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Pensions, health and long-term care

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Authors: Zorica Apostolska (pensions) and Marija Gulija (health and long term care),

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On behalf of the
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1 Executive Summary

The last years have been under the influence of the recent economic and financial crisis, a high unemployment rate and rigid labour market, as well as increased transfers from the State Budget to finance the pay-out of pension benefits. In order to ensure revenues and to improve the sustainability of the pension system, policy makers intervened with several reforms in the pension sector. This included a gradual limitation of the management costs in the mandatory fully funded pension component. Also, there has been a substantial change in the area of pension funds' supervision, where the Supervisory Authority's previous proactive method of supervision is now transformed into risk-based supervision (put into practice from 2013). The challenge for the risk-based supervisor is to identify the main risks to the DC pension system and to check that the mechanisms for mitigation of such risks are in place and are working properly. The tendency of decreasing the contribution rate for public pensions has continued, which creates an even bigger gap in the financing of the pension system and more frequent necessity for larger borrowings and transfers from the State Budget (over 35%) for pay-outs of current pensions.

The pension system and the labour market are closely connected by linking lifetime earnings with the pension wealth. The Republic of Macedonia is characterized by long-term unemployment, high youth unemployment and very low labour market participation of women and elderly. These are all causes for great concern. This assessment has been confirmed with the EU Progress Report for 2012 in the section *"Social policy and employment"* where amongst other things it was stated that the national budget allocated to the active labour market programme is low.

The Macedonian health system is struggling with the implementation of major reform objectives, which might be partially explained by the poor economic growth and the economic crisis, which is reflected in the overall financing of the public health sector in the country. Also, it seems that policy objectives of the Government lack a clear vision. Several investment policies have been introduced by the Ministry of Health aimed at refurbishment, reconstruction and building of health facilities, provision of equipment and, therefore, improving working conditions in public health institutions (PHI). Moreover, some additional supportive measures regarding achieving high professional standards for medical professionals and improved quality of health services have been undertaken, which have not given the expected results. It is probable that the capacities of PHI are inadequate for the current health needs of the population; poor management and the burden of a huge administrative apparatus are still awaiting restructuring and downsizing. Any new health policy changes and strategic goals should include the introduction of supplementary/voluntary insurance, increased revenue collection and improvement or readjustment of system performance.

Long-term care is still in its initiation. The need of structured, well-organised and multi-sector approached implementation of long-term care services has to be appreciated. The national strategy of elderly people presented by the Ministry of Labour and Social Policy recognised needs in policy patterns and strategy commitments towards a solid basis for future development. However, much needs to be improved, restructured and coordinated/correlated regarding the gap between systematic linkage of health and social services provision.

2 Pensions

2.1 System description

2.1.1 Major reforms that shaped the current system

The evolution of the major reforms that shaped the current Macedonian pension system in the last two decades historically can be described trough a few essential stages:

- A series of parametric reforms (restrictive measures: increased contribution rate, increased retirement age, reduced replacement rate-percentage for calculating old age pension benefits, etc.), were taken in order to improve the financial sustainability of the pension system in the years 1994 and 2000.

- The rationalization of the PAYG system created a solid basis for introducing a combined multi-pillar pension system, when two parallel types of pension schemes have been established in the year 2000: the PAYG and the mandatory funded component (DB and DC). - In January 2006, the reformed mandatory "mixed pillars" pension system became operational with the first contribution payments into the individual accounts. The legislation for the voluntary-third pillar was adopted in January 2008, followed by the payment of the first voluntary contributions and in April 2009, the start of asset investments.

2.1.2 System characteristics

The structure of the current Macedonian pension system is a multi-pillar system, consisting of:

- PAYG, contributing system (DB) - Public pensions (mandatory) – first pillar.

- Individual accounts (DC) - Private pensions: (mandatory) – second pillar.

- Personal/occupational accounts (DC)-Voluntary private pensions– third pillar.

The contributions are the main source of financing of the mandatory component of the pension system (59.9% of the total revenues)[1], where only employers are obliged to pay in the contributions from their employees' wages. Transfers from the State Budget (37.7%[2], of total revenues) are the second largest financial source.

The **retirement conditions are** equally valid for all insured persons in the mandatory pension system (first and second pillars): retirement age of 64 years for men, 62 years for women with a minimum of 15 working years, except in case of disability or death[3].

The level of the pension benefits from the PAYG system depends on the **pension benefit formula**: First pillar pension will be calculated based on the individual salaries from the entire career, valorised as per the average salary in the year preceding the year of retirement.

For beneficiaries which draw pensions only from the first pillar, the **replacement rate** is 80%, which starting from 2000 and in the following 40 years will be gradually reduced to 72%. After January 1, 2013, the replacement rate for future beneficiaries will decrease by 1.8% (men) or 2.6% (women) and further on it will be annually reduced by 1.61% for men

[1] Report on the operations of PDIF for 2011, page 31, published in April 2013,on http://www.piom.com.mk/informacii/statistika/240.html

[2] Report on the operations of PDIF for 2011, page 35, published in April 2013,on http://www.piom.com.mk/informacii/statistika/240.html

[3] The Law on pension and disability insurance, article 18 and 228, published in the Official Gazette, No 53, 11 April 2013 http://www.mtsp.gov.mk/WBStorage/Files/novzakon_pio.pdf

and 1.84% for women. For future employees/pensioners who participate in both pillars, a replacement rate from the first pillar as a part of the multi-pillar pension system of 30% is envisaged[4].

The Macedonian laws stipulate **Exempt-Exempt-Taxed** (EET) **tax treatment** for the mandatory and voluntary fully funded pension system. The pension contribution and the investment income are tax-exempted, whereas the payment of pension benefits is taxed.

The third pillar incentives include tax alleviations for the occupational schemes sponsors. The **indexation** formula for the pension benefits from the first pillar is composed of 50% of the living costs index, and 50% of the change of the average wage paid in the Republic of Macedonia (Swiss Formula)[5].

2.1.3 Details on recent reforms

The economic and financial crisis, a high unemployment rate and rigid labour market, have called for additional reforms in order to ensure income and to improve sustainability of the pension system. In this context, the following reforms were approached:

- By the end of 2008, the **pension contribution rate,** as a percentage from the gross wage, was reduced to 19% from 21.2% for 2009 and to 18 % for 2010. Later on, the policy-makers have recognised that the accelerated decrease of the social contributions had caused deficits in the social funds. Consequently, in December 2010, the Law on Contributions for Mandatory Social Insurance was amended prescribing a lower decrease of the contribution rate for 2011, from the planned 15% to 18%.[6] This policy continued in 2012 and 2013, whereby the contribution rate was maintained at 18%, as confirmed with the December 2011 amendments to the Law on Contributions for Mandatory Social Insurance. Further, these amendments foresee that in 2014 the rate will be 17.6%, while the long-term implementation of the systemic solution will start from 2015, with a contribution rate of 17.5%.[7]

- Furthermore the reform included the cutback of operational costs of the private pension funds. Considering the impact of the economic crisis on the value of the pension funds and the fragile state of the financial and capital markets, the **fees** from contributions where **permanently reduced** in the last three years. With the latest reform from January 2013, it was decided that the contribution fees may not exceed 3.5% in 2014, 3.25% in 2015, 3% in 2016, 2.75% in 2017, 2.5% in 2018 and 2.25% in 2019. Also, the reform included the net asset fee of the pension funds, which was set to maximum 0.045% in 2014, 0.04% in 2015, 0.04 % in 2016, 0.035% in 2017 and 0.035% in 2018.[8]

- In January 2012, the **Law on Pay-out of Pensions and Pension Benefits** from the Fully Funded Pension System[9] was adopted. This Law stipulates in details the allowed types of

[4] The Law on pension and disability insurance, article 34 and 228, published in the Official Gazette, No 53, 11 April 2013 http://www.mtsp.gov.mk/WBStorage/Files/novzakon_pio.pdf

[5] The Law on pension and disability insurance, article 37, published in the Official Gazette, No 53, 11 April 2013 http://www.mtsp.gov.mk/WBStorage/Files/novzakon_pio.pdf

[6] Amendments to the Law on Contributions for Mandatory Social Insurance, published in the Official Gazette December 2010.

[7] Amendments to the Law on Contributions for Mandatory Social Insurance, published in the Official Gazette No.185, of 30 December 2011.

[8] Amendments to the Law on mandatory fully funded pension system, article 52 and 73, published in the Official Gazette No.13, 23 January 2013.
http://www.mtsp.gov.mk/WBStorage/Files/zakon_zadolzitelno_kapitalno.pdf

[9] Law on Payout of Pensions and Pension Benefits from the Fully Funded Pension System, published in the Official Gazette No.11, of 24 January 2012.
http://www.mtsp.gov.mk/WBStorage/Files/zakon_zadolzitelno_kapitalno.pdf

pensions that shall be paid out from the fully funded pension scheme (annuities, programmed withdrawals, and the lump sum pay-outs which shall be paid out from the third pillar only).

- In mid-2012, a new Law on pension and disability insurance was adopted, integrating all amendments from the last ten years. A substantial change was made in terms of reducing the replacement rate, as explained in the previous section, with the pension benefits formula.

- In reference to 2009/2010/2011 recommendations, noted in the European Commission Progress Report, in 2012 the Law on Mandatory Fully-funded Pension Insurance was amended, thereby ensuring increased operational and functional **independence of the regulatory and supervisory** body. More precisely, changes relating to the appointment and dismissal of management (Council of the regulator) to be done by Parliament, not by the Government as was previously arranged.[10]

-At the beginning of 2013 the Law on Mandatory Fully Funded Pension Insurance was a subject to significant changes: the introduction of **risk-based supervision**, strengthening of the principles of good corporate governance, and the establishment of a fiduciary duty of the pension fund managers', to protect the interests of the pension fund members. The novelties are related to introduction of the prudent man rule and the extension of the period over which the rate of return is calculated (from 3 to 7 years) etc.[11]

2.2 Assessment of strengths and weaknesses

2.2.1 Adequacy

According to Labour Force Survey for 2012, published in 2013, the active labour force 15 years of age and older in the Republic of Macedonia amounts to 1,669,965 (835,287 men and 834,678 women)[12]. 721,974 persons are registered as working population from 15 to 64 years of age. Out of those, 507,061 persons (70.23 %) are covered by the pension system as insured persons, and 456,180 actually pay pension contributions.[13]

The replacement rate is one of the most important indicators for adequacy of pensions. The access to the data on this topic as well as on the impact of pension policies, demographic and economic factors on current and future pensions is limited. The level of all pension categories is important when considering the adequacy of the pension system, in terms of prevention of poverty of the elderly. The three types of pensions (old age, survivor, and disability) and respective ratios vis-à-vis the average wage are used for the analysis of the poverty risk (Table 2). In that direction, the average amount of all pensions is 51.3% (or half) of the average wage. The survivors' beneficiaries have the lowest ratio of 40.2%, while for disability, the ratio is 46.3%, which is slightly higher and, the best ratio is the one for old age pension with 57.9% of the average wage.[14]

[10] Amendments to the Law on mandatory fully funded pension system, published in the Official Gazette No.98, 1 August 2012 http://www.mtsp.gov.mk/WBStorage/Files/izmeni_vtor_penzii.pdf

[11] Amendments to the Law on mandatory fully funded pension system, article 52 and 73, published in the Official Gazette No.13, 23 January 2013**http://www.mtsp.gov.mk/WBStorage/Files/zakon_zadolzitelno_kapitalno.pdf**

[12] State Statistical Office, Labour Force Survey, page 40 published on the http://www.stat.gov.mk/Publikacii/2.4.13.06_kor.pdf

[13] Report on the operations of PDIF for 2012, page 9, published in April 2013,on the http://www.piom.com.mk/informacii/statistika/240.html

[14] Report on the operations of PDIF for 2011, page 25, published in April 2013,on http://www.piom.com.mk/informacii/statistika/240.html

Table 2: Average wage and average pension

Type of pension	Old age pension	Disability pension	Survivor pension	Total pension
Average pension	12,437.00	9,934.00	8,634.00	11,016.00
Average wage	21,469.00	21,469.00	21,469.00	21,469.00
Ratio	**57.9%**	**46.3%**	**40.2%**	**51.3%**

Only around 5% of the pensioners receive a pension higher than MKD 20,000.00. This amount is close to the average wage in the Republic of Macedonia, while the remaining 95% are pensioners with pension incomes below the average wage. If we take into account the data from the State Statistical Office, that in 2011 30,4% of the people in the Republic of Macedonia were poor, and that the relative poverty by age of household head are people aged 60 and over, we can conclude that the majority of the poor people are pensioners. If we consider the ageing of the population, this problem will only intensify in the future.[15]

Worst off are pensioners on minimum pensions, as the lowest amount of the minimum pension (MKD 5,795.00) constitutes only 27.1% of the average wage (MKD 21,415.00)[16]. This jeopardized group represents 8.6% of the total number of pensioners.

Unemployment in the Republic of Macedonia is the main cause of poverty among the working age population, thus the risk of poverty and exclusion from the labour market (particularly visible for women, younger people and elderly) will produce inadequacy of the pension benefits during the retirement period. Low pay, low skills, and under-employment can lead to in-work poverty and inappropriate adequacy of the future pension entitlements.

The overall picture and features of the labour market could be captured by specific data for active labour force, employment and unemployment rate by gender, age, educational status etc.

According to the official statistical data on the labour force the activity rate was 57.0 the employment rate was 40.0, while the unemployment rate was 29.9in the first quarter of 2013. More details are elaborated in the table below including the data for 2012.

Table 3: Labour market indicators 2012

Years	Activity rate	Employment rate	Unemployment rate
2011	56,8	38,9	31,4
2012	56,5	39,0	31,0
2012/I	56,4	38,6	31,6
2012/II	56,5	38,8	31,2
2012/III	56,3	39,1	30,6
2012/IV	**56,7**	**39,3**	**30,6**
2013/I	**57,0**	**40,0**	**29,9**

Source: State Statistical Office, *Active Population in the Republic of Macedonia, Results from the Labour Force Survey, I quarter 2013*, No:2.1.13.18, published in 17 June 2013, http://www.stat.gov.mk/pdf/2013/2.1.13.18.pdf

[15] State Statistical Office, News Release, No: 4.1.12.50, Relative poverty, published in 11.07.2012, onhttp://www.stat.gov.mk/pdf/2012/4.1.12.50.pdf 11July 2012

[16] Report on the operations of PDIF for 2011, page 16, published in April 2012, on http://www.piom.com.mk/informacii/statistika/193.html.

The activity rate in 2012 has been 56.5%. The employment rate is a portion of the number of employed in the working population aged 15 years and older (ILO), and amounted to 39.0% in 2012. However, the participation of the employed in the working age population aged 15 - 64 years by EUROSTAT is 44.0. The unemployment rate for 2012 was 31.0.

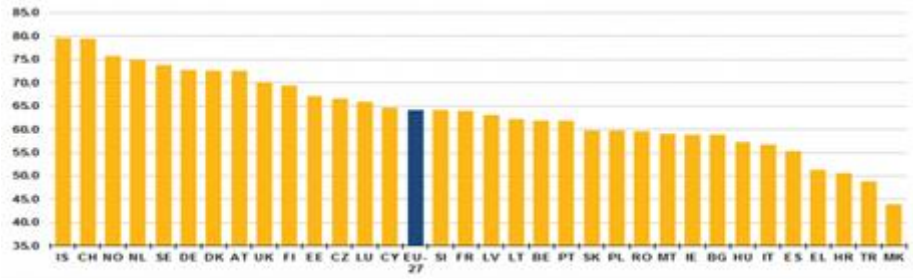
Looking at the breakdown according to age and gender, the highest activity rate at 79.5% was among the age group 25-49 (92.6 for men and 65.9 for women) , that at the same time had the highest employment rate of 55.8% , too(64.9 for men and 46.3 for women). In terms of unemployment, the highest rate (53.9%) was observed in the population aged 15-24 (55.2% for men and 51.8% for women).[17]

The analyses by age demonstrated that most (45.5%) employed persons are aged 25-49, while the fewest (0.7%) are employed persons aged 65 and older. The biggest gender gap in employment of 12.2 percentage points can be observed in the age group 25-49, while between employed men and women aged 65 and over, there is the smallest difference, at 0.3 percentage points.[18]

Long-term unemployment rate is 25.5%, (24.5% for men and 26.1%. for women). The highest unemployment rate by age groups is in the age group from 15-24 with 53.9%, broken-down by gender 55.2% for men and 51.8% for women. In the group of the elderly active labour force, between 50 and 64, the unemployed rate is almost 50.0% (total-24.4%, men-25.5% women-22.4%). By educational attainment, the unemployment rate in total is 48.3%, and the highest rate is in the group without education, where the unemployment rate for men is 41.4% and for women is 55.0%. The unemployment rate for people with university degree is 23.3%, for men the rate is 19.1% and for women it is 27.3%.[19]

According to official data by EUROSTAT 2012, in the Republic of Macedonia there is an employment ratio for persons aged 15-64 of 44.0%, the lowest one in comparison with other European countries:

Figure 1: Employment rate for persons aged 15-64, 2012



Source: EUROSTAT-2012,
http://epp.eurostat.ec.europa.eu/statistics_explained/index.php?title=File:Employment_rate_persons_aged_15-64,_2012.png&filetimestamp=20130503144441

The above data reflect the extremely high unemployment rate which for 2012 has been 30.6% while in 2013/1 a slight decline to 29.9% has been observed. Compared with ratios in the EU

[17] State Statistical Office, Labour Force Survey, page 26 published on the http://www.stat.gov.mk/Publikacii/2.4.12.11.pdf

[18] State Statistical Office, Labour Force Survey, page 27 published on the http://www.stat.gov.mk/Publikacii/2.4.12.11.pdf

[19] State Statistical Office, Labour Force Survey, page 27 published on the http://www.stat.gov.mk/Publikacii/2.4.12.11.pdf

zone and in the region (Bulgaria, Croatia, including Greece with unemployed rates from 11% to 24%), Republic of Macedonia is ranked with the lowest employment rate.[20]

The exclusion of the people from the labour market results in shortened contribution payment periods, which then create an insufficient income for the time spent in retirement. As a consequence of this and having in mind the envisaged stronger link between life time earnings and pension wealth it may be expected that future pensions will not provide adequate income security in old-age.

2.2.2 Sustainability

Demographic assumptions indicate that the difference in the longevity between men and women will remain at five years in favour of women. When comparing 2013 to 2080, the life expectancy will vary in the range of 71.55 years at the beginning to 75.00 years at the end of this period for men, and, 76.00 to 80.00 years for women. The data for life expectancy upon retirement demonstrates that women will benefit of the pension system longer than men will. In 2050, men will be beneficiaries for an average of 17.7 years, and women will be beneficiaries for up to 21.5 years.

Table 3: Basic scenario for future demographic assumptions (2013-2080)

Year	Life expectancy			
	Upon birth		Upon retirement	
	Men	Women	Men	Women
2013	71.55	76.06	15.33	18.51
2020	71.90	76.50	15.55	18.83
2030	72.40	77.10	15.88	19.28
2040	74.00	78.80	17.96	20.57
2050	75.00	80.00	17.65	21.52
2060	75.00	80.00	17.65	21.52
2070	75.00	80.00	17.65	21.52
2080	75.00	80.00	17.65	21.52

Source: Actuarial Report on the pension system in RM October, 2012, published on the http://www.piom.com.mk/informacii/statistika/40.html

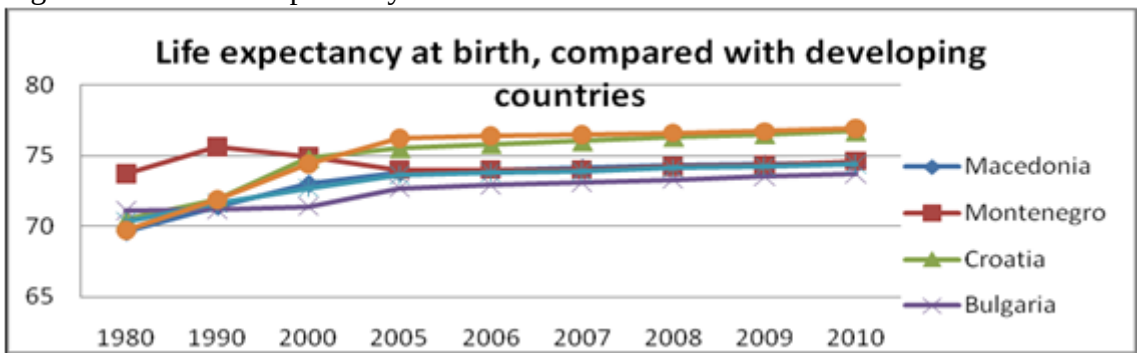
In order to have a sustainable pension system with adequate pensions it is essential to have a parallel analysis on the length of time spent as a beneficiary in the pension system versus the years of professional career, i.e. the years of active participation in the labour market. Having in mind that the unemployment rate is still very high, low and short participation in the labour market is a crucial challenge. From today's perspective, and if the longevity is taken into account, this situation will generate low pensions in the future.

In terms of the gender perspective, it is important to mention that according to default retirement rules it is allowed for employees to work until 64 years of age and 15 years of career, but upon their request they can continue working until 65 years of age, regardless of the gender. This means that by the Law on Labour Relations, the employees cannot work beyond that age, which in fact is a barrier to their longer term participation in the labour market. If we compare the figures with the official data of other countries, it can be concluded that the Republic of Macedonia has not been faced with the problem of ageing population yet, therefore there is still a need for further reforms for stabilization of the system. According to the analyses in the Report of the Centre for Economic Analyses (CEA) in Bulgaria, since 1990, the natural increase of population has been negative (in 2007 it was -5%). Also, since

[20] EUROSTAT-2012, http://epp.eurostat.ec.europa.eu/statistics_explained/index.php?title=File:Unemployment_rate,_2001-2012_(%25).png&filetimestamp=20130627102805

1992, the Republic of Serbia has been faced with negative natural increase of population which in 2009 was -4.7%. In the Republic of Slovenia, in the first quarter of 2011, the natural increase of population was 1.2%. The following comparative charts show that Macedonia is in a more favourable situation than countries in the neighbourhood.

Figure 2: Live expectancy



Source: CENTRE FOR ECONOMIC ANALYSES (CEA), Report on the publicly funded pension scheme in Macedonia, 2011, page 9, published in 12 October 2011
http://cea.org.mk/documents/studii/CEA_Pension%20PAYG%20review.pdf

In the last five years the policy of lowering contribution rates influenced the financial condition of the pension system and its stability. Transfers from the Budget have increased as a consequence of the increased deficit between revenue and expenditure in the pension system. Regarding the long-term financial sustainability after the introduction of the second pillar, it is important to say (by the actuarial simulations) that the deficit will gradually increase due to the transition costs. This is because the participation of the labour force in the mixed pillar will grow and so the inflow of contributions in the second pillar will become more significant. Up to 2030, the percentage of pension benefit expenditures of GDP will reach up to 7.20% and after that period the deficit will start decreasing with the turnout of the first retirees of the two-pillar system. The forecasts for expenditure show a decreasing trend and a tendency to stabilise to 4.77% of GDP in 2075. This is due to the decrease of expenditures for pension payments from the first pillar, resulting from the maturation of the two-pillar system, when all retirees will receive their pension benefits from both pillars. By the actuarial projections, the proportion of the population aged 65 and over to active population will grow from the current 17.62% to 43.06% in 2060 and will then decline to 35.42% by 2080. This means that in the future about one third of the population over 18 years will be old people.[21]

Such predictions are a risk to the pension system, but also a challenge for the labour market, to encourage the older working population to work longer and to ensure a more adequate relation between time spent working and time spent in retirement. The Ministry of Labour and Social Policy prepared a National Employment Strategy by 2015 where the following targets were set:

[21] Actuarial Report on the pension system in RM, October 2012, published on the http://www.piom.com.mk/informacii/statistika/40.html.

Table 4: Status and goals of the following indicators:

	National target 2015	EU target 2020
Employment rate (20-64)	**55%**	**75%**
Youth employment rate (15-29)	**29%**	/
Youth employment rate (15-24)	**17%**	/
Women employment rate (15-64)	**42%**	/
Employment rate with the elderly (55-64)	**41%**	/
Persons who had dropped out fro m education	**12%**	**10%**
Persons with university degree (30-34)	**19%**	**40%**

Source: Ministry of Labour and Social Policy, National Employment Strategy by 2015, Skopje, published in August 2011, retrieved from: http://www.mtsp.gov.mk/WBStorage/Files/nsvrabotuvanje.pdf

Pension and labour projections are interconnected and give a long-term picture of the Macedonian pension system. The expectation is that financial sustainability will be achieved after all parametric reforms have been implemented, followed by the substantial reform and the introduction of the fully-funded pension system.

2.2.3 Private pensions

As a form of savings, the pensions from the private pension funds depend directly on the paid-in contributions, which means that people while participating in the labour market will be accumulating assets that will be spent during the old age. Regarding the sustainability of the pension system, the existence of the "mixed-pillars" will contribute to a long-term decrease of obligations of the state-funded component of the pension system at the expense of the privately-funded pillar.

In 2012, the membership in the mandatory pension funds increased by 9.05% compared to 2011 and, from the total insured persons about 65% were participants in the two-pillar system. In the second pillar mostly young workers at the average age of 33 are included. As for the voluntary pension funds, which became operational four years ago, the data on the membership are very modest, but at the same time there is one encouraging fact, which is that the percentage of new members in 2012 increased by 37.4% compared to 2011. Out of the total members in the voluntary funds, 74.3% are covered by occupational pension schemes, and the remaining 25.7% are members with voluntary individual accounts.[22]

When analysing the investment portfolio, it should be considered that the funds are rather incipient due to their short term existence and the shallow financial and capital markets. The market is limited in terms of the supply of financial instruments required to invest the pension funds' assets. The Table below demonstrates the domestic investments of the mandatory pension funds and gives a comparison with countries with similar pension system reforms.

[22] Agency for Supervision of Fully-funded Pension System, Report on the Developments of the Fully-funded Pension System in 2012, page 23 and 24, published in April 2013, http://www.mapas.mk/wbstorage/files/%D0%98%D0%B7%D0%B2%D0%B5%D1%88%D1%82%D0%B0%D1%98%20%D0%9A%D0%A4%D0%9F%D0%9E%202012.pdf

Table 5: Investments portfolio in the mandatory funded pillar compared with other countries, by instruments in 2012

Macedonia with compared countries	Shares	Bonds and other state guaranteed securities	Bank deposits	Corporate bonds	Mortgage bonds	Real estate	Derivatives and hedge funds	Foreign investment
Macedonia	**19.00%**	**66.00%**	**14.00%**	**/**	**/**	**/**	**/**	**16.00%**
Bulgaria	23.00%	31.00 %	17.00%	21.00%	0.42%	3.00%	/	33.00%
Croatia	26.00%	68.00%	2.00%	3.00%	/	/	0.02% *	12.00%
Romania	11.00%	78.00%	5.00%	5.00%	/	/	0.23% **	6.36%
Poland	35.00%	52.00%	8.00%	0.05%	0.43%	/	/	0.88%

*Derivatives ** hedge funds

Source: Agency for Supervision of Fully-funded Pension System, Report on the Developments of the Fully-funded Pension System in 2012, page 33 and 34, published in April 2013, http://www.mapas.mk/wbstorage/files/%D0%98%D0%B7%D0%B2%D0%B5%D1%88%D1%82%D0%B0%D1%98%20%D0%9A%D0%A4%D0%9F%D0%9E%202012.pdf and author's presentation.

Considering that voluntary pension funds were only established in 2009 and have a short history, the data for investments portfolio will have only statistical value for the first three years of existence of these funds (investments in state bonds and securities, banking deposits and a small proportion in stocks). The portfolio of the voluntary funds does not differ significantly from the mandatory pension funds' portfolio at the beginning of the second pillar implementation. The modest performance of the mandatory pension funds in the last seven years was influenced by several factors: a very short investment history, the global economic crisis, a low number of instruments available for investment in the country, the knowledge of the foreign markets, etc.

An important indicator of the investment success is the average yearly nominal rate of return and inflation rate, which allows for the actual calculation of the real rate of return. This measurement is necessary because inflation has a significant influence on achieving the targeted rate of return and on the calculation of the future pension.

Table 6: Average yearly rates of return of mandatory pension funds and inflation rate 2006-2012

Rate of return	2006	2007	2008	2009	2010	2011	2012
Nominal rate of return	6.10 %	7.43%	**1.19%**	3.83%	3.32%	7.83%	5.83%
Inflation rate	3.08%	4.33%	**4.59%**	2.96%	2.14%	1.38%	3.54%
Real rate of return	**2.93%**	**2.97%**	**-3.25%**	**0.83%**	**1.16%**	**6.36%**	**2.21%**

Source: Authors calculation based on the data in the Report on the Developments of the Fully-funded Pension System in 2012, page 33 and 34, published in April 2013, Agency for Supervision of Fully-funded Pension System, http://www.mapas.mk/wbstorage/files/%D0%98%D0%B7%D0%B2%D0%B5%D1%88%D1%82%D0%B0%D1%98%20%D0%9A%D0%A4%D0%9F%D0%9E%202012.pdf

These data can be interpreted in a positive connotation, except in 2008 when the portfolio was affected by the global crisis and all pension funds suffered a drop in the real rate of return. The members of pension funds are mostly young people, so, in order for their pensions to be adequate, they need to have a continued, uninterrupted cycle of contribution payment in the next 20 to 30 years and, with at least 2% yield above the inflation rate.

The voluntary pension funds underperformed in 2012, by having a rate of return under the set benchmarks in the investment strategy, for a difference between 0.71 pp and 0.61 pp.[23]

2.2.4 Summary

Summary of major strengths and weaknesses of the system and need for reforms	
Strengths and best practice	*Weaknesses and need for reforms*
Increased sustainability and efficiency of the pension system financing was expected after all parametric reforms (from 1994 to 2002), followed by the substantial reform (in 2006) resulting in the **introduction of a fully-funded pension system with mandatory and voluntary components** (individual accounts and occupational schemes)**.** This combination with "mixed pillars" should make the pension system more resistant to economic crises and demographic trends, since it is structured to diversify risks and, thereby overcome, and balance all future risks. That way, the pension system will get a chance for long-term fiscal sustainability, which will subsequently provide the necessary adequacy of pensions. Such policy is in line with the proposals in the White and the Green Paper (EC social documents on adequate, safe and sustainable pensions).	The pension policy makers have no interest in raising the retirement age, nor in dealing with the current gender gap. In terms of improving long term financial sustainability and providing adequate pension benefits, it is necessary that the authorities follow the experience of other European countries and the world. One of the potential steps that can contribute to the long-term fiscal performance of the pension system should be the gradual **increase of the retirement age by adjusting the retirement age with the life expectancy**. This solution would foster longer participation in the labour market, so people would work longer and that should lead to a better balance between the periods of working and retirement. In the package for strengthening the criteria for retirement, the **gender equalization** of the retirement age between women and men is needed, particularly in the existing multi-pillar pension system. The gender inequality will have a negative effect for women that participate in the mandatory fully funded component of the pension system, which is a defined contributions system. This is because their savings on the individual accounts, accumulated throughout the years of career, would be accumulated in less number of years and, because of living longer, the amounts of the pension benefits will be lower when compared to those of men. From the systemic viewpoint, a longer presence of workers in the labour market means longer periods of contribution payment and higher incomes, which leads to an improvement in the financing of the pension system. On the other hand, the retirement period will be shortened and

[23] Agency for Supervision of Fully-funded Pension System, Report on the Developments of the Fully-funded Pension System in 2012, page 65, published in April 2013, http://www.mapas.mk/wbstorage/files/%D0%98%D0%B7%D0%B2%D0%B5%D1%88%D1%82%D0%B0%D1%98%20%D0%9A%D0%A4%D0%9F%D0%9E%202012.pdf

	consequently spending in the retirement period will be reduced, which is more favourable for the pension system.
In the mandatory fully funded pension component, the most important costs are the fees from contributions and the fees paid from net assets of the pension funds. Hence, this is a particular challenge for DC supervisory authorities. In order to manage the costs, in terms of fees, Macedonian authorities showed good proscriptive policy. Thus, with the law for 2013 the **contribution fees were decreased** to 4%, thereby introducing a gradual decline to 2.25% till 2019. The decline **of fees paid from net assets** for 2013 is 0.05 % and slightly decreasing to 0.035% until 2018. In the long run, this policy should be maintained and it should aim at making the system even cheaper and more effective in terms of pension adequacy.	The tendency of decreasing the contribution rate of in recent years is reflected in a decline in revenue and even more frequent necessity for larger borrowings and transfers from the State Budget for pay-outs of current pensions. In order to bridge the gap and to prevent the risk of a further increase of the deficit it is necessary to approach **increasing the contributions rate**, gradually, at least **in** the next five years. In this way, the deficit may be controlled.
With the recent legislative amendments the previous proactive method of supervision is transformed into **risk-based supervision** (put into practice **from 2013 on)**. Thus, it is expected that the supervisor becomes more transparent -which involves directing its limited resources to the areas of greatest risks, rather than allocating their resources equally between supervised entities up front and then dealing with problems as they occur. The challenge for any risk-based supervisor is to identify the main risks to the DC pension system and to check that the mechanisms for mitigation of such risks are in place and are working properly. OECD and IOPS believe that they can set up a good supervisory practice risk management, from which supervisors can benefit.	With the current practice of conservative portfolios and investment policies, pension funds achieve a relatively low rate of real returns. In lack of instruments supply, **pension fund managers could be more courageous in investing abroad** instead of relying only on domestic bank deposits and government bonds. In this context, it is crucial to mention the need for better education of the investment experts who are authorised to follow the movements of the stock exchanges and capital markets in the world on a daily basis. Thus, they would influence the improvement of the investment performance in the long run, which would ultimately bring higher returns and higher value of the future pensions.

Due to the fact that the members of the private pension funds are relatively young people there is space for introduction of multi funds. In favour of this decision would be the demographic facts, the readiness of the young to undertake more risks and of course, the investment diversification. This subject was presented by the authorities by announcing that the amendment to the Law in 2013 shall include multi-funds. This project shall enable a bigger choice of investment possibilities and a portfolio which shall be adequate to the calculated risk, age and life cycle of the participants.	The very high unemployment rate remains a major challenge (approximately 30%), in particular concerning women, young and elderly people. The national budget allocated to the active labour market programme is low, with limited incentives to increase the labour force participation. The Government, besides preparing more documents, long-term Strategies and Action plans for improvement of employment, especially among youth, women and the elderly, should demonstrate stronger commitment to **dialogue with social partners to create better opportunities to facilitate the entrance in the labour market**. Labour measures supposed to be guided by **Europe 2020 targets, for** the development of skills throughout the lifecycle with a view to increase the labour participation and to better match labour supply and demand. Enhancing the balance of the labour market will influence the alleviation gap between financing and spending in the pension system, due to the closer link between the lifetime earnings and pension wealth.

2.3 Reform debates

One of the recommendations noted in the EU Progress Reports (2009, 2010 and 2011), led to the August amendments to Law on Mandatory Fully Funded Pension Insurance, that increased independence of the supervisory and regulatory body (MAPAS). Namely, the amendments provided for independence in a form that the management of the Agency (the Council) would be appointed and dismissed by the Parliament of the Republic of Macedonia. With the previous solution, the Government was in charge of appointing and dismissing the management of the Agency. During the debate in the Parliament, the political parties of the opposition reacted to this solution, by stating that this particular change of appointment shall not bring much progress in the independence of the Agency. The opposition feared a high personnel turnover, as every change in government might lead to a new appointment of the management. For that reason the opposition requested that the appointment of the Agency's management by the Parliament will follow upon public announcement and not upon suggestion from the Government.

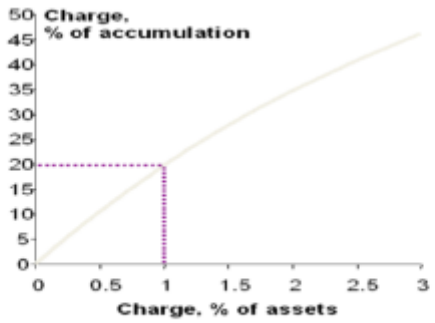
The Progress Report 2012-**Enlargement Strategy and Main Challenges 2012-2013**[24], states that the Supervisory Authority adopted new risk-based supervision manuals modelled on International Organisation of Pension Supervisors best practices for defined-contributions pension schemes. Further, the Commission in the Report notes that the new legal provisions prohibits the pension funds from investing in bonds and other securities issued and guaranteed by the state that are not traded on the domestic market. This prohibition includes state

[24] EUROPEAN COMMISSION (2012). "Commission Staff Working Document-The Republic of Macedonia 2012, PROGRESS REPORT for 2012", section 4.9 Skopje, published October 2013 http://www.sep.gov.mk/data/file/Dokumenti/Registar-na-dokumenti/PR2012_MK3(2).pdf

Eurobonds that are traded on foreign financial markets, with maturity at the end of 2015. According to this statutory requirement, the bond was prematurely eliminated from the portfolio at the latest by January 2013 Programme. Related to such issue, there was a broader public debate on the expert level. Because about 25% of the total assets of the pension fund were invested in Eurobonds, the pension fund managers reacted sharply, by pointing out the possible consequences of a lower yield due to early sales, as opposed to a full maturity return. In this context Bojan Stojanovski, manager of the pension fund "KB Prv penziski fond" expressed his fear in the weekly magazine "Gragjanski" that: "if suddenly offered, the price of the Euro bond will fall, it will have to be sold at a discount, which will affect the yield directly". The same magazine asked the opinion of the expert in pensions, Zorica Apostolska, who called this legal project a state intervention and interfering in the investment policy of the privately managed pension funds. Also, the magazine gave the opinion of the Minister of Labour and Social Policy Spiro Ristovski, who justified this legal decision by stating that it is preventing outflows of funds from the domestic economy during the global debt crisis, and that this was made in the interest of creating greater security for future retirees.[25]

The Second IOPS Regional Workshop on Pension Supervision was held in Skopje, Macedonia, on 10 May 2012. One of the main topics was costs and fees impact to DC plans and the adequacy of pensions. Fiona Stewart– IOPS, Secretariat presented "Overview of IOPS work on costs", including data of the Macedonian case. Given that an annual management charge of 1% of funds under management can reduce accumulated assets by as much as 20%, (over a 40-year period) the impact of such a fee can be substantial.

Figure 3: Impact of Charges on Accumulated Asset Balance



Source: Whitehouse, E.R. (2001), "Administrative charges for funded pensions: comparison and assessment of 13 countries", in OECD, Private Pension Systems: Administrative Costs and Reforms, Private Pensions Series, Paris

Source: Fiona Stewart, Presentation-2nd IOPS Regional Workshop on Pension Supervision, 2012, Skopje, 12 October 2013, http://www.oecd.org/site/iops/principlesandguidelines/50461605.pdf

The fees paid from net assets of the pension funds have long-term implications and if compared to countries with similar pension systems, it can be concluded that Macedonia is ranked by the figure below (after Poland) with charges ratio 9.09%. This means that the costs can reduce accumulated assets less than 20%, (over a 4- year period) and the impact can be substantial, but also the long-term effect on the adequacy of pensions would be in tolerable limits.

[25] The weekly magazine Gragjanski, No. 2 12 May 2012, page 54 and 55 www.grgjanski.mk ,

Table 7: Charges on pension funds' assets in international comparison

% Assets Under Management	40 Years Charge Ratio	
	2008	**2011**
Poland	8.68	8.74
Macedonia	**9.09**	**9.09**
El Salvador	11.97	12.62
Uruguay	12.39	13.08
Colombia	12.73	14.27
Israel	13.66	13.44
Chile	14.61	15.53
Mexico	14.87	18.40
Peru	15.01	19.18
Dominican Republic	19.35	24.82
Slovak Republic	21.03	17.43
Costa Rica	21.07	15.01
Croatia	22.21	22.22
Hungary	22.57	19.80
Bulgaria	26.51	26.51
Czech Republic	38.14	39.31
Serbia	37.51	37.67
Hong Kong	40.46	40.46
Turkey	45.88	46.34

Source: Fiona Stewart, Presentation-2nd IOPS Regional Workshop on Pension Supervision, 2012, Skopje, 12 October 2013, http://www.oecd.org/site/iops/principlesandguidelines/50461605.pdf

Towards the end of 2011, the Centre for Economic Analyses prepared a **Report on the state-run pension scheme in the Republic of Macedonia**, from which the following several substantive findings and recommendations can be pointed out[26]:

- Macedonia has a problem with unemployment and that affects the work of the state-run pension system creating a negative gap between the revenues from the contributions of the employed and the costs for pension benefit pay-outs.
- The government has limited ability to raise payroll taxes (followed by the policy for continuous decreasing) and to increase once again the level of pension's contribution. It is time for the government to prepare an evaluation and/or a cost-benefit analysis for its policies and, at least, to decrease the labour costs by decreasing the pension contribution against the sustainability of the pension system.

Therefore, the CEA has designed two scenarios for the period 2011-2016: 1. Increase in the number of employed by 5% over the next five years and 2. Increase in the number of employed by the same trend as now. The first scenario shows that an increasing number of employees (5 % each following year) would lead to a constant, though slow increase of the revenues of the system. While, according to the second scenario, if the number of employees stays the same as now (2 % growth per year) it would not lead to a mid-term improvement of the overall ratio between the contributions and costs for pension payment.

If we focus on the topic of labour market and social inclusion, then we should go back to the **EU Progress Report for 2012**[27] in the section *4.19. Chapter 19: Social policy and*

[26] Centre for Economic Analyses, Report on the publicly funded pension scheme in Macedonia 2011 page 4,16 and 17 at http://cea.org.mk/documents/studii/CEA_Pension%20PAYG%20review.pdf

[27] European Commission (2012). "Commission Staff Working Document-The Republic of Macedonia 2012, PROGRESS REPORT for 2012", Skopje, section 4.19. published October 2013 http://www.sep.gov.mk/data/file/Dokumenti/Registar-na-dokumenti/PR2012_MK3(2).pdf

employment where it is noted that some progress can be reported as regards access to the **labour market**. At the same time, the document indicates that the cooperation and coordination between enforcement bodies have not **i**mproved and labour market participation is still very low. Further, long-term unemployment, high youth unemployment and very low participation by women in the labour market are all causes for great concern. Then, the national budget allocated to the active labour market programme is low.

The Government, together with the competent authorities adopted a set of documents in order to mitigate the current situation and to contribute to enhancing the quality of development in the social sector. In that sense more significant documents would be: "National Employment Strategy by 2015", with Operational Plan on active employment measures and programmes, National Strategy For elderly 2010 – 2020, National Strategy on Alleviation of Poverty and Social Exclusion in the Republic of Macedonia (2010-2020) and the Minimum Wage Law which was adopted in January 2012.

3 Health care

3.1 System description

3.1.1 Major reforms that shaped the current system

Major reforms that influenced the transition process of the Macedonian health system can be described as:

- Reforms in organisation, management and financing of the primary health care: introduction of family medicine GPs as private entrepreneurs;
- Restructuring and reshaping the secondary health care in terms of service provision and financing: introduction of the DRGs as activity based prospective model of payment to hospitals and definition and rationalization of the specialised services packages for ambulatory care. Therefore the financing of secondary health services was based upon DRGs (for inpatients) and specialist packages (for outpatients). Fixed agreed budgeting of health care institutions has been applied by the HIF as well as the treasure monitoring system of cash flow with the PHI;
- Introduction to e-health principles and policies, which aimed at improved coordination and collaboration of health care professionals, improved access and accuracy of health data (information), patient satisfaction, decreased waiting time for service, eased referrals to higher level of care and therefore improved and more efficient health services;
- Financing of refurbishment/restructuring/building of public health facilities and huge investments in new, sophisticated equipment has been one of the most expensive investments in the health sector lately. Further on provision of adequate training of the medical personnel for optimal use of the equipment as well as complementary education of medical professional as on the job training or in excellence medical centres abroad was initialized.

All mentioned major steps aimed at improving the efficacy of the health sector performance; expected outcomes have not been seen yet.

3.1.2 System characteristics

The health care system of the Republic of Macedonia is structured as a socially based health system, a model of solidarity in health. A long-lasting transitional period has been marked with several reform steps that were undertaken, mainly towards decentralisation of some services and towards public-private partnerships, which have emerged recently.

The system itself is defined on three levels of service provision: primary health care, secondary and tertiary, including clinic hospitals. The overall regulation, surveillance and monitoring of the health care system is performed by the Ministry of Health. The system has been structured to cover the entire population of Macedonia, with general practitioners in primary health care, specialists in health houses (polyclinic centres) and specialists in ambulatory services in hospitals (general and specialised hospitals). Clinic hospitals are part of the previously disaggregated Clinical Centre in Skopje (2008), having the status of University Clinic Hospitals.

There is wide coverage of the national health insurance scheme estimated to be about 89.2% as of 2011. The health insurance benefits are linked to a basic beneficiary package (BBP) of services in primary and secondary health care, drugs and medical devices and preventive programmes. The national health insurance is provided through the Health Insurance Fund in the Republic of Macedonia (HIF). Revenues of the HIF include direct payments from beneficiaries (7.3% of gross wage), direct transfers from the state budget, own sources (mainly co-payments) and other sources (contributions from retired workers paid by the pension fund and from recipients of social benefits paid by the Ministry of Social Welfare). According to the last formal report on the financial work of the HIF the work of the HIF has a positive balance, and no financial shortages were announced.[28]

Public health functions are implemented through the National Institute for Public Health and its regional branches, through preventive programmes.

Service provision is organized on all three levels of health care. General practitioners (GPs as family medicine doctors) provide services for primary health care and have been envisaged as "gate keepers" who should cover the majority of the health needs of the population (80%). In line with the decentralisation policy of the government, a rapid privatisation of all GPs was implemented in January 2007. Since then, GPs operate as individual entrepreneurs having contracts with the health insurance and being paid 70% per capita (capitation fee) and 30% for selected service provision, selected volume of prescribed drugs and additional goals reached (mainly preventive examinations and health promotion). GPs have the status of family medicine physicians; specialisation for family medicine has been introduced at the Medical Faculty in Skopje.

Specialist services are provided for outpatients (ambulatory care) and inpatients (hospitals). About 70% of specialist services are provided as ambulatory care. The burden of patients requiring specialist consultation is especially seen at hospitals in Skopje. This is due to poor triage mechanisms for patients in policlinics, as well as the lack of specialists in policlinics.

Public hospitals count 58 facilities, out of which about 1/4 are specialised hospitals or rehabilitation centres.

3.1.3 Details on recent reforms in the past 2-3 years

The major objectives of the Government and the Ministry of Health in the reform process of the health sector are an operationalization of the health facilities based on the optimal use of all resources: new equipment in new/refurbished facilities, well trained medical professionals and the financial sustainability of the public health care sector. Major emphasize is placed on patient satisfaction from provision of high quality health care services.

Since privatization of primary health care services in 2007, the scope of services provided by GPs is satisfactory for most patients, especially as it offers the possibility of cross-coverage. Still, there is a gap in provision of services during night hours, where emergency services are not accessible. Regarding specialist care, a specialist package for specialist services was announced and introduced by the HIF in 2010. An important issue of this package is that it presents an attempt to structure, precisely define and quantify the volume and the price of services provided by specialists in secondary health care (policlinics and hospitals). Standardisation and unification of specialist services was a complementary measure to an implemented Diagnosis Related Groups (DRG) payment model for hospitals. Both models

[28] Yearly Report of the work of the HIF 2012.

give the opportunity for rationalisation of resources and the planning of the volume and the scope of service provision in the secondary level of health care.

The DRG model of payment to hospitals which was expected to be the "golden" solution for controlling the costs and expenditures of public hospitals was revised in terms of adjustment of payments per some DRG codes. The model has advantages for its prospective planning of resources and overview of expenditures, but also disadvantages for its unification of similar services, which is not always possible and applicable. Reports from the HIF on the DRG model implementation in hospitals in 2012[29] show that the model sharpened up the use of resources; while increasing the case mix value from approx. 0.9 (in 2009) to 1.2 (for 2012) which indicates the increased complexity of cases treated and increased mobilization and use of resources, the budgets allocated for HCI remained almost the same. Also, this restrictive model of payment created shortages for the hospitals, which became evident in the lack of necessary funds, especially for the provision of some expensive drugs, expensive diagnostic procedures and highly specific interventions in hospitals. As a consequence, hospitals operate with basic diagnostic procedures, basic interventions, and mostly experience a lack of medical supplies, consumables and some expensive drugs.

The Law on Health Insurance was amended in regard to the ways and methodology for implementation and preparation of the list of drugs financially covered by the HIF. The methodology is defined by a general acquisition by the HIF, upon agreement of the Minister of Health. The list of drugs is formulated by a committee consisting of 13 members, constituted by the government of Republic of Macedonia.

The Law on Medicines and Medical Devices was amended with the introduction of parallel import. Parallel import is defined as import of medicines which are already on the market in Macedonia and used in EU countries, in Switzerland, Norway, Canada, Japan, Israel or USA. These drugs are produced by the same manufacturer who already has approval for registration and trade (market authorisation) of the drugs in Macedonia, where the medicines have the same form, strength and packaging.[30]

The new regulation for establishing wholesale and retail prices of the drugs marketed in Macedonia was introduced by the Drugs Agency. The new methodology for defining prices considers 12 reference countries, definition of comparative wholesale prices and average wholesale prices, as well as the mark-ups for retail prices.[31]

A new model of referral of patients throughout different levels of health care is defined in changes to Article 29 of the same law. Thus, referral of patient starts from GPs (on primary level) to the patient's nearest specialist services (secondary level). Only specialists (from the secondary level) can further refer the patient to hospitals (tertiary level). Exceptions are defined for specific cases (mostly emergency situations).[32]

The new referral system aims at reducing the burden of patients, especially at the tertiary level of service provision. This "triage" mechanism has created a huge mess instead of putting things in order. Patients and doctors were complaining mainly of the complicated procedure, unnecessary visits per doctor for the patients, "going round in circles" and limiting GPs in referring patients directly to hospitals. From the perspective of service management and

[29] DRG Report for the period January-December 2012, HIF.

[30] Amendment on the Law on Medicines and Medical Devices. 23 January 2012 http://www.reglek.com.mk/dokumenti/274_795495026.doc.

[31] Methodology on the manner of establishment of medication prices. http://www.reglek.com.mk/dokumenti/265_699841823.doc.

[32] Amendment on the Law on Health Insurance, Official Gazette No. 53. 14.04. 2011 http://www.fzo.org.mk/WBStorage/Files/ZZO%2053-2011.pdf .

reorganisation, this model should transfer some of the services to the secondary level and decrease the visits per doctor at tertiary level, as well as decrease expenditures at tertiary level, where services are most expensive.

Electronic health cards have been introduced aiming at easing the contact of the patient with the health care providers. Thus, "electronic health" was widely opened for all insurers in Macedonia. As announced by the MoH, this system enabled adequate identification and authentication of the users as well as controlled access to all health related information. The system should make the access to health services simple and easy, communication between health workers in different levels of service provision should be simplified, and patients should benefit from electronic appointments and electronic prescriptions. The entire network should enable the system functions to be more adequate, efficient and paperless. Still, the system has showed shortages mainly due to the unpreparedness of the health institutions to fully implement it.

The introduction of the new model for payment to doctors, preliminary named as "Payment for performance model P4P" happened in a rather abrupt and rough way. Due to a lack of sufficient discussion with practitioners, specialists and all relevant medical associations, the model was not accepted by the physicians. The ignorance shown by the ministry regarding the resistance for implementation of this model led to an organized strike of physicians in the Clinical Centre in Skopje. The strike was led by the Independent Union of Health Workers in the Clinic Centre in Skopje and lasted for several months. After the strike was seized, the MoH changed the name of the project into "System of balanced approach of the achievements", where some changes were made in comparison with the previously criticised model.

In line with the emerging needs of the population, the private sector is strongly building up its position. Two major general hospitals operate in Skopje, as well as several specialist hospitals. Some services provided in private hospitals are covered by the HIF, but many are not. HIF has selected services and defined reimbursement prices for a defined volume of services provided in private hospitals.[33] The emerging private sector offers possibilities and opportunities for the patients to choose health services.

3.2 Assessment of strengths and weaknesses

3.2.1 Coverage and access to services

While all mentioned reforms should enable good coverage and easy access to health services, patients in Macedonia sill struggle with some inequalities. The introduction of e-health created confusion and difficulties for patients as well as the medical professionals. The transfer from paper to e-communication seemed to be difficult, mostly due to unprepared institutions to implement the system in full scope, problems in appropriate referral of patients and the new creation of waiting lists ad-hoc on a daily basis. Thus, medical professionals faced problems in organizing their daily schedule of activities and patients faced troubles in being referred to the closest "available-free" health service provider.

Another issue when discussing the access to services which needs to be mentioned is the inequality of service provision capacities in rural vs. urban areas and distinction of public vs. private. The City of Skopje has the primacy to concentrate health care services, both private and public. The discrepancy and differentiation between Skopje and rural regions increases the inequality in health care service provision and utilization. Lack of standardised conditions

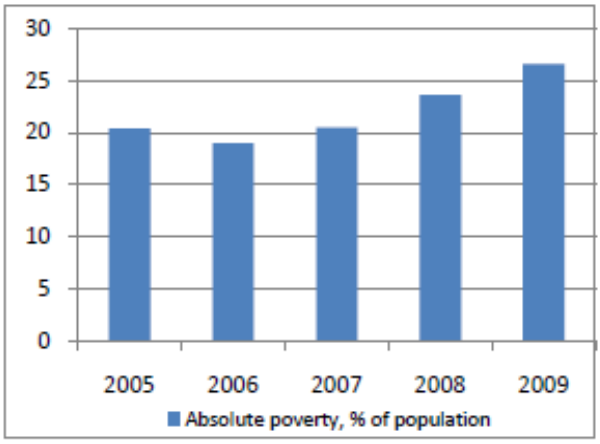
[33] http://www.fzo.org.mk/, Price list for health services in specialist care (last revised 23 March 2011).

in the private and public hospital sector and a drifting of professionals towards the private sector leave most socially deprived persons in need of health services with no option to choose, which contributes to inequality in access to health care services..[34]

Health outcomes are measured by the evolution of basic health statistic indicators, reported by the Public Health Institute (PHI). The Report on Health of the Population 2012 concludes that the health status of Macedonians has not changed significantly in the last years, which is very similar compared to the health status of the population in countries of South-Eastern Europe. This report concludes that the access to health services is adequate, because there is an adequate number of health professionals (doctors, pharmacists, dentists and nurses) per 100,000 population and a well-developed network of health institutions. Still, the overall health status of the population is characterised by a high prevalence of chronic diseases; there are notable unhealthy behaviours and lifestyles of the population and the processes of globalisation and urbanisation[35].

But, Macedonia was the third poorest among the South East European countries in 2012. Macedonia's real GDP per capita growth has been below the South East European average during the past decade. Between 2002 and 2012, Macedonia grew at 3.1 percent in real per capita terms, compared to 3.5 percent in other South East European countries. Until 2008, its growth was among the lowest in the region. Poverty rates and unemployment are high. Between 2006 and 2010, extreme and moderate poverty rates increased from 8.6 percent to 14.7 percent and from 32.1 percent to 42.5 percent, respectively. In the first quarter of 2013, the unemployment rate was 29.9 percent and youth unemployment was 53.5 percent, based on labour force surveys. According to the latest labour market data, by end-July 2013, the average real net 3 wage had been falling for 15 consecutive months on a year-on-year basis[36]. The last poverty assessment for the country by the Household Budget Survey (HBS) reported that the proportion of population living below the poverty line was previously 20% and increased to 23.5% in 2008 (with extreme poverty affecting 5.3% of the population). 2008 was marked by an increase in the income inequality, especially in respect of the gap in living standards between the city of Skopje and the northern and eastern regions of Macedonia.

Figure 4: Absolute poverty, % of population



Source: World Bank - FYR Macedonia Partnership, Programme Snapshot, March 2011.

[34] http://www.fzo.org.mk/, Information for the public from April 2011.
[35] Health of the Population in Macedonia, Public Health Institute, 2012.
[36] World Bank Group - FYR Macedonia Partnership, Country Program Snapshot , October 2013

3.2.2 Quality and performance indicators

Despite stated adequate access to the health services for the population, as well as wide coverage with health insurance, there is no relevant statistic data which elaborates quality of services measured as per some selected performance indicators.

On the other hand, the organisation and management of hospitals, their efficacy, structure and size, is not adjusted to the real needs of the population[37].

The DRG model for payment towards hospitals, together with specialist packages, is used as baseline indicator for remodelling and revising the budgets of hospitals. Even though an increase in budgets for hospitals was approved, the total budget increase in 2012 was only for selected hospitals for selected services (DRG groups of interventions) and an additional 10% at the tertiary level for service provision (subspecialist care and clinic hospitals).

The health care sector has to be analysed appropriately, bearing in mind the structure of the system, the network of existing health facilities, data on demographic trends of the population, morbidity, mortality, demand side and consumer side and realistic possibilities of provision of services. So far, realistic performance indicators for the evaluation of performance of the system at all three levels have neither been developed nor implemented. Realistic financial estimations of costs versus expenditures have not been made. An evaluation of the sustainability of the system has to be performed, with critical appraisal of its effectiveness and efficacy.

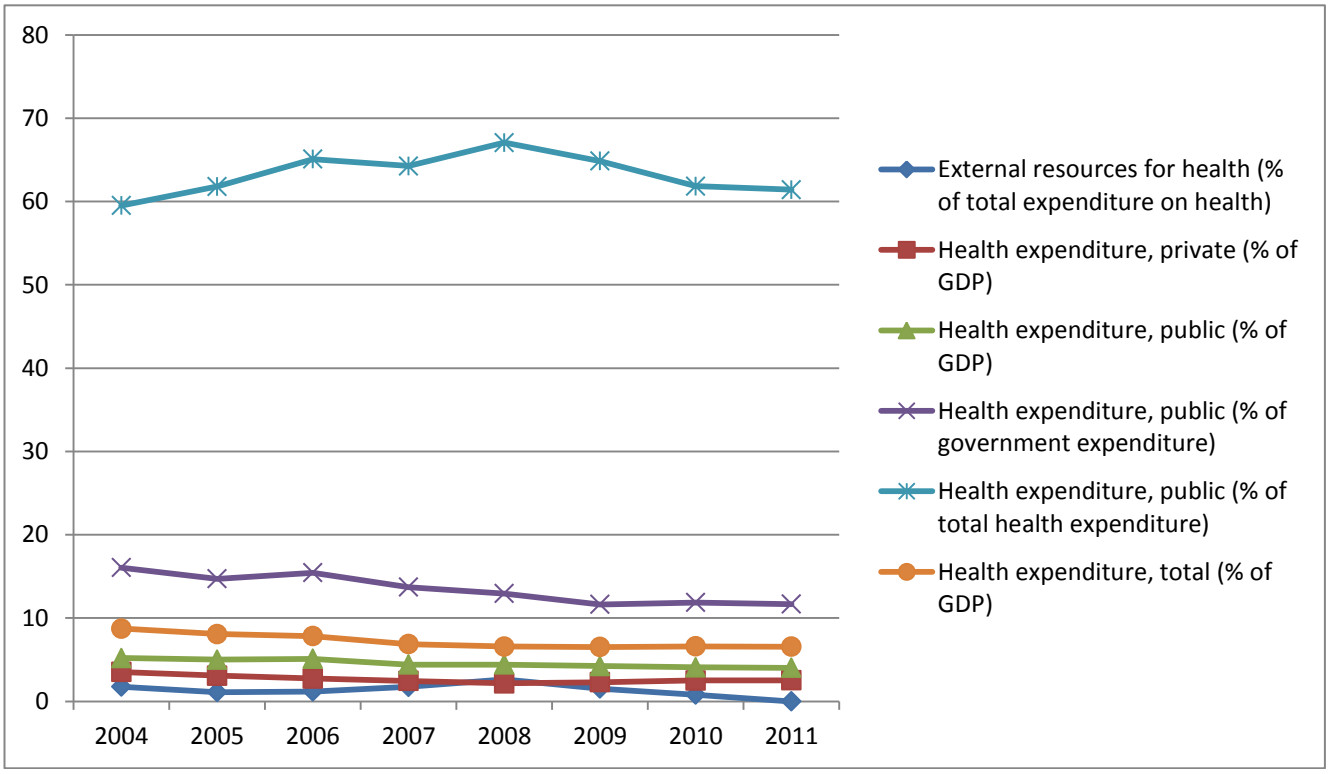
3.2.3 Sustainability

Health expenditures presented as National Health Account format, show a slight decrease in total health expenditures (THE) as % of GDP. With the indicator of general government expenditure of health as % of THE, which is decreasing as well, it can be pointed out that the government's support to the national public health insurance is decreasing. In addition to this, there is a continuous decrease of the percentage for health insurance contribution from payrolls, which has been decreasing consecutively by 1.5% each year for the last three years. Thus, the public expenditure for health is as low as 4.8% of GDP.[38]

The figure below (Figure 5.) shows some of the measured indicators regarding health expenditures: external resources for health, HE private and public as % of GDP etc. All trend lines are decreasing over years where external resources of health are reaching point 0 for 2011. Last data for THE as a % of GDP shows the flat line of 6.5% for the period 2008-2011[39].

[37] DRG Report for the period January-December 2010, HIF.
[38] The former Yugoslav Republic of Macedonia - National Expenditure on Health (Denar), NHA, WHO 2011.
[39] http://databank.worldbank.org/data/views/reports/chart.aspx

Figure 5: Total Health Expenditure (THE) selected indicators



Source: The Former Yugoslav Republic of Macedonia – Health Expenditures Selected Indicators, World Bank 2013.

In its last financial report from 2012, HIF announced a positive balance of collected revenues vs. expenditures on a yearly basis. Yet, if the structure of the budget is looked at closely, a decrease in HIF budget as % of state budget as well as a % of GDP is evident (Table 16).[40]

Table 9: Budget of the HIF related to the state budget and GDP in MKD (2007-2012)

Year	Total expenditures	HIF budget as % of state budget	HIF budget as % of GDP
2007	16.425.000.516	13.98%	4.64%
2008	19.630.339.319	14.00%	4.93%
2009	19.165.097.000	12.81%	4.71%
2010	19.803.244.000	13,88%	4,64%
2011	20.967.117.807	14,11%	4,60%
2012	21.436.409.510	13,76%	4,50%

Source: Yearly Report of the HIF, HIF 2012.

Regarding the analysis of the realisation of the funds from the HIF by public health institutions (PHI) (HIF Report 2011), which include all hospitals and policlinic centres, it is evident that out of the total funds used by PHI, 81% come from the HIF, about 2% from the state budget (for special governmental programmes) and about 17% from own resources.

On the other hand, expenditures of PHI are mostly for salaries (about 53%), drugs and medical consumables (27%) and other expenditures (about 20%). The index 2010/2009 shows

[40] Yearly Report HIF, HIF 2012.

a slight decrease in expenditures for salaries, an increase in expenditures for drugs and medical supplies and a decrease for other expenditures. This is mainly due to the migration of health professionals from the public to the private sector and the increase in total costs for drugs and medical devices. On the other hand, the existing lack of specialists in policlinic centres results in the redirection of patients requiring specialist services towards hospitals.

An emerging private sector in terms of specialised and general hospitals has also drained specialists from public to private hospitals, which has additionally emphasized the lack of specialised professionals (doctors, nurses and technicians) in public hospitals. Thus, public hospitals bear the burden of patients and work overload in ambulatory care.[41] Due to the lack of a systematised approach by the Ministry of Health to address the need of health services, the private sector "creams off" expensive health services, imposing stratification of the population and compounding inequality in access to some services.

Drainage of medical professionals has been noted to other countries as well. This migration of intellectuals and educated trained medical workforce leaves the hospitals lacking of well-trained experienced medical staff. Therefore, the Minister of Health announced and started the implementation of the initiative for education of the health professionals abroad and offering "seats" in public hospitals for all "returnees" from the private sector or abroad. The initiative is still ongoing, and the outcomes are to be seen.

3.2.4 Summary

Macedonia is trying hard to implement successful reforms in the health sector. But the reform process seems to be long-lasting and very complicated. A simple transition from the previous socialistic system into a market-oriented but shared public-private model faces difficulties in implementation. Obviously, the reforms need to be more structured and adjusted not only to the real needs of the population and the government, but also to the fiscal reality of the state, economic growth and development as well as the flow of the educated medical workforce. Stipulating positive attempts of the government is very much important and needed, but also there is a need of adequate analysis of the situation in the country and elaborating major changes which should drift reform processes. Of essential importance is to enable sustainable implementation of the reforms throughout a defined period of time.

If we look at the overall financial sustainability of the health care system in Macedonia and projections of the system development, it is evident that the health care sector is not sustainably financed. Financial aspects (at micro and macro level) have not deprived the overall financing of health care. Financing of public health care services through the national insurance scheme reflects shortages, both in financial and in human resources. So far, the possibility of supplementary insurance and introduction of private insurance has been mentioned several times, but the real possibilities of eventual implementation never tackled. It is evident that shortages in financing of health care are compounded by inappropriate management and oversized structure of the system. On the other hand, private sector institutions are rapidly emerging, providing better conditions (in terms of facilities and equipment) for the provision of health care services. Thus, inequalities in access to health care services for the population have started to appear in terms of location, available equipment, reliable human resources and possibilities for payment.

HIF financing is shackled by limited resources and limited revenues. Even though financial reports of the HIF show liquidity and no depths, the struggle and difficulties lie with the

[41] http://www.fzo.org.mk/.

public HCI. None of the mentioned reform steps in redistributing available funds of the HIF and rationalisation of expenditures managed to solve the shortages of funds. BBP is wide and imprecise. Many attempts to decrease and rationalise it have failed. Hospitals are in a similar situation, struggling with their limited budgets and oversized facilities on the one hand, and a lack of provision of efficient health care services on the other.

Medical professionals are migrating towards the private sector, because of higher salaries and better working conditions, which again leaves public HCI inadequately equipped with professional medical personnel. The last initiative of the government for the provision of sophisticated medical equipment, training for medical staff and additional new jobs for specialists in the public health care sector still leaves doctors and patients with high levels of dissatisfaction. Private-public partnerships in health were announced by the government as a possible solution in strengthening the health care sector. However, the law on public-private partnerships in health has been a draft version since 2009.

A serious rural-urban divide with regard to access to and provision of adequate health care can be observed. This is supported by the still existing overload of clinic hospitals in Skopje and the number of transfers of patients from regional hospitals to Skopje clinic hospitals.

Summary of major strengths and weaknesses of the system and need for reforms	
Strengths and best practice	*Weaknesses and need for reforms*
Massive investment has been done in restructuring, refurbishing and building new public health facilities.	Poor financial sustainability of the overall public health care services through the national insurance scheme.
There has been new equipment procured and distributed in all health institutions throughout the country, which is solid investment for improving the quality of health care services and in line with the needs of modern technology.	Poor organization and management of the PHI; oversized health care institutions not in line with the real needs of the population.
Some progress is made in terms of finding out possible solutions to approach needs for reform in terms of organized post-graduate/post-specialization education and training of health professionals and request for mandatory continuous education of health workers.	Drainage of trained medical personnel to private sector and abroad, due to the better conditions for work and better salary.
Implementation of the integrated informatics system is progressing. This should ease registration, referrals and transfers of the patients and improve the communication among health workers. Also, elaborated data should be adequate and updated	Restructuring of the payment model towards medical staff in the public sector is crucial; only satisfaction of the medical professionals can lead to improved provision of quality health care services.
Some improvement is made in terms of public health and prevention (as stated in the EU Commission Report 2012)[42], which shows positive trends towards EU regulations in public health and prevention.	Emerging inequalities in access to health care services (public/private and urban/rural).

[42] EUROPEAN COMMISSION (2012). "Commission Staff Working Document-The Republic of Macedonia 2012, PROGRESS REPORT for 2012", section 4.9 Skopje, published October 2013 http://www.sep.gov.mk/data/file/Dokumenti/Registar-na-dokumenti/PR2012_MK3(2).pdf

	Poor implementation of the announced reforms and lack of clear vision of the essential structure of the reforms.
	Need of serious analysis of the needed structural reform of the health care system; to be discussed with health professionals and professional medical associations.

3.3 Reform debates

During the year 2012-2013 there have been several debates on the current issues and future developments of the health care system; mostly generalised and mainly provocative between the government and the opposition, offering no clear statement about the problems and any real options or solutions for debated issues.

One long-lasting health-related affair which stressed the public was related to the organized scheme for false issuance of pensions for disabled persons (physically challenged persons during their working time) going through the complicated net of several levels of national medical commissions. The affair was named "Metastasis" and about 50 eminent doctors were accused and prosecuted for being involved on different levels. This shame for the health workers additionally diminished already shaken public values of the medical profession.

Another academic debate has been opened and specifically oriented towards the poor implementation of the reforms in health care, with special emphasis on the project on payment for performance. The Law on Health Protection was amended, introducing a payment-per-performance model for doctors in 2011.[43] This amendment received very strong comments and discussions among health professionals and created strong rejection from the Union of Health Workers and from the Doctors' Chamber of Macedonia.[44] The government justified the implementation of this system of payment by increasing the responsibility of doctors and their efficacy in provision of health care services. The union and the chamber complained about the positioning of the system, whereby only the supervisor (Director of the PHI) has the authority to measure and evaluate the professional work of its employees. The union is concerned that this model gives possibilities for bias in deciding the efficiency and effectiveness of individual professional performance of medical staff. The chamber strongly argued in favour of stopping the project and announced that any communication with health authorities would go "one way only". This misunderstanding, lack of communication and collaboration led to organization of strike of the medical professionals from the Clinic Centre in Skopje. Further on, other medical professionals from other PHI joined the strike. It was led by the Independent Syndicate (Union) of the Clinic Centre, chaired by Dr. Dejan Stavrik. The strike started end of November and lasted for several months. During this period many debates were opened, many discussions were led, many provocative activities were

[43] Amendment on the Law on Health Protection, April 2011.
[44] Vox Medici, No. 70, March 2011.

performed, all that diminishing and putting in question the public value and actions of the Ministry of Health[45].

Most of the discussions at the beginning of the strike were tackling the deep involvement of the politics in organization and management of the health care system, where there was no space for scientific approach to the reforms and implementation of major policy issues[46]. This is quoted conclusion in the only scientific article published regarding the implementation of the mentioned project: "Massive support against the implemented P4R (pay-for-reporting) reform was expressed by the Macedonian doctors employed in the public sector. The model should integrate parameters such as quality and complexity of delivered services to patients. Better integration and engagement of doctors is essential to assure support and smooth implementation of P4R reform as sound policy in practice. The Ministry of Health should set key parameters to be monitored by hospitals to evaluate the success of the P4R system"[47].
The strike itself was brutally interrupted several times; doctors were attacked publicly and threats were placed for their jobs and positions. The Minister showed arrogance and lack of capability to discuss and listen to the problems of medical professionals. The public perceived as the Minister is ignorant and stubborn in implementing his ideas and projects. Nevertheless, after several attempts to seize the strike and other restrictive measures, final agreement was made to revise the project objectives and to re-evaluate some changes suggested by the Union. International Project Healthgrouper successfully organized the Summit on Pay-for-Performance in Macedonia: "Who wins, who loses?", in December 2012. The Summit has given the opportunity for interesting and interactive debate among medical professionals, patients and foreign experts. Further the key messages that emerged from the discussions and the debate of the Summit were presented to the public[48]. The Summit has supported the doctors' initiative to be paid by performance. Doctors' performance needs to be measurable over indicators that are related to patients' benefit. The outcome of this reform should be patients' satisfaction from the healthcare services; Positive motivation (stimulation) of the doctors, and not punishment as an essential prerequisite for successful implementation of any healthcare reform. The expectations were that these messages will help in mediating the opposing attitudes/views of the medical doctors and health policy makers to find a common acceptable solution for modification of the project "Pay-for-reporting" that will protect the interest of patients, will motivate the doctors, and will support the Government to successfully implement its planned agenda in practice[49].

One recent study showed that physicians are dissatisfied with the reforms in the health care sector in Macedonia. The conducted survey revealed that 75% of the doctors are dissatisfied with the reforms implemented in the health care sector; 45% of the doctors consider changing their workplace (out of which 57% consider going abroad, 31.4% consider moving from public to private, 11.6% even consider changing their profession). Most satisfied are doctors working in the private sector, which has no contracts for services with the HIF.[50]

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45 Who would go on strike? Healthgrouper research unit 21 September 2012. http://healthgrouper.com/en/page/Strike

46 First scientific article on Pay for Performance in Macedonia published: Politicization in the healthcare system is documented. Healthgrouper research unit 9 December 2012. http://healthgrouper.com/en/page/Medical-doctors%E2%80%99-attitudes-towards-Pay-for-Reporting-in-Macedonia

47 Vladimir Lazarevik, Blasko Kasapinov, Medical Doctors' Attitudes towards Pay-For-Reporting in Macedonia: A Web-Based Cross-Sectional Survey, *Macedonian Journal of Medical Sciences. 2012 Dec 15; 5(4):437-443.* http://dx.doi.org/10.3889/MJMS

48 http://healthgrouper.com/en/page/Summit-P4P-Macedonia-first-announcement

49 http://healthgrouper.com/en/page/HGSummit-messages

50 Physicians dissatisfied with the reforms in the health care sector in Macedonia. Healthgrouper research unit. 8 February 2012. http://healthgrouper.com/documents/4417/PressReleaseDoctorSatisfaction-EN.pdf.

The potential impact the EU social policies have had on the Macedonian health system's reform processes can be seen in the EU Progress Report 2013, in the recommendations, conclusions and their acceptance. Chapter 28 points out some issues regarding health protection.[51] It is notable that more or less the same conclusions appear as from the previous year, with no significant improvements in any specific area.

However, inequalities in health care service provision were mentioned in the Project for Reducing Health Inequalities in Antenatal and Postnatal Care of Romani Women in the Republic of Macedonia, as a Policy Action Brief by the Open Society Institute New York and Roma Health Programme showd. This project tackles the issue of right to health with focus on reproductive health of Roma women. Findings of the project show disadvantages and inequalities in access to quality health care services for the female Roma population. Recommendations in the policy are towards improving future access in the system of health care provision in the area of reproductive health.[52]

Another brief research comments on effects of two governmental measures to fight against some inequalities in health: the adopted Law on Patient Rights and implemented reference pricing of pharmaceuticals. The aim of the selected interventions was to decrease some noted inequities in health care. The study assesses the impact of the interventions through media reporting, medical community responses and patient satisfaction (responses). The conclusion, as shown in this research, reveals that the implementation of the Law on Patient Rights has not achieved its purpose yet. And the reference pricing system only shifted the burden of financing from the HIF towards patients, in the form of increased co-payments for pharmaceuticals. More specific studies need to be designed and carried out to assess the impact of specific policies on equity in the health care system in Macedonia.[53]

4 Long-term care

4.1 System description

4.1.1 Major reforms that shaped the current system

"The existing system of long-term care in the Republic of Macedonia consists of an institutionalised system of social and health care services provision, and some services provided on community level. The scope of service provision is specified in the Laws on Health Protection, on Health Insurance and on Social Protection. The existing legal provisions are covering long-term care protection in terms of service provision to elderly persons, persons with physical or mental disabilities and deprived populations in need of assistance in carrying out daily activities." [54]

4.1.2 System characteristics

Bearing in mind the fact that only 0.3% of the elderly population is accommodated in institutions, the growing need of an improved and strengthened system of homes for elderly

[51] The Former Yugoslav Republic of Macedonia 2013 Progress Report, Brussels, 16 October 2013. http://www.sep.gov.mk/

[52] Reducing Health Inequalities in Antenatal and Postnatal Care of Romani Women in the Republic of Macedonia Policy Action Brief. Katerina Shojikj. National Roma Centrum. Skopje, 2011.

[53] Lazarevik V. Policy Interventions to Tackle Health Inequities in Macedonia: Patient Rights and Reference Pricing of Pharmaceuticals. Maced J Med Sci. 2010;3(1):57-60.

[54] Direct quotation: Dimitrievska V., The model of long-term care, June 2010.

and increased capacities of the institutions is evident. Palliative care is in the first stages of implementation. Only two centres for palliative care are operational in Macedonia: hospices Sue Rider in Skopje and Bitola with a total capacity of 150 beds. Regarding the statistical data on prevalence of neoplasm as the main cause for morbidity and mortality of the population, palliative care needs to be improved and strengthened, in line with the real needs of the population. Existing homes for the elderly have no specific programmes and departments for palliative care; therefore, a nation-wide network for the provision of an interdisciplinary approach of palliative care is a necessity.

Home-based support to elderly persons through the provision of home care services to individuals was initiated in 2009 as a joint activity of the MLSP and NGO Humanity in Skopje. Beside this initiative, there is a strong need for organising qualified systematic support and help for the elderly as home-based or community-based assistance.

Day-care centres for elderly and homeless people operate separately within the country. Their work consists mostly of community-based provision of services at the level of local self-government. Unfortunately, those are still isolated initiatives and represent only the beginnings in the organisation of access to home or community-based services for social assistance.

The National Strategy for Elderly People 2010-2020 was adopted by the Ministry of Labour and Social Policy in June 2010. The strategy focuses on the elderly population (over 60 years of age) and envisages joint activities in support of the ageing population.

The Minister of Labour and Social Policy, Spiro Ristovski, took his position in July 2011. Coming from the position of Deputy Minister in the same Ministry, he took over and continued positive policies and trends towards improving social protection in the country.

4.1.3 Details on recent reforms

The main political discourse for future development of long-term care services is elaborated in detail in the National Strategy for Elderly People 2010-2020 by the MLSP. This strategic document provides a comprehensive approach in defining and implementing social and health care services. The overall vision of the strategy emphasises an improvement of the quality of life of the elderly, the improvement of their socio-economic status, access to resources in the living environment and social and community integration, as well as respecting the right of individual choice.

As part of the activities of social protection, the Law on Family envisages obligations of the children to provide financial support to financially compromised parents, even when living separately or living in an institution.[55] According to the Law on Social Protection, old people without financial support who do not have any property or rights on properties and cannot obtain protection as defined in the Law on Family can obtain rights for social protection on several levels.[56]

Institutional care is organised for elderly who cannot take care of themselves and live in families (conditions) where there is no other possibility in providing care and protection. In Macedonia, there are four public institutions for care of the elderly.

Following the opening of the first hospice in Macedonia in 1998, the integration of palliative services into the health care system has made considerable progress. This includes providing high quality care to people reaching the end of life in different settings; developing

[55] Law on Family, official Gazette 84/08, Art. 181.
[56] Law on Social Protection, Official Gazette No. 79/2009.

interdisciplinary palliative care teams; ensuring the participation of people at the end of life and their families in decision-making; and ensuring adequate funding through the health insurance fund. The main public health institution for palliative care in Macedonia is the Gerontology Institute "13 November" in Skopje. The Institute draws on the Sue Ryder hospice model developed in the United Kingdom. One of its tasks is to evaluate, report and plan for the needs of older people, and it collaborates with several health institutes, clinical centres and a military and psychiatric hospital to improve care of older people with acute and chronic diseases, including those at the end of life. Education in palliative care for health professionals is an integral part of the Institute's activity[57].

The total capacity of homes for elderly people is 567 beds. Out of them, 215 people are accommodated by the Ministry of Labour and Social Policy, according to the Law on Social Protection.

In accordance with the Law on Local Self Government[58] and the amended Law on Social Protection from 2009, only the geriatric centre in Skopje is a public institution, while the other homes operate under the auspices of local self-government. Following the process of decentralisation in provision of social services, the MLSP licensed two institutions for care of the elderly through applied public-private partnerships. Moreover, there is an initiative for the transformation of legal subjects who operate as social care providers into institutions for systematised social care protection, which should increase the number of available institutions by 7. Estimations indicate that institutional social care covers about 0.5% of all elderly people in Macedonia, despite European recommendations for coverage of 3-5% of the elderly population.[59]

As stipulated in the Law on Family, children have to be advised and additionally encouraged to provide support to financially compromised parents, especially when the care for the elderly is questioned. The values of home-based provision of care need to be advocated promoted and endorsed.

According to the estimations made by the UN, the expected decrease of the total population in Macedonia basically is due to the decreasing fertility rates (-0.2% for the period 2010-2015). Along with a decrease of the total population in Macedonia, the UN estimates an increase of the ageing population as a share of the total population. Estimations show an increase of the share of the elderly population (over the age of 60) from 16.5% in 2009 to 33.0% in 2050. Macedonia experiences a significant internal migration of the population, most of which occurs towards the region of Skopje. Therefore, the concentration of the majority of the population is in the capital of the country, while depopulation affects rural areas. The migrating population is predominately young, while elderly people remain left behind in rural areas.[60]

In Macedonia, mortality and morbidity rates from chronic non-communicable diseases are increasing: especially rates for morbidity and mortality from circulatory diseases. This trend is due to the increased share of the ageing population in the total population and, therefore, an increased number of mortality deriving from the ageing population. According to data from the State Statistical Office, this trend stems predominately from the combined factors of decreasing fertility rates and increasing life expectancy (decreased overall mortality rate). But, the burden of disease does not show any shifting towards the ageing population. Statistics

[57] Palliative care for older people: better practices. WHO EURO 2011. http://www.euro.who.int/__data/assets/pdf_file/0017/143153/e95052.pdf
[58] Law on Local Self-government, Official Gazette No. 5/2002.
[59] National strategy for elderly 2010-2020, MLSP.
[60] National strategy for elderly 2010-2020, MLSP.

derived from the reporting of hospitals show that service provision for the elderly (aged over 65) was limited to 21% of provided services.

Regarding morbidity trends, the situation is very similar, with respiratory diseases being the leading cause of morbidity.[61]

4.2 Assessment of strengths and weaknesses

4.2.1 Coverage and access to services

The national strategy for elderly people of the Republic of Macedonia is in line with the other national policies of the country, as well as with the legal framework of the EU. The strategy values the human right to individual choice in the context of essential rights of the current population and the needs of the future population. It enables the country to build equal possibilities for the development of individuals through socio-economic developments. Thus, the strategic goals of the country can be warranted and fulfilled: moving towards values, standards and social rights which are characteristics of the European Region, especially regarding the Strategy for Sustainable Development of the EU (2001, 2006), the revised Lisbon Strategy (2000), the Madrid Action Plan for Ageing (2002) and the last Conference on Ageing (UNECE, 2007).

Elderly as all health insurees have the right to freely choose a family doctor at primary level of health protection and, if hospitalisation is required, they can choose the hospital or specialist care. Most of the difficulties elderly people face is with regards to the access to services, their rights as patients as well as obtainment of the right to continuous financing of help from third persons. This is mainly due to the current practices in health and social care provision, a lack of available and reliable information (general and on rights to services) and geographical distance to health and social care facilities. Research on the use of social services shows that 12.8% use continuous financial support from the state, 11.3% use funds for care and assistance for help from third persons and 0.2% use daily or temporary accommodation in institutions or foster homes.[62]

4.2.2 Quality and performance indicators

4.2.3 Sustainability

In general, there is an existing network of health and social care services of the country, as well as partially systematised special care for the elderly (homes for the elderly and hospices). However, there are still difficulties in obtaining the needed services, as well as a lack of an adequate network of services (organisation and appropriate structure). Yet, the Strategy for Elderly People of the MLSP draws the paths of recognition, organisation and, finally, implementation of appropriate health and social care services.

In realisation terms, most of the barriers to enabling appropriate care are the lack of information for citizens on existing services and their rights, and the geographical distance to selected facilities (health care centres and institutions), particularly for people from rural areas.

An increasing number of elderly requires the provision of services in health and social care, which then often represents an increase of the total expenditure. There has been an evident

[61] Hospital morbidity in 2008 and 2009. PHI 2010.
[62] Dimitrievska V., The Model of Long-term care, June 2010.

decrease of living standards within the population during the last years, especially within the elderly. Poor health conditions of the elderly lead to an almost complete exclusion of elderly people from society. This is in line with the information from the Ministry of Health, which points out the difficulties of elderly insured people to buy drugs and pay for health services. Thus, elderly people are in a situation of unequal access to basic health services and essential drugs. An ageing population puts an additional economic burden on the state, with regard to providing specialised health and social services for chronic diseases, rehabilitation and palliative care.

Deinstitutionalisation, in light of a decentralisation policy, is present both in health care and social protection services. Some service provision is partially organised at community level or home-based, mostly through local self-government. However, the national scope, as well as a structured approach, is lacking. The issue of weak quality of service provision remains, because of insufficient numbers of specialised professionals for elderly patients, a lack of multifunctional teams and approaches to treatment, a lack of adequate and appropriately equipped facilities and long waiting lists for admission to institutions.

The sustainability of long-term care needs to be separately projected and reviewed, especially in respect of continuous financing and possibilities of revenues. Despite the provision of some of the needed funding and resources by the state (funds for pension insurance), the majority of services are privately financed. Thus, the socially deprived population may have limited or no access to those services. Respecting the trend of population ageing and projections made, long-term care needs to be taken into serious consideration when planning health and social care budgets of the state. This also includes possibilities of not only empowering the services, but also widening the scope and range of provision.

4.2.4 Summary

It has to be taken into consideration that service provision at institutional level needs more resources (financial and human) than other forms of service provision. Therefore, in the long run, the institutionalisation of long-term care needs adequate financial sustainability. Moreover, the need for development of supplementary forms of service provision has to be taken into account, as well as the allocation of additional funds for this purpose and the search for additional forms of funding.

Summary of major strengths and weaknesses of the system and need for reforms	
Strengths and best practice	*Weaknesses and need for reforms*
There is a well-shaped legal framework for social protection of elderly people, including Law on Local Self Government, Law on Social Protection, Law on Family and Law on Health Insurance.	Poor financial sustainability of the overall social protection system, especially for elderly people; poor access to public health care services through the national health insurance scheme; poor communication and linkage between the health and social services for elderly people.
There is well defined National strategy for elderly people of the Republic of Macedonia 2010-2020 in line with the other national policies of the country, as well as with the legal framework of the EU.	Increasing number of elderly population is not followed with adequate increase of service provision (both social and health; public and private; institution based and community/home

	based).
Some improvement is made in terms of organization of sustainable network of social protection services throughout the country.	Service provision at institutional level needs more resources (financial and human) than other forms of service provision.
Considerable progress was made with the integration of palliative services into the health care system.	Institutional social care is slowly progressing. Still this type of care covers insufficient number of all elderly people in Macedonia (about 0.5%), despite European recommendations for coverage of 3-5% of the elderly population.
	There is a strong need for organising qualified systematic support and help for the elderly as home-based or community-based assistance.

4.3 Reform debates

The four-year (2012-2015) Social Policy of the Government foresees achieving sustainable economic development through good social protection of the most vulnerable layers of the population. In the part "decent life for pensioners and social partnership", the following developments are anticipated: opening of 12 food banks for old and frail persons in rural areas (by 2015), opening of five regional elderly residential care homes with a capacity of 50–100 users through a public–private partnership in four municipalities, opening of four elderly day-care centres and clubs for seniors, opening elderly home care centres in five municipalities and operationalization of the measures and activities of the National Strategy for the Protection of the Elderly (2010–2020), with a special emphasis on opening local social services in collaboration with the municipalities and civil society organisations.[63]

The implementation of the strategy will be through introduction of the basic principles of independence, community activity, protection (formal and informal), self-fulfilment and dignity for elderly people.

Ways and means for the implementation of the strategy include promotion, respect and protection of human rights; long-term planning; continuity of work and sustainability of interventions and results; long-term horizontal orientation, including activities of several ministries; inter-sector and inter-resource collaboration; collaboration with the non-governmental and private sector (as public-private partnerships); promotion and inclusion of local institutions; legal framework adjustment; promotion of family support (active policies for family support) and inter-community collaboration.

The implementation of the strategy should be through the establishment of an efficient system of financing, which has to include the state budget and the budgets of local self-governments, resources from different governmental funds, funds from non-governmental organisations and donation programmes and other international financial institutions.

For an appropriate implementation of the mentioned activities and an adequate promotion of defined principles, it is of essential importance to realise an active involvement of the

[63] Programme on Social Care 2012-2015. Government of Republic of Macedonia. http://vlada.mk/?q=node/268&language=en-gb.

Ministry of Health and other related ministries and obtain strong support from the government.

Major debates have not been undertaken. Some media reported on extremely poor housing and health conditions of recipients of social benefits, socially deprived people and homeless people in the community.

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Annex – Key publications

[Pensions]

AGENCY FOR SUPERVISION OF FULLYFUNDED PENSION SYSTEM (MAPAS), Извештај за состојбите во капитално финансирано пензиско осигурување во 2012 година, April 2012, Skopje, retrieved on 8 October 2013 at http://www.mapas.mk/wbstorage/files/%D0%98%D0%B7%D0%B2%D0%B5%D1%88%D1%82%D0%B0%D1%98%20%D0%9A%D0%A4%D0%9F%D0%9E%202012.pdf

"*Report on the Developments of the Fully-funded Pension System in 2012*"
This Report is prepared on an annual basis (2012) by MAPAS, and it gives clarifications about the features of the fully funded pension component (mandatory and voluntary) and relevant data in terms of the developments in that area. The contents of the report encompass analysis and presentation of the structure of the members in funded pillars by age, sex and working years, the investment portfolio structure by financial instruments, currencies, sectors, the investment performance, return, operational cost and comparison with other countries. The report also includes a separate chapter with a brief overview of the global trends in the pension system, especially in funded pillars. Finally, the report informs about the plans for future MAPAS activities to protect the interest of the members in the fully funded pension system.

EUROPEAN COMMISSION, Работен документ на Комисијата-Извештај за напредокот на Република Македонија за 2012, Skopje, retrieved on 8 October 2013 at http://www.sep.gov.mk/data/file/Dokumenti/Registar-na-dokumenti/PR2012_MK3(2).pdf

"Commission Staff Working Document-The Republic of Macedonia 2012 PROGRESS REPORT"

The Republic of Macedonia is a non-EU country (with a candidate-country status waiting to join the EU countries) and is, therefore, subject to annual evaluation of the progress in fulfilling given benchmarks. In Part 4. Ability to assume the obligations of membership 4.9. Chapter 9: Financial Services, of the Progress Report-2011, it is noted that **"**Some progress can be reported as regards access to the labour market. At the same time, the document indicates that the cooperation and coordination between enforcement bodies have not **i**mproved and labour market participation is still very low. Further, long-term unemployment, high youth unemployment and very low participation by women in the labour market are all causes for great concern. Then, the national budget allocated to the active labour market programme is low.

MACEDONIAN PENSION AND DISABILITY INSURANCE FUND Извештај за пензискиот систем во Република Македонија со актуарски проекции, October 2012, Skopje, retrieved in 12 October 2013 at http://www.piom.com.mk/informacii/statistika/240.html

"*Report on the pension system in the Republic of Macedonia with actuarial projections"*
Part of the Macedonian Pension and Disability Fund is the Actuarial Unit, which was established in order to strengthen the capacity for development of the policy of the pension insurance sector. The report starts with a brief overview on the reformed pension system, including data on contributions, benefits, number and structure of the pensioners. In addition, the report analyses data on the financial condition of the system with focus on the long-term actuarial projections for the future financial sustainability of the pension system, including

calculations on the percentage of GDP. This report also forecasts short and long-term projections for revenues and expenditures, by means of actuarial modelling and taking into consideration the expected demographic and economic trends, within the framework of different assumptions for the pensions' policy.

MACEDONIAN PENSION AND DISABILITY INSURANCE FUND, Извештај за финансиското работење на Фондот на пензиското и инвалидското осигурување на Македонија за 2012 година, April 2013, Skopje, retrieved in 12 October 2013 at http://www.piom.com.mk/informacii/statistika/240.html

"Report on the financial operations of the Macedonian Pension and Disability Fund for 2011"
Each year, the Macedonian Pension and Disability Fund submits a financial report to the Management Board, consisting mostly of financial data on the pension system and the operations in the current year. This report is subject to approval by the Macedonian government. Disclosed in the report are data on the financial results for 2012, with more details on the revenues and expenditures, losses, the structure of the financial sources as contributions, budget transfers, etc. The report consists of data related to the dependency ratio between the average wage and the pension benefit and includes certain transparent information for the PDIF costs for services.

INTERNATIONAL ORGANISATION OF PENSION SUPERVISORS (IOPS), JON ASHCROFT, FIONA STEWART, Managing and supervising risks in defined contribution pension system, Working Paper No. 12 2010 (IOPS), October 2010, retrieved in 12 October 2013 at http://www.oecd.org/site/iops/principlesandguidelines/46126017.pdf

IOPS as an organisation for international networking of supervisors is accustomed to providing data and preparing many documents for the pensions area. This paper highlights the key challenges for DC supervisors, outlining the different mechanisms which can be used to control risks within DC systems, and how the use of these mechanisms informs the supervisory approach. Case studies of IOPS members overseeing DC systems are also provided, including the data on the Macedonian pension system.

CENTRE FOR ECONOMIC ANALYSES (CEA), Report on the publicly funded pension scheme in Macedonia, 2011, retrieved in 12 October 2013 at http://cea.org.mk/documents/studii/CEA_Pension%20PAYG%20review.pdf

The Report analyses the developments connected to the aging population and the ambition to sustain the relative living standards of the retired. This is seen as a test of sustainability for the pension system, both private and publicly financed schemes. Therefore, this report should be regarded as an initial study that sets the basis for a more thorough and systematic analysis of the functioning of the public pension scheme in the Republic of Macedonia and its findings should be regarded in that light. The very end of the document consists of two scenarios with recommendations in light of the pension system's sustainability.

[Health care]
HEALTH INSURANCE FUND OF THE REPUBLIC OF MACEDONIA (2013). ДСГ – Дијагностичко сродни групи, извештај за периодот јануари –dekemvri 2012. Retrieved in October 2013 from:

http://www.fzo.org.mk/WBStorage/Files/Godisen%20izvestaj%20za%20DRG%202012.pdf

"DRG – Diagnostic-Related Groups, Report for the Period January – December 2012"

The report analyses the implementation of the DRG model for acute admissions in 58 public hospitals in Macedonia. The report shows the distribution of services per DRG, MDC and per facility. Case mix data shows complexity of related patients and use of resources. Valuable information on DRGs distribution and case mix complexity is presented through trends for the period 2009-2012.

Who would go on strike? Healthgrouper research unit 21 September 2012. Retreived on October 2013 from

http://healthgrouper.com/en/page/Strike

This short report presents the results of the conducted electronic survey among doctors working in the public and private health sector in the Republic of Macedonia by the international Internet research project Healthgrouper. The survey refers to the pay for performance (P4P) project, as well as the attitude of the doctors towards the scheduled strike for September 24, 2012.

First scientific article on Pay for Performance in Macedonia published: Politicization in the healthcare system is documented. Healthgrouper research unit 9 December 2012. Retreived on October 2013 from

http://healthgrouper.com/en/page/Medical-doctors%E2%80%99-attitudes-towards-Pay-for-Reporting-in-Macedonia

This article is based on the results of the survey conducted via Healthgrouper among medical doctors employed in public and private health care sector in Macedonia.
The article summarizes international experiences related to implementation of P4P projects and concludes that current evidence shows that there is no simple and easy to find successful model of P4P. From the experience it is evident that success of these reforms mainly depends of inclusion of doctors in the process of planning and implementing the reform. The scientific article for the first time documents the politicization in the health care system. Attitudes of over 85% of the medical doctors who have participated in the survey is that politics and political parties interests have crucial role in the Macedonian health care sector.

LAZAREVIK Vladimir, KASAPINOV Blasko, Medical Doctors' Attitudes towards Pay-For-Reporting in Macedonia: A Web-Based Cross-Sectional Survey, *Macedonian Journal of Medical Sciences. 2012 Dec 15; 5(4):437-443.* Retreived on October 2013 from http://www.mjms.ukim.edu.mk/Online/MJMS_2012_5_4/MJMS.1857-5773.2012-0246v.pdf

The article aims to determine medical doctors' attitudes towards the implementation of the new pay-for reporting system in the public hospital sector using the data from the electronic survey. Findings are that the majority of all surveyed doctors especially those employed in the public sector are against the proposed pay-for-reporting (P4R) reform. The recommendation stands that the model should integrate parameters such as quality and complexity of delivered services to patients and enable better integration and engagement of doctors.

Palliative care for older people: better practices. WHO EURO 2011. Retreived in October 2013 from

This report gives a wide overview on meeting the needs of elderly population, presented in frames of public health challenge. This publication aims to provide examples of better palliative care practices for older people to help those involved in planning and supporting care-oriented services most appropriately and effectively. Examples have been identified from literature searches and from an international call for examples through various organizations, including the European Association of Palliative Care and the European Union Geriatric Medicine Society. Some examples consider how to improve aspects within the whole health system; or how to improve palliative care education, support in the community, in hospitals or for specific groups of people. This publication focuses on examples from or relevant to the WHO European Region.

This publication is commissioned by the European Union Programme for Employment and Social Solidarity – PROGRESS (2007-2013)
This programme is implemented by the European Commission. It was established to financially support the implementation of the objectives of the European Union in the employment, social affairs and equal opportunities area, and thereby contribute to the achievement of the Europe2020 Strategy goals in these fields.

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