



WE ARE ALL HUMAN: HEALTH CARE FOR ALL PEOPLE REGARDLESS OF THEIR ETHNICITY

HEALTH STATUS, HEALTH CARE AND THE RIGHT TO HEALTH
AMONG ROMA PEOPLE IN THE REPUBLIC OF MACEDONIA



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Health status, health care
and the right to health among
Roma people in the Republic of
Macedonia

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LIST OF ABBREVIATIONS

GDP

Gross Domestic Product

ECSR

European Committee of Social Rights

ECHR

European Convention on Human Rights and Fundamental Freedoms

ESE

Association for Emancipation, Solidarity and Equality of Women in the Republic of Macedonia

km

Kilometre

CERD

Convention on the Elimination of All Forms of Racial Discrimination

CEDAW

Convention on the Elimination of All Forms of Discrimination against Women

MoH

Ministry of Health

ICESCR

International Covenant on Economic, Social and Cultural Rights

NAP

National Action Plan

NGO

Non-governmental organization

OSCE

Organization for Security and Cooperation in Europe

UN

United Nations

PAP

Papanicolaou smear

RM

Republic of Macedonia

WHO

World Health Organization

AIDS

Acquired Immunodeficiency Syndrome

STDs

Sexually Transmitted Diseases

UPR

Universal Periodic Review

HIF

Health Insurance Fund of the Republic of Macedonia

HIV

Human Immunodeficiency Virus

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SUMMARY

General lack of data on the health status, health determinants and access to health care among Roma people, respect for human rights in health care and national legislation's alignment with international standards on protection and exercise of health-related rights in the Republic of Macedonia imposed the need for the present baseline study to be developed.

Roma minority in RM is marginalized on multiple grounds and lives in more unfavourable social and economic conditions compared to the general population. Lack of health statistics segregated by ethnicity, as well as absence of relevant research studies conducted and developed by competent state institutions, resulted in the fact that data on these conditions among Roma people are solely based on individual/isolated knowledge about the situation in the field and on research reports that are limited in scope and coverage, developed by civil society organizations. Due to these reasons, ESE - supported by the Foundation Open Society – Macedonia and the Open Society Foundations – New York – decided to develop this research study on Roma health that would serve as baseline data for monitoring and comparing the situation of Roma people in the Republic of Macedonia.

This baseline study relies on data obtained by means of desk research and analysis of relevant documents and data collected with the survey research conducted on a selected sample of Roma people and members of other ethnic communities living in their vicinity.

Desk research and analysis of available documents included: the Constitution of RM, laws, bylaws, strategies, programmes, international treaties and other secondary information sources (analyses, reports, etc.). The resulting analysis aims to stress the need for national legislation's alignment with international standards on human rights, i.e. standards on protection and exercise of health rights guaranteed under relevant international instruments, as well as the assessment of health rights' exercise against the relevant indicators.

The right to the highest attainable standard of physical and mental health is analysed in terms of the manner in which this right is regulated under international and regional treaties on human rights, as well as in terms of national legislation's alignment with international standards. Moreover, the research study provides an overview of reports submitted by RM to relevant international treaty bodies responsible for implementation of health rights and their concluding observations and recommendations for further promotion of the situation in this regard.

For the purpose of this analysis, contextually relevant indicators for measuring the extent to which health rights are exercised were identified in several documents, such as: Human Rights Indicators: A Guide to Measurement and Implementation, developed by the Office of the UN High Commissioner for Human Rights, 2012; Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, 2005; and Health Systems and the Right to Health: An Assessment of 194 Countries, developed by the Nordic School of Public Health, 2008.

In developing this research study, we used different types of indicators (structure, procedure and outcome-oriented indicators) addressing several issues that correspond to the overall context, health policies and health needs in the Republic of Macedonia. In that, due consideration was made of national policies and the actual situation related to the exercise of human rights by the Roma population.

More specifically, the analysis is based on a series of indicators related to:

- » commitments assumed by RM under international and regional treaties on human rights;
- » constitutional and legal framework;
- » health strategies and action plans adopted by RM;
- » citizens' involvement in development and implementation of health policies;
- » funding of the health care system;
- » international assistance and cooperation;
- » protection of patients' rights and other protection mechanisms;
- » access to medicines;
- » discrimination.

The survey research complements the analysis of relevant documents and aims to provide an accurate image of the current situation in the following areas: health status of Roma people, access to health care and respect for health rights of Roma people. All these parameters among the Roma population were compared against the situation observed among members of other ethnic communities living in the vicinity of Roma settlements. The survey questionnaire was designed

for the purpose of collecting necessary data. It is comprised of 119 questions grouped in 11 topic-based sections, those being: population, demographic and socio-economic parameters; self-reported health status; coverage with primary, secondary and tertiary health care; self-reported health status, acute and chronic health problems; access to medicines; patients' rights; preventive check-ups for women's reproductive health; antenatal and postnatal health care; outreach services. The survey was conducted on a sample comprised of Roma respondents (total of 691) and non-Roma respondents (total of 609) from 10 municipalities throughout the Republic of Macedonia with dominant share of Roma people. Details about the survey sample are given in ANNEX 3.

Necessary data were compiled by means of questionnaire-guided interviews conducted with the sample population. In addition to the survey, individual focus group discussions were organized with groups of Roma and Macedonians in the municipalities of Delcevo and Suto Orizari. Discussions were moderated on the basis of questionnaires designed for that purpose.

All parameters covered by the survey were analysed by comparing data obtained from Roma population and data obtained from non-Roma population living in the vicinity of Roma settlements. This comparison was necessary with a view to determine extent of differences between the situations observed among Roma and non-Roma respondents.

More specifically, the analysis of survey data included the following parameters:

- » assessment of main social determinants that affect Roma health;
- » self-reported health status of Roma people;
- » coverage of Roma people with primary and preventive health care;
- » access to specialist (out-patient) and in-patient health care for Roma people, including the main obstacles faced by Roma in obtaining access thereto;
- » access to medicines for Roma people, including the main obstacles faced by Roma in this regard;
- » access to health services for Roma women, including antenatal and postnatal health care;

- » assessment of violations made to health rights enjoyed by Roma, with special focus on discrimination, and actions taken by competent institutions for protection of patients' rights.

Statistical analysis and findings related to these parameters are shown in the charts presented in ANNEX 1 and the tables presented in ANNEX 2.

Following are the **key findings and conclusions**.

Republic of Macedonia has signed several international and regional treaties that are of great importance in terms of the right to health, those being: International Covenant on Economic, Social and Cultural Rights; Convention on the Elimination of All Forms of Discrimination against Women and Convention on the Elimination of All Forms of Racial Discrimination. Nevertheless, RM has not ratified the Optional Protocol to the International Covenant on Economic, Social and Cultural Rights, and has not signed the Additional Protocol to the European Social Charter Providing for a System of Collective Complaints.

Periodic reports submitted by the Republic of Macedonia to the relevant international treaty bodies on the implementation of the right to health do not reflect the actual situation in the country and the problems faced by marginalized groups. Concluding Observations and Recommendations for the Republic of Macedonia issued by the international treaty bodies tasked with the implementation of human rights, including the right to health, indicate serious deviations from and non-implementation of health rights enjoyed by particular vulnerable groups. Majority of concluding observations remark the non-implementation of strategic documents and health plans targeting vulnerable population groups, such as Roma, and allocation of insufficient funds for their implementation.

In 2007, the Ministry of Health of RM adopted the strategy "Health 2020: Reliable, Efficient and Equitable Health Care System", but this document is not aligned with the goals and objectives defined under the European policy "Health 2020", i.e., the issues of health and health promotion are yet to be integrated in other public policies. Moreover, implementation of this strategy is not transparent and accountable and there is no publicly available information and data on the manner in which activities anticipated therein are implemented and their effects.

Furthermore, the health strategy does not include specific measures and activities targeting Roma health. According to the commitments assumed under the Decade of Roma Inclusion, to present, RM has developed two National Action Plans on Health, but they have not been revised since 2011. Given the fact that there are no reports and data on the implementation of the National Action Plan on Health, it cannot be determined whether the activities anticipated therein have been implemented and what are their effects and results.

Relevant legislation in RM does not stipulate a specific obligation for citizens and other vulnerable groups to be involved in health policy-making and development of strategic plans in the field of health care. At the same time, the Ministry of Health does not anticipate specific measures and activities by means of which citizens and civil society organizations will be included in the decision-making processes.

Health care is a central budget account supported with the lowest share of budget funds. While private costs for health care are marked by a continuous increase, public expenditure in health care, with minor variations, remains on the same level. From the 2009 central budget onwards, the Government of RM initiated a trend on allocating the minimum amount of funds for advancing Roma health. Nevertheless, lack of information on the implementation of measures targeting Roma communities and official data on public spending does not allow conclusions to be inferred whether and how much of these funds had been actually spent for the purpose of promoting Roma health.

Unlike the situation observed among the general population, Roma people are more often affected by unfavourable social determinants that negatively affect their health and access to health care services. Consequently, the health status of Roma people, according to the self-reported health and frequency of acute infectious diseases, is more unfavourable compared to the health status of non-Roma.

Although the coverage of Roma with health care services at all levels is satisfactory and is similar to the coverage of non-Roma, Roma are affected by provision of health services of lower quality compared to the services delivered for the general population and are therefore less satisfied with these services.

Despite the fact that patients' rights in RM are regulated under a special law, its implementation is incomplete and flawed, whereby the biggest shortfalls are noted in terms of mechanisms for protec-

tion of patients' rights. In the capacity of patients in out-patient and in-patient health care, Roma suffer from more frequent violations of their rights compared to the general population.

Access to medicines in RM is burdened due to the introduction of reference lists of medicines and participation fees charged for procurement of these medicines. These practices are especially detrimental for Roma people as a socially marginalized community, because they are faced with bigger obstacles in obtaining access to medicines, most often due to their financial inability to purchase the medicines needed and their inability to find these medicines on the cost of HIF.

Coverage of Roma women with primary gynaecological health care services is satisfactory, but the antenatal care they receive is inadequate compared to the services enjoyed by women from other ethnic communities. Moreover, cases have been noted of Roma women giving birth at home in the absence of trained medical staff, which is

not the case among women from other ethnic communities. Unlike non-Roma women, main barriers in access to women health services faced by Roma women include the physical distance of health facilities, charges imposed by registered gynaecologists for provision of free-of-charge services and lower quality of services. These practices and other factors result in lower number of Roma women visiting their registered gynaecologists for regular preventive check-ups.

Law on Health Protection and Law on Protection of Patients' Rights prohibit discrimination in health care on all grounds, but they do not stipulate penal provisions for non-compliance and violation of these legal obligations. Although discrimination is prohibited, Roma are more often subjected to different forms of discrimination at health facilities compared to the general population, but the rate of reported violation of health rights and discrimination by Roma people remains very low. Main reason indicated by Roma respondents for the occurrence of discrimination is their ethnicity and skin colour.

I.

INTERNATIONAL AND REGIONAL LEGAL FRAMEWORK ON THE RIGHT TO HEALTH

International and regional legal framework for protection of human rights directly affects the respect for, protection and exercise of human rights in all State parties. International treaties signed and ratified by the Republic of Macedonia directly or indirectly influence the national legal system and the situation related to the exercise of human rights. On one side, ratification of international documents renders them part and parcel of the national legislation, but on the other hand, international treaty bodies responsible to monitor the implementation of different human rights documents addressed the Republic of Macedonia with recommendations for alignment of its national legislation with the provisions contained in the international treaties and their implementation in practice. Here it should be noted that said international documents stipulate human rights standards, i.e. they determine the actions to be taken by State parties with a view to achieve progressive exercise of human rights for their citizens.

Regional legal framework is very important, especially having in mind that the Republic of Macedonia aspires to join the European Union and for that purpose continuously adopts and implements the Annual National Programmes on the Adoption of the EU Acquis.

The next section provides an overview of the manner in which the right to health is regulated under international and regional treaties on human rights, as well as RM's reports on the implementation of provisions contained in these documents.

Right to Health

Right to health is regulated in several international documents on human rights and, according to the manner in which this right is realized, it is considered a precondition for people to be actively involved in exercising other rights and freedoms. The right to enjoy the highest attainable standard of physical and

mental health was first referred to in the Constitution of the World Health Organization (1946) and was later reaffirmed in the Alma Atta Declaration (1978) and the WHO Declaration adopted by its General Assembly (1998).

Right to health is regulated in several international and regional treaties which the Republic of Macedonia has signed and ratified, those being: Universal Declaration of Human Rights; International Covenant on Economic, Social and Cultural Rights (ICESC); Convention on the Elimination of All Forms of Racial Discrimination; Convention on the Elimination of All Forms of Discrimination against Women; Convention on the Rights of the Child; European Convention on Human Rights and Fundamental Freedoms; European Social Charter. Ratification status of above-enlisted international and regional treaties is given in ANNEX 3.

Namely, the Universal Declaration of Human Rights stipulates that „*Everyone has the right to a standard of living adequate for the health and wellbeing of himself and of his family, including food, clothing, housing and medical care and necessary social services*”.

Right to health, i.e. right to the highest attainable standard of physical and mental health is most comprehensively regulated under Article 12 of the International Covenant on Economic, Social and Cultural Right and is elaborated in detail under the General Comment no.14 “Right to the Highest Attainable Standard of Health”. General Comment no.14 was developed in 2000 as a result of the cooperation between the Committee on Economic, Social and Cultural Rights and the World Health Organization.

As regards the manner in which the right to the highest attainable standard of physical and mental health is regulated, primacy is given to the General Comment no.14, because it stipulates all aspects pertaining to the right to the highest standard of health care. Namely, General Comment no.14 enlists the constitutional elements of the right to health, those being: availability, accessibility of health facilities, goods and services; acceptability and quality.

Availability means existence of functional public health and health care facilities, goods and services, as well as programmes in sufficient quantity, trained medical and professional personnel, and availability of essential medicines.

The second segment of this right, i.e. *accessibility of health facilities, goods and services*, includes four dimensions, those being:

- » non-discrimination and accessibility, especially for the most vulnerable and marginalizes population groups;
- » physical accessibility, especially for the most vulnerable population groups;
- » economic accessibility or affordability, i.e. health care services should also be economically accessible for poorer households, irrespective of the fact whether they are offered by public or private entities; and
- » information accessibility, i.e. the right to seek, receive and impart information and ideas concerning health issues.

Next aspect of the right to the highest attainable standard of health is *acceptability*, which means that all health facilities, goods and services must be respectful of medical ethics and culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as designed to respect confidentiality and improve the health status of those concerned.

Last and most essential aspect which complements other dimensions of the right to health is *quality*, whereby health facilities, goods and services must be scientifically and medically appropriate and of good quality, which requires skilled medical personnel, scientifically approved and unexpired medicines and hospital equipment.

General Recommendation no. 30 to the Convention on the Elimination of All Forms of Racial Discrimination (CERD) calls the State parties to the Convention, as appropriate to their specific circumstances, to respect the right of non-citizens to an adequate standard of physical and mental health by, inter alia, refraining from denying or limiting their access to preventive, curative and palliative health services.

Right to health for special population groups is regulated under the Convention on the Rights of the Child and the Convention on the Elimination of All Forms of Discrimination against Women.

Namely, Article 12 of the Convention on the Elimination of All Forms of Discrimination against Women obliges the State parties to take all

appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning. Article 14, paragraph 2-b elaborates the obligations of State parties to take all appropriate measure to eliminate discrimination against women in rural areas in order to ensure, on the basis of equality of men and women, that they participate in and benefit from rural development, and in particular to ensure that such women the right to [...] have access to adequate health care facilities, including information, counselling and services in family planning. In addition, General Recommendation no.24 elaborates in detail the provisions contained in Article 12 of the Convention for the purpose of eliminating discrimination and enabling women to enjoy the right to the highest attainable standard of health. In fact, the State parties to the Convention are obliged to take appropriate legislative, judicial, administrative, budgetary, economic and other measures to the maximum extent of their available resources to ensure that women realize their rights to health care.

Article 24, paragraph 1 of the Convention on the Rights of the Child stipulates that the State parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. State parties to the Convention should strive to ensure that no child is deprived of his or her right to access to such health care services. In pursuing full implementation of this right, they should take appropriate measures: to diminish infant and child mortality; to ensure provision of necessary medical assistance and health care to all children with the emphasis on the development of primary health care; to combat disease and malnutrition, including within the framework of primary health care through, inter alia, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking water, taking into consideration the dangers and risks of environmental pollution; to ensure appropriate prenatal and postnatal health care for mothers; to ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents; to develop preventive health care, guidance for parents and family planning education and services.

General framework of the Council of Europe related to the right to health includes the following legal instruments: European Convention on Human Rights and Fundamental Freedoms – ECHR (and the 14 Protocols thereto), European Social Charter (1961), Revised European Social Charter (1996) and European Convention on Patients' Rights.

Overview of periodic reports submitted by the Republic of Macedonia to the international treaty bodies, with a focus on the right to health

Despite the formal regulation of the right to health under international documents and their ratification by the State parties, another important aspect is the implementation of international standards on protection and promotion of human health in their respective societies. In this regard, the Republic of Macedonia monitors the situation and submits periodic reports on the situation observed and actions taken to promote the right to health before the competent international treaty bodies monitoring their implementation. Right to health, and the right to health of particular population groups, is regulated in individual international and regional treaties, those being: International Covenant on Economic, Social and Cultural Rights; Convention on the Elimination of All Forms of Discrimination against Women; Convention on the Rights of the Child; and Convention on the Elimination of All Forms of Racial Discrimination. The analysis presented in this report includes the concluding observations addressed to the Republic of Macedonia and aimed at promotion of health, especially the health of marginalized population groups.

International Covenant on Economic, Social and Cultural Rights

Republic of Macedonia submitted its Initial Periodic Report on the implementation of ICESCR and on its 37th session held in November 2006, the Committee tasked with the monitoring of this international covenant adopted the Concluding Observations for the Republic of Macedonia. According to them, Republic of Macedonia is obliged to report on the activities taken with a view to improve implementation

of provisions contained in ICESCR and present them in the next periodic report.

Concluding Observations no. 29, 30, 32, 45 and 46 (1) concern the exercise of rights in the field of health care, with special focus on health care for the Roma population.

Namely, the Committee expressed its concerns with the situation observed in several areas and put forward relevant recommendations.

„The Committee is concerned that, although the Human Rights Ombudsman is competent to investigate complaints about alleged violations of economic, social and cultural rights, the Ombudsman’s requests for information and recommendations relating to such complaints have not always been acted upon”. On this account, the Committee recommends that: “the State party respond to information requests and act on all recommendations of the Ombudsman’s Office relating to the investigation of complaints about alleged violations of economic, social and cultural rights. It invites the State party to provide detailed information in its next periodic report on the outcome of and follow-up to such complaints, including complaints about [...] the denial of access to health insurance and health care facilities”.

*“The Committee regrets the absence of court decisions directly applying the rights recognized in the Covenant, including **the right to health**”, and recommends “the State party to ensure that the provisions of the Covenant are given effect by its domestic courts, that legal and judicial training take full account of all Covenant rights, as defined in the Committees’ general comments, and that it promote the use of the Covenant as a source of domestic law. The Committee draws the attention of the State party to the General Comment no. 9 (1998) on the domestic application of the Covenant and invites the State party to include, in its next periodic report, information on court decisions giving effect to the Covenant rights”.*

“The Committee is concerned at reports that Roma face widespread discrimination in access to employment, social assistance, health care and education, that Roma and Albanian applicants sometimes experience difficulties in obtaining citizenship, and that a certain number of Roma lack personal documents, such as identity cards, birth certificates and medical insurance or employment cards, which are necessary for them to access social insurance, health care or other benefits”. Given the observed factual situation, the Committee recommends that “the State party intensify its efforts to

combat discrimination against Roma in all fields covered by the Covenant, urgently process pending citizenship claims from Roma, Albanian and other minority applicants, and take immediate steps, e.g. by removing administrative obstacles, to issue all Roma applicants with personal documents, with a view to ensuring their equal access to social insurance, health care and other benefits”.

The Committee is concerned with the fact that *“the infant mortality rate has increased over the years and that the perinatal mortality rates remains high”*. On this account, the Committee recommends that *“the State party increase the number of mandatory visits of patronage nurses per child, incorporate a family nursing approach in its national health strategy, and allocate sufficient funds towards the implementation of the national preventive programme on mother and child health”*.

The Committee expressed its concern with the *“limited access of young persons to sexual and reproductive health, especially in rural areas, the limited use of contraceptives and the significant number of abortions and undesired teenage pregnancies, in particular among **Roma girls**”*. This has compelled it to recommend that *“the State party intensify its efforts to educate children and adolescents on sexual and reproductive health and to enhance the accessibility of sexual and reproductive health services, including gynaecological and counselling services, in particular in rural areas and in communities where Roma and other disadvantaged and marginalized individuals or groups live”*.

In compliance with the obligations related to periodic reporting, in 2013 the Republic of Macedonia developed the Second, Third and Fourth Periodic Report. This report contains information on the legislative, administrative and other measures taken to implement the Covenant in the period after the submission of the Initial Periodic Report of the Republic of Macedonia. The official session for reconsideration of this report is not scheduled yet.

Republic of Macedonia has not ratified the Optional Protocol to the International Covenant on Economic, Social and Cultural Rights, although the need for signing and ratifying this international document on human rights was noted in the first cycle of the Universal Periodic Review to the Council of Human Rights.

Convention on the Elimination of All Forms of Discrimination against Women

In January 2006, the Republic of Macedonia for the first time submitted its Initial, Second and Third Periodic Report on the Convention on the Elimination of All Forms of Discrimination against Women. After considering the report, the Committee adopted several concluding observations for the Republic of Macedonia and noted that, although there has been a 20% decrease in the abortion rate since 1994, abortion continues to be used as method of birth control. Moreover, the Committee expressed concerns about the limited use of contraceptives. On this account, it recommended that *“the State party implement programmes and policies aimed at providing effective access for women to contraceptives and health care information and services, thus avoiding the need for women to resort to abortion as method of birth control. At the same time, the Committee urges the State party to implement programmes of sexual and reproductive health education for women, men and adolescents in order to foster responsible sexual behaviour and to further discourage abortion as method of birth control”*.

Recommendation 28 of CEDAW’s Concluding Observations requests the State party to provide, in its next report, a comprehensive picture of the *de facto* situation of rural women, as well as of ethnic women, in particular Roma women, in the four areas, including health, and of the efforts taken by the Government to eliminate discrimination against these women. Furthermore, the Committee called the State party to provide information on specific projects targeting Roma women implemented as part of the Decade of Roma Inclusion 2005 – 2015.

The next periodic report, i.e. the combined Fourth and Fifth Periodic Report of the Republic of Macedonia was reconsidered by CEDAW on its session held in February 2013. Following are the recommendations provided by the Committee and related to health of Roma people in general and health of Roma women in particular (recommendation no.34): *“The Committee urged the State party to take all measures necessary to improve women’s access to quality health care and health-related services within the framework of the Committees General Recommendation no. 24 (1999); to raise awareness, through public education campaigns, education on sexual and reproductive health in schools and enhanced counselling services, about the importance of using contraceptives for family planning and increase efforts to provide adequate family planning services and affordable contraceptives; and to integrate a gender perspective in all health interventions and policies and collect and analyse sex-desegregated data”*.

At the same time, the Committee is concerned about the lack of adequate financial resources allocated for the implementation of strategic policies targeting Roma, and indicated *“While noting the adoption of the Decade of Roma Inclusion 2005 – 2015, the National Action Plan for Promotion of the Status of Roma Women, the Committee is concerned about the lack of adequate financial resources allocated for the implementation and evaluation of these measures, as well as the continuing marginalization of Roma women and the intersecting forms of discrimination they face, especially with regard to access to education, employment, adequate housing and health care, identity documents, protection from violence and access to justice”*. Having in mind the observed situation, the Committee recommended the Republic of Macedonia (paragraph no. 38) *“to implement and expeditiously allocate adequate financial resources to national action plans and strategies aimed at eliminating all forms of discrimination against Roma women”*.

Convention on the Rights of the Child

The Initial Periodic Report (2) of the Republic of Macedonia on the implementation of the Convention on the Rights of the Child was reconsidered by the competent committee in January 2000. On that occasion, the Committee expressed concerns about the fact that not all children have equal and adequate access to health care, including children from regions facing particular economic hardship, and the fact that state policies require adolescents aged 15 to 18 to make financial contributions to their health care costs, which may limit their access to health care, including sexual health education. On this account, the Committee recommended the Republic of Macedonia to continue efforts to ensure that all children, from all regions, have equal access to health care services and to review its policies that restrict access to full health care for adolescents.

The Committee recommended effective health care for mothers and children and measures aimed at reducing the high infant mortality rate. Recommendation 37 of the Concluding Observations reads: *“Noting the correlation between low education among mothers and the high infant mortality rate, as well as the correlation between the incidence of such mortality and certain regions, the Commission urges the State party to continue its efforts address this concern, inter alia, through effective provision of adequate health education for mothers”*. Furthermore, the Committee adopted a recommendation on the health of adolescents, the high abortion rate among girls and the incidence of sexually transmitted

diseases. Recommendation 41 of the Concluding Observations notes: *“The Committee urges the State party to strengthen data collection methods on health concerns among adolescents. The Committee recommends that the State party increase its efforts to promote adolescent health policies and strengthen reproductive health education and counselling services, inter alia, with regard to HIV/AIDS, STDs, pregnancy among girls and abortion”.*

UN Committee on the Rights of the Child reconsidered the second periodic report of the Republic of Macedonia in June 2010. As part of its Concluding Observations (3), the Committee welcomed the significant reduction of infant and toddler mortality rates, but is concerned with the infant mortality rates among Roma, which is higher than the national average, and with the perinatal mortality that is the highest in the region. Furthermore, the Committee is concerned about rural-urban disparities in access to health care services, and that refugee children under humanitarian protection who lack proper documents have been refused medical treatment. On this account, recommendation 55 of this document recommends that *“the State party continue raising the standard of health among children, in particular, by: a) strengthening efforts to prevent and reduce infant mortality among the Roma communities; b) increasing the quality and availability of health services to eliminate rural-urban disparities; c) ensuring the provision of necessary medical assistance and health care to all children with emphasis on development of primary health care, in particular by extending coverage of children belonging to the most vulnerable segments of the population; and d) raising the quality of pre- and postnatal care for mothers with a view to prevent perinatal mortality”.*

Convention on the Elimination of All Forms of Racial Discrimination

In 2013, the Republic of Macedonia presented its Eight, Ninth and Tenth Periodic Report (4) on the implementation of the Convention on the Elimination of All Forms of Racial Discrimination, although the deadline for its development and submission was September 2010. CERD has not scheduled the official session for the reconsideration of this report. The said report contains information on the realization of recommendations put forward during the reconsideration of the previous cumulative report, i.e. the Fourth, Fifth, Sixth and Seventh Periodic Report (5) from March 2007. Notably, *“the Committee is deeply concerned about the difficulties that some Roma experience in obtaining personal documents, including birth certificates, identity cards, passports and other documents related to the provision of health insurance and social security benefits (Article 5 of the Convention).* On the account of the observed

factual situation, the Committee adopted the following recommendation: *“The Committee, in the light of its General Comment no. 27 (2000) on discrimination against Roma, urges the State party to take immediate steps to remove all administrative obstacles that currently prevent Roma from obtaining personal documents that are necessary for the enjoyment of economic, social and cultural rights, including health care”.*

The report, particularly the section on the exercise of the right to health, medical care, social security and social services, refers only to the existence of a strategic framework for improving health care and social status of Roma by introducing Roma Health Mediators (adopted in 2011). The report does not include information on the implementation of the strategic document.

Universal Periodic Review

As part of the first reporting cycle (2008-2011) related to the Universal Periodic Review (UPR), in 2009 the Republic of Macedonia presented the UN Human Rights Council with the First Report on the overall situation concerning human rights protection. Following the report’s reconsideration, the working group at the UN Human Rights Council adopted the recommendations for the Republic of Macedonia put forward by UN member states.

The recommendations (6) drafted by members states and addressed to the Republic of Macedonia concern different health issues, especially the health of marginalized groups. More specifically recommendation no. 15 urges the country to *“continue efforts to promote rights of vulnerable groups, including the right to health of Roma people (Georgia)”*; paragraph no. 41 includes several recommendation from different states and reads: *“continue efforts to ensure that Roma, Albanian and other minorities have access to suitable and affordable housing, employment, education and health care (Algeria); ensure speedy implementation of the measures in the National Roma Strategy (Austria); align the national strategy with the Decade of Roma Inclusion, which is to end in 2015 (Brazil); implement the Roma Strategy and Action Plans, in compliance with the Strategy and the Decade of Roma Inclusion (Canada); ensure equal and unhindered access to health care for Roma (Austria); promote the exercise by Roma of their economic, social and cultural rights, in particular by implementing programmes to facilitate birth registration and issuing of identity documents for this population category (Mexico); improve the situation of inclusion of some minority ethnic groups, in particular the Roma, who are frequently facing a situation of lack of protection (Spain)”.*

In 2011, after it was presented with the above-referred recommendations, the Republic of Macedonia prepared its Midterm Report (7) on the progress made in implementation of recommendations. This report does not reflect on the positive progress made in implementation of strategic documents adopted (Decade of Roma Inclusion 2005 – 2015 and National Roma Strategy), nor the funds allocated and spent for this purpose.

Republic of Macedonia is scheduled to report on the human rights situation within the second cycle of the Universal Periodic Review (2012 – 2016), i.e. on the 18th session of UN Human Rights Council (January 2014).

European Social Charter

Republic of Macedonia has ratified the Revised European Social Charter in 2012 and signed the Additional Protocol to the Charter, but failed to sign and ratify the Additional Protocol Providing for a System of Collective Complaints (8).

In the period 2007-2013, the Republic of Macedonia submitted a total of 6 reports to the European Committee on Social Rights (ECSR) (9) competent to monitor the implementation of the European Social Charter by means of periodic reports and collective complaints. The last report submitted in February 2013 focused on issues related to health and social security and social protection and included information on the following articles from the European Social Charter: Article 3 (right to safe and healthy working conditions); Article 11 (right to benefit from any measures enabling people to enjoy the highest possible standard of health attainable); Article 12 (right to social security); Article 13 (right to social and medical assistance); Article 14 (right to benefit from social welfare services); and Article 4 of the Additional Protocol (right to social protection for every elderly person).

II.

CONSTITUTIONAL AND LEGAL FRAMEWORK

Alignment of the national legislation with the international standards on human rights is necessary for the establishment of an adequate system and mechanism for protection of human rights and freedoms in the state.

In this regard, one of the constitutional commitments of the state is to integrate international treaties in the internal legal order by means of ratifications that would render them unchangeable by law [10]. Moreover, essential constitutional values contained in Article 8 of the Constitution of the Republic of Macedonia include: *“basic fundamental freedoms and rights of the individual and the citizens, recognized in the international law”* and *“respect for the generally accepted norms of the international law”*. In addition to the general values and commitments, the Constitution of the Republic of Macedonia guarantees individual civil, political, economic, social and cultural rights, including the right to health.

Constitution of the Republic of Macedonia guarantees the right to health and health care to all citizens and stipulates that citizens have the right and duty to protect and promote their own health and the health of others. However, it does not regulate the quality of health care services provided.

Health system, health care and rights and responsibilities of health professionals, health facilities and patients in the Republic of Macedonia are regulated under different laws, those being: Law on Health Protection [11]; Law on Protection of Patients’ Rights [12]; Law on Health Insurance [13]; Law on Public Health [14]; Law on Mental Health [15]; and other laws adopted in the field of health care.

Law on Health Protection

New Law on Health Protection was adopted in 2012, i.e. 20 years from the adoption of the first Law on Health Protection. It should be noted that the expert and general public assessed the adoption process as non-transparent and non-inclusive. Namely, the Law was adopted in a fast-tracked procedure, although the preparation thereof lasted for a year and half prior to its submission to the Parliament. Only

one public hearing was organized in the course of the law's reconsideration, while representatives of relevant chambers, professional associations, associations on patients' rights, citizens' associations and the academia requested the Law to be withdrawn from procedure and urged the authorities to enable participation of all stakeholders in the drafting process. In the period of 2 years from its adoption, the Law was subject to four rounds of amendments.

In terms of the general principle on human rights protection, the Law on Health Protection regulates the right of all citizens to the highest attainable standard of health care, i.e. physical and psychological integrity, safety and non-discrimination. Specific elements of the right to the highest attainable standard of health care are indirectly stipulated in the definition of the term "health care", as follows: *"health care shall mean a system of social and individual measures, activities and procedures for maintenance and promotion of health, early detection and prevention of diseases, injuries and other health disorders caused by the working and living environment, timely and efficient treatment and health care and rehabilitation. Measures, activities and procedures referred to in paragraph 1 of this article must be based on scientific evidence and should be safe, secure, efficient and in compliance with the professional ethics"* (16).

2012 Law on Health Protection, for the first time defines the principles of health care, those being: availability, efficiency, continuity, equality, coverage and provision of quality and secure medical treatment. These positive and generally defined provisions on the basic principles underlying health care do not allow their operationalization at different health care levels. Primarily, this is due to the fact that the principles are too vaguely defined and elaborated in terms of their applicability and orientation towards the individual, family and the community as beneficiaries of health care.

This is particularly applicable to the principle of availability, which is defined in the following manner: *the principle of availability shall be attained by providing adequate health care services for the population, i.e. health care services that are geographically, physically and economically accessible*. Nevertheless, this definition does not include detailed elaboration of individual dimensions of availability, i.e. geographical, physical and economic accessibility of health care services.

Having in mind the fact that the principle of availability of one of the basic principles underlying the health care system in the Republic of Macedonia, specific aspects (geographical, physical and economic accessibility) should include understanding and meeting of health

concerns of the overall population, with due consideration of specific health concerns and health status of the most vulnerable and marginalized population groups.

Mechanisms for promotion of health care availability are developed by the Ministry of Health and include a network of health facilities and rulebooks and guidelines on the operation of health facilities, including: health service needs of the population; number, age, gender, social structure and health status of citizens in the area for which the network is established; securing equal access to health services; establishment of health facilities pursuant to several factors such as economic justifiability, technological and scientific development in medicine, urban planning, traffic considerations, etc.

The principle of availability is directly correlated to the principle of equality in health care which, according to the Law on Health Protection, is realized by prohibiting discrimination in provision of health care services on the grounds of race, gender, age, ethnicity, social status, religion, political or other affiliation, property rights, culture, language, type of disease, mental or physical disability.

The above-listed principles are incorporated in the specific measures and activities (17) for provision of health care to all citizens in the Republic of Macedonia on the basis of the population's health status and health issues and priorities defined in the health care strategies and policies adopted. With a view to implement enlisted measures and activities, every year the Government of RM, on the proposal from the Ministry of Health, adopts relevant programmes and supports their realization by allocating funds from the Budget of RM.

Law on Health Insurance

Law on Health Insurance regulates the health insurance of citizens, rights and responsibilities in the field of health insurance and manner in which health insurance is exercised.

Health insurance in the Republic of Macedonia is based on the principle of solidarity and subsidiarity, investments and provision of universal coverage of the population with a basic package of health services. The basic package of health services determines the type of services enjoyed by health insurance holders in primary, secondary (out-patient) and tertiary (in-patient) health care.

Law on Health Insurance stipulates that all citizens of the Republic of Macedonia shall enjoy health insurance, including the people who are not insured on any basis (18). The Ministry of Health covers the costs for citizens who do not have health insurance by contributing to the Annual Programme on Mandatory Health Insurance. Health insurance holders are obliged to make personal contributions for utilization of health services and medicines set in the amount of up to 20% of average costs for relevant health services or medicines. In cases of health services provided abroad and approved by the Health Insurance Fund, health insurance holders are obliged to cover 20% of total costs for these services, but not more than 200 EUR in MKD counter value.

The Law provides for exemptions from personal contributions to the benefit of special population groups (19), as follows: medical examination with the registered general practitioner and emergency medical care on call; health insurance holders who are beneficiaries of social allowance; people accommodated at social protection institutions; mentally ill people accommodated at psychiatric hospitals and mentally disabled children without parental care; and health insurance holders who, within a period of one calendar year, have paid personal contributions for health services in an amount higher than 70% of the average salary in RM for the previous year.

Unemployed persons who earn income on different bases are obliged to make health insurance payments according to the pre-defined threshold stipulated in the Law on Mandatory Social Insurance Contributions (20).



HEALTH 2020 AND HEALTH ACTION PLANS OF THE REPUBLIC OF MACEDONIA

The Health Strategy of RM includes an analysis of deficits (challenges) in several fields that affect health and health care, and defines the strategic priorities. The strategy is implemented by means of biannual strategic plans. Main shortfalls in the Health Strategy of RM include: the strategy is not aligned with the new European policy framework “Health 2020” adopted by WHO; the strategy does not anticipate specific activities, timeframes and entities responsible for their implementation; the strategy does not include specific measures targeting vulnerable population groups. To date, there are no reports and/or analyses on the strategy’s implementation, which prevents conclusions to be inferred on the activities implemented and results achieved.

As regards the commitments assumed under the Decade of Roma Inclusion, especially in the field of Roma health, Republic of Macedonia has adopted the National Action Plan on Health 2005 – 2015 and the revised National Action Plan 2009 – 2011. At the moment, there is no updated or revised Action Plan for the period after 2011, which creates confusion about the valid Action Plan implemented by the Ministry of Health. As was the case with the Health Strategy, the National Action Plan is not followed-up with reports on its implementation and the effects and results thereof. Only reports available concern the implementation of the National Action Plan on Promoting the Social Status of Roma Women in the Republic of Macedonia for the period 2011 – 2013, but they do not allow conclusions to be inferred on the implementation status of anticipated activities.

Health Strategy

In February 2007, the Ministry of Health adopted the strategy “Health 2020: Reliable, Efficient and Equitable Health Care System” (21). As indicated in the document, this strategy defines the vision for promotion of health and advancement of the health system with a view to address population’s needs. Furthermore,

the strategy defines the needs and goals, i.e. priorities that will be pursued by 2020. It contains an analysis of deficits, i.e. challenges in several fields, such as: the demographic and socio-economic situation; health; provision of health services for citizens; public health; human resources; ensuring quality of health care; funding of the health care system; and other issues (pharmaceutical services, health information system, consumer interests).

On the basis of the analysis performed, the strategy defines the following priorities:

- » to improve health status of the population, with special attention to vulnerable groups and an emphasis on promotion of health;
- » to improve the health care system's effectiveness and efficiency by introducing professional management at health facilities, as well as structural changes in provision of health care services, with an emphasis on primary health care;
- » to modernize the public health system in compliance with EU standards, with an emphasis on the network of Public Health Centres and occupational medicine services;
- » to improve the human resource management at health facilities, according to the needs identified;
- » to establish a comprehensive system on oversight and control of the quality of health care services provided;
- » to improve the funding of the health care system by establishing a sustainable mechanism on financing and allocation of resources, in particular by providing a basic package of services for all citizens covered by the mandatory health insurance, improving the mechanisms on financial control and improving the collection of health insurance contributions, signing service contracts with health facilities and introducing different forms of additional (private) health insurance.

Attainment of these priorities is pursued by means of biannual strategic plans developed by the Ministry of Health. From the adoption of the Health Strategy to present, strategic plans were adopted for the following time intervals: 2008 – 2010; 2009 – 2011; 2010 – 2012; 2011 – 2013 and 2012 – 2014. At the moment, valid is the strategic plan for the period 2012 – 2014 (22) and it is the only publicly available document.

It should be noted that RM, as a member of the World Health Organization (WHO), is obliged to implement the European policy framework "Health 2020" (23). This document is a result of the work of 53 states from WHO European Region and aims to significantly improve population's health and welfare, reduce inequalities in health care, strengthen public health and enable a health system oriented towards patients' needs, i.e. universal, equitable, sustainable and quality health care systems. "Health 2020" is a result of an extensive two-year process of consultations with member states from WHO European Region and beyond and is based on several studies (24) conducted for this purpose. This policy framework was adopted in 2012. On the account of its importance, WHO Regional Office expects the states to take activities aimed at adjusting, implementing and developing national level health approaches in compliance with the policy framework. In January 2014, WHO organized the first round of training for the group of accredited consultants that should support and advise member states in regard to developing their national strategies in compliance with European policy framework "Health 2020". According to this document, member states can make actual improvements in their respective health care systems by pursuing the following strategic goals: improve health of all people and reduce inequalities in the health care system, as well as strengthen leadership and governing capacity for health, i.e. introduce participatory governance in the health sector. Implementation of this commitment in RM will imply adoption of a health strategy with activities aimed at integrating health issues in all policies and promoting health, as well as activities targeting people at risk. Moreover, RM will have to take activities identified by the citizens and patients, which can serve as key elements to improve health, health system's efficiency and patients' satisfaction.

In addition to the Health Strategy 2020, which provides the general policy framework of the Ministry of Health, there are several individual (25) strategic documents (with accompanying actions plans) that are currently in effect, those being: National Strategy on HIV for the period 2012 – 2016; Strategy on Adjusting the Health Sector to Climate Changes in the Republic of Macedonia and Action Plan 2011 – 2015 (including the individual action plan on prevention of harmful effects and consequences of cold weather and cold waves on the population's health and the action plan on prevention of consequences of heat waves on the population's health); Immunization Strategy of the Republic of Macedonia 2012 – 2020 and Action Plan 2012 – 2015; Na-

tional Strategy on Prevention of Oral Diseases among Children aged 0 – 14 years for the period 2008 – 2018; Strategy on Health and Safety at Work 2011 – 2015 and Action Plan 2013 – 2014; Strategy on Sexual and Reproductive Health of the Republic of Macedonia by 2020 and Action Plan by 2013; National Strategy on Prevention and Control of Non-Communicable Diseases and Strategy on Safe Motherhood 2010 – 2015 and Action Plan 2010 – 2013.

As indicated in the introduction of the Health Strategy, it is based on the Constitution of RM, whereby all citizens are guaranteed the right to health care on the principles of equality, i.e. equal access to the basic package of health care services that are financially and geographically accessible for the overall population, the principle of solidarity and subsidiarity realized by means of health insurance, and the principle of accountability, whereby health is a shared responsibility of citizens, the Government, all health facilities, public and private sector undertakings, and non-governmental organizations. Health Strategy and the accompanying strategic plan for the period 2012 – 2014 do not explicitly stipulate the obligation for provision of universal health care. Except for defined priorities, the Health Strategy does not include specific activities, timeframes and entities responsible for its implementation. Although it includes a priority concerning the promotion of population's health, with a special emphasis on vulnerable groups and health promotion, this document's text does not refer to specific activities targeting vulnerable groups.

Strategic Plan 2012 – 2014 contains the priorities and goals of the Ministry of Health that overlap with those defined in the Health Strategy. It should be noted that MoH realizes the priorities from the strategic plan by means of individual programmes. Integral part of these programmes are defined outcomes and indicators used to measure the successful implementation of the programme, but they do not contain plan of activities, timeframes and entities responsible for implementation of activities (exemption therefrom are activities implemented by MoH under the National Strategy on Fight Against Human Trafficking and Illegal Migration and the accompanying National Action Plan 2009 – 2012). Strategic Plan 2012 – 2014, under the programme on health protection and prevention, includes interventions targeting vulnerable population groups (in addition to regular preventive health programmes, this programmes also includes the Strategy on Demographic Development, Strategy on Prevention and Combat against Sexual Abuse of Children and Paedophilia 2009 – 2012, De-

cade of Roma Inclusion and the National Strategy on Youth).

The analysis presented in the Health Strategy relies on statistical data from the official publications of the Ministry of Health, the Institute of Public Health and the database "Health for All" of WHO Regional Office for Europe. There are no officially available documents that provide insight in the fact whether MoH has conducted an analysis on the exercise of the right to health in RM.

Except for the Health Strategy and the Strategic Plan 2012 – 2014, the official website of the Ministry of Health does not host any other documents or reports on previously implemented and realized activities. Therefore, unclear is whether and how data is collected for the purpose of measuring the success of activities implemented, although relevant indicators have been defined for that purpose.

Decade of Roma Inclusion

As regards the commitments stemming from the Decade of Roma Inclusion (Roma Decade National Action Plans for the period 2005 – 2015 and 2009 – 2011), the Health Strategy 2020 does not refer to the health status and health rights of Roma people, while the Strategic Plan 2012 – 2014 includes these commitments under the programme on preventive health care, more specifically expected outcome no. 24: Roma Decade and successful implementation thereof will be measured on the basis of implementation of activities anticipated in the Roma Decade Action Plan. Nevertheless, the actual situation with the implementation of the Roma Decade National Action Plan on Health raises serious concerns. Namely, the National Action Plan on Health was adopted in 2005 and covers the period 2005 – 2015 (26) (including the Operational Plan for the period 2005 – 2008 (27)). This plan was revised in 2008 (28) and resulted in the adoption of the Revised National Action Plan on Health for the period 2009 – 2011. After the expiration of the Roma Decade National Action Plan on Health, the competent authorities failed to adopt a new, revised National Action Plan for the period 2012 – 2015. Therefore, questions are raised about the valid document in effect that guides ongoing activities of the Ministry of Health in this regard.

Monitoring the progress of the Decade of Roma Inclusion in general and in the field of health in particular is difficult, primarily due to the

lack of official data and their unavailability. This conclusion is further supported with the findings of relevant analyses conducted on this issue (29). In practice, there are only several information sources (30) that allow the establishment of the health status among Roma, but none of these documents is prepared by the state authorities. More specifically, there are no annual or other reports that would enable an assessment of the progress made in terms of improving the status of Roma people in different spheres of social life, which is based on activities anticipated under the Roma Decade and the National Action Plans on Health. Analyses and documents available provide an indirect insight in the actual situation. This is due to the fact that available documents do not analyse the situation against the goals and activities anticipated under the Action Plan and Operational Plan on Health adopted by the Republic of Macedonia.

Exception from this situation, i.e. absence of reports on the progress made under the relevant actions plans and programmes is the National Action Plan for Promotion of the Social Status of Roma Women in RM for the period 2011 – 2013 (31). This plan anticipates four activities in the field of health care aimed at improving access to primary health care for Roma women by means of increased information and awareness-raising on the need for disease prevention and establish-

ment of gynaecological practices in the municipalities with dominant Roma population. Activities anticipated under this plan include: informative meetings for promotion of healthy life habits; acquisition and exercise of rights in the field of health care; improving relations between patients and medical doctors; conducting a research on establishing the health status of Roma women in RM; media campaign on prevention of infectious diseases, tuberculosis, sexually transmitted diseases, breast and uterus cancer; determining legal possibilities for establishment of gynaecological practices in the municipalities with dominant Roma population (municipalities where these services are not available). Ministry of Health is responsible for the implementation of these activities and their realization is supported with funds from the budget¹ of the competent ministry and from donations (amounts and specific donor sources are not specified).

Reports on the implementation of this plan were prepared for the year 2012 (32) and the first half of 2013 (33). Nevertheless, they do not include data on the extent of implementation of activities anticipated under the plan. On the contrary, these reports are developed as communications on the activities implemented by the Ministry of Health and the Institute of Public Health.

¹ Specific indication is made of funds needed only for the researching activities intended for determining the current health status among Roma women.

IV.

CITIZENS' PARTICIPATION IN HEALTH POLICY-MAKING AND IMPLEMENTATION

In addition to the fact that there is no legal obligation for involvement of citizens and civil society organizations in the process on developing the health strategy and strategic plans, the Ministry of Health is not introducing practices or activities that would enable active participation of civil society organizations in the development and implementation of health strategies and strategic plans.

On the other hand, the process led by the Ministry of Labour and Social Policy for the revision of the Roma Decade National Action Plan on Health was organized with broad involvement of civil society organizations. In that, the revised Action Plan anticipated civil society organizations' participation in the implementation thereof.

Health Strategy

There are no specific legal obligations on involvement of citizens, i.e. certain vulnerable groups, in development of health strategies and strategic plans, except for the legal provision whereby all health insurance holders are entitled to have their representative in the Executive Board of the Health Insurance Fund.

Public's involvement in development of health policies and their influence on the health care system is insignificant.²

² Textbook "Law and Public Health" assesses citizens' involvement as "relatively low", Borce Davitkovski, Ph.D. and others, 2009.

More specifically, the only way for citizens to be involved in these processes is through the civil society organizations profiled in the field of health issues and health rights, which indirectly represent citizens' interests. According to official data from the Central Register,³ 816 of the total number of 6,922 citizens' associations work on health issues, while 17 of the total number of 118 Roma CSOs are profiled in health-related issues. This provides the conclusion that a sufficient number of CSOs exist and can contribute in the promotion of health.

The Health Strategy does not include data whether and how were citizens, i.e. health care beneficiaries, involved in the development of this document. In the section on priorities related to management of health reforms, the commitments of the Ministry of Health by 2020 include: "patients' satisfaction with health care services will be monitored and will be an important indicator of the progress made by reform activities and attainment of quality health care system". These commitments do not refer to civil society organizations and the possibility to be included in the work of MoH.

Section on better cooperation and exchange of information among all interested parties from the Strategic Plan 2012 – 2014 under item 2 (transparent operation) anticipates involvement of the civil society in decision-making of public interest, public finance management and development of concept on participation of local authorities and NGOs in development and implementation of information campaigns

and education workshops on promotion of health and prevention of diseases (pages 23 and 24 of the Strategic Plan). In addition to commitments and indicators for measuring progress achieved, the plan indicates that a programme on financing citizens' associations and foundations has been developed, that campaigns and projects have been implemented in cooperation with NGOs and local authorities and that the interdepartmental cooperation and coordination has been improved (page 38 of the Strategic Plan).

This provides the conclusion that, as part of its Health Strategy and Strategic Plans, the Ministry of Health did not anticipate specific activities for involvement of citizens and civil society organizations in the decision-making process, which means that the Ministry of Health treats them as service consumers and data source on the success of its reforms.

Decade of Roma Inclusion

The process on developing specific strategies addressing Roma issues, i.e. the revision of the Roma Decade National Action Plan on Health led by the Ministry of Labour and Social Policy implied broad consultations with civil society organizations, primarily Roma CSOs and those profiled in the field of health (28).

³ FOI Response no. 08-2553/4, Central Register of the Republic of Macedonia. Data disclosed are valid by 15 November 2013.

V.

FUNDING OF THE HEALTH CARE SYSTEM

In the last eight years, the Republic of Macedonia has made several changes to the funding of the health care system that negatively affected its operation. Actually, the changes implied reduced amount of revenue collected in the public health budget and limited citizens' access to health care services, health care system's increased dependence on funds secured by means of loans and private contributions paid by the citizens, which ultimately undermined the financial sustainability of the health care system.

Under the current policy in effect, funding of the health care system in the Republic of Macedonia leads to: continuous increase of personal funds spent by citizens for health care and decrease of public expenditure for this purpose; allocation of less funds for health from the central budget; lower public expenditure on health care compared to other central budget accounts; intensified increase of funds from donations and credits in the health budget compared to funds secured from the central budget.

Existing health policies and programmes refer to Roma people as a particularly vulnerable group and identify the need for activities directly targeting Roma communities, but most of them do not allocate relevant budget funds for the implementation of these activities. In the last eight years, the Government of RM anticipated allocation of funds as part of two central budget accounts for implementation of measures aimed to improve the health of Roma. In that, the central budget funds allocated for this purpose were in minimum amount. Nevertheless, central budget's final balance sheets developed by the Government do not include information on the amount of funds spent for this purpose.

Key changes to the funding of the health care system in RM

Republic of Macedonia is a country with a social health care system, which is dominantly financed with money collected on the basis of mandatory social contributions paid by employed citizens, and a small share of funds allocated from the central budget.

Amendments to the rate of mandatory health insurance contribution (34) and amendments to the terms and conditions for health insurance of persons that are not insured on any grounds (35) are the key changes made to the funding of the health care system. Contributions for mandatory health insurance paid by employed citizens are the most important revenue source in the health budget (more than 80% of all revenue collected in the health budget). In the period 2010 – 2012, the rate of salary contributions for mandatory health insurance was reduced on two occasions, i.e. from 9.2% in 2006 to 7.3% in 2010 and to 6% in 2011. In the same period, the total number of persons with health insurance was reduced by 8% and the number of persons with private health insurance was reduced by 4% (36). Official data published by the State Statistical Office show that the number of employed citizens in 2012 has been reduced by 0.3% compared to 2010 figures.⁴ Governmental policies aimed at reducing the unemployment rate, reducing the costs for health insurance and maintaining or increasing revenue from health insurance have actually led to decreased revenue from mandatory health insurance contribution in the health budget by 4.9%⁵ in 2012 compared to 2010 figures.

The group of people without health insurance includes the citizens who do not enjoy health insurance on any grounds, live in unfavourable social and economic conditions and are not beneficiaries of social allowance. In 2009, in order to facilitate access to health for this group of citizens, the Government introduced the measure on free-of-charge health insurance financed by the budget of the Ministry of Health, but the amount of funds allocated for this purpose was insufficient to cover health-related costs of this group of citizens (37). Two years later, in 2011 and 2013, the Government amended the measure on free-of-charge health insurance and limited the univer-

⁴ Number of employed citizens: 659,557 in 2010; 639,340 in 2011; and 657,849 in 2012.

⁵ Revenue from social insurance contributions in the budget of the Health Insurance Fund amounted to 287 million EUR in 2010 and 273 million EUR in 2012.

sality of health insurance, whereby the this right can be enjoyed only by citizens without health insurance on any other grounds who do not earn monthly income in an amount higher than 131 EUR. The Government assessed these changes as positive because they decrease budget costs for health insurance of this category of citizens, but the concerned citizens consider them to be negative because they limit their access to health care services.

The ultimate result of these policies is the creation of a financially unsustainable health care system, derogation of the principle of solidarity and universality underlying the social health care system and health care system's increased dependence on funds secured by means of loans, donations and private contributions from citizens.

Regulations on the funding of the health care system

Financial operations and financial management at public institutions in the health sector in Republic of Macedonia are regulated by a series of legal norms stipulated in the Law on Budgets (38), Law on Budget Execution (39), laws governing individual types of public revenue, Law on Mandatory Social Insurance Contributions (40), Law on Public Debt (41), Law on Donations and Sponsorships for Public Activities (42), Law on Health Protection (11) and Law on Health Insurance (13). These legislative acts directly or indirectly stipulate the procedure on collection, allocation and management of funds at public institutions in the health sector for the purpose of promoting health and providing health care services for the population. As indicated in these laws, these procedures should enable: regulated, planned, timely and transparent collection of funds; equitable distribution of funds collected with a view to address basic health needs of the citizens in the Republic of Macedonia; regulated, planned, cost-effective and transparent spending of available funds and provision of basic health care services; and addressing current health problems.

Revenue sources in the health budget

According to the Law on Health Protection and Law on Health Insurance, the basic package of public health services is supported with funds from the **budget of the Health Insurance Fund of the Republic of Macedonia and the Budget of the Republic of Macedonia**, i.e. budget of

the Ministry of Health. Funds in the budget of the Health Insurance Funds are secured by collection of mandatory social contributions for health care,⁶ additional contributions for occupational diseases and injuries at work, transfers from the central budget and private contributions of health insurance holders. On the other hand, central budget funds (budget of the Ministry of Health) are secured from the primary budget accounts, self-financing activities, funds from donations and loans.

Basic package of health care services financed by the public health budget

According to the Law on Health Protection and Law on Health Insurance, funds collected in the Budget of the Republic of Macedonia (budget of the Ministry of Health and budget of the Health Insurance Fund) provide the citizens **services in primary, secondary and tertiary health care and services stipulated under governmental programmes on preventive and curative health care.**

As part of primary health care, citizens are entitled to: health services for establishing, monitoring and checking the health status of individuals; provision of expert and medical measures and procedures aimed at promoting health; prevention and early detection of diseases and other health disorders; provision of emergency medical care, including transportation with ambulance vehicles; treatment at medical practices or at home; antenatal and postnatal health care; implementation of preventive, therapeutic and rehabilitation measures; prevention, treatment and curing of oral diseases; access to medicines from the list determined by the Fund and approved by the Minister of Health.

As part of secondary (specialist) health care, citizens are entitled to: testing and diagnosis of diseases, injuries and health status; implementation of specialist diagnostic, therapeutic and rehabilitation procedures; orthopaedic and other medical aids; and orthodontist services as determined in the general act adopted by the Fund and approved by the Minister of Health.

⁶ Contributions paid from salaries and reimbursements for employed citizens, pensions and pension and disability insurance contributions, contributions paid by self-employed citizens, and funds from other categories of contributions paid by health insurance holders.

As part of tertiary (in-patient) health care, citizens are entitled to: testing and establishment of health status; treatment, rehabilitation, care, accommodation and food at hospitals; and medicines from the list determined in the general act adopted by the Fund and approved by the Minister of Health, including necessary medical aids used for administration of medicines, sanitary and other supplies necessary for the medical treatment, accommodation and food for parents and guardians of children up to 3 years old while admitted for in-patient care, and for a period of up to 30 days, and forensic medicine for diseased, on the request of health facilities.

Funds from the Budget of the Republic of Macedonia are used to provide preventive and curative health care services for the citizens, those being: measures and activities for protection from harmful effects of gases, noise, ionizing and non-ionizing radiation, polluted waters, land and food on human health and other harmful effects from the working and living environment; measures and activities for protection of population's health; measures and activities for detection and prevention of communicable diseases; provision of hygiene and epidemiological minimum standards for the population; prevention and treatment of addictive diseases and drug use; measures and activities for protection of women's health during pregnancy, birth and postpartum period and infant health care; measures and activities for organization and promotion of blood donation; coverage of costs for diseased people treated with dialysis; provision of medicines for people with transplanted organs; provision of insulin, cytostatic medicines and growth hormones; measures and activities provided for under special programmes and emergency medical care.

Analysis of costs in health care

According to the data published by WHO, in the period 2006 - 2011, **the health care system in the Republic of Macedonia, on an annual level, is funded with an average of 434 million EUR in nominal value or 377 million EUR in actual value.** Actual health care costs show the real amount of money spent for health care, exempting the inflation effect. This means that on annual level, RM spends 57 million EUR less, having in mind the erosion of funds' value caused by the inflation.⁷ In that, 64% of all costs in health care are covered by public budget funds, while

⁷ All data presented in this chapter are calculated according to the 2005 exchange rate.

the remaining 36% are private costs⁸ for health care. Almost the entire amount of private funds is paid from citizens' own budgets (99%)⁹ (Chart no. 1). In the same period, public and private costs for health care are increased by 2% per year. However, the analysis of the rate of these costs provides the conclusion that private costs for health care are marked by progressive growth from one to another year, while the public funds are characterized by continuous variations, without specific progression (Chart no. 2). Private costs of citizens paid from their personal budgets are marked by an increased share in the household's total expenditure. This means that participation of private funds paid by the citizens is increasing by an average rate of 3% per year. On the other hand, public (state) funds spent for health care are decreased by 3% per year (Chart no. 3).

According to WHO data, in the period 2005 – 2011, on annual level, **the Republic of Macedonia spends an average of 184 EUR per capita for health care**. At the same time, individual citizens spend an average of 67 EUR per year for health care from own funds. On annual level, the state spends an average of 117 EUR per capita for health care (Chart no. 4).

Analysis of health costs in terms of their share in the GDP of the Republic of Macedonia provides the conclusion that **in the period 2005 - 2011, total costs for health care, in average, accounted for 7% of RM's annual GDP¹⁰**. Consequently, public health care costs, in average, accounted for 5% and private health care costs, in average, account for 2% of annual GDP. In absolute figures, GDP's growth rate in the Republic of Macedonia is more intensive compared to the growth of total costs for health care. Therefore, in the analysed period, **the realized GDP growth in RM is increased by an average annual rate of 6% and is by 4 percentile points higher than the growth of total costs for health care, which accounts for 2%** (Chart no. 5).

⁸ Private costs imply costs of citizens and costs of private organizations that substitute public health services.

⁹ According to WHO, private costs also include health-related costs incurred by civil society organizations.

¹⁰ GDP is the value of all manufactured goods and services in the country's economy.

Analysis of public costs for health care

Funds for the operation of the public health sector in the Republic of Macedonia are secured from two funding sources, those being: the budget of the Health Insurance Fund and the budget of the Ministry of Health. According to WHO data, in the period 2005 – 2011, **in average, HIF's budget has allocated and spent 234.8 million EUR per year, and the budget of the Ministry of Health has allocated and spent 5.9 million EUR per year**.

In average and on annual basis, 3% of all funds from the central budget of the Republic of Macedonia (central government's budget, without the public funds) **are allocated for health care, under a separate budget account**. Under the current dynamic related to allocation of central budget funds, the health care system is a central budget account that is allocated the lowest share of funds. This means that the central budget allocates and spends less funds for health care compared to the funds intended for culture, defence, public services, public peace and order, education, social protection and economic matters¹¹ (Chart no. 6).

According to WHO data, in the period 2005 - 2011, **12.9% or 240.7 million EUR of the total annual budget expenditure** (1,854 million EUR) **are spent for the operation of the public health care sector¹²** (Chart no. 7).

Highest share of funds allocated from the Budget of RM are intended for health insurance of pensioners (funds spent from the budget of the Health Insurance Fund), **which - in average - account for 20% of all central budget funds allocated for health care per year**. They are followed by funds intended for: curative health care (10%), capital expenditure in health (9%), health insurance for unemployed persons (8%) and maternity leave reimbursement (5%). Insignificant share of central budget funds are allocated and spent for other health-related functions (Chart no. 8).

¹¹ Ranking of central budget accounts, according to the amount of funds allocated for performance of these public activities is based on central budget's official data.

¹² This calculation does not include the budget of the Ministry of Health and the budget of the Health Insurance Fund.

In the period 2005 - 2012, **the highest amount of funds from the budget of MoH and the budget of HIF were spent on goods and services**¹³ (74% of all health-related costs from the central budget). Remaining portion of these funds were spent on procurement of equipment and construction works (9%), disbursement of social benefits¹⁴ (8%) and coverage of unemployed people with health insurance (7.5%) (Chart no. 9).

Public health budget funds for promotion of Roma health

In the period 2005 - 2012, the Government of RM has anticipated specific activities, measures and central budget funds to promote health and health protection of Roma people on several grounds, as follows: funds for implementation of measures and activities aimed at promotion of Roma health and addressing health problems faced by Roma people, as indicated in the National Action Plan on Roma Health, which is a commitment assumed by the Republic of Macedonia under the Decade of Roma Inclusion (2005 - 2015), and in the Programme for Active Health Protection of Mothers and Children.

Several governmental strategies, operational plans and programmes indicate the Roma population as an especially vulnerable group and identify the need for implementation of targeted activities aimed at promoting health and health care for Roma, but failed to allocate funds for implementation of specific activities targeting this ethnic group. They include: Programme on Systematic Check-Ups for Pupils and Students; Immunization Action Plan 2012 - 2015; Action Plan for Safe Motherhood 2010 - 2015; Action Plan on Sexual and Reproductive Health 2013, etc.

communication and transportation, small inventory, tools, repairs and ongoing maintenance, contracted services and temporary employments. The highest amount paid under this budget item is noted in relation to contracted services, which accounts for 90% of all funds.

¹⁴ This budget account includes: salary reimbursement for sick leaves, travelling costs, salary reimbursement for maternity leaves and other reimbursements. The highest amount paid under this budget item is noted in relation to maternity leaves, which accounts for almost 50% of all funds.

In the period 2005 - 2011, the Government of RM has spent a total of 60,553.00 EUR or 1.2% of all central budget funds intended for health (5.9 million EUR) to implement specific measures and activities aimed at promoting Roma health. These funds account for only 1.4% of total funds planned for implementation of specific measures aimed at promoting Roma health (4,270,456.00 EUR).

In the period 2005 - 2011, the Government of RM planned to allocate a total of 4,231,919.00 EUR for implementation of activities from the Roma Decade National Action Plan on Health. For the first time, the Government allocated central budget funds for this purpose in 2009, but in 2011 the budget of the Ministry of Health included a total of 22,016.00 EUR or 0.5% of total funds planned. Final balance sheets for the Budget of RM and the financial reports published by the Ministry of Health do not include information on the amount of funds spent to support the Decade of Roma Inclusion in the period 2009 - 2011 (Chart no. 11).

From 2011, the budget of the Ministry of Health includes funds allocated for implementation of specific preventive measures aimed at promoting health of children in Roma communities, notably under the Programme for Active Health Protection of Mothers and Children. In the period 2011 - 2012, the budget of the Ministry of Health allocated a total of 38,537.00 EUR for this purpose, which account for only 11% of the Programme's total budget (338,211.00 EUR). There are no official data on the amount of funds intended and spent for implementation of these specific activities in the monitored period (Chart no. 11).

VI.

PUBLIC HEALTH BUDGET FUNDS SECURED FROM EXTERNAL SOURCES

In the period 2005 - 2012, **the total public debt of the central government of RM¹⁵** is marked by a continuous trend of increase with an average annual rate of **6% increase**. In the monitored period, the increase of central government's public debt is counter-proportional to the GDP's growth rate. This means that the central government's debt is continuously increasing under a dynamic higher than the GDP's growth rate (Chart no. 10). Overall debt of the central government and public funds in the period 2005 - 2012 amounts to an average of 1,785 million EUR per year, and is by 30% higher than the GDP. Analysis of the public debt's structure provides the conclusion that the highest amount of funds secured by the central government and the public funds come from loans taken from foreign creditors. This amount accounts for 66% of the total amount of funds secured by means of loans (Chart no. 10).

According to data presented in the final balance sheet of the Budget of RM in the period 2005 - 2012, **91.5% of health budget funds spent are secured from the public funds,¹⁶ 7% are secured from the central budget of RM,¹⁷ 2% are secured from loans and donations and 1% from self-financing activities.¹⁸**

According to WHO data, in the period 2005 - 2011, an average of 5.6 million EUR secured from external sources are spent on annual level, which accounts for 2% of total public costs for health. Amount of funds secured from external sources is 3 EUR per capita.

¹⁵ Central government's total debt includes the total amount of funds secured by the central government and the public funds by means of borrowing on the domestic and foreign capital markets.

¹⁶ Funds secured from the public funds are actually the funds from the budget of the Health Insurance Fund.

¹⁷ Funds secured from the primary budget are revenue collected by the state on the account of public charges and fees and are intended for health care.

¹⁸ Shares are calculated on the basis of data presented in the final balance sheet for the Budget of RM.

The highest growth rate in the period 2005 - 2012 **was noted in terms of funds secured by means of loans and donations.** On annual level, funds in the public health budget secured by means of loans are increased by 62% in average, while the funds secured as donations are marked by average annual increase of 42%.

Funds secured from the central budget and intended for health are marked by annual increase by 7%, funds secured from different public funds are not marked by significant variations, while funds secured from self-financing activities are marked by significant decrease (Chart no. 12).

According to data presented in the final balance sheets for the Budget of RM in the period 2009 - 2012,¹⁹ 2 million EUR secured from donations and grants were spent on promotion and development of the

health care sector. Nevertheless, accumulated foreign assistance in the same period accounts for 27.7 million EUR.²⁰ The highest amount of donations in the central budget for health has been secured by the HOPE project (16.4 million EUR) and was intended for procurement of equipment, medicines and medical supplies. In the same period, a total of 7 million EUR were paid to the central budget as grants provided by the Global Fund to Fight AIDS, Tuberculosis and Malaria (5.6 million EUR) and by the Government of the Kingdom of Netherlands (so called ORIO grant, in the amount of 487,250.00 EUR).

According to information provided in the final balance sheet for the Budget of RM, the public health budget in the period 2009 - 2012 disbursed 14 million EUR secured by means of loans. There are no official data on the institutions that have credited the health care system in RM and the purpose for which these funds were spent.

¹⁹ 2009, 2010, 2011 and 2012 data are subject to analysis due to the fact that there are no publicly available data on the actual amount of funds secured as foreign assistance for public health for any of the monitoring years, and therefore the necessary information were obtained by means of Freedom of Information (FOI) applications.

²⁰ Data obtained by means of FOI applications.

VII. SOCIO-ECONOMIC FACTORS AS HEALTH DETERMINANTS

“Unemployment and poverty are the greatest factors affecting our health. If you have money, you will be healthy and have everything. If you don’t have money, you won’t have anything. I am 55 years old, unemployed and looking for job. Wherever I go to find work, they tell me I am too old. I would like to work instead of being on social allowance. I want to earn my own money.”

(statement made by male Roma respondent from Delcevo).

“I am a diabetic and suffer from other diseases. We benefit from social allowance, but the amount we receive is not sufficient. Both of my children are unemployed. We need to pay for electricity and water, and money is always short. I have to eat four times a day, but our food is poor. I don’t always have the medicines needed, although I suffer from different complications due to the diabetes. I cannot move anymore.”

(statement made by female Roma respondent from Delcevo)

Education, employment status, household income, family and housing conditions are important social determinants that affect the health of individuals and population groups.

Low education of Roma, unemployment, low income and higher number of family members, including the inadequate housing conditions, are social determinants that negatively affect the health status of Roma and their ability to exercise their health rights.

Education

Roma have a significantly lower education degree compared to members of other ethnic groups. Especially worrying is the high share of Roma people who do not know how to read and write and those without completed primary education, which is not the case among non-Roma. On the other hand, the share of Roma respondents with completed secondary or higher education is significantly lower compared to the share of non-Roma respondents. For illustration purposes, 17.4% of Roma do not know how to read and write, while this share among non-Roma population is only 0.5%. Furthermore, as low as 26.3% of Roma have completed secondary education compared to the members from other ethnic groups, where the relevant share is 47.3% (Table no. 1).

Employment status

Significantly higher share of Roma compared to non-Roma are unemployed and majority of them are beneficiaries of social allowance. 32.3% of Roma are unemployed compared to 13.8% of non-Roma. 21.3% of Roma and only 5.3% of non-Roma are beneficiaries of social allowance (Charts no. 13 and 14).

Income

Monthly income among Roma households is significantly lower than the income generated by other households. Most certainly, this situation is due to the fact that significant share of Roma households live on social allowance and on income generated by informal or irregular work. Namely, slightly more than one quarter of Roma households sustain themselves with monthly income of less than 3,000.00 MKD, which is the case with only 5.4% of non-Roma households (Chart no. 15).

Average monthly income among Roma households amounts to 6,000.00 MKD, while the average monthly income among non-Roma households amounts to 18,000.00 MKD. According to official data of the State Statistical Office, in 2012 the total amount of average monthly funds per household accounted for 27,370.00 MKD (43). These data provide the conclusion that average monthly income among Roma households is by 2.5 times lower compared to the average income among non-Roma households. Moreover, average monthly income among Roma households is by 4.5 times lower compared to the official data on average monthly funds available per household on the level of Republic of Macedonia.

Marital status and family

Significant share of Roma live in so-called traditional, i.e. unregistered marriages, which is much less common among members of

other ethnic groups. The phenomena of Roma people entering traditional marriages, but failing to officially register their wedlock may negatively affect their right to health protection, in compliance with the Law on Health Insurance (44), especially in terms of coverage with health insurance possessed by their spouses. Namely, 22.7% of Roma live in unregistered marriage, while this is the case with only 3% of members of other ethnic groups (Chart no. 16).

In average, Roma have more children compared to non-Roma, as around 40% of Roma respondents have three or more children, while slightly over half of non-Roma respondents have two children (Chart no. 17). Having in mind the number of family members among Roma households, low income earned by these families is yet another problem, which was not observed with the non-Roma population.

Housing

Roma live in more unfavourable housing conditions compared to respondents from other ethnic groups. Homes of Roma people, in average, have 0.5 rooms per family member, while the house area per family member among non-Roma is one room.

Although majority of Roma and non-Roma households have access to the water supply system, homes of non-Roma respondents more often have water supply infrastructure within their homes (92.1%) compared to Roma homes (77.4%) (Chart no. 18). Furthermore, high share of households are connected to the sewage system (93.5% of Roma and 96.8% of non-Roma homes), but lower share of Roma households have the sanitary infrastructure within their homes (63.1%) compared to non-Roma household (86.5%). Twice as higher share of Roma households use cesspits (5.9%) compared to non-Roma households (3.1%). Although their share is very low, there are Roma homes without sanitary infrastructure, while the number of such homes among non-Roma families is non-existing (Chart no. 19).

VIII. HEALTH STATUS

Social determinants of Roma people have an obvious negative effect on the health status of this population. On the basis of self-reported health status and frequency of acute diseases affecting their health, Roma people are characterized by a more unfavourable health status compared to the members of other ethnic groups.

Furthermore, lower number of Roma who suffer from chronic diseases are able to manage them, notably due to their failure to comply with the prescribed therapy, but also due to the fact that they receive health care services of lower quality compared to the general population.

Self-reported health status

In average, Roma assess their health as worse compared to the respondents from other ethnic groups. Namely, 16.1% of Roma respondents and 20.7% of non-Roma respondents assessed their health as “very good”, while 17.1% of Roma respondents and 11.5% of non-Roma respondents assessed their health as “poor” (Chart no. 20).

Acute health problems

Roma, in significantly higher share and more frequently, are affected by acute respiratory and gastrointestinal diseases compared to the self-reported health of non-Roma respondents. Evidence in support of this observation is the fact that in the last 12 months, by 10% more Roma compared to non-Roma have suffered from acute respiratory diseases (including colds, flu, acute bronchitis, etc.) (Chart no. 21). Moreover, in the last 12 months

Roma more frequently suffered from these diseases (an average of 2.9 times) compared to non-Roma respondents (an average of 2 times).

In terms of gastrointestinal infections, the situation is dramatically more unfavourable among Roma, as one half of Roma respondents and one third of non-Roma respondents suffered from at least one gastrointestinal infection in the last 12 months (Chart no. 22).

Unlike non-Roma, Roma more frequently suffered from sexually transmitted diseases, notably because 5.1% of Roma respondents and 2.5% of non-Roma respondents reported that they have been diagnosed with STDs in the last 12 months.

Chronic health problems

Almost equal shares of Roma and non-Roma respondents suffered from chronic non-contagious diseases, but lower share of Roma who

suffer from chronic diseases regularly receive their therapy and they receive health care services of lower quality compared to members of other ethnic groups who suffer from same diseases.

Although majority of these people regularly receive the therapy needed, the share of Roma respondents is by 10% lower compared to the share of non-Roma respondents (Chart no. 24).

Evidence in the support of the statement that lower number of Roma who suffer from chronic diseases receive quality health care services compared to members of other ethnic groups is identified in the following survey findings: 60.8% of Roma respondents and 82.1% of non-Roma respondents indicated that their medical doctors have advised them on the need to practice healthy lifestyles; 74.3% of Roma respondents and 87.6% of non-Roma respondents indicated that their medical doctors have advised them on the need for regular administration of the prescribed therapy (Charts no. 25 and 26).

IX. HEALTH PROTECTION

According to the Law on Health Protection, the health care system in Republic of Macedonia is primarily based on preventive, diagnostic and therapeutic and rehabilitation measures and the principles of availability, efficiency, continuity, equality, comprehensiveness and provision of quality and reliable health treatment. Health care is an activity of public interest performed by the public services in primary, secondary and tertiary health care. Mandatory health insurance covers a basic package of health care services, including measures aimed at promoting health and preventive health measures and activities, which are an important part of this package.

Population's coverage with health insurance is on high level, both among Roma and non-Roma, but the main obstacle preventing Roma to benefit from health insurance is lack of documents. Moreover, high shares of Roma and non-Roma have already selected their registered general practitioner, but the main obstacle for non-selection of registered general practitioner among Roma is the lack of health insurance. Regular immunization among Roma children is still lower compared to the immunization rate among children from other ethnic groups.

Roma, just as members of other ethnic groups, are entitled to secondary and tertiary health care services, i.e. specialist out-patient and in-patient, i.e. hospital health care services, and the need for these services is similar between the two groups of respondents. Nevertheless, an impression is obtain that, in general, Roma are less satisfied with health care services they receive in secondary and tertiary health care, including the behaviour of health professional, quality of health care services, non-provision of additional information on the health status and inability to ask the medical staff, primarily the medical doctors, additional questions about their health.

A. Primary health care

Health insurance

Coverage with health insurance of Roma and non-Roma is on high level and there are no significant differences between them in this regard, as 92.9% of Roma and 93.9% of non-Roma respondents indicated that they have health insurance. Among the group of respondents without health insurance, the most common reason indicated is lack of documents needed for exercising the right to health insurance. Higher share of Roma (45.8%) compared to non-Roma respondents (37.8%) indicated this as a reason for not having health insurance. Second most frequently indicated reason for lack of health insurance among Roma respondents is the lack of knowledge on how to exercise this right (14.6%), while the second most indicated reason for lack of health insurance among non-Roma respondents is the fact that their employers have not registered their work (18.9%) (Chart no. 27).

Registered general practitioner and dentist

Similar to the situation observed in regard to health insurance, high number of both, Roma and non-Roma respondents, have selected their registered general practitioner (93.3%). Nevertheless, among the group of respondents who have not selected their registered general practitioner, significantly higher share of Roma (47.5%) compared to non-Roma respondents (4.9%) indicated lack of health insurance as the main reason, while the most frequent answer among non-Roma for not having selected a registered general practitioner is the fact that they do not feel the need to do so (26.8%) (Chart no. 28). In average, Roma respondents visit their registered general practitioner 6.8 times per year, while the average calculated for other ethnic communities is lower and accounts for 4.9 visits in the last 12 months.

As regards registered dentists, the coverage among Roma and non-Roma respondents is smaller, but Roma more frequently indicated that they have not selected their registered dentist (66% of Roma and 74.9% of non-Roma respondents have selected their registered dentist).

Majority of respondents provided affirmative answers on the question whether their general practitioners provide them with sufficient information on the diseases and the medicines prescribed. Nevertheless, smaller share of Roma (85.1%) compared to non-Roma (91%) indicated that their general practitioners have provided them with detailed information about their health status.

Accessibility of health care facilities

Principle of health care availability, as indicated in the Law on Health Protection, is exercised by the provision of relevant health protection for the population in the Republic of Macedonia, in a geographically, physically and economically accessible manner, especially in terms of primary health care.

Physical accessibility of primary health care services was assessed in terms of the distance of health facilities from the respondents' place of residence, whereby they were asked to indicate the distance in kilometres to the closest ambulance, dentist office and pharmacy from their home. According to survey findings, Roma and non-Roma respondents are almost equally distanced from the health facilities, where the average distance to the ambulance is 2.28 km among Roma and 2.38 km among non-Roma, the average distance to the dentist office is 2.39 km among Roma and 2.42 km among non-Roma, and the average distance to the pharmacy is 1.75 km among Roma and 1.92 km among non-Roma.

Emergency medical care

Emergency medical care, as defined in the Law on Health Protection, is provision of health care services whose non-performance in timely manner might result in irreparable and serious damage to the patient's health or his/her death. Although the difference is small, Roma respondents were more rarely denied provision of emergency medical care compared to non-Roma (9.8% of Roma and 12.1% of non-Roma respondents indicated this answer). In average, the ambulance services needed 14 minutes to arrive at homes of Roma respondents and 17.2 minutes to arrive at homes of non-Roma respondents.

“When I was ill, I had to call the ambulance and pay 100 MKD for their services. I paid out of my pocket for the injections, ampules, although I have a health card. Ambulance charges are high and we are poor. We live on social allowance. Should we eat or pay for the medical services. For a period of 15 days I had to pay 100 MKD for their visits irrespective of the fact whether I have the money or not. I had to borrow from my neighbors to pay for my treatment.”

(statement made by male Roma respondent from Suto Orizari).

“General practitioners located in Suto Orizari are not kind to all patients. In my view, they are not good medical doctors, they are inhospitable. When you enter their office, instead of explaining the history of the disease, its symptoms and consequences, they exchange few words and write the prescriptions. This is not good.”

(statement made by male Roma respondent from Suto Orizari).

Immunization of children

Immunization coverage of minor children with mandatory vaccines, as one of the method for control of vaccine-preventable diseases, is on solid level, but slightly lower share of Roma (87.5%) regularly take their minor children for immunization compared to the non-Roma respondents (93%). Main reason indicated for irregular vaccination of children among Roma is lack of information on the vaccination timetable (39.3%), followed by the fact that there is no need for vaccination (10.7%) and lack of knowledge on how are children to be immunized (8.9%) (Chart no. 29).

B. Specialist services in secondary and tertiary health care

Secondary and tertiary health care is intended for diagnosis and treatment of patients that cannot be adequately treated as part of primary health care, which should have the role of the “gate keeper” towards the higher and more expensive health care services.

Lower share of Roma (47.8%) compared to non-Roma (57.2%) have visited a specialist MD at public health facilities in RM. No differences were noted in terms of the health facility where the respondents visited a special MD, i.e. whether they went to a health care facility, clinical or university hospital.

“I would like to say something about emergency medical services, since I had experience with them in last 2-3 months. I have an ill mother who is 85 years old and bed-bound. For the last few months, whenever I call the emergency services they tell me that the ambulance vehicle is occupied, is in the field and cannot arrive at our house, so I have to manage on my own. I tell them it is a matter of emergency, but they tell me to manage on my own. When I passed a house in the neighborhood, I spotted the vehicle outside although the residents are all healthy. I entered inside and saw the medical staff administering an infusion. The house owners were their friends and they treated them with coffee. I told them that I have an emergency at my home, and they told me they will come once they are finished. Emergency medical services are disastrous.”

(statement made by male Macedonian respondent from Delcevo)

Behaviour of MDs towards patients and provision of information about patient's health

In general, Roma are less satisfied with the behaviour demonstrated by specialist MDs in secondary and tertiary health care and the information they have provided about their health status. 53.9% of Roma and 73% of non-Roma respondents are completely satisfied with the general behaviour demonstrated by MDs. 49.2% of Roma and 73.3% of non-Roma respondents are completely satisfied with services provided by MDs. 53.9% of Roma and 75.5% of non-Roma respondents completely understood the information provided by MDs. 41% of Roma and 62.9% of non-Roma respondents had the possibility to ask additional questions about their health status. Only 40% of Roma compared to 59.7% of non-Roma respondents had the feeling that their questions were not seriously taken into consideration by MDs. 50.5% of Roma and 68.9% of non-Roma respondents are completely satisfied with the quality and quantity of information about their health status. Finally, 42% of Roma and 56% of non-Roma respondents are completely satisfied with the time spent on explaining their health status (Charts no. 30 to 36).

C. In-patient services in secondary and tertiary health care

Coverage of Roma and non-Roma respondents with in-patient health care and treatment is on similar level, and there are no significant differences in terms of type of health care facilities where in-patient treatment was provided (general, clinical or university hospital). The most common reasons for in-patient health care include diagnosis, treatment and therapy administration, whereby lower share of Roma (59.2%) were hospitalized compared to members of other ethnic groups (49.2%).

“MDs at the hospital are phenomenal. They have instruments and work to the best of their abilities. Nevertheless, the assisting medical staff is worse.”

(statement made by male Macedonian respondent from Delcevo).

“An unfortunate event happened with people from Vinica. They came here for dialysis, because these services are not available in their hometown. They were unaware of the fact that they are entitled to reimbursement of travelling costs and paid out of their pocket for cab transportation. When we advised them to request reimbursement of these costs, the dialysis doctor addressed them with profanities. Incredible! The woman was upset and almost died. They were lucky and now receive dialysis services in Stip. This is an example of inhumanity. Doctors have made a pledge and cannot behave in such manner. Somebody must take actions to correct this situation.

(statement made by male Roma respondent from Delcevo)

Behaviour of MDs and other medical staff towards patients and provision of information about patients' health

Unlike non-Roma respondents, lower share of Roma indicated complete satisfaction with the behaviour demonstrated by MDs and other medical staff in secondary and tertiary health care, as well as the information provided about their health status. Only 34% of Roma compared to 67.4% of non-Roma respondents are completely satisfied with the general conduct of health professionals. 33.3% of Roma compared to 68.2% of non-Roma respondents are completely satis-

fied with the services provided at hospitals. 39.1% of Roma and 67.4% of non-Roma respondents fully understood the information provided by MDs. 32.7% of Roma compared to 59.1% of non-Roma respondents had the possibility to ask additional questions about their health status. Only 30.8% of Roma respondents have the feeling that their questions were seriously taken by MDs, while the relevant share among non-Roma respondents is 56.1%. 44.9% of Roma and 68.9% of non-Roma respondents are completely satisfied with the quality and quantity of information about their health status. 37.8% of Roma compared to 57.6% of non-Roma respondents are satisfied with the time spent on explaining their health status (Charts no. 37 to 43).

X.

PATIENTS' RIGHTS

Law on Protection of Patients' Rights

Patients' rights in health care are regulated under the Law on Protection of Patients' Rights (12) adopted in July 2008. This Law stipulates in detail the protection of patients' rights when benefiting from health care, duties of health facilities and health professionals and assisting staff when providing health care services, competences of municipalities and the Health Insurance Fund in terms of promotion of patients' rights, procedure on protection of patients' rights and supervision and control over the Law's enforcement.

Articles 2 and 5 of the Law on Protection of Patients' Rights regulate individual aspects of the right to health, i.e. the right of all citizens to the highest attainable standard of health care, and specifies that health care should be of high quality and provided in continuation and in compliance with individual patient's needs, free of psychological and physical abuse, fully respectful of the patient's dignity and in his/her best interests. At the same time, the Law elaborates in detail the principles underlying protection of patients' rights, such as the principle of humanity and the principle of availability.

Contrary to the Law on Health Protection, the Law on Protection of Patients' Rights elaborates in detail the principle of availability. Namely, the principle of availability (45) implies health care services available to all patients under equal terms and conditions and without discrimination. In this regard, it should be noted that special emphasis is put on availability of health care services on call, i.e. services based in the community where the patient lives. Furthermore, the Law elaborates the aspect of continuous provision of health care, as well as the cooperation between health professionals and assisting medical staff involved in provision of medical treatment. The principle of availability includes equitable and fair procedure on the selection of medical treatment based on scientific criteria and non-discrimination, as well as the selection and change of health professionals and health facility at patient's request.

Law on Protection of Patients' Rights stipulates series of rights enjoyed by the patients, those being: right to participate in the decision about the medical treatment; right to receive or reject information; right to accept or reject the medical intervention; to have his/her rights protected in case the patient is unable to make a statement; to have his/her rights protected when participating in scientific research; to have his/her rights protected when included in medical teaching or human genome research; right to access his/her medical records; right to confidentiality of personal and medical data; right to maintain contacts; right to leave the health facility at own request and right to privacy.

For the purpose of promoting patients' rights, the Law anticipates establishment of special bodies (municipal committees and state commission). Concerns are raised with the fact that these bodies have not been established and that there are no punitive provisions on sanctions to be imposed in cases these bodies do not exist. More specifically, research data (46) show that only 5 councillors on patients' rights have been appointed at the total of 56 in-patient care facilities, while 21 of the total of 84 municipalities have established local commissions on promotion of patients' rights.

In addition, the Law stipulates mechanisms on protection of patients' rights at in-patient care facilities (councillor on protection of patients' rights), as well as at out-patient care facilities. Be that as it may, the Law does not provide clear indications about the type of person at the out-patient facilities that will provide these services and the manner in which these services should be provided, i.e. unclear is how patients will receive legal aid and advice at these facilities. Such unclear and imprecise legal provisions will create difficulties in terms of access to and provision of protection of patients' rights in cases they have been violated and limited by these health facilities.

Health professionals and patients are insufficiently familiarized with their rights and responsibilities stipulated by the Law. This situation, to a great extent, contributes to increased occurrence of violation of patients' rights and mistrust between patients and medical doctors in terms of decision-making and provision of health care services. The situation observed in relation to exercise and protection of patients' rights raises major concerns, especially among marginalized population groups, such as Roma.

"There are things that we do not know, we are unaware of. For example the rights we have as patients, knowledge about the medicines prescribed, documents that should be and should not be charged. We have been charged for services that are free-of-charge. Doctors charge us for these services because we do not know."

(statement made by a male Roma respondent from Delcevo).

"I have learned about patients' rights from the television and how doctors have to treat patients. But that is not implemented in practice. What you see on television about your rights is one thing, but the situation is different when you visit the doctor. We are treated differently."

(statement made by a male Roma respondent from Suto Orizari).

Specialist MD services in secondary health care

No significant differences were noted between Roma and non-Roma respondents in relation to protection of the rights they enjoy as patients in specialist health care. Negative practices have been reported and they almost equally affect both Roma and non-Roma respondents. In this regard, particularly worrying is the violation of patient's right not to suffer from unnecessary pain, as small share of patients (both Roma and non-Roma) have been administered anaesthesia prior to being subjected to surgery or other medical procedures that might cause pain.

Nevertheless, as regards the right to privacy and confidentiality, it should be noted that Roma are in much more unfavourable situation, which means that they more frequently indicated that their right to privacy and confidentiality has been violated by the medical staff.

As regards the *time of waiting for medical examination*, although there are no significant differences between Roma and members of other ethnic communities, small share of Roma respondents indicated that they have waited for a significant period of time (more than 1 month) to be examined by a specialist MD. More than two thirds of Roma and non-Roma respondents were examined immediately or within a period of seven days, where higher number of Roma (2%) compared to non-Roma respondents (0.3%) have waited for more than three months to be examined by a specialist MD (Chart no. 44).

On the other hand, alternative solutions to shorten the waiting period, i.e. payment out of their pocket, were more frequently offered to Roma patients compared to patients from other ethnic groups. Almost twice as much Roma respondents (19.3%) compared to non-Roma respondents (10.8%) have been offered an alternative solution to shorten the waiting period for the medical intervention or examination (Chart no. 45). This situation should be thoroughly analysed, especially having in mind the unfavourable social and economic status of Roma people compared to members of other ethnic communities in the state.

Furthermore, significant differences were noted in terms of the respect for *patient's right to privacy*. Negative practices have been reported and concern violation of the right of privacy during examinations and medical interventions when there was a person in attendance which should not have been there and for whose presence the patient has not given consent. Worrying is the fact that these negative practices more frequently affect Roma (25.1%) compared to non-Roma respondents (3.6%) and results in violation of and disrespect for the right to privacy of every fourth Roma respondent.

Right to avoid unnecessary suffering and pain - Medicine includes diagnostic and curative procedures that cause pain and major discomfort for the patients. Even the diseases affecting the health of people often imply pain and discomfort. Modern-day medicine tends to reduce these occurrences to the minimum or eliminate them. Therefore,

“13 days ago I had a surgery. A problem occurred during the administration of the anesthesia. I told the MD that I was feeling everything, but he kept saying ‘just a while longer and you won’t feel a thing’. I felt everything, especially the incision. I cried the entire time, but he kept saying ‘just a while longer’.”

(statement made by male Roma respondent from Delcevo)

“I suffer from diabetes and hypertension. I have a scheduled medical examination in four-five days, but had to wait for 5 months to be scheduled an appointment.”

(statement made by male Roma respondent from Suto Orizari)

“I would not recommend entering the hospital in Stip. It is a disaster. I was there in January and wanted to close the window, but I saw that the glass was broken, and there was draft everywhere. We were cold. When you go to the toilets, the doors are all broken and you are exposed.”

(statement made by male Macedonian respondent from Delcevo).

“A month ago I was in Kocani to have my blood checked, but the apparatus had broken down. Around 20 people waited for an hour and a half, but nobody told us that the apparatus is not working so that we would not wait. Finally, the manager came out and told us about the apparatus. ”

(statement made by male Roma respondent from Delcevo)

medical procedures and treatments that are painless or imply minimum pain should be applied whenever possible. Administration of local anaesthesia in such cases serves the purpose of avoiding unnecessary suffering and pain (47). As regards the question on being submitted to unnecessary suffering and pain during surgery or other procedures that may cause pain, no differences were noted in the answers indicated by the Roma and non-Roma respondents. Only 20.1% of Roma and 14.1% of non-Roma respondents were administered local anaesthesia when undergoing the said medical procedures. 15% of Roma and 12.7% of non-Roma respondents indicated that they have not been administered anaesthesia. Survey findings provide the conclusion that the right to avoid unnecessary suffering and pain was equally disrespected among Roma and non-Roma respondents.

Analysis of respondents' exercise of the right to complain shows certain differences between Roma and non-Roma patients when benefiting from secondary and tertiary health care services. On one side, differences were noted in regard to the grounds for lodging a complaint indicated by Roma and non-Roma respondents. On the other side, Roma and non-Roma respondents lodged their complaints to different instances.

As regards the grounds indicated, Roma most often complained about the behaviour of health professionals (5.2%), while non-Roma respondents most frequently expressed dissatisfaction with the conditions at health facilities (7.2%) (Table no. 2). This statement should be reconsidered in a broader context, i.e. they should be reconsidered in conjunction with the fact that Roma indicated their ethnic background as the dominant reason for discrimination, where the subjective behaviour on the part of health professionals significantly contributed to their perception. Lower share of Roma people complain about the conditions at or health care services provided by health facilities.

On the other hand, due to the difference between the number of people who wanted to complain about health care services and those who actually lodged complaints, most Roma respondents complained about the conditions at health facilities, followed by complaints about the health services and the behaviour of health professionals. It seems that despite their intention to complain about the behaviour of health professionals (5.2%), only 2.7% of Roma have made written or oral complaints (Table no. 3) on this ground. Lowest number of com-

plaints lodged by non-Roma respondents concerns the conditions at health facilities.

Difference in the number of cases where there were actual grounds for reaction and cases in which patients lodged complaints is indicative of the need for greater promotion of provisions contained in the Law on Protection of Patients' Rights, i.e. mechanisms available for protection of patients' rights.

As regards the instance to which complaints are addressed, unlike non-Roma respondents, higher share of Roma have addressed all instances, except for the Ombudsman. Ombudsman's Office was not addressed with complaints lodged by Roma or non-Roma respondents. Equal number of Roma and non-Roma respondents lodged complaints to the health professionals providing them health care services (4.6% each) (Table no. 4).

5.1% of Roma and 9.7% of non-Roma respondents received written responses to their complaints. 12.5% of Roma have faced difficulties when lodging the complaints, while members of other ethnic communities have not faced any problems in this regard.

In-patient services in secondary and tertiary health care

Analysis of the actual situation in terms of protection of patients' rights during in-patient care in secondary and tertiary level shows lower respect for health rights of Roma compared to non-Roma people. As regards the right to consent, right to privacy and right to avoid unnecessary suffering and pain, survey respondents reported negative practices on the part of health professionals, which more often affect the Roma population and their overall health status.

As part of protection of patients' rights, *the right to consent* reflects the patients' free will to undergo surgery or other medical procedure, once the medical personnel has informed them about the advantages, negative effects and possible risks of the procedure in question (47). Worrying is the fact that higher share of Roma have undergone

such procedures without having signed a consent form. Namely, 11% of Roma and 4.6% of non-Roma respondents have undergone surgery or another complicated medical procedure without having signed a consent form, while 33.8% of Roma and 30.5% of non-Roma respondents indicated that they have signed such consent forms.

Survey findings related to the *right to avoid unnecessary suffering and pain* when receiving in-patient health care in secondary and tertiary level show an unfavourable situation among Roma compared to members of other ethnic communities. Namely, 14.1% of hospitalized Roma and 3% of hospitalized non-Roma respondents have not been administered local anaesthesia when undergoing surgery or another procedure that might cause pain.

Worrying is the fact that the *right to privacy and confidentiality* of Roma patients is less respected compared to non-Roma patients. 22.3% of hospitalized Roma and 3.8% of hospitalized non-Roma patients reported that a person was in attendance (assisting staff, craftsmen, other patients, visitors, health professionals that do not work in the hospital ward and like) during their in-patient care or when they were undergoing certain examinations and medical interventions and that they have not consented to their presence.

In addition, the right to privacy was violated by the fact that during their in-hospital stay the patients were examined by students without being asked to give their consent. 12.5% of all hospitalized Roma were examined by students without their consent, while 16.4% of them were examined by students with their consent. 9.2% of all hospitalized non-Roma patients declared that they have been examined by students with their consent and 4.6% of them were examined without their consent.

Subject of analysis was the extent to which patients exercise their *right to complaint*. Differences were noted in the manner in which Roma and non-Roma patients exercise their right to complaint. Namely, these differences concern the grounds on which Roma and non-Roma respondents lodged complaints during their hospital stay (Table no. 5). Equal shares of Roma wanted to complain about the conditions at health facilities and the behaviour of health professionals, while non-Roma primarily wished to complain about the conditions at health facilities.

Only a small portion of those who intended actually lodged complaints, the dominant share of complaints lodged concern the conditions at health facilities and the behaviour of health professionals (Table no. 6).

Overview of instances addressed with complaints shows that Roma patients have addressed all instance to express their dissatisfaction, with the exception of the Ombudsman. Highest share of complaints lodged by both Roma and non-Roma patients were addressed to the health professionals providing health care services (Table no. 7). 3.6% of Roma received a written response to their complaint, while non-Roma patients have not received any responses.

Exercise of the right to complaint is affected by the problems faced by patients in this regard, where Roma face greater difficulties compared to non-Roma patients. Namely, 7.5% of Roma and 4.5% of non-Roma patients have faced problems in lodging a complaint about their in-patient care.

Patient's *medical records* contain information about the person's health, such as diseases he/she has suffered from, medicines he/she receives, whether the patient is allergic to some medicine or suffers from other allergies, vaccines, etc. Patients have the right to access their medical records at any time, i.e., they can obtain a copy of these records at their own cost, which must be set in a realistic amount. Lower share of Roma patients were given insight in or transcript of their medicinal records. 7.7% of Roma and 2.3% of non-Roma patients who have requested insight in their medical records were denied this right.

Right to watch TV and listen to radio - Similar share of Roma and non-Roma respondents indicated that during their hospital stay they were allowed to watch TV and listen to radio. Namely, 24.8% of Roma and 28.2% of non-Roma respondents answered that during their hospital stay they had the necessary conditions to exercise this right.

Right to maintain contacts - The situation observed in terms of the exercise of this right is similar to the one observed in regard to the right to watch TV and listen to radio. This means that equal shares of Roma and non-Roma respondents were allowed to receive visitors during the time intervals set by the hospital's housekeeping order.

Namely, 73.65% of Roma and 67.2% of non-Roma respondents answered that they were allowed to receive visitors during the time intervals set by the hospital's housekeeping order. On the other hand, 26.1% of Roma and 19.8% of non-Roma patients indicated that they were occasionally allowed to receive visitors during their hospital stay. 4.5% of Roma and 2.3% of non-Roma respondents indicated that they were not allowed to receive visitors during their hospital stay.

XI. ACCESS TO MEDICINES

The issue of access to medicines in the Republic of Macedonia is regulated under the Law of Medicines and Medical Devices, but there is no separate strategy document on this issue. Barriers identified in terms of access to medicines include: out of pocket payments for procurement of medicines, as well as established lists of reference prices which are marked by increase of out-of-pocket payments made by the patients. However, due to the lack of publicly available analyses, the situation regarding availability and accessibility of medicines cannot be established, including the barriers faced by the patients for their procurement. Survey data show that the main problem faced by Roma in regard to procurement of required medicines is their financial situation, followed by their inability to secure these medicines on the cost of HIF.

Legal framework

Law on Health Protection (11) does not regulate the issue of access to medicines. This issue is indirectly regulated by means of a general provision from the Law related to the principle of availability of health care services. In compliance with the Law, the principle of availability in RM is attained by provision of adequate health care services for the population, in a geographically, physically and economically accessible manner, with special emphasis on primary health care.

Republic of Macedonia does not have a separate strategy document concerning the issue of access to medicines. Series of issues related to medicines and medical devices used in human medicine (such as: conditions and methods on ensuring quality, safety and efficiency of medicines and medical devices; manner and procedure on manufacturing, testing and marketing of medicines and medical devices; pricing; quality control; advertising and inspection) are regulated under the Law on Medicines and Medical Devices (48).

Access to medicines in the Republic of Macedonia is burdened with out-of-pocket payment, even for health insurance holders. Namely, when procuring medicines from the positive list, i.e. medicines covered by HIF, health insurance holders are obliged to cover a participation fee set in the Decision on Establishing the Participation Fee for Health Insurance Holders as share of Total Costs for Health Care and Medicines (49) adopted by HIF. Persons without health insurance have to procure medicines needed at their market price. The same applies to procurement of medicines that are not included in the positive list of medicines covered by HIF.

One of the issues affecting access to medicines is the introduction of so-called lists of reference prices. This issue is regulated under the Rulebook (50) on Reference Prices for Medicines Covered by HIF and the relevant price-setting decisions. The system of reference prices means that the entity procuring the medicines, i.e. HIF, establishes the share of costs to be covered by it for different types of medicines and the participation fee levied to patients, i.e. health insurance holders. The overall goal pursued by the introduction of the system of reference prices is to enable a more diverse offer and a possibility the medicine to be chosen by the health insurance holder. On the other hand, this means reduction of costs covered by HIF for procurement of medicines. In reality, this system emphasizes the generic composition of medicines instead of pharmaceutical brands. Albeit being beneficial for both parties concerned, i.e. health insurance holders and HIF, this system may have negative implications in the practice. Namely, the system of pre-defined reference prices conditions the procurement of medicines in the country. More specifically, any decrease of reference prices for particular medicines results in decreased interest on the part of procurement entities for the medicine in question. Difference between medicine's reference and market price is covered by patients, and in some cases, it can be two to three times higher than the established reference price. In this context, it should be noted that HIF makes regular efforts to expand the positive list of medicines and to reduce or eliminate the participation fee for particular medicines with a view to relieve patients from additional costs and reduce its expenditure, but one cannot truthfully establish whether these actions have led to the desired outcome. Actually, there are no publicly available analyses that would indicate whether health insurance holders can procure the necessary medicines and what types of barriers they face in this regard. The Bureau of Medicines, established for the purpose of performing administrative and expert matters related to medicines, and the Health Insur-

“We can rarely find the medicines prescribed with the health insurance coupons. They are available for out of pocket procurement, but not at the cost of HIF. This situation is observed in continuation. We always pay for medicines with our money.”

(statement made by female Roma respondent from Suto Orizari).

“You can find medicines at HIF's cost only from 1st until 5th day in the month. Afterwards you are referred from one pharmacy to another. To make matters worse, the new system of prescriptions includes a deadline by which you can procure the medicines needed. Procurement of medicines is the most difficult thing for ill people. We pay them at our own cost. Another interesting thing is the fact that pricelist at pharmacies indicate a participation fee in the amount of 5 MKD, but we pay a participation fee in the amount of 120 MKD.”

(statement made by male Roma respondent from Suto Orizari).

“Doctor-prescribed medicines are not always available at HIF's cost. Even if they are in stock, the pharmacist will hide them and won't issue them at HIF's cost. We are often told that medicines are not available at the moment and we have to wait. It is a common practice. If you are lucky, you can find the same medicines at another pharmacy.”

(statement made by male Roma respondent from Delcevo).

ance Fund, collect and process data on medicines' circulation and consumption, but they do not collect data on medicines' availability for patients. For example, HIF makes regular reviews of medicine consumption²¹ per type, number of prescriptions issued and HIF's costs related to the procurement of the medicine in question. The same applies to availability of medicines for patients in public and private hospitals.

Access to medicines

In practice, the unfavourable financial situation among Roma people is a serious obstacle for them to exercise the right to access to medicines, as higher number of Roma compared to non-Roma respondents indicated this answer. Namely, only 20.5% of Roma respondents were always able to purchase the medicines needed and prescribed by their MDs compared to 51.4% of non-Roma respondents²² (Chart no. 46).

In addition to financial barriers, the situation is further complicated with the fact that Roma are more often faced with the inability to find the medicines prescribed at the pharmacies without having to pay for them out of their pocket, compared to respondents from other ethnic groups. Namely, 13.6% of Roma and 38.3% of non-Roma respondents indicated they were always able to find the medicines prescribed without having to pay out of their pocket (Chart no. 47).

Higher share of Roma are not aware of their right to reimbursement of costs for medicines or medical aids, i.e. 19.8% of Roma and 7.2% of non-Roma are unaware of the possibility to apply for reimbursement of costs. On the other hand, although the shares of Roma and non-Roma respondents who requested reimbursement of costs are identical, the number of approved applications among Roma respondents is lower compared to other ethnic groups. Only 35.8% of Roma who submitted applications for reimbursement of costs were refunded, while the relevant share among non-Roma respondents is 71.3% (Chart no. 48).

²¹ <http://www.fzo.org.mk/default.asp?ItemID=CE3DA43F7BDF0348872DA1D09514764B>.

²² This section analyses answers provided by respondents who were prescribed medicines in the last 12 months (Roma n=661, non-Roma n=532).

XII. ACCESS TO WOMEN HEALTH SERVICES

Unfavourable financial situation, lack of health education and ignorance of their health rights are the main social determinants that have negative influence Roma women's access to services related to their health.

Coverage with different health services related to women's health is less favourable among Roma women compared to non-Roma women. Moreover, differences were also noted in regard to the coverage with different health services among Roma women. Thus, although a satisfactory number of Roma women have selected their registered gynaecologist, significantly lower share of Roma women undergo preventive gynaecological check-ups. However, the situation related to regular preventive breast examinations among Roma women is more unfavourable than the situation observed in terms of preventive gynaecological examinations.

Differences were also noted in terms of health protection during pregnancy and at childbirth, and although significant share of Roma women do not undergo relevant number of antenatal health controls, many of them give birth at health facilities. However, cases have been noted of home births in the absence of trained medical staff.

A significant barrier related to access to health services, especially for Roma women, is identified in the negative practices pursued by service providers, such as, for example, the participation fee charged by registered gynaecologists for services that are covered by the health insurance. Unlike non-Roma women, Roma women are less satisfied with the behaviour demonstrated by health professionals and the quality of services during childbirth. Also, lower share of Roma compared to non-Roma women were visited by outreach nurses and they are less satisfied with these services.

Selection of registered gynaecologists

Coverage of Roma and non-Roma women²³ with registered gynaecologists is on solid level and there are no significant differences between them as 76% of Roma and 75% of non-Roma women have selected their registered gynaecologist (Chart no. 49). The most frequently indicated reason for not having selected their registered gynaecologist among both, Roma and non-Roma women, is their position that they do not need to select a registered gynaecologist (this answer was indicated by 62.8% of Roma women and 67.9% of non-Roma women). However, lack of health insurance as a reason for not having selected a registered gynaecologist is more common among Roma women (13.8%) compared to non-Roma women (2.4%) (Chart no. 50).

Accessibility and availability of health services provided by registered gynaecologists

Women from other ethnic groups have better physical access to gynaecological practices, because they are located in the vicinity of their places of residence compared to the places where Roma women reside. Namely, the average distance of the nearest ambulance with gynaecological practice from respondents' place of residence is 3.7 km among Roma women and 2.7 km among non-Roma women.

Roma women were more often imposed participation fees by their registered gynaecologists for services which, according to the decision taken by HIF (51), are covered by the health insurance. Nevertheless, this practice was also observed among non-Roma women. 28.8% of Roma women and 28.4% of non-Roma women were always charged participation fee for free-of-charge services when they visited their gynaecologists. 15.1% of Roma and 13.4% of non-Roma women indicated that they have been often charged for these services, while 34.3% of Roma and 26.8% of non-Roma women indicated that they have been sometimes charged (Chart no. 51). This phenomenon represents a significant barrier for Roma women's access to these services, especially having in mind in their unfavourable socio-economic status.

²³ This section of the survey questionnaire concerns coverage with gynaecologist services and access to preventive health examinations and was answered only by female respondents (Roma women n=391 and non-Roma women n=341).

"I am requested to pay for the services when I visit my registered gynaecologist in Suto Orizari, but was examined without additional charged at the gynaecology practice in the settlement Zelezara. I told my gynaecologist that the services should be free of charge, and he replied that the fee charged should cover his costs related to procurement of protective gloves and other supplies, so I have to pay every time I am examined."

(statement made by female Roma respondent from Suto Orizari).

"If you have contracted a gynaecological disease or infection, he [N/A GYN in Suto Orizari] makes up lies. He forces you to buy the pills from his practice in order to earn more money."

(statement made by female Roma respondent from Suto Orizari).

"I was charged 100 MKD for the gynaecological examination. Moreover, I was charged for the echo examination, because the doctor has recently purchased this apparatus. Nevertheless, the last time I visited his practice, I was not charged."

(statement made by female Roma respondent from Delcevo).

Preventive gynaecological examinations and mammography

Programme on Early Detection of Malign Diseases of the Republic of Macedonia (52) anticipates screening for early detection of cervical cancer and screening for early detection of breast cancer. In that, all costs for cervical cancer screening and mammography are covered by the Programme's budget, which means these screenings are free of charge for women of certain age groups.

According to the standards adopted by the Government of RM (52), every two years women should undergo a preventive gynaecological examination with PAP smear, for the purpose of early detection of cervical cancer. At the same time, mammography, as a specific diagnostic screening method for early detection of breast cancer, should be performed by all women aged above 50 years within regular time intervals of 2 years²⁴.

However, Roma women more rarely undergo preventive gynaecological examinations compared to non-Roma women. Namely, 30.7% of Roma women and 34.2% of non-Roma women undergo these examinations less than once every two years, while 18.9% of Roma women and 10% of non-Roma women have never been examined by a gynaecologist (Chart no. 52). According to the statements made by female respondents, main reasons for not visiting the gynaecologists is their position that gynaecologists should be visited only when they have health issues and not for preventive examinations. Moreover, additional reason indicated by Roma women is lack of financial means (Chart no. 53).

The analysis shows that the crucial reason for the situation observed among Roma women is their lack of health education, since almost one third of Roma women do not know that regular preventive gynaecological examinations can contribute to early detection and treatment of cervical cancer. Only one tenth of women from other ethnic communities are not familiar with this fact. This provides the conclusion that Roma women are less knowledgeable about their reproductive health compared to non-Roma women.

In terms of preventive breast examinations, significantly lower share of Roma women compared to non-Roma women indicated that they undergo preventive breast examinations. This is indicative of the fact that almost 70% of Roma women and 46% of non-Roma women never visited a MD to have their breasts examined (Chart no. 54). As regards mammography tests, the situation is less favourable among Roma women as the share of Roma women who have undergone mammography is almost twice as low compared to non-Roma women (17% of Roma women and 31% of non-Roma women aged above 45 years have had a mammography performed at least once in their life).

The situations observed are affected by the fact that women, especially Roma women, are not sufficiently familiar with their health rights, and they lack knowledge about their rights and entitlements, which results in lower exercise and active pursuit of health rights. In that, almost 60% of Roma and almost 50% of non-Roma women are not familiarized with the right to free-of-charge PAP smear test and mammography every two years.

Irregular preventive examinations imply a significant threat for women's reproductive and general health, as they risk untimely detection and successful treatment of malign and other reproductive diseases.

Health care during pregnancy

According to the newly adopted protocols in RM, during their pregnancy women are entitled to 10 control check-ups with a gynaecologist, while WHO standards recommend a minimum of 4 control check-ups in the gestation period (53).

However, antenatal health care for Roma women is inadequate, as they are in significantly more unfavourable situation compared to non-Roma women.²⁵ Namely, in average, Roma women benefit from lower number of gynaecological controls during the pregnancy. Only 30% of Roma women have visited their gynaecologists more than seven times during their pregnancy, which is in compliance with the protocols applicable in the Republic of Macedonia. On the other hand, 25.8% of Roma women have not been to the four mandatory control check-ups with their gynaecologists during the pregnancy, which is not in compliance with the minimum standards established by WHO, and 8% of them have never visited their gynaecologists for control check-ups (Chart no. 55). Majority of non-Roma women (61.1%) have visited their gynaecologists more than seven times during the pregnancy, and only one tenth of them visited their gynaecologists less than four times (Chart no. 56). The situation observed among Roma women significantly endangers the health of pregnant women and represents a risk factor for higher morbidity and mortality of mothers and newborns.

²⁴ According to the European Guidelines on Provision of Quality Screening and Diagnostics of Breast Cancer, adopted by the Government of the Republic of Macedonia.

²⁵ The analysis of health care during pregnancy and at childbirth, and health care provided by outreach services included women who gave birth in the last 2 years, i.e. 60 Roma women and 18 non-Roma women.

“Everything went well with the childbirth at the clinic, except for the hygiene. It’s a new building, but there are bugs and insects and the toilets were not clean.”

(statement made by female Roma respondent from Suto Orizari).

Unfavourable financial situation and lack of health education are the main barriers to relevant health protection among Roma women during pregnancy. This conclusion is based on the survey findings related to the most frequently indicated reasons by Roma women for irregular control check-ups, i.e. their financial situation and lack of funds to pay for check-ups (35%), while the second most frequently indicated reason is women’s belief that if they feel good during the pregnancy there is no need to visit the gynaecologist (23%). Although marked by lower frequency, other reasons indicated by female respondents include: no health insurance (12%), fear of being examined (12%), household chores and responsibilities towards other children (6%).

Health care at childbirth

Although majority of Roma women have given birth at public health facilities, worrying is the fact that there are still cases of Roma women who have given birth at home in the absence of trained medical staff (6.1%). Cases of home births have not been recorded among non-Roma women (Chart no. 57).

Roma women are less satisfied with health services received at childbirth compared to women from other ethnic groups. For example, 39.7% of Roma women are completely satisfied with the health care received, while the relevant share of non-Roma women is 55.6%. In addition, Roma women received services of lower quality compared to non-Roma women. This conclusion is based on the sur-

vey findings whereby only 34.5% of Roma women completely agree with the statement that health professionals spent sufficient time on explaining their health, compared to 61.1% of non-Roma women who indicated the same answer. Furthermore, 56.9% of Roma women reported that they completely understood the information provided by health professionals compared to 72.2% of non-Roma women (Charts no. 58 and no. 59).

Health care provided by outreach services

Programme for Active Health Protection of Mothers and Children in the Republic of Macedonia (54) anticipates that during the pregnancy and within one year from giving birth women should be visited seven times by outreach nurses. In addition, the Programme anticipates two additional visits to women in Roma communities and women exposed to socio-economic and health risks, which means that during their pregnancy and in the first year after they have given birth Roma women should be visited by outreach nurses a total of nine times.

However, despite the anticipated measures, the coverage of Roma women with these services is lower compared to non-Roma women and in general they are not satisfied with the services received. This confirms the fact that more than one third of Roma women and slightly less than one third of non-Roma women have never been visited by outreach nurses during their last pregnancy and within one year from giving birth (Chart no. 60). Nevertheless, even the women who reported that they have been visited by outreach nurses were not visited the required number of times as indicated in the Programme. Namely, the average number of outreach visits to Roma women is 2.6 and the average number of outreach visits to non-Roma women is 3.

As regards women’s satisfaction with the services provided by outreach nurses, only half of Roma women (51%) expressed complete satisfaction with the services received compared to 77% of non-Roma women (77%) (Chart no. 61).

XIII. DISCRIMINATION

In spite of the formal and legal equality, the exercise of the right to health is characterized by utter disregard for the principles of equality and non-discrimination on the part on health professionals. Survey results show discriminatory practices targeting the Roma community, whereby major concerns are raised by the fact that ethnicity is identified as the major reason for discrimination.

Constitutional guarantees for the right to health care and citizens' duty to protect and promote their own health are further translated into laws that govern health protection and health insurance and they do not make any difference in terms of persons entitled to exercise these rights. This means that all citizens equally enjoy the health rights. With a view to ensure full and unhindered exercise of health rights, as well as to introduce protection against discrimination, several laws in the field of health care prohibit discrimination.

Law on Health Protection (11) prohibits discrimination on the following grounds: race, gender, age, nationality, social status, religion, political or other affiliation, property, culture, language, type of disease, psychological or physical disability. Nevertheless, the Law does not stipulate sanctions in cases when this legal provision has been violated. Under this Law, prohibition of discrimination was first introduced in 2012 under Article 9. Moreover, the Law on Protection of Patients' Rights (12) stipulates exercise of patients' rights without discrimination on the grounds of: gender, race, skin colour, religion, political or other opinion, national or social background, national minority, material status, origin of birth, sexual orientation, or other status. This Law does not stipulate sanctions for non-compliance and violation of this legal provision. It has been noted that the two laws indicated above differ in terms of the number of discrimination grounds indicated therein. Comparison of grounds on which discrimination is prohibited under the two laws provides the conclusion that both legislative acts include eight common grounds for prohibition of discrimination, and four different grounds (for example, the Law on Health Protection

prohibits discrimination on the grounds of age, culture, type of disease and disability, while the Law on Protection of Patients' Rights prohibits discrimination on the grounds of skin colour, origin of birth, sexual orientation, and other status). When combined, these two laws prohibit discrimination on all grounds enlisted under the international documents on human rights. The only deviation noted concerns prohibition of discrimination on the grounds of citizens' place of residence, i.e. discrimination of citizens that live in rural areas.

In compliance with the Constitution and the laws, the Ombudsman's Office holds special competences related to protection of citizens' rights and freedoms (55). Namely, when this institution has established violation of citizens' rights on the part of state administration bodies and other entities performing public services, it is obliged to initiate a relevant procedure in front of competent courts. Available data on the complaints submitted to the Ombudsman in the last five years (2008 – 2012) include information on reported violations of health rights and they are marked by an increase.²⁶ Despite this trend, the number of submitted complaints in the field of health care is insignificant compared to the total number of complaints submitted to this institution. Namely, health-related complaints account for 1.8% of all complains made in 2008 and 3.1% of all complaints made in 2012. However, the analysis of complaints submitted by Roma people and related to discrimination in the field of health care provides the conclusion that Roma do not report the discriminatory practices. In 2008, two of the total number of complaints were submitted by Roma, while their number in 2009, 2010, 2011 and 2012 is only one.

Major concerns are raised with the situation observed in terms of frequency of discriminatory practices against Roma at different levels and for different types of health care services. Namely, one third of Roma patients are exposed to unkind and disrespectful behaviour on the part of health professionals during their visits to specialist MDs and during their hospital stay. Unlike the situation observed among Roma, non-Roma patients are treated more kindly and respectfully. The share of Roma respondents who reported negative behaviour on the part of health professionals is three to four times higher compared to non-Roma respondents. Health care services received by Roma women and the behaviour demonstrated by their registered

²⁶ In 2008, the Ombudsman's Office was presented with 69 complaints, in 2009 - 72, in 2010 - 93, in 2011 - 115 complaints and in 2012 it was presented with 166 complaints.

“Health professionals at the health care center in Suto Orizari and at other hospitals treat us differently due to our skin colour and our nationality. If it's your turn, they will receive 20 other persons before you, so you have to wait and wait. Then you start to get upset, your blood pressure rises and that is not good for your health. If it's our turn, we should be attended to.”

(statement made by male Roma respondent from Suto Orizari).

“When I was giving birth at the hospital, one of the nurses treated me harshly. She said that Roma women are speaking nonsense. She insulted me and I felt bad. I wanted to leave the hospital as soon as possible. But I didn't complain about her behaviour.”

(statement made by female Roma respondent from Suto Orizari).

gynaecologists and other health professionals in the course of their gynaecological control check-ups during their last pregnancy and at childbirth were assessed as unkind and disrespectful. This type of behaviour is most prominent during childbirth of Roma women.

Discrimination during visits to specialist MDs

Share of Roma patients that have been unkindly and disrespectfully treated, have been called names or were insulted and maltreated during their visits to specialist MDs is significantly higher. As high as 34.6% of Roma were treated unkindly during their visits to specialist MDs, which is not the case with other patients. Only 5.3% of non-Roma reported unkind behaviour during their visits to specialist MDs. In addition to the unkind treatment, Roma respondents reported that they have been treated with less respect. The number of Roma pa-

tients that have been subject of disrespectful treatment is four times higher compared to the number of non-Roma patients treated in this manner during their visits to specialist MDs (31.8% of Roma and only 6.9% of non-Roma respondents). Roma respondents reported that during their visits to specialist MDs they have been called names or have been insulted (9.8%). Such behaviour on the part of health professionals was reported by only 1.6% of non-Roma patients. 7.8% of Roma and 0.9% of non-Roma patients have faced threats and maltreatment. Around one third of Roma patients reported that during their visits to specialist MDs they have been targeted with negative behaviour (this answer was provided by 27.6% of Roma and 6% of non-Roma respondents) (Charts no. 62 and 63).

In the opinion of Roma people, the dominant reason behind the negative behaviour of health professionals is their ethnicity, as indicated by 63.2% of Roma respondents, followed by skin colour (13.6%), religion (8%) and their education level (4%). Unlike Roma, non-Roma patients believe that the main reason behind the negative behaviour and treatment demonstrated by health professionals is their income level (28%), age (24%), ethnicity (18%) and religion 10% (Table no. 8).

Discrimination of hospitalized patients (in secondary and tertiary health care)

As was the situation observed in terms of discrimination during visits to specialists MDs, Roma patients are also targeted with unkindness, disrespect and disrespect for their dignity during their hospital stay. 31% of Roma respondents reported unkind and 35.3% of them reported disrespectful treatment on the part of health professionals. Unlike Roma patients, only 4.6% and 6.9% of non-Roma patients reported unkind and disrespectful treatment on the part of health professionals, respectively. During their hospital stay, 9.6% of hospitalized Roma patients were called names and were insulted, contrary to 3.1% of hospitalized non-Roma patients who reported these practices. 6.4% of hospitalized Roma and only 0.8% of hospitalized non-Roma reported that they have been threatened and maltreated during their hospital stay. 34% of Roma have been targeted with negative behaviour, while 4.6% of non-Roma patients indicated that they were

“It is very important for us Roma, to overcome the fear and demand equality and justice everywhere, at hospitals, pharmacies and elsewhere. We need to tell the truth. Fear is widespread among Roma and our low education prevents us to seek justice. We will not achieve anything by being silent about the injustices. If you come with us to any health care facility - be it an ambulance, state or city hospital - I guarantee you will witness the manner in which we are treated. When Roma people come with emergency cases, they are not provided medical care. They would say ‘he is a drunken Gypsy, leave him aside’. You never know whether they will admit you to the hospital or not. Half an hour later, the doctor will make three or four stitches. We are all humans and doctors need to pay attention to all persons, regardless of the ethnicity. Doctors have pledged to help all people.”

(statement made by male Roma respondent from Suto Orizari).

exposed to such behaviour. Physical violence, i.e. use of physical force was reported by 3.2% of hospitalized Roma and 0.8% of hospitalized non-Roma (Charts no. 64 and 65).

According to Roma respondents²⁷, ethnicity (54.3%) is the dominant reason behind the negative treatment they have received, followed by their education level (15.7%), skin colour (12.9%), religious affiliation (8.6%), income level (5.7%) and age (1.4%). Non-Roma respondents believe that age (26.7%), income (26.7%) and ethnicity (20%) are the three almost equally important reasons behind the negative behaviour of health professionals (Table no. 9).

²⁷ Respondents who reported some of the above-enlisted negative behaviours during the hospital stay (70 Roma and 15 non-Roma patients) were asked to indicate the main reason behind such behaviour and practices.

Behaviour and treatment targeting Roma women at registered gynaecology practices

In general, Roma women have received worse treatment by their registered gynaecologists compared to non-Roma women. Around one third of Roma women at least once found themselves in a situation when they have been treated in unkindly manner during their visit to the registered gynaecologist (27.4%). Only 1.6% of non-Roma women reported that they have encountered unkind treatment at least once. During the visits to their registered gynaecologists, one fifth of Roma women have been disrespectfully treated (19.3%) compared to non-Roma women (2.7% of them reported such behaviour). Being called names and being insulted, as forms of discrimination, is a reality for Roma women when they visit their registered gynaecologists, and five of them reported that they have been physically attacked. Around one fifth (16.8%) of Roma women indicated that they have been maltreated by their gynaecologists. Reports on such behaviour are insignificant among non-Roma women (0.5%) (Charts no. 66 and 67).

Every second Roma woman (51.7%) believes that her ethnicity is the main reason behind discriminatory practices demonstrated by gynaecologists, while every fourth Roma woman (25%) indicated skin colour as the main reason thereof (Table no. 10). Having in mind these two dominant reasons for discrimination, the conclusion is inferred that more than two thirds of Roma women perceive discriminatory practices as specifically targeting their ethnic group. Unlike Roma women, women from other ethnic communities believe that the main reason behind the negative behaviour and treatment on the part of gynaecologists is their ethnicity (29.4%), followed by their income level (11.8%).

Treatment of Roma women during pregnancy

As regards the control check-ups during their last pregnancy, Roma women reported that health professionals have treated them unkindly (11.7%), without respect (19.9%), have called them names (5%) and have maltreated them (18.3%). On the contrary, the share of non-Roma women who reported unkind treatment on the part of health professionals is twice as lower (5.6%) (Charts no. 68 and 69).

Three out of four Roma women believe that ethnicity is the main reason behind the negative behaviour demonstrated by health professionals during their check-ups in the last pregnancy (75%), while 15% of them women identified skin colour as the main reason thereof (Table no. 11). Non-Roma women did not identify the reason behind health professionals' unkind treatment.

Treatment of Roma women at childbirth

Significant share of Roma women reported unkind (37.9%) and disrespectful treatment (36%) at childbirth. Some of them indicated that they have been insulted and called names. On the contrary, non-Roma women reported that they have not been exposed to such treatment at childbirth (Charts no. 70 and 71).

As high as 87.5% of Roma women believe that the main reason behind the negative behaviour at childbirth is their ethnicity, followed by their religious affiliation (8.3%) and skin colour (4.2%) (Table no. 12).

ANNEX 1 CHARTS

Chart no. 1.

Public and private costs for health care (expressed as share of total costs)

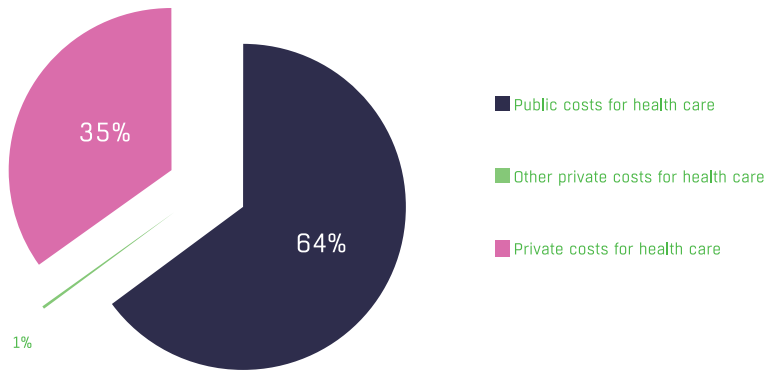


Chart no. 2.

Increase of private costs for health care compared to public costs for health care

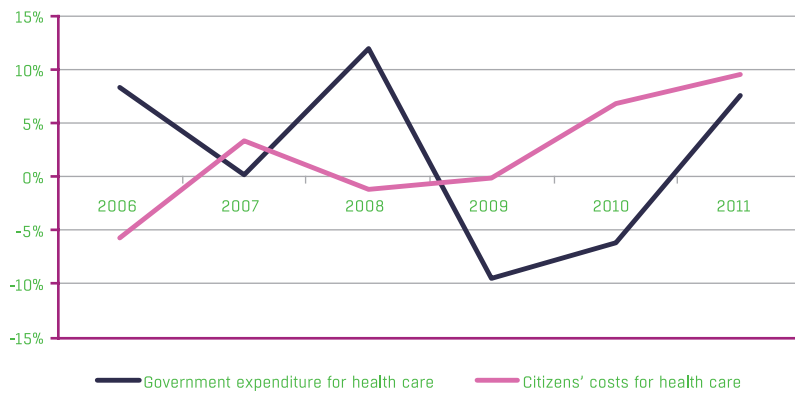


Chart no. 3.

Share of private costs for health care in total private costs and share of public costs for health care in total public spending



Chart no. 4.

Health-related costs from citizens' budget and the state budget, per capita (amounts are expressed in EUR)

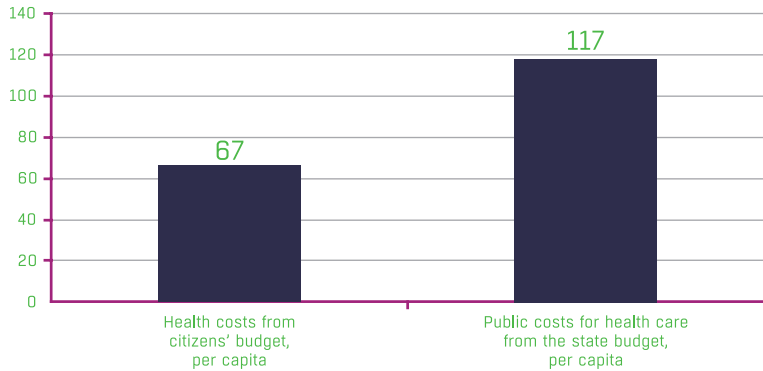


Chart no. 5.

Increase of health care costs compared to GDP's growth rate, in the period 2005 – 2011

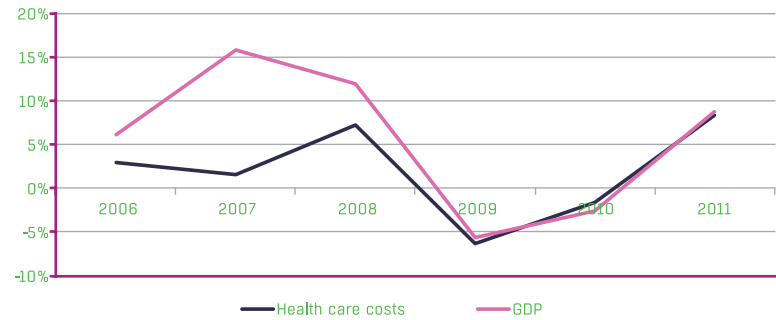


Chart no. 6.

Average amount of central budget funds for different budget accounts, in the period 2005 - 2012 (expressed as share of central budget funds)

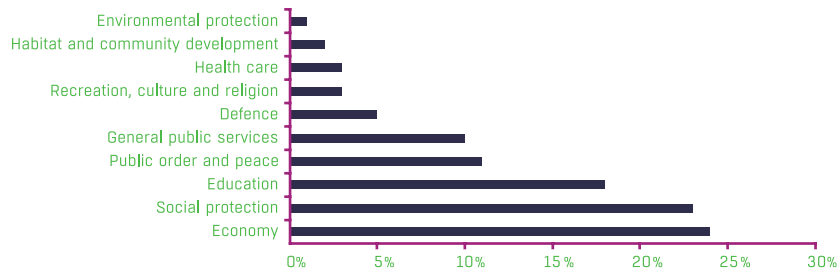
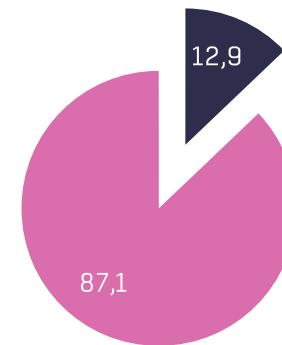


Chart no. 7.

State budget funds spent for health care compared to total state budget funds, in the period 2005 - 2011 (expressed as shares)



■ Funds spent for health care
■ Funds spent for other purposes

Chart no. 8.

Average amount of health budget funds in RM per budget item, in the period 2005 - 2012 (expressed as shares)

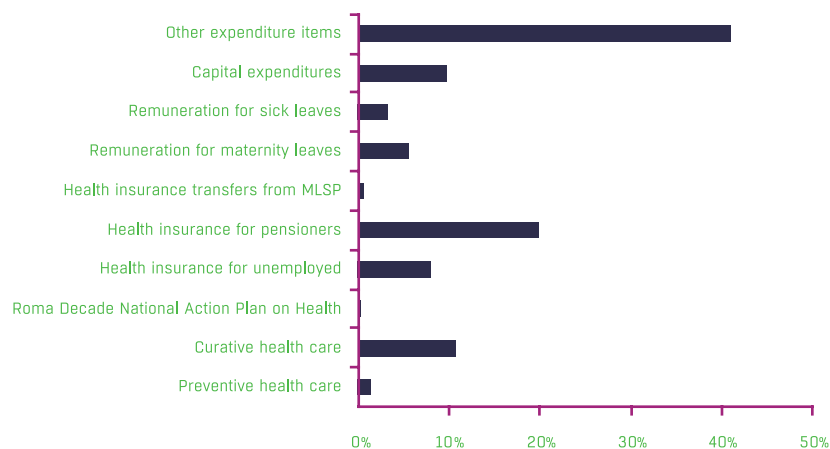


Chart no. 10.

Increase of central government's debt compared to GDP's growth rate, in the period 2005 - 2012 .



Chart no. 9.

Structure of health budget expenditure, in the period 2005 - 2012 (expressed as shares)

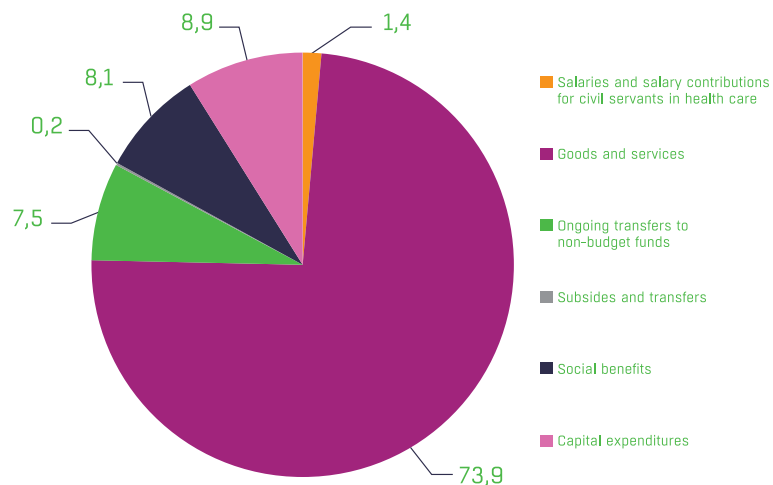


Chart no. 11.

Funds allocated for implementation of activities under the Roma Decade National Action Plan on Health in the period 2005 - 2011 (amounts are expressed in EUR)

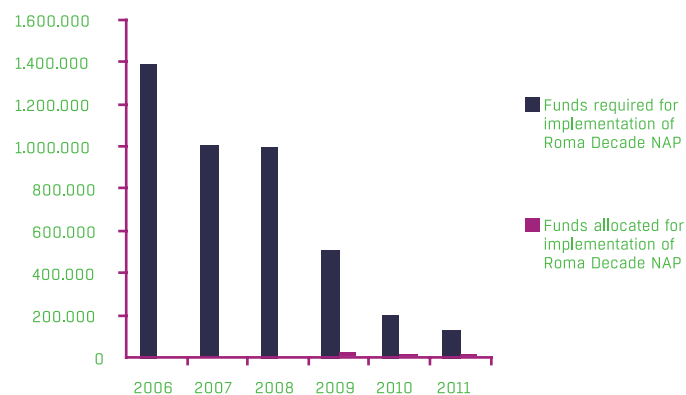


Chart no. 12.

Overview of funds spent for health care and secured from the state budget, special funds, loans, donations and self-financing activities, in the period 2005 - 2012 (expressed as shares)

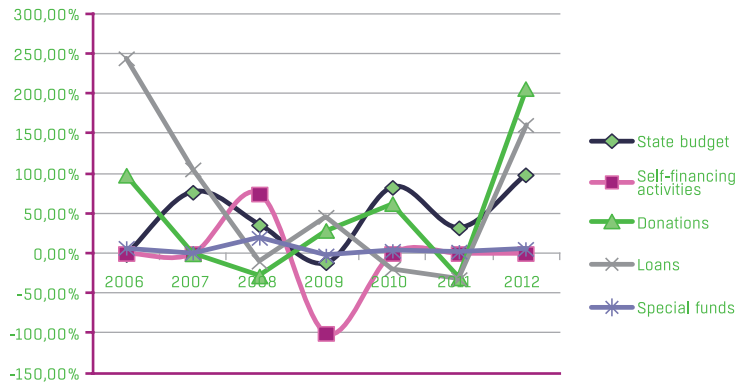


Chart no. 13.

Overview of Roma respondents' employment status

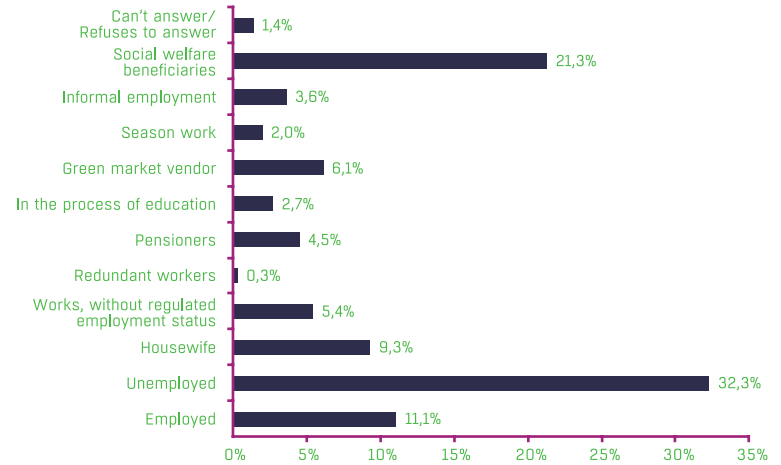


Chart no. 14.

Overview of non-Roma respondents' employment status

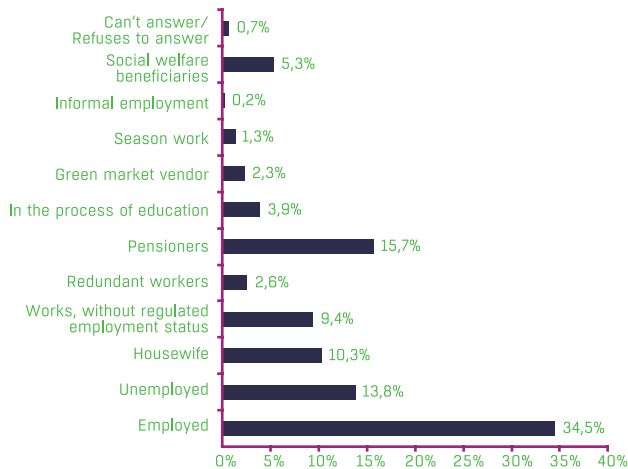


Chart no. 15.

Overview of average monthly income per household

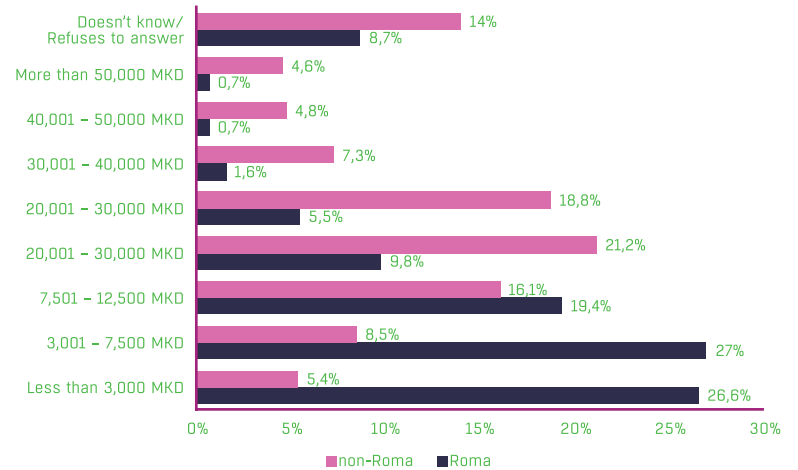


Chart no. 16.

Overview of survey respondents' marital status

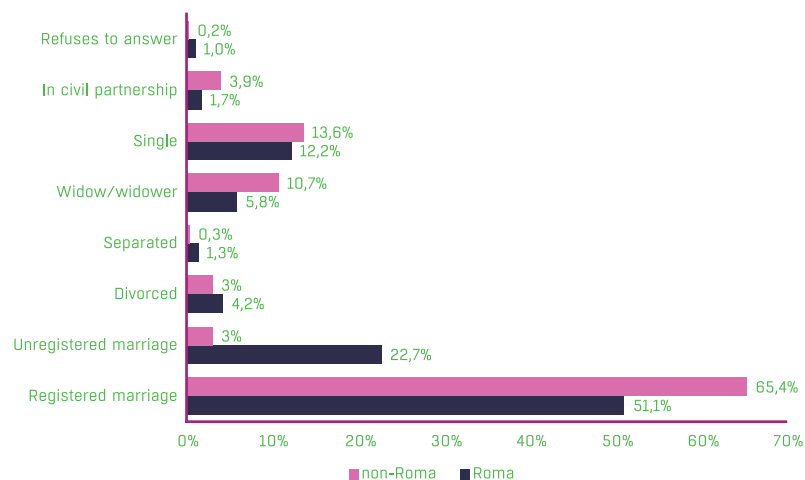


Chart no. 17.

Overview of survey respondents' number of children per family

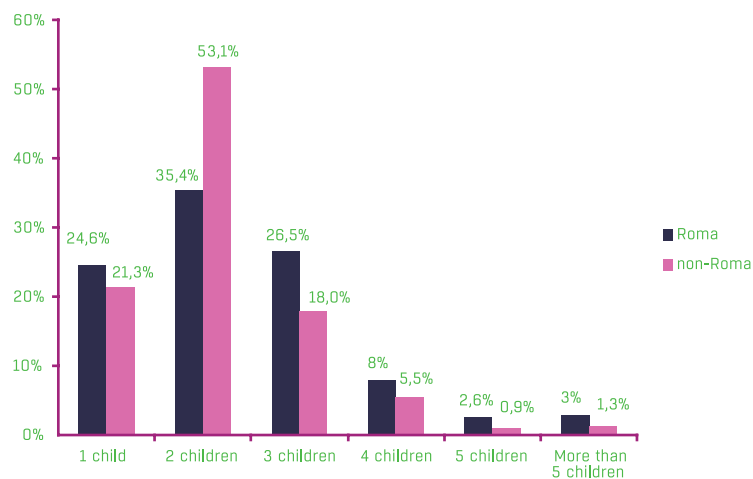


Chart no. 18.

Overview of survey respondents' water supply infrastructure

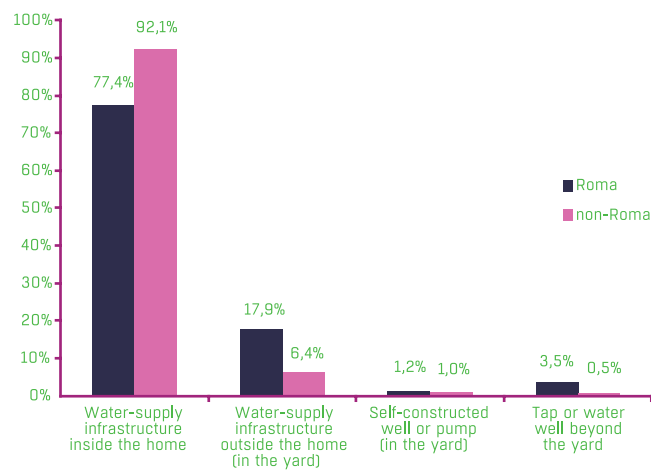


Chart no. 19.

Overview of survey respondents' sanitary infrastructure

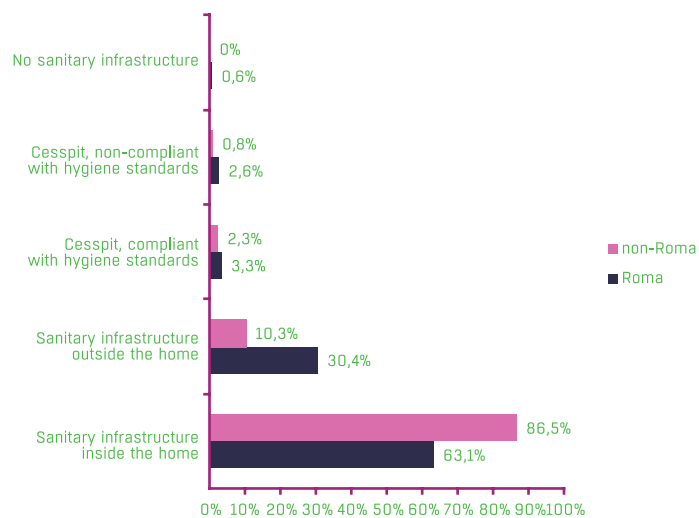


Chart no. 20.
Self-reported health status

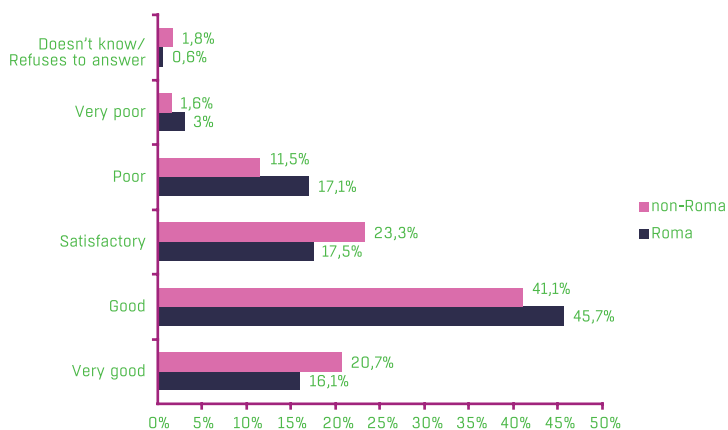


Chart no. 21.
Overview of respondents who suffered from cold, flu and other acute respiratory infections in the last 12 months

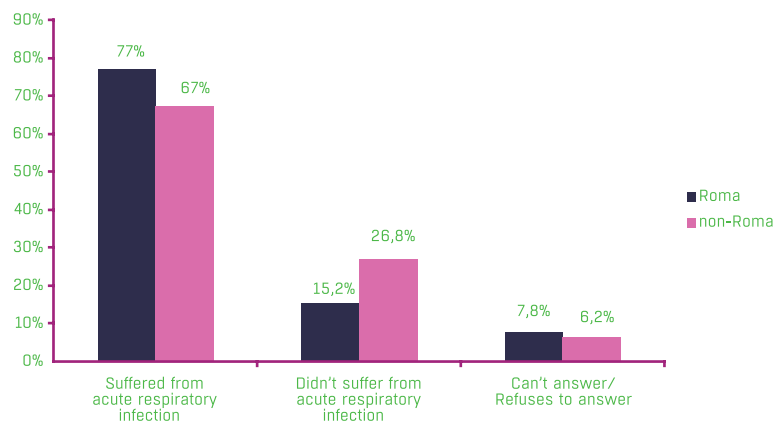


Chart no. 22.
Overview of respondents who suffered from acute gastrointestinal infection (diarrhoea, vomiting, stomach pains, etc.) in the last 12 months

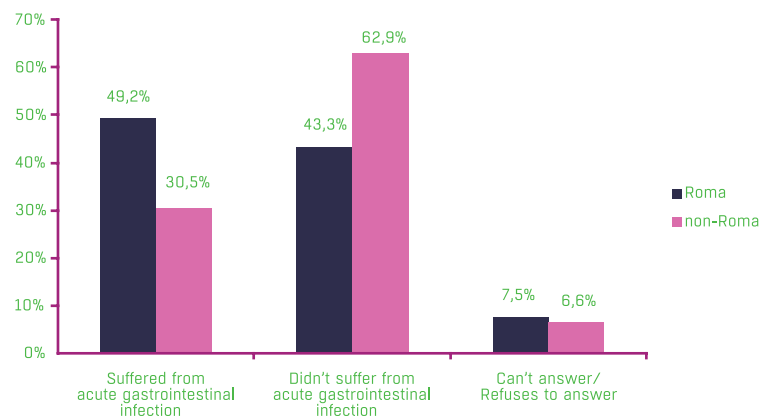


Chart no. 23.
Overview of respondents who suffer from chronic health problems that require regular health services and regular visits to health institutions

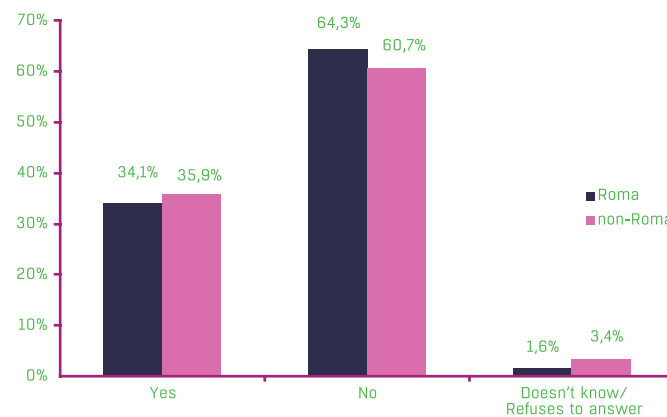


Chart no. 24.

Overview of respondents with chronic health problem about regular therapy

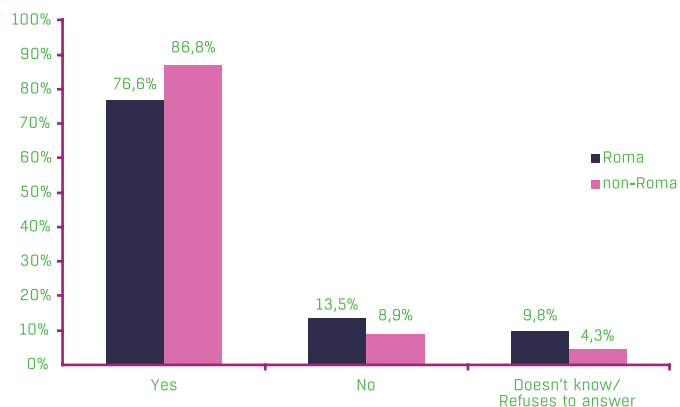


Chart no. 25.

Quality of health services provided by MDs for Roma patients with chronic health problems

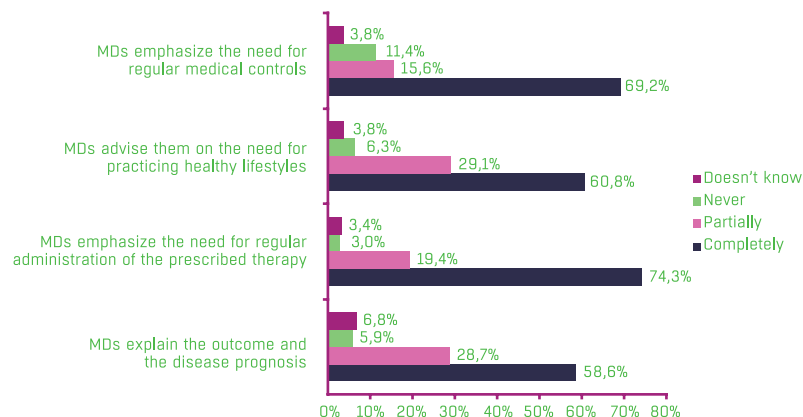


Chart no. 26.

Quality of health services provided by MDs for non-Roma patients with chronic health problems

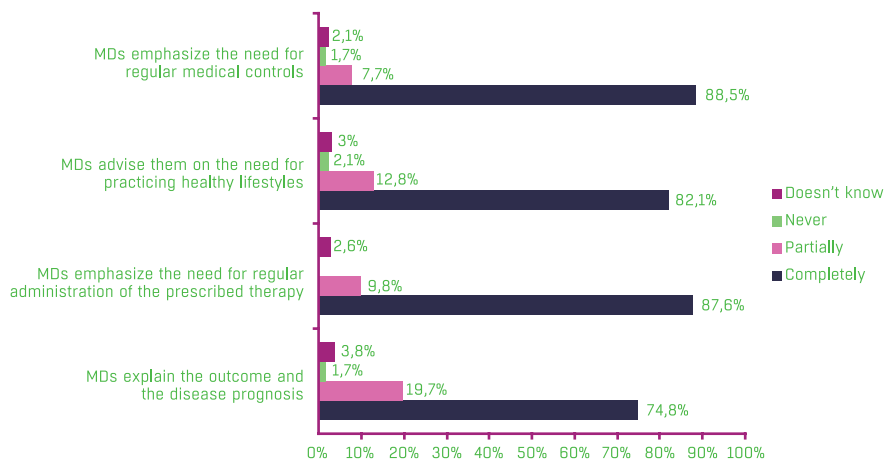


Chart no. 27.

Overview of reasons for not having health insurance

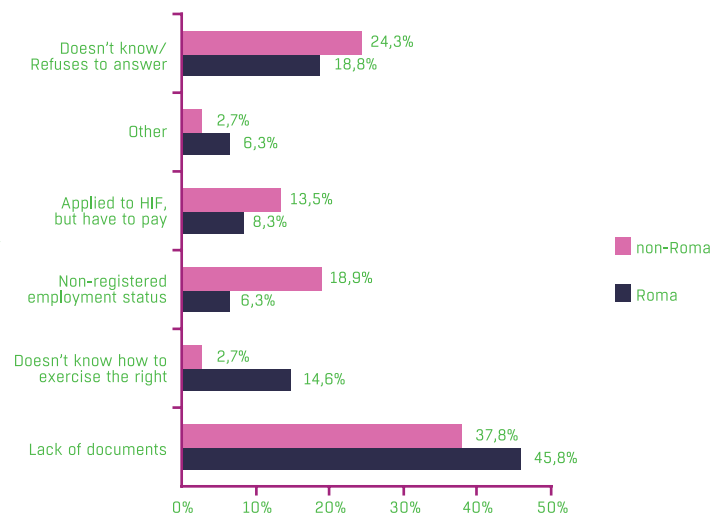


Chart no. 28.

Overview of reasons for not having selected a registered general practitioner

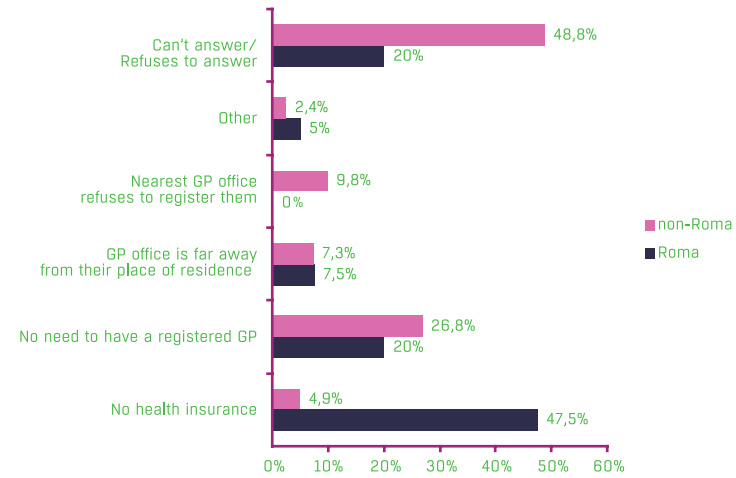


Chart no. 29.

Overview of regular immunization of minor children

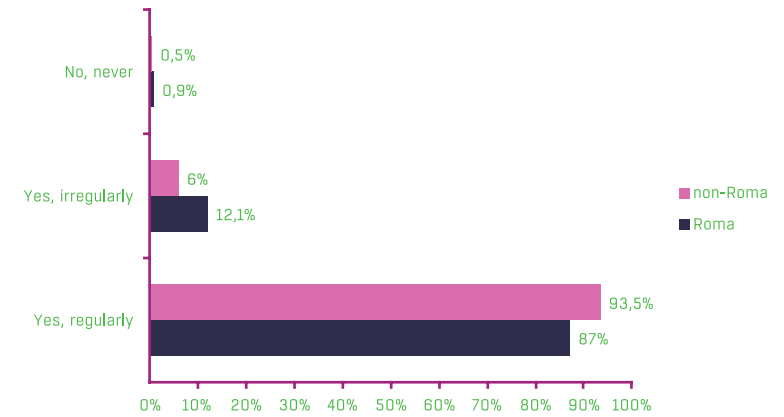


Chart no. 30.

Satisfaction with the behaviour demonstrated by specialist MDs at public health facilities

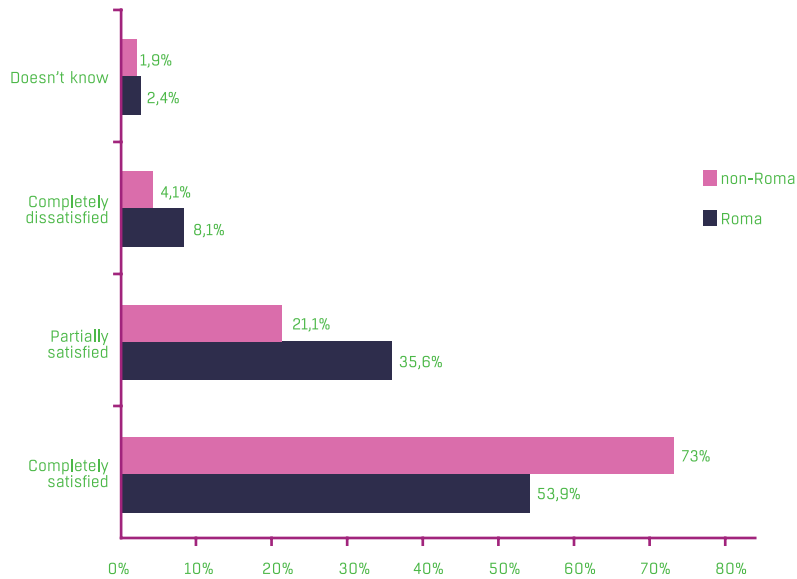


Chart no. 31.

Satisfaction with the health services provided by specialist MDs at public health facilities

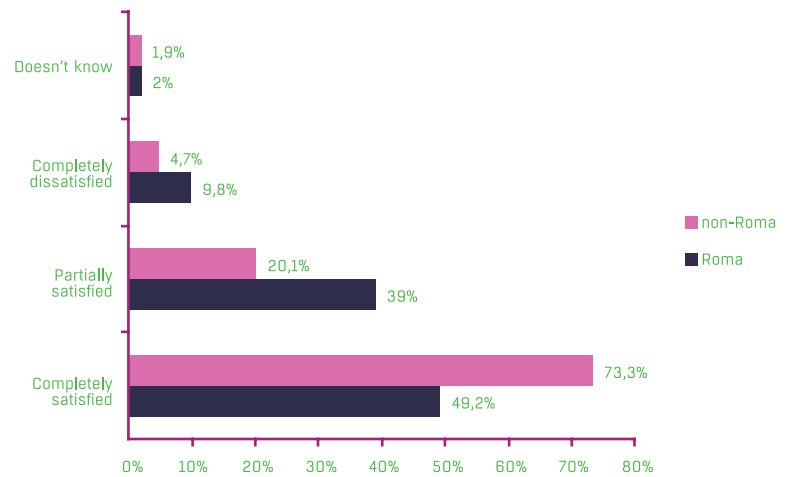
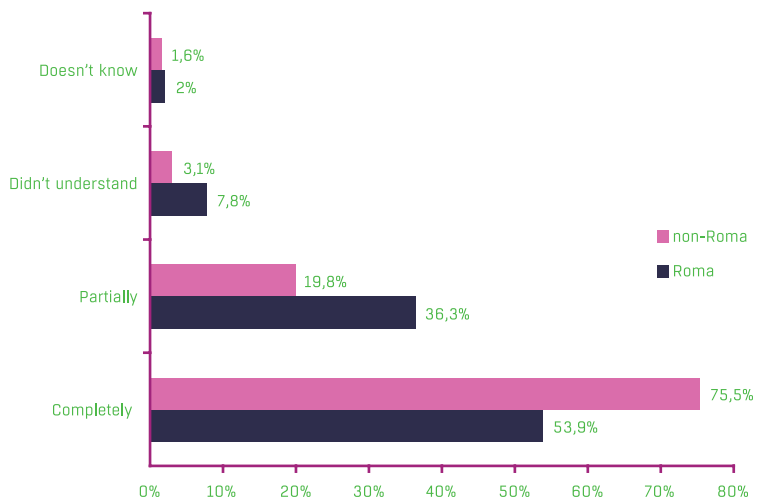
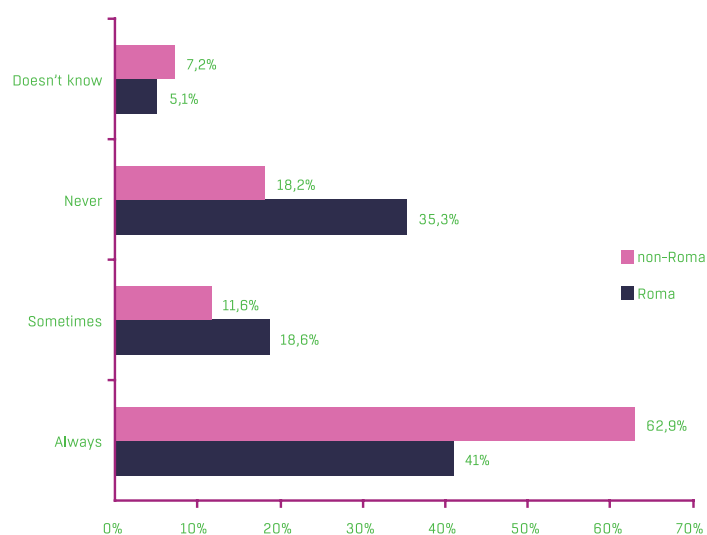


Chart no. 32.

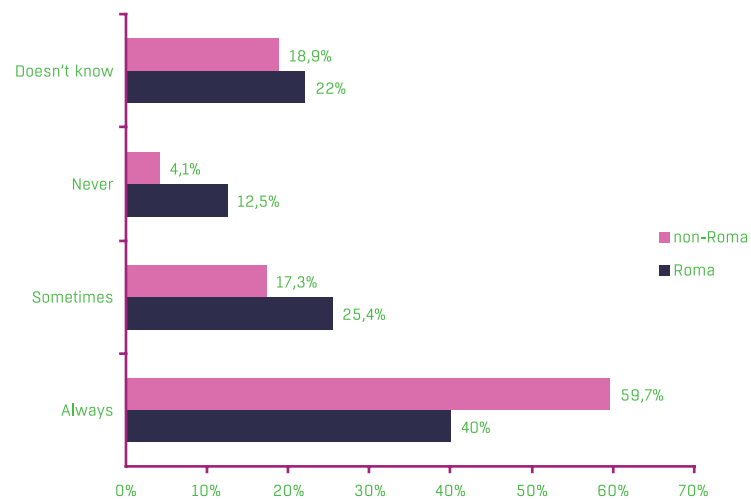
Overview of respondents' understanding of information provided by specialist MDs at public health facilities

**Chart no. 33.**

Overview of respondents' answers whether they have been asked if they have additional questions for specialist MDs at public health facilities

**Chart no. 34.**

Overview of respondents' answers whether their questions has been seriously taken into consideration by specialist MDs at public health facilities

**Chart no. 35.**

Overview of respondents' answers whether their specialist MDs at public health facilities provided them sufficient information about their health status

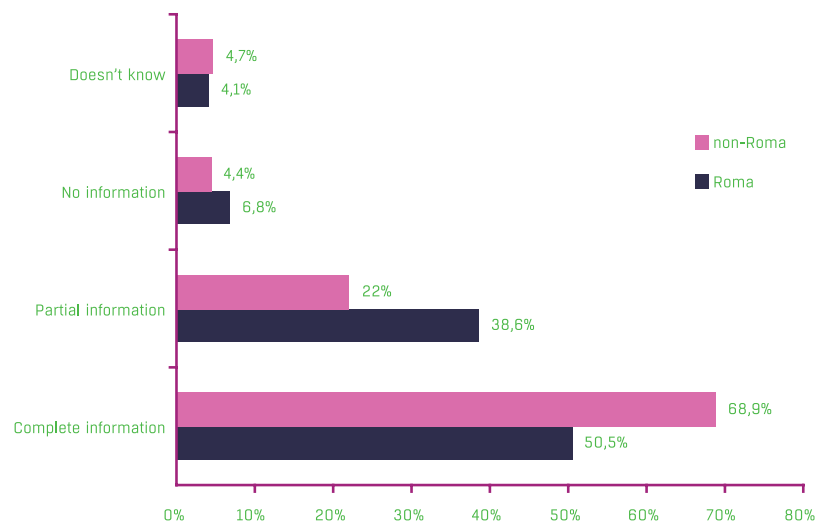


Chart no. 36.

Overview of respondents' answers whether their specialist MDs at public health facilities spent sufficient time on explaining their health status

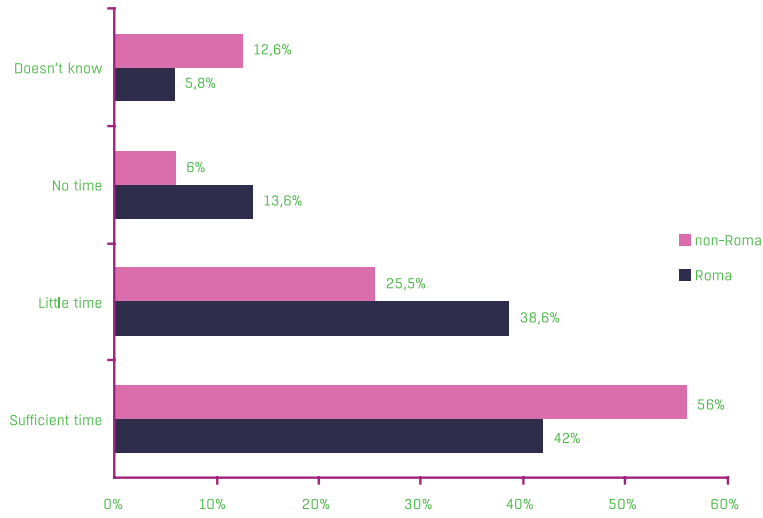


Chart no. 37.

Satisfaction with the behaviour demonstrated by health professionals at public hospitals

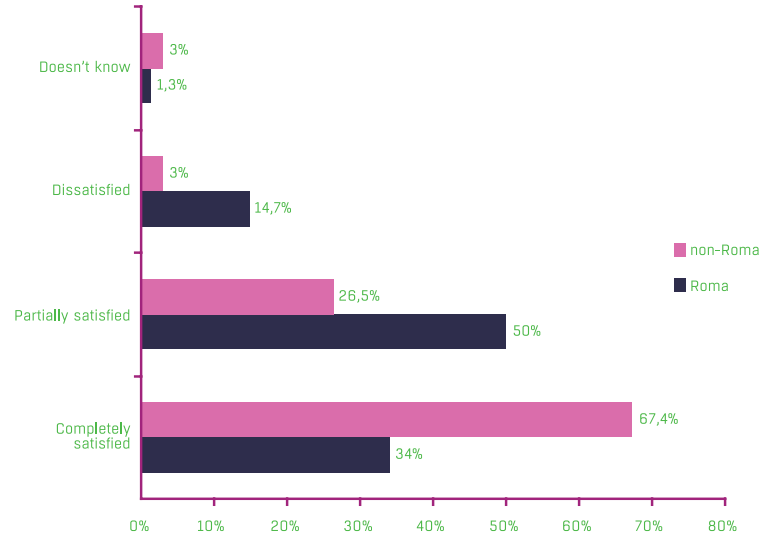


Chart no. 38.

Satisfaction with the health services provided at public hospitals

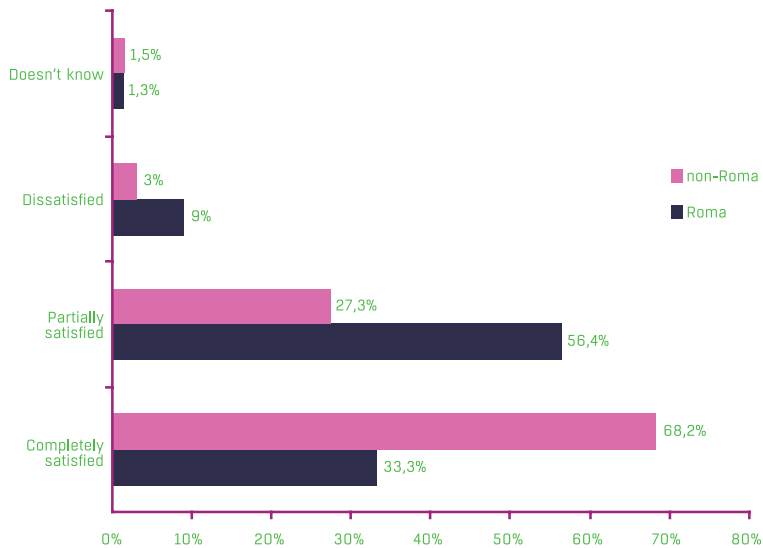


Chart no. 39.

Overview of respondents' answers whether they understand the information provided by MDs during their stay at public hospitals

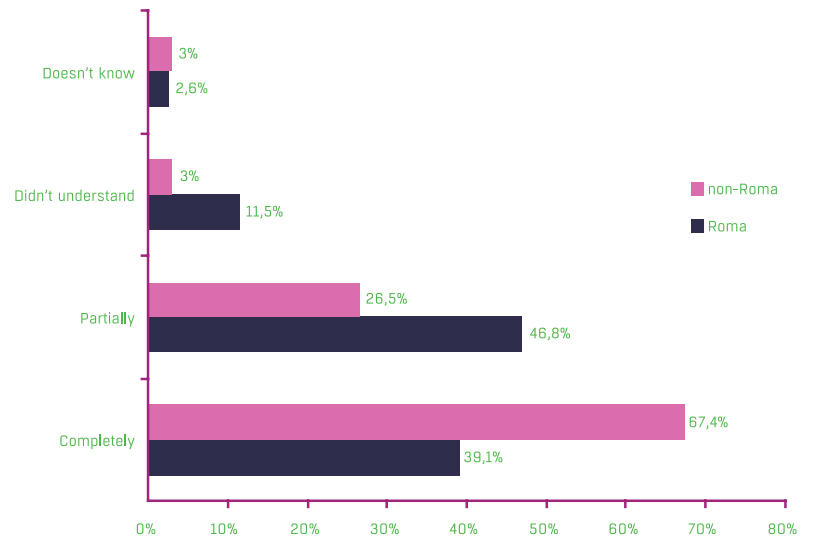
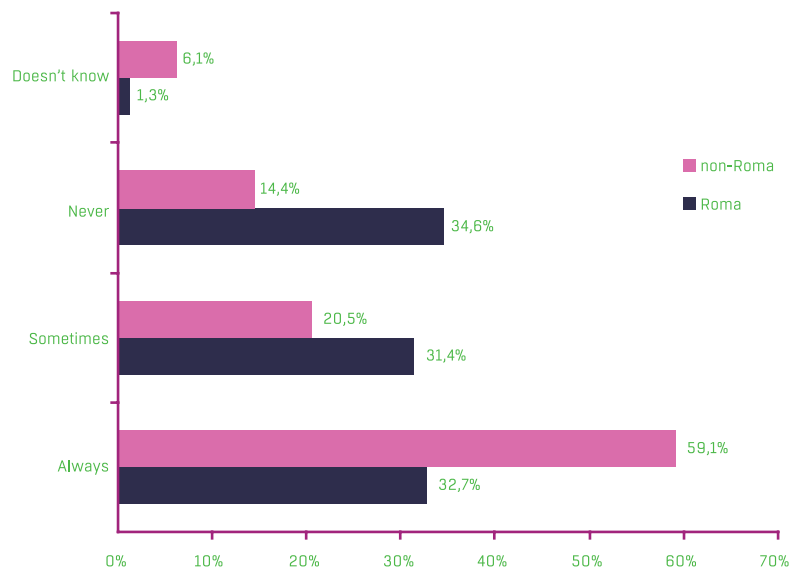
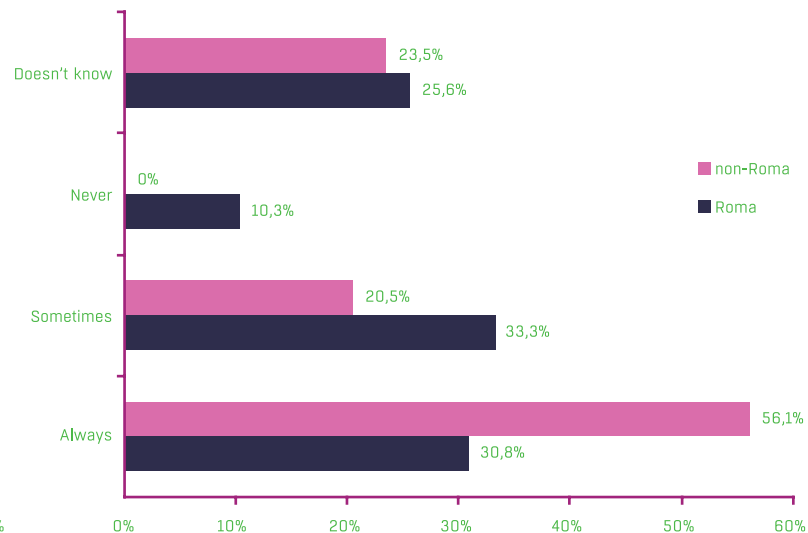


Chart no. 40.

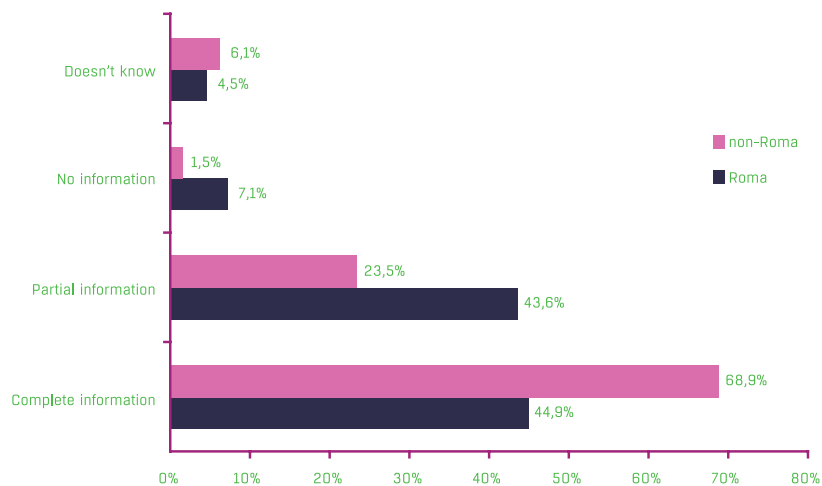
Overview of respondents' answers whether they have been asked by MDs at public hospitals if they have additional questions

**Chart no. 41.**

Overview of respondents' answers whether their questions were seriously taken into consideration by MDs at public hospitals

**Chart no. 42.**

Overview of respondents' answers whether MDs at public hospitals provided them with sufficient information about their health status

**Chart no. 43.**

Overview of respondents' answers whether MDs at public hospitals spent sufficient time on explaining their health status

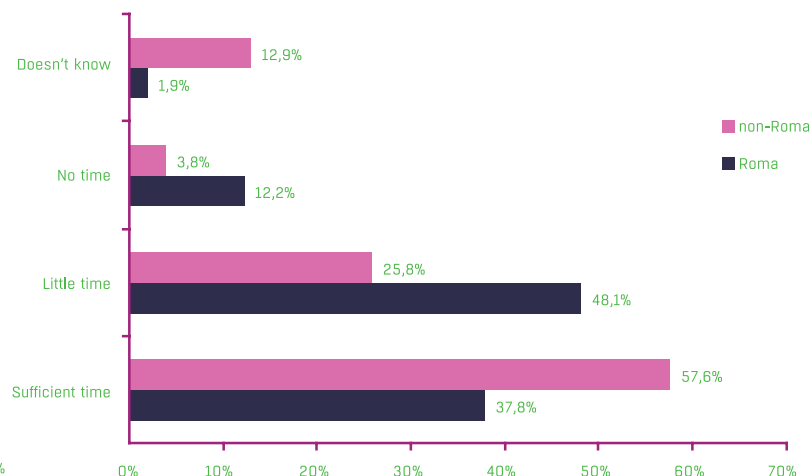


Chart no. 44.

Overview of waiting time prior to being examined by specialist MDs

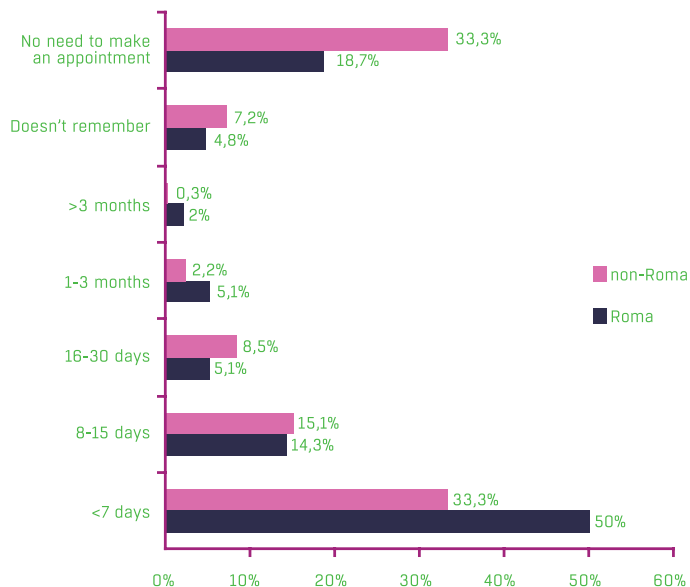


Chart no. 45.

Overview of respondents' answers whether they have been offered an alternative solution, such as shorter time of waiting, if they pay out of pocket for the intervention

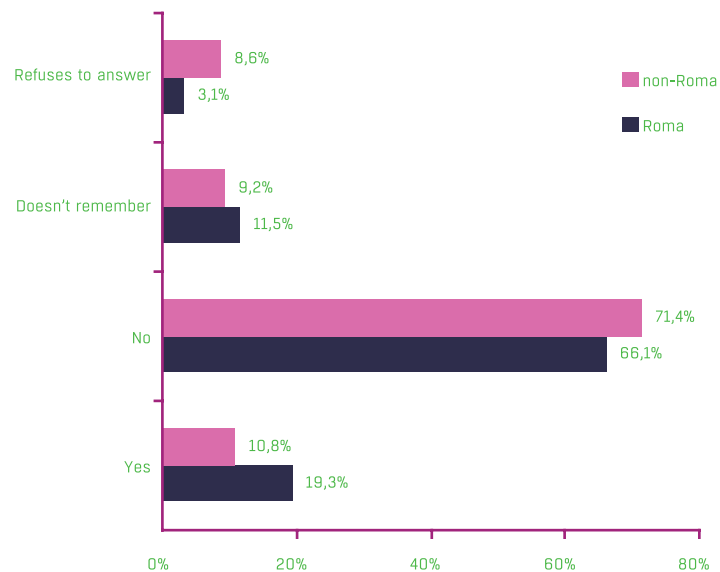


Chart no. 46.

Frequency of cases in the last 12 months when the respondents were unable to purchase the prescribed medicines due to lack of funds

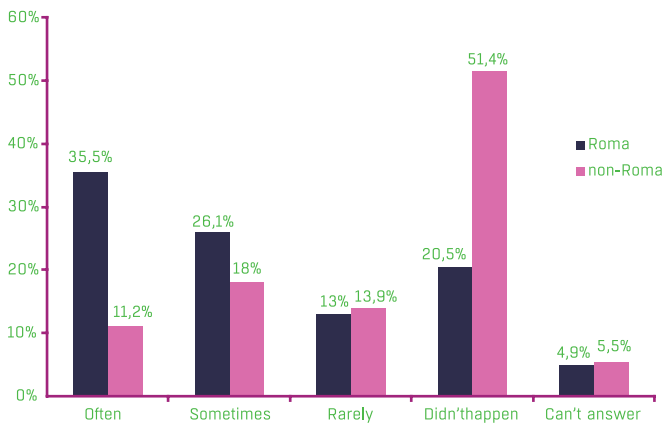


Chart no. 47.

Frequency of cases in the last 12 months when the respondents were unable to find the prescribed medicines at pharmacies at the cost of the Health Insurance Fund and had to pay for them out of pocket

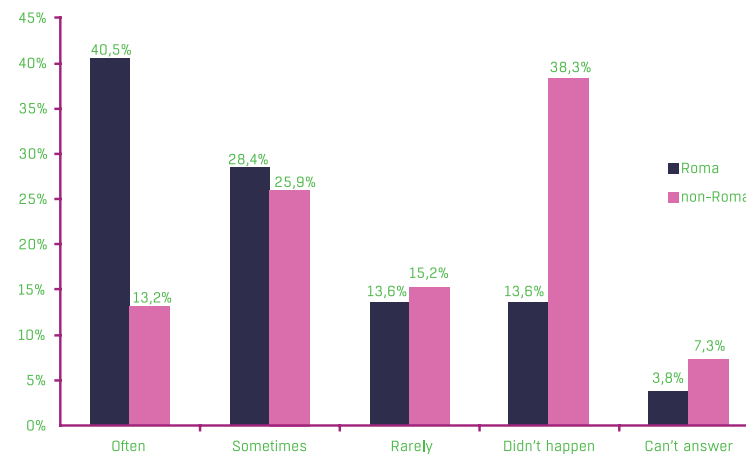
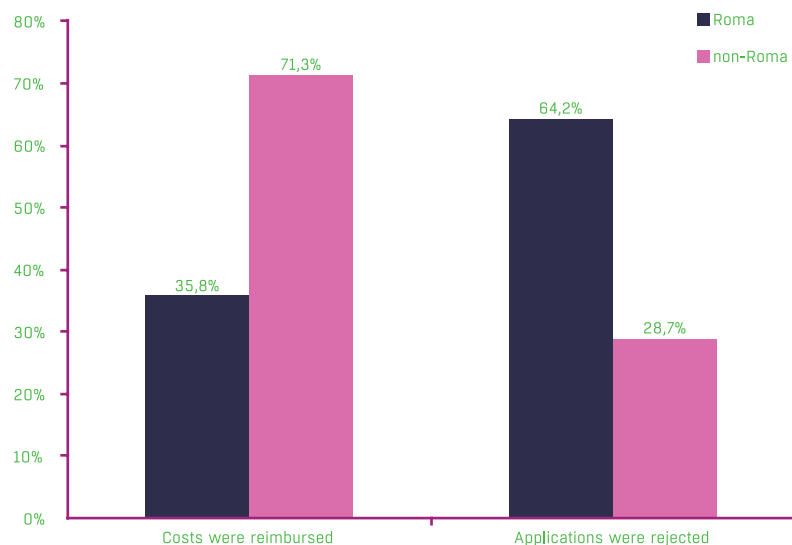
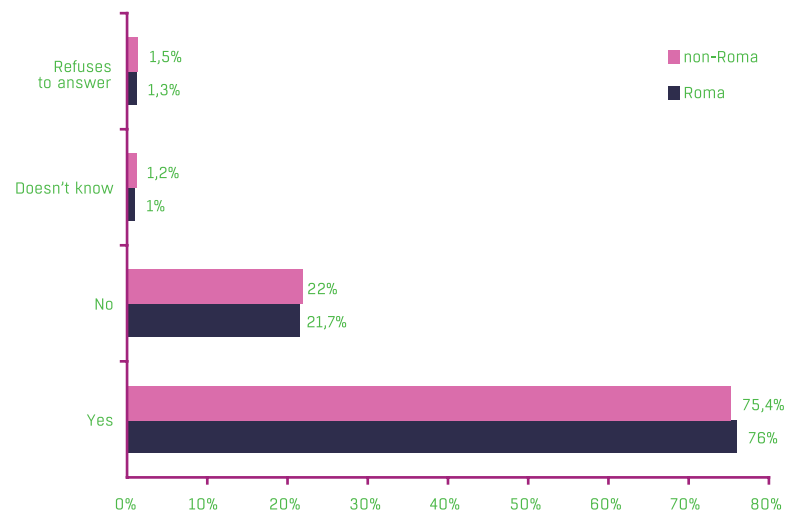


Chart no. 48.

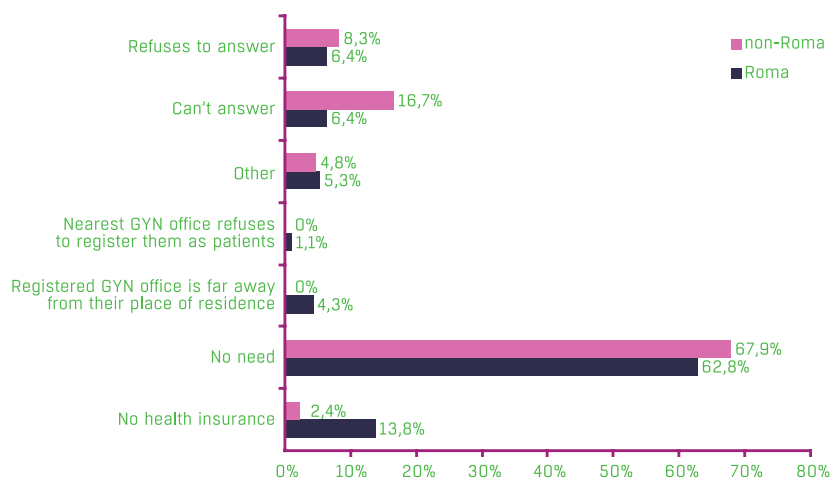
Overview of respondents' answers about the outcome of their applications to HIF for reimbursement of costs for medicines or medical aids in the last 12 months

**Chart no. 49.**

Overview of female respondents' answers whether they have selected their registered gynaecologist

**Chart no. 50.**

Reasons for not having selected their registered gynaecologist

**Chart no. 51.**

Overview of female respondents' answers whether and how often has their your gynaecologist charged them for services that are free-of-charge according to HIF's regulation

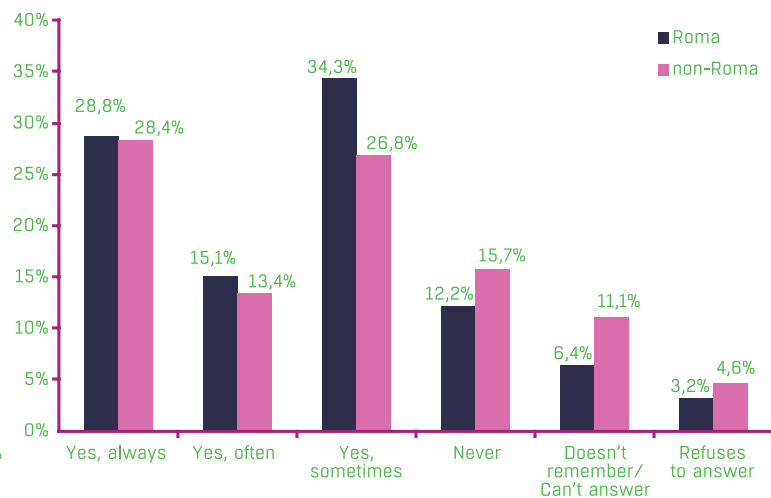


Chart no. 52.

Frequency of visits made to the gynaecologist for preventive gynaecological examinations

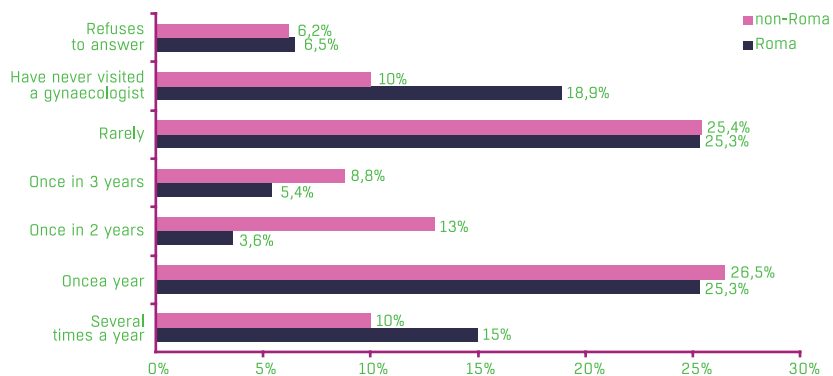


Chart no. 53.

Reasons for women's failure to make regular preventive gynaecological examinations

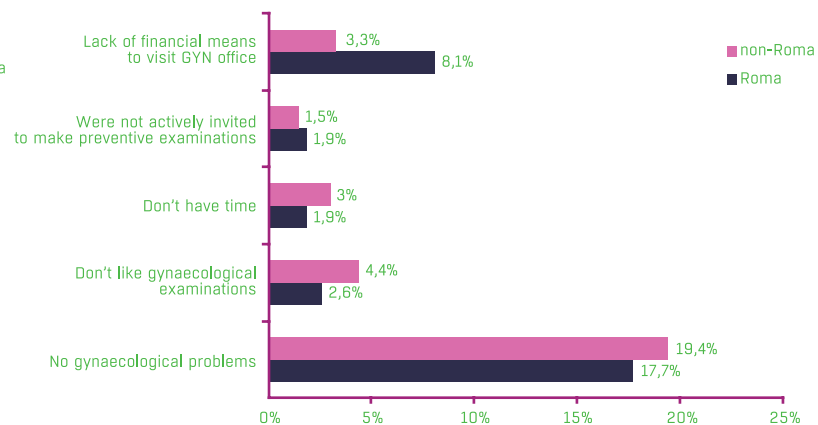


Chart no. 54.

Overview of female respondents' answers whether and when did they visit a MD to have mammography

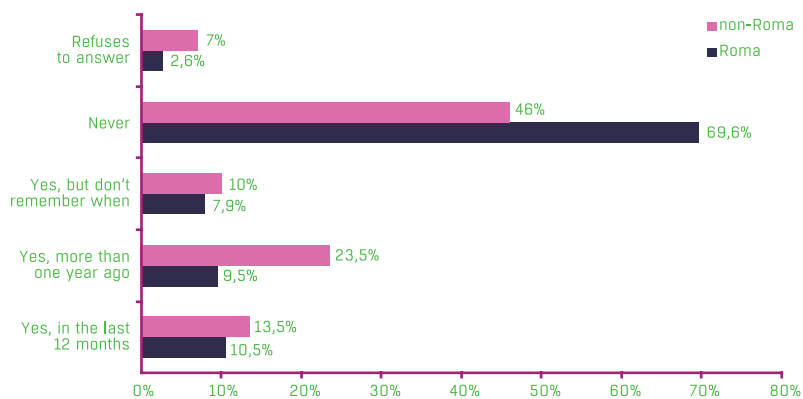


Chart no. 55.

Number of control check-ups with their gynaecologist during the last pregnancy among Roma women

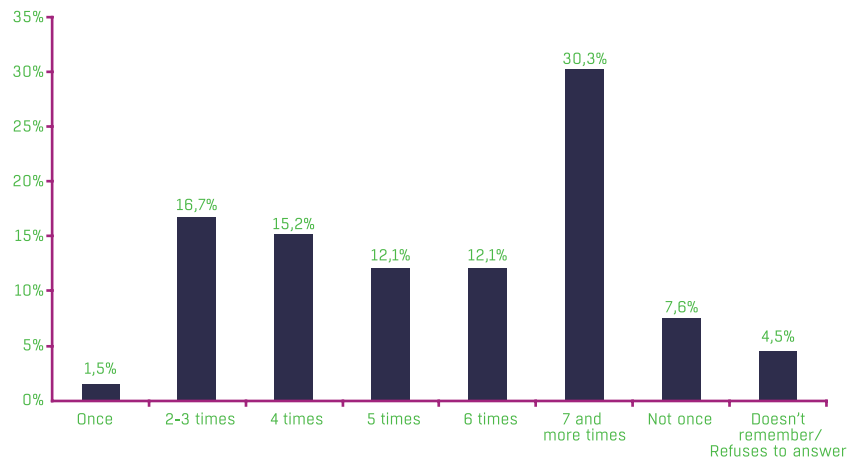


Chart no. 56.

Number of control check-ups with their gynaecologist during the last pregnancy among non-Roma women

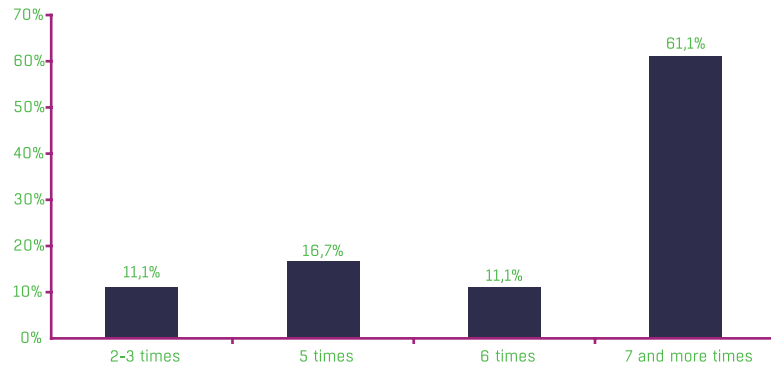


Chart no. 58.

Overview of Roma women's satisfaction with the health services for childbirth and their quality

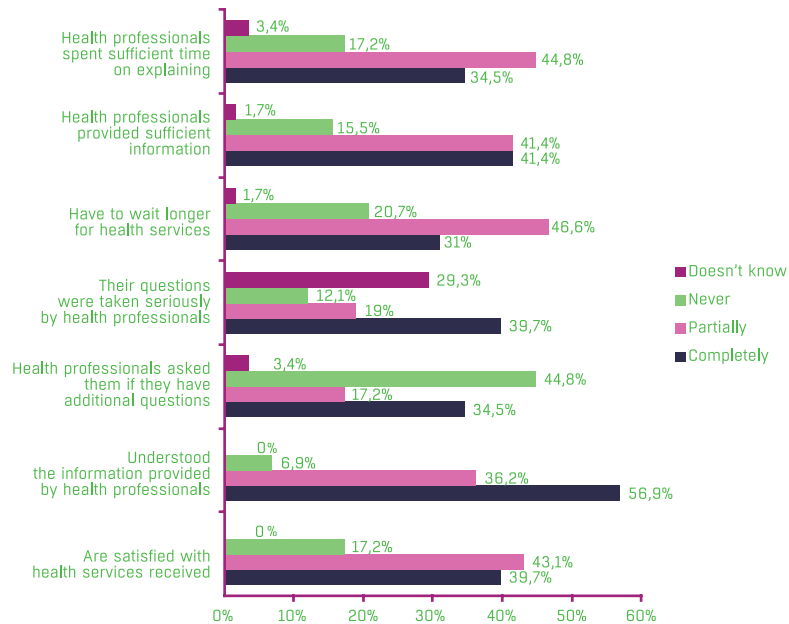


Chart no. 57.

Overview of the place of childbirth for the last pregnancy

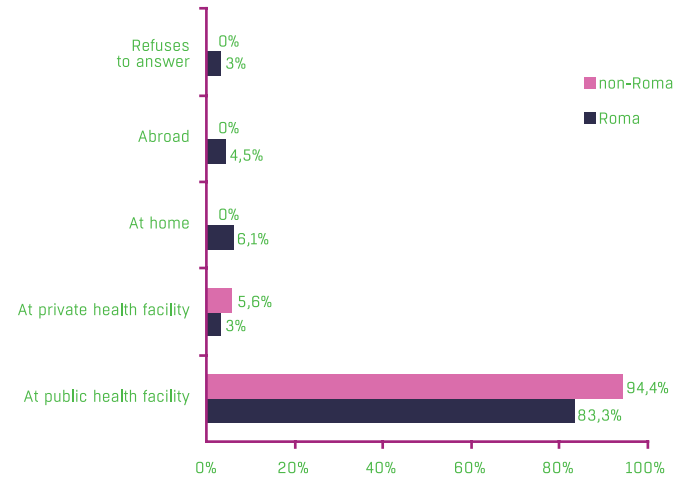


Chart no. 59.

Overview of non-Roma women's satisfaction with the health services at childbirth and their quality

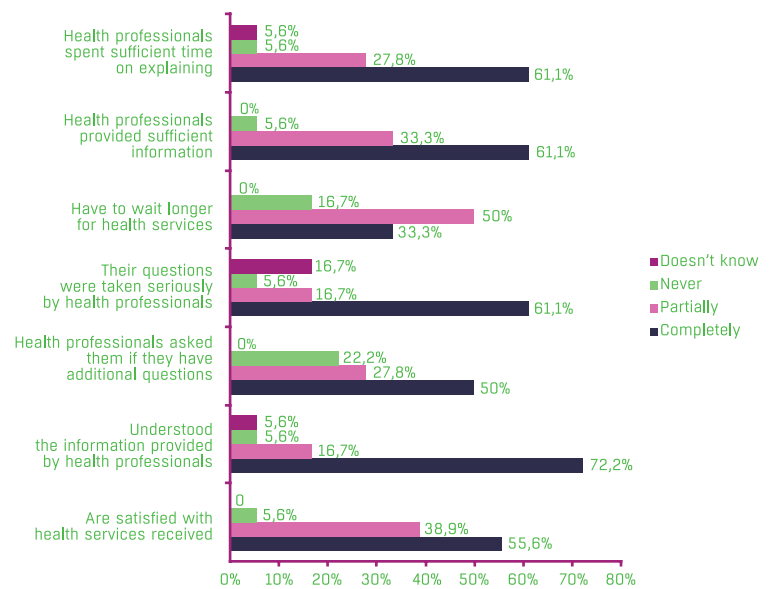


Chart no. 60.

Number of outreach visits during pregnancy and after they have given birth

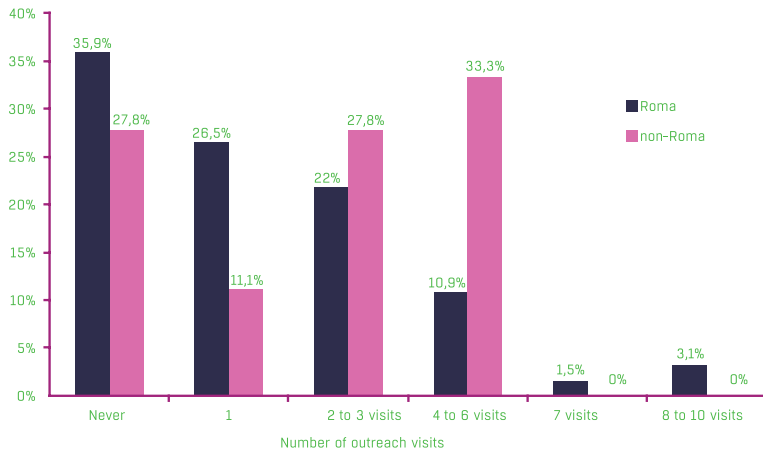


Chart no. 61.

Overview of female respondents' satisfaction with the behaviour and explanations provided by outreach nurses

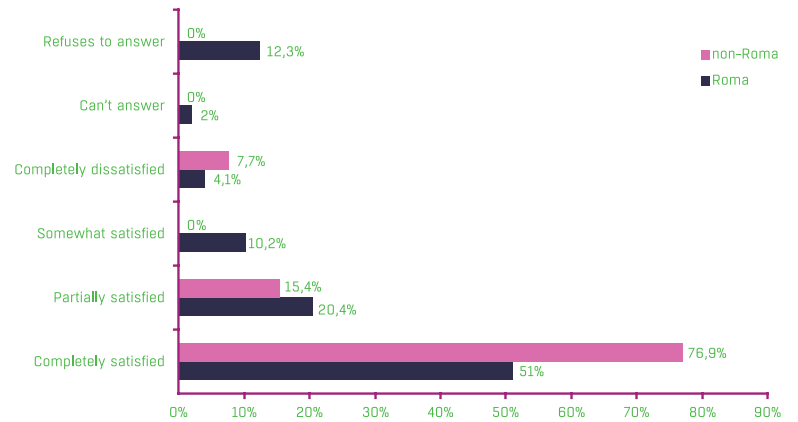


Chart no. 62.

Overview of Roma respondents' answers about the behaviour of health professionals during their visits to specialist MDs at public health facilities

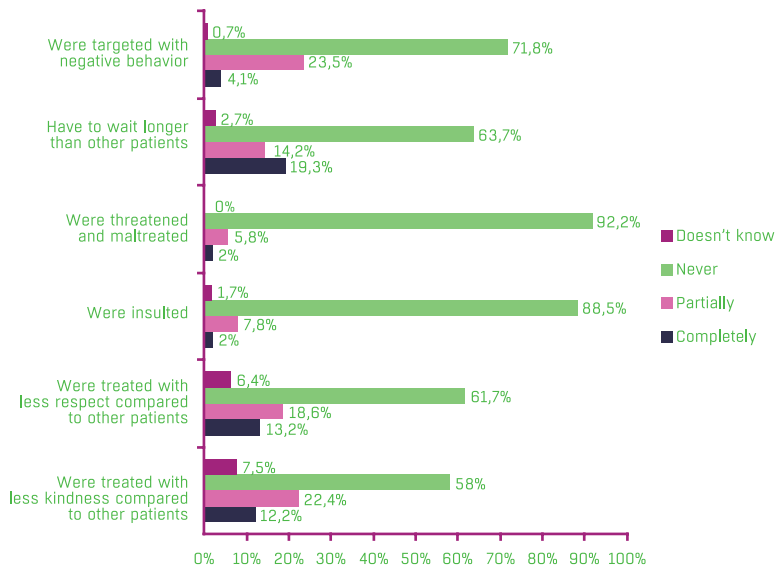


Chart no. 63.

Overview of non-Roma respondents' answers about the behaviour of health professionals during their visit to specialist MDs at public health facilities

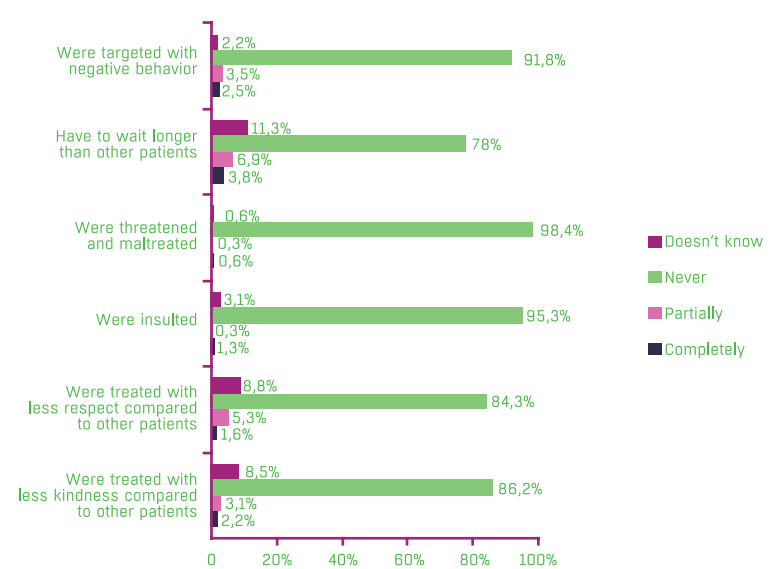


Chart no. 64.

Overview of Roma respondents' answers about the behaviour of health professionals at public hospitals

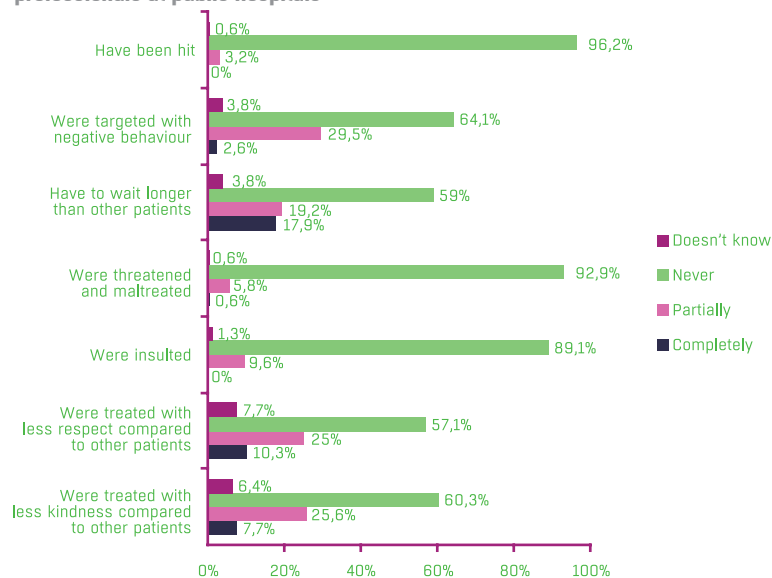


Chart no. 66.

Overview of Roma women's answers about the behaviour of health professionals during their visits to registered gynaecologist

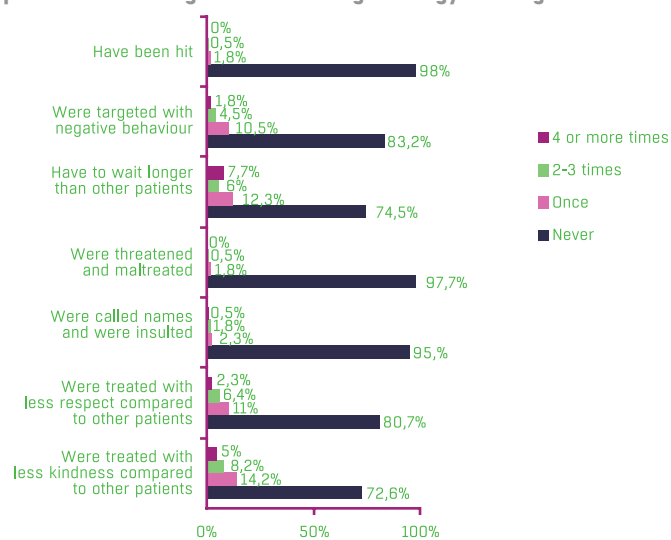


Chart no. 65.

Overview of non-Roma respondents' answers about the behaviour of health professionals at public hospitals

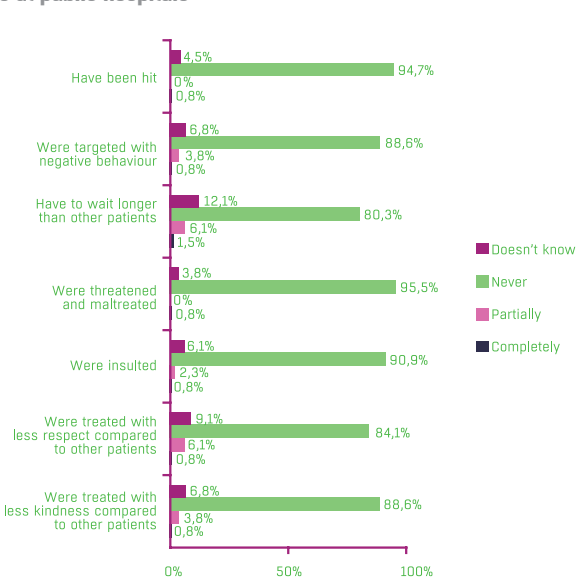


Chart no. 67.

Overview of non-Roma women's answers about the behaviour of health professionals during their visits to registered gynaecologist

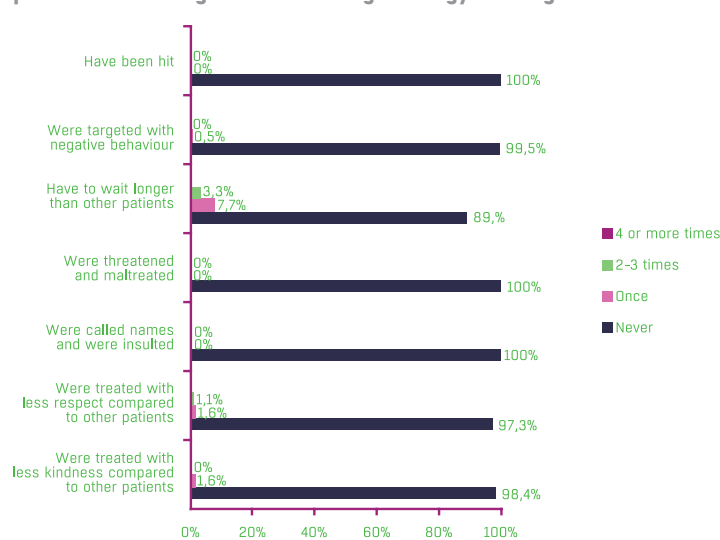


Chart no. 68.

Overview of Roma women's answers about the behaviour of health professionals at control check-ups with gynaecologists during the last pregnancy

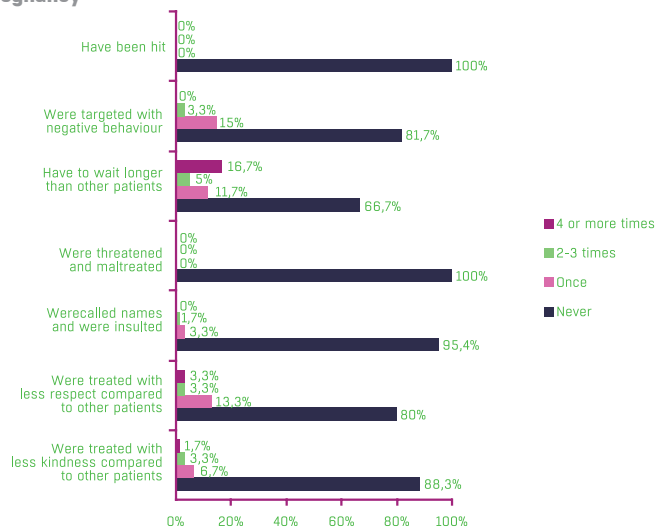


Chart no. 69.

Overview of non-Roma women's answers about the behaviour of health professionals at control check-ups with gynaecologists during the last pregnancy

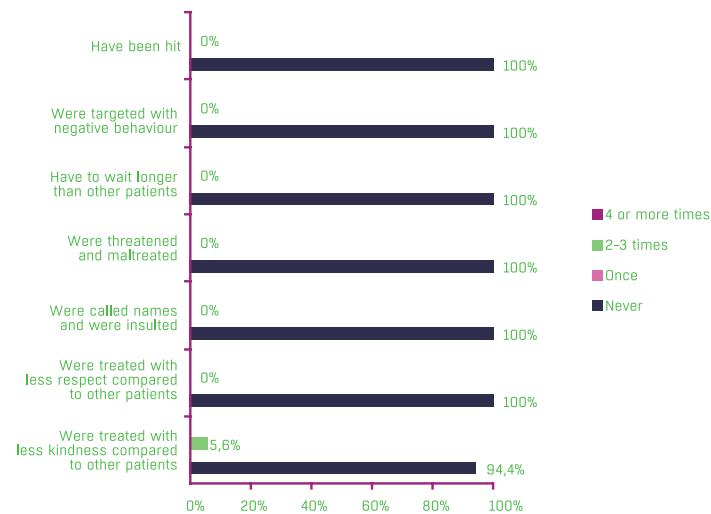


Chart no. 70.

Overview of Roma women's answers about the behaviour of health professionals at childbirth

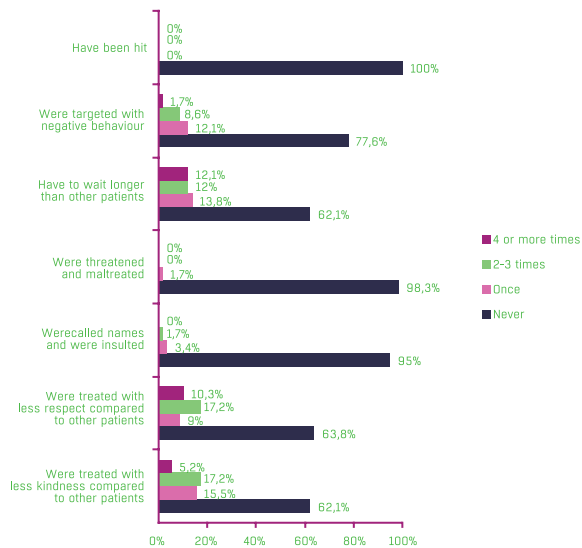
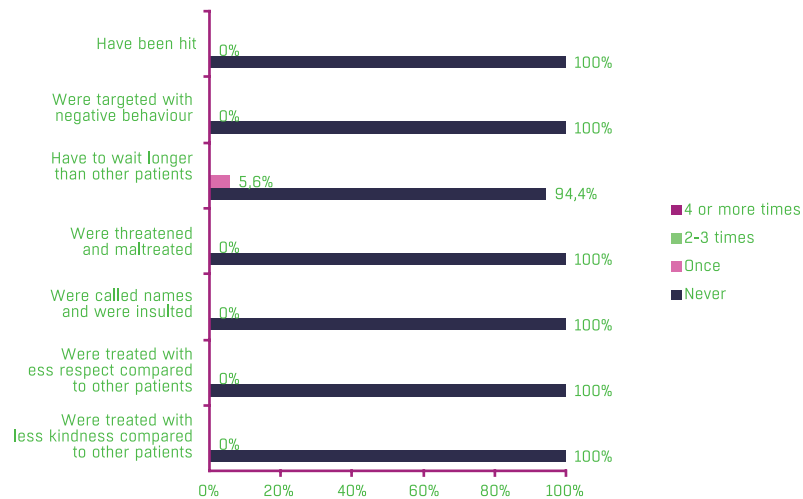


Chart no. 71.

Overview of non-Roma women's answers about the behaviour of health professional at childbirth



ANNEX 2 TABLES

Table no. 1.

Overview of survey respondents' education level

Education level	Roma	non-Roma
Cannot read or write	17,4%	0,5%
No formal education, but literate	6,4%	2,8%
Have not completed primary education	13,5%	3,4%
Have not completed secondary education	31,4%	16,4%
Have completed secondary education	1,9%	4,1%
Have completed secondary education	26,3%	47,3%
Have completed college education	1,2%	7,6%
Have completed higher education	1,7%	16,7%
Have completed post-graduate education (Master degree)	0%	0,8%
Other	0%	0,2%
Одбива да одговори	0,3%	0,2%
TOTAL	100%	100%

Table no. 2.**Grounds on which respondents wished to make a complaint in relation to specialist health services at public health facilities**

Grounds	Roma	non-Roma
Behaviour of health professionals (MDs and nurses)	5,2%	3,9%
Conditions at the health facility	4,2%	7,2%
Health service in question (incomplete care, examinations and tests, non-administered therapy and treatment, etc.)	3,3%	4,6%

Table no. 3.**Grounds on which respondents made a complaint in relation to specialist health services at public health facilities**

Grounds	Roma	non-Roma
Behaviour of health professionals (MDs and nurses)	2,7%	2%
Conditions at the health facility	3%	1,6%
Health service in question (incomplete care, examinations and tests, non-administered therapy and treatment, etc.)	2,9%	2,1%

Table no. 4.

Competent entities to which respondents addressed the complaint related to specialist health services at public health facilities

Competent entities	Roma	non-Roma
Health professionals who provided the health service in question	4,6%	4,6%
Manager of the health institution or head of the department	2%	0,5%
Ministry of Health	0,9%	0,2%
Municipal Commission for Protection of Patients' Rights	0,4%	/
Ombudsman	/	/

Table no. 5.

Grounds on which respondents wished to make a complaint about the care received at public hospitals

Grounds	Roma	non-Roma
Behaviour of health professionals (medical doctors and nurses)	4,3%	1%
Conditions at the health facility	4,6%	6,1%
Health service in question (incomplete health service, examinations and tests, administered therapy and treatment, etc.)	1,2%	1,6%
Did not wish to make a complaint	12,6%	12,6%

Table no. 6.

Grounds on which respondents made a complaint about the care received at public hospitals

Grounds	Roma	non-Roma
Behaviour of health professionals (medical doctors and nurses)	3,2%	0,8%
Conditions at the health facility	3,6%	2,3%
Health service in question (incomplete health service, examinations and tests, administered therapy and treatment, etc.)	1,2%	1%
Did not made a complaint	14,3%	16,9%

Table no. 7.

Competent entities to which respondents addressed the complaint about the care received at public hospitals

Competent entities	Roma	non-Roma
Health professionals that provided the health service in question	4,6%	1,6%
Manager of the health institution or head of the department	2,7%	0,7%
Councillor for protection of patients' rights	0,1%	0,3%
Ministry of Health	0,6%	0,7%
Municipal Committee for Protection of Patients' Rights	0,1%	/
Ombudsman	/	0,2%

Table no. 8.

Main reasons for the negative behaviour of health professionals in specialist health care at public health facilities

Main reason	Roma	non-Roma
Ethnicity	63,2%	18%
Gender	/	/
Age	2,4%	24%
Religious affiliation	8%	10%
Skin colour	13,6%	/
Education level	4%	8%
Income level	7,2%	28%
Physical disability	0,8%	2%

Table no. 9.

Main reasons for the negative behaviour of health professionals at public hospitals

Main reason	Roma	non-Roma
Ethnicity	54,3%	20%
Gender	/	6,7%
Age	1,4 %	26,7%
Religious affiliation	8,6 %	6,7%
Skin colour	12,9%	/
Education level	15,7%	6,7%
Income level	5,7%	26,7%

Table no. 10.

Main reasons for the negative behaviour of registered gynaecologists

Main reasons	Roma	non-Roma
Ethnicity	87,5%	/
Gender	/	5,5%
Age	/	/
Religious affiliation	8,3%	/
Skin colour	4,2%	/
Education level	/	/
Doesn't know	/	/

Table no. 11.

Main reasons for the negative behaviour of health professionals during control check-ups with gynaecologist in the last pregnancy

Main reasons	Roma	non-Roma
Ethnicity	87,5%	/
Gender	/	5,5%
Age	/	/
Religious affiliation	8,3%	/
Skin colour	4,2%	/
Education level	/	/
Income level	/	/

Table no. 12.

Main reasons for the negative behaviour of health professionals at childbirth

Main reasons	Roma	non-Roma
Ethnicity	51,7%	29,4%
Gender	/	17,6%
Age	3,3%	5,9%
Religious affiliation	1,7%	11,8%
Skin colour	25%	/
Education level	13,3%	/
Income level	1,7%	11,8%

ANNEX 3

DESIGN OF THE SURVEY SAMPLE

1. Sample selection

The research project titled *“Health Status of Roma People in the Republic of Macedonia”* necessitated the organization of a survey. In compliance with the project goals, the survey was conducted on two independent samples. Each sample represents a separate target group, i.e. population group.

On the basis of available information about the target group and the general population, the survey was conducted on a combined sample, developed by means of targeted (nonprobability) and systematic selection of respondents. Namely, the survey sample was designed in three phases. Phase 1 implied selection of settlements. Phase 2 included identification of neighbourhoods and streets predominantly populated by Roma¹. Finally, phase 3 included a systematic selection of households, followed by identification of a nuclear family from the household that would nominate a member to be surveyed. It should be noted that surveyors were given detailed guidelines on the sampling process in advance.

Settlements targeted by the survey were determined in advance. The selection criterion used in this regard was the share of Roma population living in the given settlement. Only settlements where the share of Roma people is equal or higher than the relevant share of Roma in the general population in the Republic of Macedonia² were selected.

¹ Partner NGOs assisted the Association for Emancipation, Solidarity and Equality of Women (ESE) in identifying the neighbourhoods populated by Roma people.

² A unique characteristic of Roma people in the Republic of Macedonia is the fact that they mainly live in urban areas. Two rural settlements, Zlokukani and Crnik, were included in the sample due to the compatibility of Roma people who live there with the survey sample characteristics.

Settlements included in the survey sample are:

1. Skopje region: **Suto Orizari and Zlokukani**,
2. Pelagonija region: **Prilep and Bitola**,
3. East region: **Stip, Delcevo, Vinica and village Crnik**,
4. Polog region: **Tetovo**,
5. Northeast region: **Kumanovo**.

Basic parameters used to design the survey samples are:

Sample 1

Target group (or relevant population) is defined as all persons aged 18+ years who are members of the Roma community.

Accessible population is defined as all persons from the municipality in question aged 18+ years who are members of the Roma community.

Sample selection framework defines the streets mainly populated by Roma.

Sample unit is defined as household.

Respondent unit is defined as person aged 18+ years who is member of the Roma community.

Sample 2

Target group (or relevant population) is defined as all persons from the municipality in question aged 18+ years who are not members of the Roma community.

Accessible population is defined as all persons from the municipality in question aged 18+ years who are not members of the Roma community.

Sample selection framework defines the streets in close vicinity of

neighbourhoods mainly populated by Roma.

Sample unit is defined as household.

Respondent unit is defined as person aged 18+ years who is not member of the Roma community

It should be noted that, with the exception of Suto Orizari, survey respondents were selected from the streets mainly populated by Roma. Suto Orizari is a municipality with majority of Roma population and therefore, in order to cover all streets, the municipality was divided into eight burrows and each burrow is represented in the sample with an identical number of respondents.

As regards the second sample, survey respondents were selected from the streets that fall within the territory of the municipality with surveyed Roma respondents. In the case of Suto Orizari, survey respondents were selected from streets in the municipalities bordering with Suto Orizari, i.e. Cair and Butel.

Systematic selection of households included in the survey was pursued by means of identifying a starting point in advance, followed by selection of the next household on the basis of a precisely determined selection interval (K).

Selection of survey respondents (sample unit) within the settlements was performed by surveyors in compliance with the previously provided guidelines.

2. Survey sample's size

The size of the survey sample was determined in advance and includes 650 Roma respondents and 650 non-Roma respondents.

Table no. 1 shows the planned number of respondents for the survey samples. Relevant numbers of respondents from individual settlements were distributed in proportion to the total number of respondents.

Table no. 1:

Number of respondents and their distribution across the settlements

Settlements	Roma		non-Roma	
	No.	Share (%)	No.	Share (%)
Suto Orizari	250	38,5	205	31,5
vil. Zlokukani	30	4,6	35	5,4
Prilep	80	12,3	85	13,1
Bitola	40	6,2	45	6,9
Stip	40	6,2	45	6,9
Vinica	30	4,6	35	5,4
Delcevo	30	4,6	35	5,4
vil. Crnik	30	4,6	35	5,4
Tetovo	40	6,2	45	6,9
Kumanovo	80	12,3	85	13,1
Total	650	100,0	650	100,0

The size of the survey sample is adequate for inferring statistical conclusions and making comparisons between the two target groups.

3. Main characteristics of the survey sample

Table no. 2 provides information on the survey samples, as well as the main characteristics of respondents from the two target groups.

According to data collected in the field, the samples representing two individual population groups deviated from the initially planned numbers. Although the population samples were defined with 650 respondents each, the surveyors interviewed 691 Roma persons and 609 non-Roma persons. The ratio between the two samples does not affect the comparative analysis' relevance. As regards sample no. 1

(Roma people), deviations were primarily noted among respondents from settlements in Prilep and Kumanovo. Initially, respondents from Prilep should have accounted for 12.5% of the Roma sample, but in the final sample they account for 4.9% of all Roma respondents. On the other hand, respondents from Kumanovo should have accounted for 12.3% of the Roma sample, but in the final sample they account for 23.0% of all Roma respondents. As regards sample no. 2, greater deviations were noted among respondents from Prilep and in the final sample they account for 8.4% of all non-Roma respondents, although initially they should have accounted for 13.1%.

Table no. 2.

Number of respondents and their relevant shares, according to gender, age group, ethnicity and settlement

Respondents' characteristics	SAMPLE 1		SAMPLE 2	
	No. of Roma	Share (%)	No. of non-Roma	Share (%)
A. Total	691	100,00	609	100,00
B. Settlement				
Suto Orizari	248	35,9	208 ³⁰	34,2
vil. Zlokukani	30	4,3	35 ³¹	5,7
Prilep	34	4,9	51	8,4
Bitola	50	7,2	35	5,7
Stip	40	5,8	45	7,4
Vinica	30	4,3	35	5,7
Delcevo	30	4,3	35	5,7
vil. Crnik ³	30	4,3	35	5,7
Tetovo	40	5,8	45	7,4
Kumanovo	159	23,0	85	14,0

³⁰ Respondents live in the municipalities Cair and Butel.

³¹ Respondents live in the municipality Gjorce Petrov.

Respondents' characteristics		SAMPLE 1		SAMPLE 2	
		No. of Roma	Share (%)	No. of non-Roma	Share (%)
C.	Gender				
	Male	298	43,1	270	44,3
	Female	393	56,9	339	55,7
D.	Age				
	18-25 years	139	20,10	58	9,50
	26-35 years	203	29,40	128	30,50
	36-45 years	144	20,80	113	18,60
	46-55 years	114	16,50	110	18,10
	56-65 years	74	10,70	121	19,90
	66+ years	17	2,50	79	13,00
E.	Ethnicity				
	Macedonians			371	61,02
	Albanians			164	26,97
	Turks			55	9,05
	Serbs			10	1,64
	Vlachs			1	0,16
	Bosniaks			7	1,15

Source: 2013 General Survey

In terms of respondents' *gender*, both samples are characterized by relatively identical shares of male and female respondents. As regards the Roma sample, 43.1% of respondents are men and 56.9% are women. As regards the non-Roma sample, 44.3% of respondents are men and 55.7% are women.

Disproportion was noted in terms of the age distribution of respondents within the two samples. Differences appear in the share of respondents from the youngest age group (18-25 years) where this group of respondents within the Roma sample is higher and accounts for 20.10% of all respondents. On this account, the shares of respondents from older age groups within the Roma sample are smaller and account for 10.70% (56-65 years) and 2.50% (66+ years) of all respondents. As regards sample no. 2, respondents aged 56-65 years account for 19.90% and respondents aged 66+ years account for 13.00% of all respondents. This distribution of respondents according to their age does not deviate from the general population's structure in terms of age and ethnicity. Namely, on the account of shorter life expectancy among Roma people, this ethnic community is the youngest one in the Republic of Macedonia and is characterized by the lowest share of elderly people. Shares of respondents from other age groups are relatively equally distributed within the two samples.

As regards the ethnicity of respondents comprising sample no. 2 (non-Roma population), 61.02% of them are Macedonians, 26.97% are Albanians, 9.05% are Turks and 2.95% are Serbs, Vlachs and Bosniaks.

³² Respondents are from the municipality Pehcevo.

ANNEX 4

INTERNATIONAL AND REGIONAL TREATIES RATIFIED BY THE REPUBLIC OF MACEDONIA

International and regional treaties	Ratification date / Succession date (c)
International Covenant on Civil and Political Rights	18.1.1994 (c)
International Covenant on Economic, Social and Cultural Rights	18.1.1994 (c)
International Convention on the Elimination of All Forms of Racial Discrimination	18.1.1994 (c)
Convention against Torture and Other Cruel Inhuman or Degrading Treatment or Punishment	12.12.1994 (c)
Convention on the Rights of the Child	2.12.2003 (c)
Optional Protocol of the Convention against Torture Other Cruel Inhuman or Degrading Treatment or Punishment	13.2.2009
Convention on the Elimination of All Forms of Discrimination against Women	18.1.1994 (c)
Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women	17.10.2013
Convention for the Protection of Human Rights and Fundamental Freedoms	10.4.1997
Protocol No. 12 to the Convention for the Protection of Human Rights and Fundamental Freedoms	13.7.2004
European Social Charter 1961	31.3.2005
European Social Charter (revised) 1996	06.1.2012

³³ http://tbinternet.ohchr.org/_layouts/TreatyBodyExternal/Countries.aspx?CountryCode=MKD&Lang=EN.

ANNEX 5

LIST OF SURVEYORS

Bilent Kazimoski
Biljana Dimitrievska
Darko Kocevski
Elvis Kovacev
Elena Kostovska
Erol Ademov
Zoran Bikovski
Zoran Zivkov
Irfan Martez
Jasmina Memed
Marija Vrckovska
Nadica Taseva
Perica Lazarovski
Radmila Maksimovska Simonovski
Sabina Asani
Sanja Babuskovska
Sonja Tripunovska
Tefik Sali

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- 3) Committee on the Rights of the Child. Concluding Observations about the Second Periodic Report of the Republic of Macedonia. 2010. Available at: <http://daccess-dds-ny.un.org/doc/UNDOC/GEN/G10/431/64/PDF/G1043164.pdf?OpenElement>.
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