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Neda Milevska-Kostova

The Health Care System in North Macedonia

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Content

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1. Country Overview

Source: On The World Map 2020

- Sub-Region: Southern Europe
- Capital: Skopje
- Official Language: Macedonian
- Population size: 2.08 million (World Bank 2019, est.)
- Share of rural population: 41.8% (World Bank 2019)
- GDP: $ 12.695 billion (World Bank 2019)
- Income group: Upper-middle income (World Bank 2019)
- Gini Index: 34.2 (World Bank 2017)
- Colonial period: n/a
- Independence: 1991

2. Selected health indicators

Indicator	Country	Global Average	EU Average
Life expectancy at birth, male (2018)	73.7	70.4	78.2
Life expectancy at birth, female (2018)	77.7	74.7	83.7
Mortality rate, infant (per 1,000 live births) (2018)	8.7	28.9	3.4
Maternal mortality ratio (modelled estimate, per 100,000 live births) (2017)	7.0	211.0	8.0 (2015)
Prevalence of HIV, total (% of population ages 15-49) (2018)	0.1	0.8	
Incidence of tuberculosis (per 100,000 people) (2018)	13	132	11.0 (2016)

Source: (The World Bank 2020; Eurostat 2020)

3. Legal beginning of the system

Name and type of legal act	Law on Sickness Insurance of Workers, Law of the Kingdom of Yugoslavia
Date the law was passed	14.05.1922
Date of *de jure* implementation	01.06.1937
Brief summary of content	The law instituted compulsory social insurance in the Kingdom of Yugoslavia. It encompassed all insurance risks (except for unemployment) and was based on the principles of compulsoriness of insurance, uniform application in the territory of the whole country, financing of the system through contributions paid in by employees and employers (except in cases of occupational accident insurance, which was financed solely through employers' contributions), with the widest inclusion of all employed persons, including pupils, persons in practical training, volunteers, seafarers, persons employed abroad and people engaged in crafts industry (artisans).
Socio-political context of introduction	The law was enacted as part of the establishment of a social, health and welfare system in the Kingdom of Yugoslavia, and was considered one of the most progressive laws in Europe, based on the principles of the German system of social insurance introduced in Germany by Chancellor Bismarck. The provisions of this law stipulated entrusting the insurance administration with the Central Office for Insurance of Workers (seated in Zagreb) and district offices for workers' insurance in certain administrative centres. Despite such a centralized structure, there were still so-called Support Funds (such as insurance institutions for miners and smelters, employees' retirement insurance funds, trades' support associations, etc.).

4. Characteristics of the system at introduction

a. Organisational structure

- At the onset in 1937, the health system in the geographic area known as Macedonia was very rudimentary with one hospital and several dispensaries.
- Centralization of the health care system: The Yugoslavian health care system established in 1950s in the then People's Republic of Macedonia was highly decentralized, owned and operated by the 30 municipalities, whereby only large capital projects were centrally executed.
- Regional allocation of responsibilities for health care: The decentralized health care system allowed the municipalities to establish and run facilities and provide health services autonomously. This led to significant over-provision and duplication of services, including the establishment of health care facilities providing a mixture of services at primary, secondary and tertiary levels (Hajioff, Pecelj, and Tozija 2000).
- Eligibility: All citizens were eligible for health care services under social insurance, and the basic benefits package included outpatient and inpatient services, medical devices, and pharmaceutical products.
- Coverage (principal health insurance, 1945-1991)

Population covered by government schemes	Minor share
Population covered by social insurance schemes	Majority
Population covered by private schemes	Not available
Population uncovered	Negligible

b. Provision

Health care infrastructure (1948)		
Public health institutes	1	
Dispensaries	21	(for malaria: 18; for children: 2; for tuberculosis: 1)
Outpatient offices	56	(50 general/specialist; 6 for schoolchildren)
Dental surgeries	7	
Hospitals	9	
Hospital beds	868	(0.72 beds per 1,000 population)

Human resources in health (1948)		
Doctors	120	(1 per 10,000 population)
Pharmacists	96	(1 per 12,000 population)
Nurses	120	(1 per 10,000 population)

Source: (Donev and Polenakovic 2012)

- The above insufficient health infrastructure was expanded with the establishment of community health centres in the early 1950s.
- A typical municipality-owned community health centre in the 1950s carried out seven distinct primary care functions: (a) general practice; (b) occupational medicine; (c) pre-school paediatrics; (d) school medicine; (e) gynaecology and obstetrics; (f) laboratory diagnostics (including for X-rays); and (g) hygiene and epidemiology (Atun et al. 2007).
- However, decentralization encouraged a high degree of autonomy, leading to a non-systematic proliferation of diverse provider units and structures, often combining elements of primary, secondary and tertiary care (Hajioff, Pecelj, and Tozija 2000). This contributed to duplication of services, infrastructure and staff, and ultimately to profound regional inequalities in the scope and quality of care provision (Gjorgjev et al. 2006).

c. Financing

- No information is available on the total health expenditure at the time of the implementation of the 1922/1937 law.
- The established general health insurance programme extended overall coverage from a quarter of the population in 1952 to over 80 percent by 1984 (Menon 2006) and, combined with the public health interventions proposed by Dr Andrija Stampar, led to a significant reduction in the incidence of communicable diseases common during the 1950s.
- The health system was mainly funded through social contributions deducted from wages; however, large capital investments and preventive/public health measures were funded through the state budget. As there was no provision of services by private providers, there were – at least formally – no out-of-pocket costs; informal payments were used for securing services, consumables or medicines that were free of charge but scarce or insufficiently available.

d. Regulation

- The post-World War II Government took direct control of the country's health care system and, under the provisions of the 1974 Constitution, introduced complete decentralization, through municipality-owned, workers' 'self-managed communities of interest' for health care. The 'self-managed communities of interest' known as SIZ for health protection (samoupravna interesna zaednica za zdravstvena zastita), acted as joint provider/consumer decision-making forums relating to planning, resource generation, financing and health service delivery. Each municipality had a health centre managed by health care workers, representatives of the population served and local enterprises. These health centres were funded through social insurance contributions (Menon 2006).
- Health professionals were licensed by passing state exams (i.e. obtaining medical qualifications). No structured approach for continuous professional development or re-licensing existed.
- Although the system was decentralized, the federal law regulated the scope of the basic benefits package, which included all services, medicines and medical aids at preventive, primary, secondary and tertiary level. However, while the population was de jure entitled to the broadest health package possible, in reality there were issues concerning uninterrupted availability.

5. Subsequent historical development of public policy on health care

a. Major reform I

Name and type of legal act	Law on Health Care
Date the law was passed	31.07.1991
Date of *de jure* implementation	08.08.1991
Brief summary of content	Regulates the right to health care, organisation of the health care system, access to health services, and health care financing. It was developed on the basis of previous laws (enacted during the SFRY), with some changes, as explained below. Liberalization of the health service provision market, enabling private providers to deliver health services including hospital care, outpatient care, pharmaceutical products (medicines) and medical aids. Initially, growth was slow, with a small number of privately paid dental care and specialist services and pharmacies. There was a major expansion of the private sector between 2004 and 2007, when the primary care sector was privatized (Milevska Kostova et al. 2017). This law was terminated upon adoption of the new one in 2012, which among other things restructured the health system.
Socio-political context of introduction	After gaining independence, the country was faced with huge socio-economic and political changes in the transition from a planned to a market economy. This inevitably affected the health sector, as state-provided health care services and medical supplies from the federal level or other SFRY republics were no longer available. Upon gaining independence, Macedonia had to gradually develop and adopt its own laws, partly retaining the Yugoslavian system's organisation and financing, yet responding to the new circumstances of economic transition and political sovereignty. Under these circumstances, and valuing the health sector as one of the most important public goods (together with the social, education, labour, and internal affairs sectors), this law was among the first ones adopted by the first technocratic government of the country in 1991.

b. Major reform II

Name and type of legal act	Law on Health Insurance
Date the law was passed	29.03.2000
Date of *de jure* implementation	07.04.2000
Brief summary of content	This law regulates health insurance and related rights and obligations. The law prompted the separation of health insurance from the Ministry of Health and introduced the third-party payer system through the establishment of the Health Insurance Fund responsible for contracting and purchasing health services. When adopted, the law stipulated 14 eligibility criteria for insurance (including employment, disability, retirement, etc.); in 2009 it was amended with additional criteria for insurance based on citizenship and became universal, expanding health coverage to other, previously non-eligible population groups.
Socio-political context of introduction	The third-party payer system was introduced with the establishment of the Health Insurance Fund and aimed at separating service delivery and purchasing functions. The current health care system is based on a statutory health insurance, with a purchaser-provider split and a mix of public and private providers.

c. Major reform III

Name and type of legal act	Amendment to the Law on Health Care
Date the law was passed	27.09.2005
Date of *de jure* implementation	10.10.2005
Brief summary of content	This amendment introduces stipulations pertaining to the privatization of primary health care including primary care physicians, dentists, and community pharmacies that had previously been in public ownership; it also introduced a capitation model with incentive-based payment.
Socio-political context of introduction	In 2005, with the aim to improve the system's efficiency, the transformation of primary care was initiated, whereby primary care providers were transformed into private entities (without transfer of premises ownership). contracted by the HIF under a capitation model to deliver health insurance-covered services. To ensure access and even geographic distribution, subsidies were offered for rent in public health facilities and bonus payments for providers in rural areas. Community pharmacies were also privatized. Preventive services, such as immunisation and medical check-ups for school children, as well as the secondary and tertiary care remained fully within the public domain. By October 2007, a total of 3521 health professionals at primary level (medical doctors, dentists, pharmacists and nurses) had moved to the private sector, constituting 95% of the licensed primary care physicians and over 35% of all licensed practicing physicians in the country at the time (Milevska-Kostova 2017).

6. Description of current health care system

a. Organisational structure

- The health system is highly centralized from the perspective of the three separate components of decentralization (political, administrative and fiscal), with few exceptions. One of the main arguments for strong centralization was to prevent fragmentation of scarce health care resources. In 2006, the policy idea emerged to introduce new legislation for increasing the autonomy of health care providers, which the government postponed, however, due to political reluctance to devolve power to lower levels. Hence, the key player remains the central government and the Ministry of Health (Milevska Kostova et al. 2017).
- With the process of administrative and fiscal decentralization, municipalities were initially interested in assuming responsibility for local decision-making in health care, granted to them by the 2002 Law on Local Self-Government. But lack of financial and human resources at local level thwarted their ambitions. Currently, their influence is exercised only through their representatives on the managing boards of public health care providers and the local of public health councils, once they are established and become operational. As a result, the influence of municipalities has so far been very limited (Milevska Kostova et al. 2017).
- Coverage

Percentage of population covered by government schemes	7%
Percentage of population covered by social insurance schemes	89%
Percentage of population covered by private schemes	>1%
Percentage of population uncovered	4%

b. Provision

Indicator	Value	Source
Physicians (per 1,000 inhabitants)	2.8 (2013)	WHO Health for all Database 2013
Nurses and midwives (per 1,000 inhabitants)	3.79 (2015)	WHO Global Health Observatory
Hospital beds (per 10,000 inhabitants)	42.8 (2017)	WHO Global Health Observatory
Acute hospital beds (per 100,000 population)	302 (2013)	WHO Health for all Database 2013
Hospital beds in private for-profit hospitals (number)	272 (2013)	WHO Health for all Database 2013

» Both public and privately owned facilities provide hospital care. The number of hospitals increased from 50 hospitals in 1990 to 65 in 2019, mostly as a result of private initiative and capital investment (Milevska Kostova et al. 2017).
» In the past two decades the number of doctors, dentists and pharmacists increased by nearly 29%, bringing the country in line with the EU13 average at 2.8 physicians per 1000 population in 2013. However, more recently, doctors are increasingly attracted abroad by better working conditions; over the past 5 years more than 600 doctors left the country and about 70% of those remaining have considered the possibility (Lazarevik et al. 2016).

c. Financing

Indicator	Value	Source
Total expenditure on health (% of GDP)	6.48	(World Health Organisation 2014)
Domestic private health expenditure (% of current health expenditure)	32.22	(GHED 2017)
Domestic general government health expenditure (% of current health expenditure)	67.35	(GHED 2017)
Out-of-pocket expenditure (% of current health expenditure)	31.91	(GHED 2017)
External health expenditure (% of current health expenditure)	0.42	(GHED 2017)

» The Health Insurance Fund is the sole insurer in the country entitled to provide mandatory health insurance. The HIF's main sources of revenue are compulsory, wage-based SHI contributions (89%), transfers from other agencies (7%), central budget transfer (1%), revenue from patients' co-payments collected at facility level (2%) and other revenues (1%) (HIF 2014, 2018). Contributions from other agencies include funds for covering economically inactive citizens, (e.g. unemployed who receive compensation from the Employment Service Agency, families on permanent social assistance from the Ministry of Labour and Social Policy, pensioners from the Pension and Disability Fund), transfers for maternity leave from the Ministry of Labour and Social Policy, and so forth.

d. Regulation of dominant system

» Regulation and/or organisation of the system: the health system in Macedonia is governed by the Ministry of Health, which has a role of overall policy making and implementation monitoring; the Macedonian Agency for Medicines and Medical Aids (MALMED) is the regulatory body for medicines and medical aids; the Agency for Quality and Accreditation of Health care Facilities is responsible for setting standards of care and facility accreditation; the financing of health care is executed through a third-party payer represented by the semi-autonomous Health Insurance Fund; supervision is carried out by the State Sanitary and Health Inspectorate; the integrated health information system is within the mandate of the Directorate for e-Health, and surveillance and epidemiology is governed by the Institute of Public Health.
» Medical licensing: introduced in late 1990s, after the establishment of the Medical, Dental and Pharmaceutical chambers in 1992 under the 1991 Law on Health Care with the function of serving as syndicates for the

protection of rights of the health workforce, issuing and re-issuing work licenses upon passing of exam and undertaking continuous medical education, to monitor health professionals for due diligence and to investigate claims of human rights breaches in health care (Milevska Kostova et al. 2017).

» The mandatory health insurance is based on the principle of solidarity, and provides coverage for all services at primary, secondary and tertiary levels, with a few exceptions (e.g. cosmetic surgery, etc.), as well as medication from a pre-defined list of medicines. Co-payments of max. 20% costs for service or medicine have been introduced to control overuse, but there are waivers for specific population categories such as children, the elderly, socially vulnerable, disabled, and so forth. The basic benefits package also covers a large portion of the costs for treatment abroad, subject to pre-approval confirming such procedure is essential for treatment but not available in the country (Parnardzieva-Zmejkova and Dimkovski 2017).

e. Co-existing systems

» The 2012 Law on Voluntary Health Insurance regulates supplementary health insurance or private voluntary insurance, that can only be used as additional insurance to the mandatory one. The uptake of voluntary health insurance is still very slow and plays only a minor role on the insurance market.

f. Role of global actors

» Health care in Macedonia became a matter of interest in the international community in the late 1990s in the course of the post-transition political reform process. The major donor financing health care during the 1990s was the World Bank (World Bank 1993), which significantly influenced and stewarded the national health agendas of the SEE region countries, including Macedonia (Milevska-Kostova, King, and Stojanovski 2018).
» During the 2000s, the country received large grants to fund regular activities and services for the prevention, diagnosis and management of HIV/AIDS and TB from the Global Fund, which ceased when the country reached maturity according to the Global Fund's rules in 2012.
» While no global or regional actors have regulatory responsibilities within the health system, the country is aligning its health policies to the global and regional health agenda, including the UN 2030 Agenda, WHO resolutions and the EU Acquis Communautaire.
» Churches or other charity organisations do not play any role in the provision or financing of health care in the country.

g. List of additional relevant legal acts

» Constitution of the Republic of Macedonia, Official Gazette No. 52/1991
» Law on Health care, Official Gazette No. 38/1991
» Law on Pension and Disability Insurance, Official Gazette No. 80/1993
» Law on Health Insurance, Official Gazette No. 25/2000
» Law on Medicines and Medical Devices, Official Gazette No. 106/2007
» Law on Protection of Patients' Rights, Official Gazette No. 82/2008
» Law on Contributions for Mandatory Social Insurance, Official Gazette No. 142/2008
» Law on Health Statistics, Official Gazette No. 20/2009
» Law on Public Health, Official Gazette No. 22/2010
» Methodology for Determining Prices of Pharmaceuticals, Official Gazette No. 156/2011
» Law on Concessions and Public-private Partnership, Official Gazette No. 06/2012
» Law on Health care, Official Gazette No. 43/2012
» Decree on Network of Health care Facilities, Official Gazette No. 81/2012
» Law on Pension and Disability Insurance (new), Official Gazette No. 98/2012
» Law on Voluntary Health Insurance, Official Gazette No. 145/2012

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