies started dropping in first quarter of 2009.

The global financial crisis that threatens the world may affect the country with even more acute unemployment and severe poverty. This may result in more people becoming dependent on the state provided social assistance. Apart from the manufacturing and construction industries that are most hit by enterprise bankruptcies and restructuring, other sectors appear vulnerable too in Macedonia. After the period of low inflation, the inflation rate has now

started rising as a consequence of external commodity price shocks. The impact of the global financial crisis and the economic downturn has reduced prospects for exports, FDI and private transfers in 2009. This will affect Government revenues and might result in pressure to reduce spending on social protection. At the same time, due to falling household incomes from employment and reduced remittances, the demand for social assistance benefits is likely to grow (World Bank, 2009).

The macroeconomic trends in 2009, as presented in the general part of the state budget for 2009, is expected to continue with high rates of economic growth. The projections of the Macedonian Government is that the real GDP will be 5.5% in 2009. The projection of high growth rates in conditions of a global financial and economic crisis refers to the statement that in the predictions the real limiting circumstances that will influence the slowing down of the economic growth of Macedonia in 2009 are not included – actually they are not even mentioned. Under the influence of the global financial and economic crisis, for the year 2009 it is totally logical to foresee a significant activity decrease, at least within certain sectors, such as the basic metals industry, civil engineering, the mining and the textile industry, which will certainly influence the total economic activity, i.e. lead to a decline in the GDP of Macedonia in 2009 (OSI 2009).[4]

There are in fact possibilities for realising sufficient budget revenues. GDP growth is expected to be realised in conditions of a stable and low general level of prices, while the inflation rate, measured as an average rate, is not expected to surpass the projection of 3,5 %.

Significant factors to influence the sustainability of such a projected inflation rate in Macedonia in 2009 will be: the trend of prices of the oil derivatives on the world market; the prices of electric and thermal energy; as well as the coordination of the monetary and fiscal policy. It is necessary for the restrictiveness of the monetary policy (which aims to maintain the macroeconomic stability) to be followed by restrictiveness of the fiscal policy, too (Uzunov, in OSI 2009).

With respect to the monetary policy in 2009, the primary activity of the National Bank of the Former Yugoslav Republic of Macedonia will continue to aim at maintaining the price stability and the stability of the exchange rate of the Denar. Also, monetary policy is expected to be consistent in 2009; but due to the emerged financial crisis and its negative effects which will continue throughout the year, a growth of the banks' interest rates is expected.

The situation on the labour market and in the social sphere, in accordance with the Government's efforts, are expected to show further improvement. Salaries are expected to maintain an upward trend. A further decrease of the unemployment rate to a level of 32% is projected, with employment growing by 4 %.

The projected budget deficit is expected to be financed via the increase of the foreign debt as well as via a higher domestic debt (Uzunov, in OSI 2009).

The long-term impacts of the crisis on social security schemes are currently hard to predict. Two particular issues deserve attention. Some plans clearly specify that increased spending in some areas will be counter-balanced by cuts in others or that overall social spending will be cut across the board. This could substantially impact the health care system.

The crisis has prompted quick national policy responses to tackle the immediate social impact of the crisis, building upon the long-term objectives of the Open Method of Coordination

[4] Due to the existing world crisis, the foreseen GDP growth rates in 2009 of the neighboring countries are significantly lower than the ones realised in the past years; the foresights for the growth of the Macedonian GDP in 2009 by the World Bank and the European Bank for reconstruction and development are also significantly lower (around 2,5%).

(OMC). There is a need to enhance the capacity to monitor closely the social impacts of the crisis. It will be required that the short-term measures addressing the negative impact of the economic crisis on employment and social cohesion be consistent with the long-term objectives and structural reforms (EC 2009).

Intervention

Complementary to employment initiatives, main areas for intervention are the following: A strong emphasis should be put on supporting people's incomes, including the most vulnerable groups, increasing the level of minimum income or minimum wage, extending the coverage or duration of unemployment benefits, reinforcing other social benefits, introducing tax rebates or exemptions for specific groups. As most EU Member States Macedonia has to take measures to preserve employment, support activation and promote re-integration in the labour market, and anticipate and manage the impact of restructuring (EC 2009).

In interviews, representatives of both the Ministry of Finance and the Ministry of Labour and Social Policy emphasised that, as reflected in the National Employment Strategy, growth and employment, supplemented by increased investment in education, are the tools they have chosen to reduce poverty and promote social inclusion. To achieve these goals, the Government of Macedonia has adopted an economic policy strategy to improve the business climate by limiting liquidity to maintain a low inflation rate, lowering tax rates, and increasing labour flexibility (Rosenberg 2008).

Macedonia has undertaken an ambitious series of major reforms in the social sector in the past few years, addressing the pension, social insurance, social welfare, and health care systems. But many of those were either not yet funded or had just been embarking on implementation and thus not yet been functioning long enough for any conclusions to be drawn (Rosenberg 2008).

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By-Law for criteria for contracts and payment of specialty-consultative health care services in the health institutions. Правилник за критериумите за склучување договори и за начинот на плаќање на здравствените услуги на здравствените установи кои вршат специјалистичко-консултативна здравствена заштита. Management Board session 16.01.2008. Health Insurance Fund, Skopje, Macedonia, 2008

Закон за евиденции во областа на здравството. Службен весник на РМ бр. 20 од 16.02.2009г. Law on evidence in health. Official Gazette of RM no. 20/2009, Skopje, Macedonia, 2009

Закон за социјална заштита. Law on Social Protection (LSP)

Law on control of drugs and psychotropic substances (Official Gazette of the Republic of Macedonia Nm.103/08)

Law on Protection of consumers ("Official Gazette of the Republic of Macedonia " No.38/04,77/07 и 103/08)

Law on protection on patients rights (Official Gazette of the Republic of Macedonia No.82/08)

4 Abstracts of Relevant Publications on Social Protection

Introductory remark on pensions

In 2008, the pension system was not subject of specific research nor of any in-depth analyses with projections performed by specialised institutions. However, the relevant institutions published their regular reports (e.g. Report on the developments in the fully funded pension insurance; Report on the operations of the Pension and Disability Insurance Fund; Report on the Custodian) and worked on adopting legislation concerning the pension system. Still concrete topics/problems related to pensions were intensively treated by some experts and institutions in particular in the printed and electronic media, as well as in reports.

[R] Pensions

[R1] General trends: demographic and financial forecasts
[R2] General organisation: pillars, financing, calculation methods or pension formula
[R3] Retirement age: legal age, early retirement, etc.
[R4] Older workers activity: active measures on labour market, unemployment benefit policies, etc.
[R5] Income and income conditions for senior workers and retired people: level of pensions, accumulation of pensions with earnings from work, etc.

[R2] ПРЕЗЕНТАЦИЈА-ОКРУГЛА МАСА/PRESENTATION-ROUND TABLE, наслов/title-улога на чувар на пензиски фондови/the role of the custodian of pension funds, тема/issue-округла маса за можноста и услови за банка во улога на чувар на пензиските фондови/ Round table on possibilities and conditions for banks to take the role of a custodian of the pension funds, 22 февруари 2008 година/22 February 2008.

The explanations for the parts 5 and 6 are common since they address the same issues about the role of the custodian and the round table. Currently, the Central Bank of Macedonia is the custodian of pension funds, which is a transitional solution. MAPAS and the Ministry of Labour and Social Policy organised a round table, with participation of a Croatian expert and representatives from the Macedonian banks dealing with the possibilities of Macedonian commercial banks to take over the role of custodians. After the round table, expert Mr Shtimac delivered a report in which he recommended that all obstacles for transferring the custodian role from the Central Bank to the commercial banks should be removed as soon as possible.

[R1, R2, R5] УЗУНОВ Ванчо-универзитетски професор/UZUNOV Vancho - professor at the university, наслов/title - новиот систем на бруто плати во Република Македонија и неговите можни импликации врз животниот стандард, текст во Ревија за социјална политика бр.2 издадена од Фондацијата „Фридрех Еберт"-Скопје/The new system of gross wage-based calculation in the Republic of Macedonia and potential implications on the living standard, text in the Review for Social Policy No.2 edited by Foundation „Friedrich Ebert"-Skopje, тема/issue-можни импликации врз животниот стандард поради намалување на придонесите за задолжително социјално осигурување/potential implications on the living standard due to the reduction of contributions for mandatory social insurance, декември 2008 година/December 2008.

[R1, R2, R5] МАНОВСКИ Милан-претставник на Сојуз на Синдикати на Македонија/ MANOVSKI Milan-representative of Trade Union Association, наслов/title- системот на бруто плати низ законот за придонеси за задолжително социјално осигурување, текст во Ревија за социјална политика бр.2 издадена од Фондацијата „Фридрех Еберт"-

Скопје/The system of gross wage-based calculation seen through the Law on Contributions for Mandatory Social Insurance, text in the Review for Social Policy No.2 edited by Friedrich-Ebert-Stiftung, Skopje, тема/issue-видување на Сојузот на Синдикати за законот за придонеси за задолжително социјално осигурување/Trade Union view of the Law on Contributions for Mandatory Social Insurance, декември 2008 година/December 2008.

In section 6, part 21 contains information on the adoption of the Law on Contributions for Mandatory Social Insurance. The parts from 22 to 24 contain descriptions on the public opinion, different views and expert discussions. The new system of gross wage-based calculation and the potential implications on the living standard were important issues discussed in expert papers and debates on the round tables for effective policies on the improvement of the standard of living in Macedonia.

In this light, professor Uzunov concluded that the benefits from the gross wage reform with the reduction of the social contributions will indeed result in savings for the labour force, but how this will impact on their living standard depended on the employers As a result the savings from the reduced contributions could be used by some employers for increasing the wages of their employees, some could hire new employees or use the savings for company growth and development, while others might simply save them as profit. The Trade Union's approved of the new concept but called for further discussion among the social partners.

[H] Health

[H1] Health expenditures: financing, macroeconomic impact, forecasting, etc.
[H2] Public health policies, anti-addiction measures, prevention, etc.
[H3] Health inequalities and access to health care: public insurance coverage, spatial inequalities, etc.
[H4] Governance of the health system: institutional reforms, transfer to local authorities, etc.
[H5] Management of the health system: HMO, payments system (capitation, reimbursement, etc.)
[H6] Regulation of the pharmaceutical market
[H7] Handicap

[H2] SCHAAPVELD K., Trajanovski M. Progress Report – Consultancy on Development of a New Public Health Law. Health Sector Management Project. Ministry of Health, Skopje, Macedonia, 2009.

The outline of the new public health law is the key element of this progress report based on the analysis of the Macedonian public health legislation and analysis of the public health reforms (progress and challenges). The key elements of the proposed public health law are: description of tasks of the national institute of public health and the centres for public health, organisational structure of the National Institute of Public Health and the centres for public health, link with existing legislation, the establishment of an intersectoral public health coordination council, the involvement of local authorities in public health, food risk management; public health authorities, public health emergencies, data management, new regulation will be needed for land border crossings, financing of public health activities.

[H3] UNTERHOFER F., Mladenovic N., Kuehhas B. Пристап заснован на човековите права во општество во транзиција – искуства од Македонија. Human Rights-Based Approach in the context of a society in transition – experiences from Macedonia. Ludwig Boltzmann Institute of Human Rights (BIM). Skopje, Macedonia, 2008

The general project objective is the implementation of the human rights-based approach (HRBA) in poverty reduction and the support of the creation of the MDG-based strategies for social and economic development on both national and local level. The main objective is to assess which MDG-related services (education, health,

social aid, etc.) the municipalities are offering to their citizens, and double-check who is using what services, if there is an adequate participation in the decision making processes at local level, and, consequently, if there are any patterns of social exclusion.

[H2, H3, H4] VERME P. A Proposal for Reform of the Social Assistance System and for the Introduction of Conditional Cash Transfers in the Republic of Macedonia. Ministry of Labour and Social Policy. Skopje, Macedonia, 2008.

This is a proposal for the reform of the existing system of social assistance and for the introduction of new Conditional Cash Transfers (CCTs) in Macedonia. At present, Macedonia disposes of a very weak administrative system in the social assistance sphere represented by the Social Work Centres (SWCs) and of a complex and inconsistent system of cash benefits. The SWCs lag behind the Pension and Disability Fund and the Employment Agency, and they are in urgent need of structural reforms. Social assistance benefits need to be redesigned in order to function as a coherent social assistance system. Any reform related to social assistance, including the introduction of new CCTs will have to address these issues. The report provides a detailed analysis of all currently existing cash benefits for social and child protection, their legal backgrounds, eligibility and benefits composition.

[H2, H3, H4] AYALA FV., Shafi CA. Second Consultancy Report – Diagnostic and Options for Conditional Cash Transfers. Ministry of Labour and Social Policy. Skopje, Macedonia, 2008.

As part of an ongoing reform process of Macedonia's social safety net (SSN), including reforms of the pension sector, the unemployment schemes and the social protection programmes, the Government of Macedonia has decided to reform also the current social protection and child allowance schemes and, as part of this reform process, introduce a Conditional Cash Transfer (CCT) programme. Such a programme will be promoting more equal chances for the development of children, aiming to mitigate the impact of poverty on children's access to education and health care, supporting families in the lower deciles. The report aims to combine and build up on the work of previous consultants to the SSN and contribute to an ongoing reform process by presenting and discussing options for the introduction of a CCT in Macedonia.

[H3] NATIONAL ROMA CENTRUM «Просперитет и здравје на жената Ромка 'Пат кон предизвик'».. Skopje, Macedonia, 2008 (www.nationalromacentrum.org).

"Prosperity and Health of the Roma Woman 'The Road to challenge'"

The goal of this research is to determine the present condition and top-priority problems regarding the access of Roma women to health care. This is an attempt to include the Roma women - the most marginalised entity in this society - in the public health care agenda. Lack of personal identification documents: 76.5% of interviewed women do not have passports, 48% do not have marriage certificates; 14.5% do not even have personal identification cards, and 11% do not have citizenship. Only 4.7% do not have transcripts from the birth registry and 3.7% do not have health care booklets. Illiteracy is a problem (52% are illiterate and 26% are semiliterate) that generates a lack of education for Roma women, unemployment (41.9% of all 17,672 unemployed Roma are women) and social exclusion (64% women interviewed are welfare recipients).

[H3] TOZIJA F. Социјална инклузија на Ромите во здравството: состојба, предизвици и можности. Social inclusion of Roma population in health: situation, состојба, challenges and opportunities. Journal for social policy (Ревија за социјална политика). Friedrich-Ebert-Stiftung, Skopje, 2008, No. 1 (58-67)

The National Health Action Plan is designed to support the implementation of the Millennium Development Goals and the Decade for Roma inclusion 2005-2015, adapted to the local health needs of the Roma population. Implementation of the defined activities of the Plan: positive discrimination of Roma; vertical preventive programmes; special preventive programme for Roma (healthy life style; reproductive health; safe pregnancy; immunisation); health promotion; improvement of the primary health care for Roma; Roma inclusion in health policy will contribute to better health for the Roma population, especially children, youths and women; better access, quality and quantity of health services, and more benefits from health insurance.

[H4, H5] MILEVSKA-KOSTOVA N., Cicevalieva S., Tozija F. Privatisation of Primary Health Care – The Macedonian Case. EUPHA-ASPHER Conference. Lisbon, 2008. Book of proceedings

The number of private primary health care providers has shown a trend of constant growth in the past 10 years; during the privatisation period 2004-2007, a total number of 3,521 medical staff in PHC has switched from the public to the private sector, most of them in urban areas; the smaller number of private practices in the rural areas contributes largely to the inequity in the access to the health services as one of the basic and constitutionally guaranteed rights of the citizens. Merely two years after completion of the privatisation of the PHC, which included general medicine, occupational medicine, gynecology, pediatrics, school medicine, dental services, and pharmacies, it may be too early to assess the privatisation impact based on the health indicators.

[H4, H5] TOZIJA F., Nikovska Gudeva D. Истражување за задоволство на пациенти. Patient Satisfaction Survey. Republic Institute for Health Protection. Ministry of Health. Skopje, Macedonia. 2008

This is a report on the patient satisfaction survey undertaken by the Republic Institute for Health Protection in Macedonia, on a nationally representative sample of 2,404 persons, 71.6% interviewed in urban PHC institutions, all doctors have contracts with HIF, 68% are general practitioners. Out of 1,225 persons surveyed in public health care settings only a minor percentage (between 3% and 7%) show complete dissatisfaction of the services offered; other indicators, including the services and conditions in the ambulatory and hospital care, organisational and infrastructural requirements are scored between 79% and 90%; overall, the survey ascertains a "high level of satisfaction of the patients". Bearing in mind the goals of the health care sector reforms, this opens up a new view on the privatisation of PHC in the first instance, and potentials and challenges for the privatisation of the secondary and tertiary health care.

[H3, H4, H5] TOZIJA F. et al. Здравјето на населението во Република Македонија. Republic Institute for Health Protection. Skopje, Macedonia, 2008.

"Health of the nation of the Republic of Macedonia"

The report gives an overview of the health status of Macedonia's population in. The demographic change and, as a result, population ageing (decreased natality and fertility and increased mortality) combined with migration has changed the contingents of working, active, supported, and dependent population. The health status is characterised by a high prevalence of non-communicable diseases in morbidity and mortality figures, typical for developed countries and resulting from unhealthy lifestyles. The population, especially the youths and females, are faced with challenges resultinig from bad habits: smoking; overuse of alcohol and other psychoactive substances; food rich in fats; risky sexual behavior that leads to infectious diseases such as Hepatitis C and other sexually transmitted diseases; disorders in physical and mental health. The Former Yugoslav Republic of Macedonia has been introducing important changes in health system management through implementation of worldwide and European strategic goals and trends for the future development and health promotion.

[H5] RISTOVSKA R. Менаџмент на хуманите ресурси – Алгоритам за подобрување на учинокот на докторите во примарна здравствена заштита. Master thesis. School of Medicine, Skopje, Macedonia, 2008

"Human resource management – Algorithm for improving doctors performance on the primary health care level"

The study took place during 2005/2006. As many as 358 doctors were included in the retrospective and 78 in the prospective study with the same or similar characteristics as the population of primary care physicians. The results of this study show that human resource management is a key factor for doctors' performance and better care for patients. The analysis of the factors obtained by factor analysis of the study shows that primary health care in public health institutions is based mainly on the work of half of the employed physicians. Human resource management development needs to be strongly promoted by strengthening individual capacities to lead, negotiate and communicate and by developing institutional tools to deliver health care more effectively and efficiently.

[H3, H4] Tozija F. Utilisation of Emergency Medical Services in the Republic of Macedonia. Republic institute for health protection. Skopje, 2008

This cross-sectional study was conducted on a representative sample of 19 hospitals consisting in a review of medical records at Emergency Medical Services (EMS log books) and patients interview questionnaire. A total of 1,457 patients were interviewed and for 3,316 patients data were extracted from the ED logbook in one week. Hospitals have a daily workload of more than 30 cases compared to 33.8 patients/per day seen in the EMSs. Most of the surveyed hospitals have some capacity to provide the essential diagnostic tests within 24 hours or less, needed for the ED patients. In general, the hospital EDs are not organised as a separate division, with big differences and discrepancies in their organisation. EMS do not function as a true provider of urgent care with insufficient or out-of-date diagnostic/therapeutic procedures. Emergency services are underused and immediate efforts should be undertaken to transform them in effective services.

[H2, H4] NIKOVSKA GUDEVA D., Tozija F. Gjorgjev D., Arnikov A., Kishman A. Analysis of the potential for good governance in health sector in the Republic of Macedonia. Open Society Institue Macedonia. Skopje, 2008 (in print)

CDC PAHO methodology and instruments are applied to evaluate the functioning of public health sector across 11 essential public health functions by means of a set of 49 indicators, measures and sub-measures. Results provided recommendations for improvement of the essential public health functions, reduction of barriers and costs associated with them identification of "grey zones", critical issues and dilemmas, as well as the development of strategies to address them. Repeated measurements over time are recommended to facilitate consistent quantification between measurement and identification of the "grey zones" in the public health system, thus facilitating the design of targeted interventions for institutional capacity strengthening.

[H2, H4] GJORGJEV D., Sedgley M. The evaluation of public health in South-East Europe: from transition to progress. Italian Journal of Public Health. 2009. (in print)

The evaluation was oriented around "essential public health operations" that are deemed to form the core of public health activities and services and to be indispensable for the delivery of modern public health services in any country. The evaluation analysed these activities and services within the structure of the health system functions of stewardship, resource generation, financing and service delivery, as developed by the WHO. The results demonstrate a mixed picture of strengths and weaknesses within the context of significant social, economic and political challenges in the region. Among the many visible and significant strengths in public health services in the region are a well developed network of public health institutes with well defined surveillance systems, highly experienced and well educated public health professionals, as well as many positive examples of service delivery. But there are also many concerns and challenges, not the least of which is political focus, direction and support for modern public health services, as well as funding.

[H3, H5] LAZAREVIK L., Risteska M., Simonovska V. The Impact of Social Assistance Programmes on Reducing Inequities in Health Care Among Vulnerable Groups in the Republic of Macedonia (A Small Scale Descriptive Study). Macedonian Journal of Medical Sciences. Maced J Med Sci, 15 March 2009; 2(1)xx-xx (in print)

The aim of this research was to look at the impact of social assistance programmes on reducing social inequities in health care among the vulnerable groups in Macedonia. A small-scale descriptive study was conducted using an open-ended questionnaire among the homeless, socially excluded Roma, and people dependent on state-provided financial allowances. These vulnerable groups were considered to be at highest risk of poverty and social exclusion. This situation contributes to the deepening of their poverty. There is need to raise the awareness and to improve the communication strategies of the Government. Special programmes should be designed and implemented at local level to target these vulnerable groups in order to increase the availability and access to health care services.

[H2, H4] SARKANJAC B. **Јавно здравје и здравствена реформа**. Политички и социолошки перспективи. Public health and health reform. Political and sociologic perspectives. Faculty of philosophy. Institute of Health and Society. Skopje, 2008

This book gives an overview of the situation within Macedonia's health sector. Main challenges were to give a notional framework in order to make easier a normative debate regarding reforms in Macedonia; to establish an ideological context and

background of the reforms; to speak about doubtfulness of health reforms, or more precisely about the problems arising during its implementation. Since the health reform is a political issue, or more precisely an issue of governance and governance reform, equally as it is an issue of management and organisation, the author tries to reach those aspects of the reform that are exposed through most modern political and social conceptions of governance.

[H2, H3, H5] Здравтсвена карта на Република Македонија 2007 година. Прв дел Состојби во Република Македонија. Македонија. Health Map of the Republic of Macedonia 2007. Status of the Republic of Macedonia. Republic Institute for Health Protection. Skopje, 2009

The Health Map of the Former Yugoslav Republic of Macedonia represents the health system and health status of the population in the Republic in general, and separately for each health region in 2007, in terms of their organisational structure, health services, health personnel, morbidity and mortality. The preparation of the Health Map is based on official data, collected and processed by the Department for Health Statistics and informatics of the Social Medicine Unit within the Republic Institute for Health Protection, Skopje, provided by the Institutes for Health Protection in the Republic of Macedonia and the State Statistical Office. The Health Map consists of three parts: General Part I: presenting the general status of health protection in the Republic, and by level of health protection – primary, secondary, tertiary – in the health regions in Macedonia and Special Parts II and III representing the status of health protection by health regions, in alphabetic order. The data are presented in tables and maps.

5 List of Important Institutions

Ministry of Health

Contact with the Cabinet of the minister
Phone: +389 (02) 3112 500 – ext. 102
Phone: +389 (02) 3126 206

Contact with the public relation office
Phone: +389 (02) 3112 500 - ext. 133
Phone: +389 (02) 3296 522
Webpage: www.moh.gov.mk

The competences of the Ministry of Health are: health care protection and health care insurance of the population; organisation and development of health; attending the health care conditions of the population; protection of the population from contagious diseases, the influence of gases, radial rays, noise, pollution of the air, water and the earth; consumer products and products for public use; hygienic and epidemiological condition; medicines, additional medications, medical supporting assets, medical equipment, sanitary offices and materials; poisons and drugs; surveillance;

Medical Association of the Former Yugoslav Republic of Macedonia
Phone: +389 2 323 90 60
Phone/fax: +389 2 312 40 96
Email: nachamed@mt.net.mk
Webpage: www.lkm.org.mk

The Medical Association of the Former Yugoslav Republic of Macedonia is an independent and professional organisation of medical doctors, associated in order to protect and promote proficiency, ethical obligations and rights, improvement of health protection quality, monitoring of the relation of those working in health professions to society and citizens, and protection of doctors' profession interests. The association advocates and protects the interests of its members and looks after the reputation as part of the performance of the doctors' profession.

Medical Faculty – Skopje
Phone: +389 2 31 65 155
+389 2 31 11 254
Fax: + 389 2 32 20 935
Webpage: www.medf.ukim.edu.mk

Education and research centre.

Health Insurance fund of Macedonia
Phone: +389 2 3289-000
Fax: +389 2 3289-048
Email: info@fzo.org.mk
Webpage: www.fzo.org.mk

The health insurance fund of Macedonia is founded with the Law on health protection (Official Gazette of RM, No. 25/2000,34/2000 and 96/2000), in order to conduct mandatory health insurance as a institution providing public activities and public authorisation defined by law. The Law on health insurance regulates the health insurance of the citizens, rights and obligations from health insurance as well as means of conducting health insurance.

Foundation Open Society Institute - Macedonia (FOSIM)

Address: Bul. Jane Sandanski 111, Skopje, Former Yugoslav Republic of Macedonia
Phone: +3892/ 2444-488
Fax: +3892/2444-499
Webpage: osi@soros.org.mk
www.soros.org.mk

The Foundation Open Society Institute – Macedonia (FOSIM) was founded in 1992 as a foreign entity representative office, becoming a national legal entity foundation in 1999, in accordance with the Law on Associations of Citizens and Foundations. FOSIM is part of the Soros network in Central and Eastern Europe. FOSIM's works towards EU integration. Dedicated to the promotion of an open society, FOSIM initiates supports and implements a wide spectrum of programmes

UNDP - United Nations Development Programme

Address: 8-ma Udarna Brigada Str.2, 1000 Skopje
Phone: +389 - 2 - 3249 500
Fax: +389 - 2 - 3249 505
Email: registry.mk@undp.org
Webpage: www.undp.org.mk

UNDP in the Former Yugoslav Republic of Macedonia provides support to the Government through its current programme activities in the following flagship areas: decentralisation, jobs, environment, security, and aid coordination. In accordance with its corporate goals, UNDP is also active in the areas of poverty reduction, HIV/AIDS, and in its support to the Government in meeting the Millennium Development Goals.

WORLD BANK – Country Office Macedonia

Address: 34, Leninova Street, 1000 Skopje
Contact: Mr. Denis Boskovski, External Affairs Officer and NGO Liaison
Phone: +389-2 3 11-71-59
Fax: +389-2 3 11-76-27
Email: dboskovski@worldbank.org
Webpage: http://web.worldbank.org

Healthy Options Project Skopje

Address: Ul. Hristo Smirnenski 48-1/6, 1000 Skopje, Former Yugoslav Republic of Macedonia
Contact: Vlatko Dekov, Executive Director
Phone: +389 (0)2 3 246 205
Phone / Fax: +389 (0)2 3 246 210
Email: hops@hops.org.mk, vlatkod@hops.org.mk
Webpage: www.hops.org.mk

Established in1999, the Healthy Options Project Skopje is a non-governmental, non-profit and non-partisan organisation that started operating as a project supported by The Lindesmith Center and The Open Society Institute Macedonia in 1997. During this period it has successfully implemented programmes for reduction of drug-related harm, prevention of HIV/AIDS and other sexually transmitted and blood-borne diseases, as well as programmes

for social reintegration and re-socialisation targeting young people and vulnerable groups (drug users and their families and sex workers and their families) in Skopje, Macedonia.

Ministry of Labour and Social Policy (MLSP)

Address: ul. "Dame Gruev",14 1000 Skopje Former Yugoslav Republic of Macedonia
Contact: Irena Risteska, Head of Department for pension and disability Insurance
Webpage: www.mtsp.gov.mk

MLSP is a public institution which is responsible for creating and implementing the policy on pension and disability insurance and for supervising the legality of operations with respect to this insurance. MLSP is also responsible for labour market development policy, labour protection of workers during their working careers, social protection, child care, wages policy and living standard, protection of disabled persons, gender policy and other obligations defined by law.
Publications: Macedonian Social Picture, International Labour Standards, Report on Equal Rights between Men and Women.

Agency for Supervision of Fully Funded Pension Insurance (MAPAS)

Address: ul."Vasil Glavinov b.b Intex Biznis Centar 2, 1000 Skopje, Former Yugoslav Republic of Macedonia
Contact: Biljana Petroska, Head of Research Sector
Webpage: www.mapas.gov.mk

MAPAS is a public institution with a regulatory and supervisory role established to supervise the operations of pension companies and pension funds, to protect the interests of pension fund members and to stimulate the development of the fully funded pension insurance. The Agency performs the following activities: Grants, withdraws and abrogates licenses for establishment and approvals for managing pension funds; supervises the operation of pension companies and the pension funds under their management and especially controls their legal operation; supervises the operation of legal entities acting as custodians or foreign asset managers of pension fund assets in relation to operating with such assets; promotes, organises and enhances the development of the funded pension insurance in the Former Yugoslav Republic of Macedonia, in cooperation with the Ministry of Labour and Social Policy. MAPAS is also responsible for the development of the public awareness on the purposes and operating principles of the pension companies and the pension funds, on the benefits from pension fund membership, on the rights of pension fund members and other issues relating to the pension fund system. The agency has active procedural legitimisation and may intervene, either directly or indirectly, in any process against a pension company and any entity or entities in a legal relationship with the pension Companies, when such action is necessary for the purpose of protecting the interests of the pension fund members.

Publications: Annual Report on the Developments in the Mandatory Fully Funded Pension Insurance (annually: 2006-2008); Annual Statistical Report (annually: 2006-2008); Quarterly Statistical Report/ (quarterly in years: 2006-2008); Monthly Bulletins and daily information on the value of the pension fund accounting unit.

Pension Management Companies (PMCs)

For PMC-KB webpage: www.kbprvo.com.mk
Address: Bul."Ilinden" br.1 Skopje 1000, Former Yugoslav Republic of Macedonia,
Contact: Janko Trenkoski, President of Company's Management Board
For PMC-Nov webpage: www.npf.com.mk
Contact: Kristijan Pavlovski General menager
Address: ul. "Vodnjanska" br. 1 , 1000 Skopje, Former Yugoslav Republic of Macedonia,

Description: PMCs are private joint stock companies founded by financial institutions whose only object of activity is the management of pension funds, representing them in front of third parties and other activities related to the pension funds. The shareholders of the pension company, in accordance with their participation in the pension company's capital, have equal position in the pension company. The statutes of a pension company shall not award any additional rights or privileges to certain shareholders, limit their rights or impose on them additional responsibilities.

A Pension Company for managing pension funds may be founded by domestic and foreign legal entities. The founders which would hold 51% of the share capital of a pension company shall be banks, insurance companies, pension companies and other financial institutions or entities which, directly or indirectly, hold more than 50% of the shares of such institutions. The same legal entity may not be a shareholder of more than one pension company.

Publications: Financial Audit Report for Pension Companies and Financial Audit Report for Pension Funds (annually: 2006-2008), Financial Reports on Financial Results; Assets under Management (annually); Value of the Accounting Unit (annually), Pension Fund Return (annually).

Pension and Disability Insurance Fund (PDIF)

Address: ul. "Vladimir Komarov" bb, 1000 Skopje, Former Yugoslav Republic of Macedonia
Webpage: www.piom.com.mk
Contact: Menka Temelkovska, Head of Statistics Unit

PDIF is a public institution which undertakes centralised collection and allocation of contributions and gathers relevant data for members of the selected pension funds and companies. PDIF main activities are: implementation of the policy on development of pension and disability insurance; follow and study the area of pension and disability insurance; propose steps aimed at improving the pension and disability insurance system; suggest the size of pension and disability insurance premiums; ensure the efficient use of the funds needed for securing pension and disability insurance rights; issue an annual report on the work of the fund's special service; regulate the rights, commitments and responsibilities of the administrative authority, the director, and the special fund service; implement international agreements and agreements between countries in the area of pension and disability insurance; and others.
Publications: Annual Reports of PDIF Activities; Actuarial Report for 2006, and statistical data on pension payouts (monthly).

Institute of Social Work and Social Policy / Faculty of Philosophy

Address: ul. "Krste Misirkov" bb, Box 576, 1000 Skopje, Former Yugoslav Republic of Macedonia,
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Webpage: www.fzf.ukim.edu.mk

This is public a institution that educates in the field of social protection policy by preparation of analyses, research, projects, social journal and other forms of social points of view. The main subjects are: 1) Theory of Social work. 2) The subject Social Politics. 3) Sociology. 4) Family Law and Social Law. 5) Psychology. 6) Pedagogy.

Publications: Reviews for Social Policy.

Trade Union Association – SSM

Address: "Udarna brigada" bb, 1000 Skopje, Former Yugoslav Republic of Macedonia,
Contact: Milan Manovski, Secretary of the Socio-Economic Research Unit
Webpage: www.ssm.org.mk

This association has been established to protect the rights of workers and is one of the members in the three-party body for social dialogue and negotiations (Social-Economy Council). SSM participates in many debates regarding social issues, including comments on legislation concerning labour, pensions, social protection, living standard and other social issues.

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(1) to improve the knowledge and understanding of the situation prevailing in the Member States (and in other participating countries) through analysis, evaluation and close monitoring of policies;
(2) to support the development of statistical tools and methods and common indicators, where appropriate broken down by gender and age group, in the areas covered by the programme;
(3) to support and monitor the implementation of Community law, where applicable, and policy objectives in the Member States, and assess their effectiveness and impact;
(4) to promote networking, mutual learning, identification and dissemination of good practice and innovative approaches at EU level;
(5) to enhance the awareness of the stakeholders and the general public about the EU policies and objectives pursued under each of the policy sections;
(6) to boost the capacity of key EU networks to promote, support and further develop EU policies and objectives, where applicable.

For more information see:
http://ec.europa.eu/employment_social/progress/index_en.html