Social Protection and Social Inclusion in the former Yugoslav Republic of Macedonia

European Commission

Directorate-General for Employment, Social Affairs and Equal Opportunities
Unit E2

Manuscript completed in October 2007

European Commission

This report was financed by and prepared for the use of the European Commission, Directorate-General for Employment, Social Affairs and Equal Opportunities. It does not necessarily represent the Commission's official position.

http://Ec.europa.eu/employment_social/spsi

Contractor:
Euro Balkan Institute

www.euba.com.mk

Authors:
Maria Donevska
Dragan Gjorgjev
Maja Gerovska Mitev
Tanja Kalovska

Table of Contents

ACRONYMS CITED IN TEXT

AIDS	Acquired immune deficiency syndrome
BBP	Basic Benefits Package
BCG	Bacillus Calmette-Guérin vaccine
BMI	Body Mass Index
CARDS	Community Assistance for Reconstruction, Development and Stabilization
CCT	Conditional Cash Transfer Project
CEE	Central and Eastern European region
CIS	Commonwealth of Independent States
CRPM	Rationalization of Health Care Services in the former Yugoslav Republic of Macedonia
CSW	Centers for Social Work
DFID	UK Department for International Development
DG ECFIN	Directorate General for Economic and Financial Affairs
DPT	Vaccine to immunize against diphtheria, pertussis, and tetanus
EA	Employment Agency
EC	European Council
ECA	Europe and Central Asia region
ECHO	European Commission Humanitarian Aid department
EF	Employment Fund
ENT	Ear, Nose and Throat Department
ESA 95	European System of Accounts 95
ESM	Electric Power Company of Macedonia
ESSPROS	European System of Social Protection Statistics
ETF	European Training Foundation
EU	European Union
EURAC	European Academy Bozen/Bolzano
FDI	Foreign Direct Investments
GP	General Practitioner
GTZ	Gesellschaft für Technische Zusammenarbeit, international cooperation enterprise for sustainable development
HESME	Health, Environment and Safety Management in Enterprises initiative
HFA-DB	European health for all database
HIF	Health Insurance Fund
HIV	Human immunodeficiency virus
ILO	International Labour Organization
IMF	International Monetary Fund
ISCED	International Standard Classification of Education
JIM	Joint Inclusion Memorandum
LFS	Labour Force Survey
MAPAS	Agency for Supervision of Mandatory Fully Funded Pension Insurance
MDGs	Millennium Development Goals
MF	Ministry of Finance
MH	Ministry of Health
MICS	Multiple Indicator Cluster Survey methodology
MLSP	Ministry of Labour and Social Policy
NAP	National Action Plan
NGO	Non-governmental organization
NBRM	National Bank of Republic of Macedonia
Norad	Norwegian Agency for Development Cooperation

NSE	National Strategy for Employment
NSPR	National Strategy for Poverty Reduction
NUTS	Nomenclature of Territorial Units for Statistics
OECD	Organization for Economic Co-operation and Development
OFA	Ohrid Framework Agreement
OSCE	Organization for Security and Co-operation in Europe
PAP	Papanicolaou test
PAYG	Pay as-you-go pension system
PDIF	Pension and Disability Insurance Fund
PHC	Primary Health Care
PIRLS	Progress in International Reading Literacy Study
PPP	Purchasing Power Parity
PPS	Purchasing Power Standard
RIHP	Republic Institute for Health Protection
SDR	Standardized Death Rate
SEI	Sector for European Integration
SIDA	Swedish International Development Cooperation Agency
SILC	Statistics on Income and Living Conditions
SME	Small and Medium-Sized Enterprises
SSO	State Statistical Office
TB	Tuberculosis
UN	United Nations
UNAIDS	Joint United Nations Program on HIV/AIDS
UNDP	United Nations Development Program
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VET	Vocational Education and Training
WB	World Bank
WHO	World Health Organization
WTO	World Trade Organization

Summary

Social Protection and Social Inclusion in former Yugoslav Republic of Macedonia

The study

The study provides an up-to-date analysis of the current system of social protection in the former Yugoslav Republic of Macedonia, with particular emphasis on the problems of social exclusion. Contextual exploration was based on the analysis of the economic, demographic and labour market trends that are influencing the social protection system. Also, a detailed overview was given on the role of social welfare, pension, health and long-term care systems. Throughout, the study has addressed main institutional and legislative structures of the social protection system, as well as current reforms and challenges. A particular emphasis within the analysis was also given to the cross-cutting issues, such as gender, ethnic communities and vulnerable communities.

This study has also tried to mainstream the ongoing process of decentralization as well as the impact of the Ohrid Framework Agreement[1] on the future organization and outcomes in the social protection system. These two processes are supported from the international community and future relations between the former Yugoslav Republic of Macedonia and the EU have also been premised upon their successful implementation. Therefore, the study carefully examines the associated challenges and tries to provide evidence of main capacities and needs at the local level.

Former Yugoslav Republic of Macedonia became independent country in 1991. Until then it shared same structure of the political, economic and social welfare system with other Yugoslav Republics, such as Croatia (EU candidate country). Other similarities, especially concerning challenges and trends in the economic and labour market capacities are also close to those in Bulgaria and Romania (EU member states). Due to that, the majority of statistical comparisons in the study involve the former Yugoslav Republic of Macedonia with the above mentioned countries.

Although, the study follows the general outline of a previous series of studies conducted in other candidate countries realized till 2006[2], still it is based on the new objectives and the new framework for the social protection and social inclusion process[3], adopted at the European Council in March 2006.

Study's main purpose is to inform the forthcoming process of negotiations for the accession of the country to the EU in the area of social protection and social inclusion and to contribute to the Joint Inclusion Memorandum (JIM). The summary

[1] The Framework Agreement signed on 13.08.2001 ended the internal conflict in the former Yugoslav Republic of Macedonia. Its basic aim is to promote the peaceful and harmonious development of society, while respecting the ethnic identity and interests of all citizens of the Republic of Macedonia. Based on this Agreement a list of particular constitutional changes and legal reforms has been implemented in the field of decentralization, equitable representation, special parliamentary procedures for protection of the ethnical non-majority communities, education, use of languages, flags, expressing the ethnical and cultural identity and measures for implementation. Some of the most important next steps regarding OFA will be its implementation at local/municipal level.

[2] http://ec.europa.eu/employment_social/social_protection/health_en.htm#studies
http://ec.europa.eu/employment_social/social_inclusion/docs/2006/study_croatia_en.pdf

[3] http://ec.europa.eu/employment_social/social_inclusion/docs/2006/objectives_en.pdf

provides a brief overview of the study in English, Macedonian and Albanian languages.

Economic, demographic and social trends influencing the social protection system

The former Yugoslav Republic of Macedonia entered the independence period in 1991 with very unfavorable economic conditions. In comparison to other republics in ex-Yugoslavia it was least developed, with high unemployment (20%) and underdeveloped infrastructure. The process of transition from a closed and centrally planned economy to an open and functioning market system was challenged with many internal and external shocks, which repeatedly interfered with the initiated policies and reforms.

A decade of sluggish economic growth began to improve slowly but constantly since 2001. In 2002 the real GDP grew by 0.9%, followed by a 2.8% growth in 2003 and 4% growth since 2004. DG ECFIN spring forecasts (2007) point to a relatively moderate growth of 3.1% in 2006, compared to 3.8% in 2005. The main reason for this relatively moderate performance was lower than expected expansion in manufacturing, agriculture and construction. In particular, industrial production increased by only 2.5% in 2006. Per-capita GDP in terms of purchasing power is roughly at 26% of the EU-25 average. However, there is an evident regional difference in GDP per capita in purchasing power standards (PPS), which is nearly twice as high in the capital region (approximately 50% of the EU average, compared to a national average of some 25% of the EU average). This is due to the significant differences in infrastructural endowment and income levels between the capital and rural areas. According to the ECFIN 2007 forecasts GDP growth is estimated to accelerate to about 4.3% in 2007 and 5.3% in 2008.

The average monthly gross wage in 2006 was Denar 23,036 or the equivalent of Euro 374.56 (inclusive of personal income tax and employees social security contributions). The average monthly net wage for the same period was Denar 13,527 or the equivalent of Euro 219.95. In 2006 the average paid monthly net salary increased by 7.3% in comparison to 2005. In addition to low wages, there is also a significant number of employed not receiving regularly their salaries (in December 2006, 13.3% of all employees have not received any payment). Comparatively, the average monthly net wage is only higher from that of neighboring Bulgaria (Euro 200) and Albania (Euro 170).

The weakness of the labour market performance in the former Yugoslav Republic of Macedonia can be attributed to a combination of factors, among which: loss of jobs due to economy restructuring, unfavourable economic surrounding (Greek embargo 1994-95, Kosovo crisis 1999 etc.), barriers to entry or inflexibility of the labour market accompanied with the prevalence of passive rather than active labour market policy. The overall employment rate in the former Yugoslav Republic of Macedonia has basically remained static at an extremely low level with 39.6% of persons of working age (15-64) being registered as employed in 2006 (with activity rate of 62.2%) This is comparatively quite lower than the employment rates (2006) in Croatia – 55.0%, Bulgaria and Romania (58.6% and 58.8% respectively), and particularly lower than that of EU 27 - 63.4%.

Improvements regarding employment of ethnic communities in the former Yugoslav Republic of Macedonia have been associated with the Ohrid Framework Agreement (2001). The principle of equitable representation, which is part of the OFA, has

brought developments in the employment of ethnic communities mainly in the public institutions. As of 31 of August 2006, the percentage of employed in the public sector (i.e. ministries and other state institutions, judicial institutions and public enterprises) according to ethnic belonging, includes: 74.19% Macedonians, 8.93% Albanians, 1.74% Serbs, 0.93% Turks, 0.55% Vlachos, 0.26% Bosnians, 0.42% Roma and 0.91% others.

The grey economy is widely present, which contributes towards exaggeration of some of the labour market indicators (i.e. unemployment). The latest ETF country plan on former Yugoslav Republic of Macedonia (2007) suggests that the grey economy in the country represents an estimated 33%–37% of GDP.

Labour Force Survey data suggest that in 2006 the unemployment rate (15-64) was 36.3%, which is extremely above the unemployment rates in Croatia (11.8%), Bulgaria (9.0), Romania (7.3%) and the EU-27 (7.9%). Additional problematic aspect is the prevalence of the long-term unemployment, as the share of long-term unemployed (unemployed longer than 1 year) in 2005 was 32.3% of the total workforce. Gendered unemployment rates in 2006 (LFS) show male unemployment rate of 35.6% and female unemployment rate of 37.5%. In both cases, the figures have dropped since 2005, for 0.9 percentage points for both genders.

The labour market is also characterized with huge skills deficit. ETF calculations regarding educational attainment level of adults aged 25-64 show pretty low figures, with 41% with ISCED[4] 0-2 (twice as high as in the 10 new EU member states), 45% with ISCED 3-4 and 14% with ISCED 5-6. Comparatively, ISCED 0-2 figures are: in Croatia-30%, Bulgaria-28% and Romania-27%.

According to the 2002 National Census, former Yugoslav Republic of Macedonia has a population of 2,022,547 inhabitants. The ethnic picture of former Yugoslav Republic of Macedonia is diverse, with 64.18% Macedonians, 25.17% Albanians, 3.85% Turks, 2.66% Roma, 1.78% Serbs, 0.84% Bosnians, 0.48% Vlachos and 1.04% of other nationalities. Total fertility rate in 2005 was 1.5, which is rather low compared to 2.1 rate set by the EU as required to replace the population. According to the demographic forecasts given by the UN Population Division (2004), the total number of population in the former Yugoslav Republic of Macedonia could fall from 2,034,000 in 2005 to 1,884,000 in 2050. The number of working age population (15-64) is projected to fall from 69.3% in 2005 to 60.0% in 2050.

Social Protection and Social Welfare System

Social protection in former Yugoslav Republic of Macedonia comprises of services and benefits from the tax-financed social welfare system (social prevention - which according to the Law on Social Welfare includes - educational and advisory work, development of self-assistance forms, volunteering work etc., institutional care, non-institutional care and monetary assistance) and contributory- based social insurance system (pensions and disability[5], health and unemployment insurance). The tradition of egalitarian social welfare and Bismarckian social insurance has slowly given room to more residual and individualized social protection, mainly as a result of the impact of international financial institutions (i.e. the World Bank).

[4] International Standard Classification of Education

[5] In the former Yugoslav Republic of Macedonia all types of pensions i.e. old-age, disability, family pension etc. are regulated under one legal act – Law on Pension and Disability Insurance as well with the subsequent - Law for Mandatory Fully Funded Pension Insurance.

Data on expenditures on social protection according to the ESSPROS methodology are not yet available. According to the State Statistical Office, social expenditures in former Yugoslav Republic of Macedonia are calculated according to the European System of Accounts 95 (ESA 95). According to this methodology, social transfers as amount of the GDP rose from 13.6% in 1995 to 15.3% in 2004 and then decreased to 12.2% in 2005. The amount of social transfers as percent of the central budget increased from 52.7% in 1995 to 60.3% in 2003 and then decreased to 58.8% in 2005. For the same year, central budget expenditures for health represented 1.8%, for pensions-45.2%, transfers for the Employment Agency-11.3% and for child protection -0.4%.

Administratively, the main responsibility for organization of the public social protection and welfare rests with the Ministry of Labour and Social Policy (MLSP). Institutions responsible for social welfare and care delivery are Centers for Social Work (CWS), Social Protection Institutions (for institutional care), as well as the kindergartens. Rights and services from the social insurance system are given through the Pension and Disability Insurance Fund (PDIF), including private pension companies, Health Insurance Fund (HIF) and the Employment Agency (EA).

Financial benefits from the social protection system comprise of contributory and non contributory benefits. Those, which are non-contributory and means-tested, include: social assistance (including all sub-categories) and the child benefit, which are managed through the SWCs (the social assistance) and the Child Protection Department (child benefits). The contributory benefits include: pensions, unemployment benefit, maternity benefit and sickness benefit. These are managed through the PDIF (pensions), EA (unemployment benefit) and the HIF (maternity and sickness benefit). Throughout the transition period, especially after the late 90ties, a common feature for all financial benefits from the social protection system has been the tightening of the eligibility criteria and amounts of benefits.

In 2006, the average monthly amount of the social assistance benefits paid per person were: for permanent financial assistance - Denar 3,046 (Euro 49.79), for social financial assistance – Denar 2,154 (Euro 35.21), for financial reimbursement and care – Denar 3,390 (Euro 55.42), for one-off financial assistance – Denar 2,080 (Euro 34.00), for reimbursement of salary for shortened working hours due to care of disabled child – Denar 6,590 (Euro 107.73) and for financial reimbursement for children without parents and parental care – Denar 3,567 (Euro 58.31).

Child benefits are generally low. Child allowance is Denar 691 (Euro 11.3) per child below the age of 15 and Denar 1,174 (Euro 19.19) per child between the age of 15 and 18 if in education. Special allowance which is offered to support families caring for disabled children is Denar 3,632 (Euro 59.38) per month and allowances for new born babies can vary between Denar 1,000 (Euro 16.35) and Denar 3,500 (Euro 57.22) accorded only to the first born baby.

In 2006, the average monthly number of social assistance beneficiaries (all sub-categories) was 92,506 recipients, while the average monthly number of child benefits beneficiaries was 22,362 families and 36,649 children.

Social insurance benefits are financed through compulsory contributions for pension and invalidity, unemployment and health. These amount to 32% of the gross salary of the employees and are paid by the employers. The high percentage of social insurance contributions, paid only by the employers, presents an enormous burden on the costs of employment, and is probably among the leading disincentives for

employment creation. Apart from the employer's contributions, the state budget also partly contributes towards the costs for social insurance.

Unemployment benefit is paid only to those that have been working and paying contributions continuously at least 9 months or 12 months with interruptions out of the last 18 months. Particular categories, such as farmers can receive this benefit if there activity was registered, and if they were paying contributions according to the stipulated criteria. There is no minimum limit, while the maximum cannot be higher than 80% of the average wage in the Republic. The number of beneficiaries of the unemployment benefit has been slowly decreasing, from 41,375 recipients in 2001 to 30,572 in December 2006 (8.3% of the total number of registered unemployed). It is important to emphasize that the reduction of unemployment benefit recipients has been decreasing as a result of the tightening of eligibility criteria, but also due to lesser number of closures and redundant enterprises in this period. Maternity benefit is continuously paid for: 9 months (28 days before anticipated delivery), or 12 months in case of multiple-birth. HIF pays maternity benefits in the amount of 100% of the average monthly net wage paid to the employee (mother) in the six months before maternity leave (monthly payment). Regarding sickness benefit, the employer pays workers compensation for the first 21 working days from his funds, whereas after 21 days it is paid by HIF. The workers' compensation rate during sickness leave is specified by the employer or HIF by general by-law in amount of at least 70% of the basis of the workers compensation.

Parallel with the monetary assistance, the system of social welfare also provides social services, which according to the Law on Social Welfare are categorized as: (1) Social prevention; (2) Institutional care; and (3) Non-institutional care. These services are predominantly organized and administered by the state, but recently with the trends of pluralization and de-institutionalization, there are some other non-residential forms of protection offered also by NGOs and private organizations. The process of decentralization of Centers of Social Work (social services) is still not initiated, due to several reasons, such as: 1) lack of legal provisions in the Law on Local Self Government (article 22.7), which does not envisage decentralization of financial transfers; 2) non existence of second instance organ (at the local level) regarding decisions on complaints 3) lack of human resources in most of the SWCs, in dealing with both administration of social transfers and social service provision.

Poverty and social exclusion

Currently, poverty measurement in former Yugoslav Republic of Macedonia is not based on harmonized data sources nor there are EU comparative indicators applied when estimating poverty line. Similarly, there is no nationally accepted or adopted definition of social exclusion, according to which this condition can be analyzed. Despite lack of formally accepted definition of social exclusion, the Ministry of Labour and Social Policy, in its Policy paper (2004) for tackling problems of the socially excluded, has defined four target groups in the socially excluded population. These comprise of: (1) drug users and members of their families; 2) street children/children on the streets and their parents; (3) victims of family violence and 4) homeless people. Separation of these categories as a particular social group is aimed at enabling their effective access to social protection services (MLSP, 2004, p. 1). Yet, this categorization suggests an arbitrary approach which is not based on previous statistical research considering the prevalence of these groups in the overall socially excluded population. It also does not include other important vulnerable groups, such as Roma, rural poor etc.

Since 1996, former Yugoslav Republic of Macedonia adopted a relative poverty line as the national standard for calculation of poverty level. The relative method defines poverty at the level of 70% of the median equivalent consumption, with application of the old OECD equivalent scale (1.0/0.7/0.5). Because of subsistence economy and remittances, the methodology for statistical calculation of poverty is based on consumption rather than on income as an indicator of the living standard. Calculations for the period 1997 to 2005 show an increase of the poverty rate from 19.0 in 1997 to 30.0 in 2005.

Laeken indicators on social exclusion are still in early stages of preparation. There are some existing estimations, but these indicators should be carefully interpreted (especially those concerning unemployment) due to the size of the grey economy in the country as well as certain issues related with the quality of the Labour Force Survey, especially in connection with the activity/inactivity status of the categories, such as: unpaid family workers, self-employed and pensioners. With this in mind, the following are the very first calculations, taken (and recalculated) from the National Report for Millennium Development Goals (2005): (1) The share of the persons living in jobless households in 2004 was 27.7%; (2) The rate of long-term unemployed in 2005 was 32.3%; (3) The long-term unemployment share in 2005 was 86.7%; (4) The very long-term unemployment rate in 2005 was 28.4% ; (5) Gini coefficient/index for 2003 was 29.3%; (6) Life expectancy at birth for the period 2003/2005 was 73.62 for all and 71.4 years for man and 75.8 for women; (7) The figure for persons with a low educational attainment (ISCED level two or less), for 2005 is 41%.

Concerning at risk groups, both Poverty Reduction Strategy in 2002 and the latest available national report on Millennium Development Goals shows that there have been no greater change to the households with the highest-risk profiles, thus indicating that multi-member households, households with no employed members, households whose members have a low level of education and households of elderly people are at the highest poverty risk.

Pensions

In comparison to all other forms of social protection, the pension system has been a subject of most profound changes since 1991. The changes were of both parametric and paradigmatic character. However, the main aspect of change has involved the modernization of the pension system, with very little or no real concern about its sustainability and adequacy. Our study reveals that despite general and official estimations about the high coverage of the pension system, more than 70,000 (or 31.1%) people above the age of 65 are not covered with pension benefit. Additional worrying factor comes from the increase of the initially planned transitional costs (2.2% from the GDP in case of 86,000 switchers i.e. 25% of the insured persons). As the numbers of switchers in the second pillar doubled the expectations, it implies that the transitional costs will also double, peaking to 4.5% from the GDP in 2025-2030.

Concerning its structure, the pension system in the former Yugoslav Republic of Macedonia is a World-Bank type three-pillar system consisting of: First pillar - Mandatory defined benefit reformed pay-as-you-go system; Second pillar - Mandatory defined contribution and Third pillar – Voluntary defined contribution (whose implementation is planned for 2008). Eligible for a retirement benefit are contributors with 64 years (for man) and 62 years of age (for woman) and minimum 15 years of pension service. The contribution rate is 21.2% of the gross salary for contributors that will remain in the mono-pillar system and 13.78% of the gross salary for the contributors that will switch to the new two-pillar system. The contributors

included in the new system pay a contribution of 7.42% of the gross salary for the second pillar.

There are two private pension companies, collecting the contributions to the mandatory second pillar. The fees that are charged by the pension companies, include: (i) 7.9%-fee on the contributions; (ii) monthly fee of 0.05% of the Pension Fund net assets value, to cover costs of the Pension Company for the management of the Pension Fund and the (iii) fee on the amount standing to the account of a Pension Fund Member, in case of transfer of those assets to another Pension Fund (which has still not been determined). Comparatively, the administrative charges in former Yugoslav Republic of Macedonia are high (i.e. Croatia up to 0.8%, in Hungary 5-6% on average, Poland - 7% but set to fall to 3.5% in 10 year period). Higher administrative charges can erode savings levels substantially throughout the workers career. According to OECD estimations, a monthly fee equal to just 1% of assets can be expected to reduce a worker's retirement savings by 20% over his or her working years.

At the end of 2005, there were 405,542 insured persons in the country. For the same period, the number of pension beneficiaries (old-age, disability and survivor pension) was 265,152. As of December 31 2006 there were 128,031 members into the second pillar, which presents 31.5% from all the insured persons, or 14.35% from the active population. According to the available information on the number of contributors to the private pension's funds out of 128,031 contributors, until 31.12.2006 no contribution has been paid for 14,467. That represents around 11% of all contributors in the private pension funds.

The average paid amount of pension in 2005 was: for old-age pension – Denar 8,517 (Euro 139.2), for disability pension –Denar 6542 (Euro 106, 93) and for the survivors' pension –Denar 6,018 (Euro 98.37). The guaranteed minimum pension level in the former Yugoslav Republic of Macedonia is Denar 3,918.50 (Euro 64.06).

The share of the cost for pension and disability insurance for 2005 is 10.5% from the GDP and it has decreased compared with 2004 and 2003 year. In 2006 year the payment of contribution is increased for 10.5% in comparison with previous year, from which 7% are result of the nominal increase of the income in the country, and 3.5% is assessed as a result of the better payment of contribution.

Health and long term care

The former Yugoslav Republic of Macedonia is going through a long and painful process reforming the provision and financing of health services. The health insurance coverage is reportedly close to 100 percent, the indicators of physical access are impressive, and the basic benefit package is quite broad covering practically all health services. This generosity of publicly financed system is not affordable and creates significant inefficiencies, is ridden by corruption and balanced by expenditure cuts that are affecting the primary health care system, and the maintenance of facilities which are important for the poor. The quality of health care has also deteriorated due to lack of materials with wages and salaries absorbing most of the health budget. There is evidence from various beneficiary assessments that the availability and the quality of health care are inadequate for those who cannot afford to pay for drugs, pay out of pocket informally to public or unable to afford private doctors' fees.

Though monitoring of this dimension in and of itself is informative, combining health data with income poverty data would add much more to the understanding of poverty and design of policies. In this respect the situation for health sector is worse than for others. Furthermore, in regard to the housing, access to water and sanitation, many poor households live in unsafe, unhealthy conditions, especially in substandard settlements, without access to basic physical and social infrastructure.

However, the health profile of the country presents a similar pattern as in other European countries, with a predominance of the cardio vascular diseases as causes of death. There is also an evidence of a decreasing trend in communicable diseases as well as infant and maternal mortality. But the impact of health care reforms on living standards, most specifically for the poor should be still explored. While improvements in the health care system are critical to ensuring the sustainability of the system, there is more work needed to assess the extent these reforms have trickled down to the poor, and what effects there have been from hardening budget constraints on access for certain groups.

Among other issues in former Yugoslav Republic of Macedonia, the process of decentralization seeks to change the organizational structure and to reform government service delivery. This process should increase the empowerment of community groups; creates opportunities for citizens to express their needs; delivers services that promote the social inclusion of vulnerable groups, health care reforms aiming in improving the capacity and efficiency of the primary health care level, and reducing the costs of treatment in the hospitals. Similarly as in other countries of the region, the health care reforms in the former Yugoslav Republic of Macedonia were initiated and advocated by the World Bank through two main reform projects. A number of serious challenges still remain as priorities.

Key challenges ahead

For the sake of consistence, the key challenges are structured according the EU objectives for the social protection and social inclusion process, adopted at the European Council in March 2006.

Challenges concerning social protection and social welfare system:

- Targeting of social welfare benefits according to the social welfare demand. Efficiency of the social welfare benefits should be focused either (a) on eligibility or (b) on duration and amount of benefits. Rigidities in both aspects can jeopardize adequacy, accessibility and social cohesion of its beneficiaries.

- Delivery of social welfare and social insurance benefits by institutions specifically created for those purposes. Currently, there seems to be overlapping of roles between institutions, for example in the case of the delivery of free health insurance, which can be obtained through the Employment Agency (institution not at all connected with the health sector). Such overlapping leads to increase/duplication of numbers of registered beneficiaries, as well introduction of unnecessary (rigid) eligibility rules, which potentially distance social welfare applicants at risk from the social protection system.

- Decentralization of Centers of Social Work, both in terms of financing and delivery of social welfare. Evaluation of the local resources and needs should

be undertaken in order to assess the capacities of the local municipalities. Decentralization of the SWCs should lead towards improved access and efficiency of the social welfare system.

- Transparency and supervision of the social welfare system. Open and accessible social protection system can improve the trust among social welfare beneficiaries. Introducing more rigid legal stipulations regarding violations of the social welfare law, as well as giving more authorization to already existing supervision bodies within the MLSP can improve the current public image of the professionals involved in the social protections system.

- Increasing administrative capacity of the Ministry of Labor and Social Policy, as well as other institutions in charge for administration and delivery of social services, both on central and local level.

Challenges concerning eradication of poverty and social exclusion:

- Expanding current governmental arbitrary defined scope of socially excluded categories, to include: working poor, rural poor, redundant workers, women from ethnic community groups living in rural places, Roma, children from large families (3 and more children) in particular with unemployed parents and children living in institutions.

- Development of new mobile, de-institutionalized services for more categories of socially excluded groups (than those existing), especially for the elderly people, as well as increasing the numbers of the daily care centers for homeless people as well as for street children/children on the streets.

- Differentiation of policy measures for different poverty groups. The National Strategy for Reduction of Poverty has identified three categories of poor in the former Yugoslav Republic of Macedonia, but as needs of these groups are different, so should be the measures directed towards them, i.e. (i) emphasis on training and counseling services for those defined as ‘new poor’; (ii) need for greater eligibility for financial transfers for those defined as ‘traditional’ and ‘chronic’ poor.

- Increased access to the resources, rights and services needed for the participation in society for those living in geographically remote locations. This can encompass mobile services, such as health check-ups, food supply, enabling of necessary pre-conditions for participation in trainings and other activities.

- Active social inclusion of young unemployed, which are not included in education, employment or training.

- Prevention of social exclusion from early years through: expanding pre-school education to more universal provision, increasing access to primary education for vulnerable groups, i.e. Roma children, rural girls, children with disabilities and reduce drop-outs by strengthening the outreach component of the school, cooperation with local communities and inter-active methods that support each individual child learning and progress.

- Improved governance in the social protection system. Participation from different relevant governmental and non-governmental actors as well as

people experiencing poverty in drafting and coordination of social inclusion policies. The NGO sector needs to be supported to de-concentrate and re-locate its services to places where there is need but no relevant capacity for provision of day-care services.

Challenges concerning adequate and sustainable pensions:

- Assessment of the elderly people not covered with the pension insurance. This report suggests that there might be around 70.000 people above 65 years of age not covered with pension insurance. Elderly people from this group that lack additional support from formal and informal social networks should be included in the social inclusion programs.

- Assessment of the coverage rate of the pension system among the elderly women. As women tend to live longer, it might be expected that those currently not included by the pension system are mainly women. They too should be incorporated as to be able to benefit from the social protection system.

- Assessment of other excluded groups from the pension system, i.e. redundant workers, rural farmer's spouses, members of certain ethnic groups (i.e. Albanians) as well as vulnerable ethnic groups (Roma) with no adequate working record.

- Adequacy of the retirement income. Indirect solutions, like reduction or elimination of participation for medicines and health services for the elderly population, especially for those with age over 70, if they have sub-standard pension; increasing the positive list of medicines and provide sufficient quantities of medicines from the positive list in the pharmacies, as well as other direct subsidies should be considered that will make the retirement income sufficient and adequate for maintaining living standard of the elderly.

- Financial sustainability of the pension system. Improved contribution collection should be a priority issue since it has a severe impact on the financing and the viability of the pension system. The most efficient collecting networks should undertake the task and relevant legislation with clear functions must be enforced. Information networks, databases and coordination mechanisms should be put in place.

- Improve the transparency of the pensions system, through introduction of more frequent reports (than currently) from the private pension funds to the pension contributors. In this way any unpaid contribution of employers can be signaled more promptly, which can also be used by the Labour Inspectorate to control and sanction those violations.

- Costs of the new System – in particular charging structure and how benefits will be paid at retirement.

Challenges concerning accessible, high-quality and sustainable healthcare and long-term care:

The well-organized and effective health care system a prime responsibility of the Ministry of Health should have the following characteristics:

- Effectiveness: medical interventions must be based on evidence of health benefit.
- Efficiency: health care services should try to obtain the best results for the cost that society can afford which in former Yugoslav Republic of Macedonia is extremely limited.
- Equity: all citizens should have equal access to the services they need, without regard for income or background.
- Solidarity: in pooling the funds for health care services, the healthy should contribute for the sick, the rich for the poor, and the young for the old.
- Further strengthening of primary health care. More efforts should be made to strengthen the capacity of preventive health teams, update standards and protocols for the key health prevention and health promotion interventions (strengthen the outreach immunization work, antenatal care, and systematic check-ups of children, especially for the most marginalized children, families and vulnerable groups). As a possible form Youth Friendly Services could be mentioned as an effective strategy to carry out health promotion and health prevention among children and young people
- In the context mentioned above, strengthening the capacity of the patronage nursing system could be an effective strategy for implementation of several health promotion and health prevention programmes. Also, the patronage nursing system could function as a structure to lessen the burden of the secondary and tertiary health care, i.e. care and treatment for chronic and other diseases can be done at the community level thus shortening the hospital stay and reducing costs of higher levels of health care
- The Ministry of Health should insists on the existence of a network of the different types of primary and secondary health services in the whole country that combines good accessibility, lack of duplication, and an efficient and sustainable use of financial and human resources. The network should function as a system, which means that the various elements are complementary to each other and all contribute to the common goal of providing effective and efficient services to the public. In order the proper accessibility to be ensured, all health care facilities will need a license from the Ministry of Health, with regular re licensing, which is one of the aims of the ongoing health mapping process.
- There is a need of further upgrading and harmonization of existing public health services and functions with the internationally recognized standards.
- Decentralization needs to be designed such that it doesn't interfere with, or weaken, the ability of the country to achieve its central health system goals. A major issue will be ensuring that decentralization does not increase inequities in access to necessary services and/or in the quality of services received between different localities or between different population groups. Increased autonomy of health care institutions will require adequate regulatory structures to be put in place.
- The current Basic Benefit Package is felt necessary to be reviewed by comparing it to international practices and taking into account demographic and epidemiological characteristics as well as fiscal sustainability issues. The most socio economically deprived population should be seen as the primary target group for exemptions of co-payments.
- In regard to the long term care services, it is expected that the process of transformation and de-institutionalization of the health care system in former

Yugoslav Republic of Macedonia, will enable dispersion of the palliative and mental health care on community level and enhance home care throughout the country. Also, this process should support the conditions for establishment of daily hospitals and centers for palliative and mental health care.

Резиме

Социјална заштита и Социјална инклузија во Поранешната Југословенска Република Македонија

За студијата

Студијата нуди најнова анализа на постојниот систем на социјална заштита во поранешната Југословенска Република Македонија, со посебен фокус на проблемите поврзани со социјалната исклученост. Контекстуалното истражување се потпира на економските и демографските трендови како и на трендовите на пазарот на работна сила кои влијаат на системот за социјална заштита. Исто така, детален преглед е направен за улогата на социјалната заштита, пензискиот и здравствениот систем, како и системите за долгорочна заштита. Студијата ги разгледува основните институционални и законодавни структури на системот за социјална заштита, како и тековните реформи и предизвици. Посебен акцент во рамките на студијата е ставен на аспекти кои ги опфаќаат прашањата на родот, етничките заедници и ранливите групи.

Дополнително, студијата ги разгледува тековните процеси на децентрализација како и влијанието на Охридскиот рамковен договор[6] врз идната организација и резултатите од системот за социјална заштита. Овие два процеса се поддржани од страна на меѓународната заедница и идните односи меѓу поранешната Југословенска Република Македонија и Европската Унија меѓу другото зависат од нивното успешно спроведување. Оттука, студијата внимателно ги анализира можните предизвици и се обидува да ги дефинира основните капацитети и потреби на локално ниво.

Поранешната Југословенска Република Македонија стана независна држава во 1991 година. Дотогаш политичкиот, економскиот, и системот на социјална заштита беше заеднички со останатите Југословенски републики, како што е Хрватска (земја кандидат за членство во ЕУ). Останатите сличности, посебно во однос на предизвиците и трендовите карактеристични за економските капацитети и капацитетите на пазарот на работна сила, се исто така блиски до оние кои се забележуваат во Бугарија и Романија (земји членки на ЕУ). Оттаму, поголемиот дел од споредбите на статистичките податоци на студијата ги вклучува поранешната Југословенска Република Македонија и наведените држави.

Иако, студијата ја следи генералната линија на претходно спроведените истражувања спроведени во другите земји кандидатки за членство во ЕУ до 2006[7] година, сепак истата се потпира на новите цели и новата рамка за

[6] Рамковниот договот потпишан на 13.08.2001 го заврши внатрешниот конфликт во поранешната Југословенска Република Македонија. Неговата цел е да промовира мирен и хармоничен развој на општеството, почитувајќи ги етничкиот идентитет и интересите на сите граѓани во земјата. Врз основа на овој договор, се спроведе листа на конкретни уставни промени и правни реформи на полето на децентрализација, правична застапеност, посебни парламентарни процедури за заштита на етничките немнозински заедници, образование, употреба на јазици, знамиња, изразување на етничкиот и културен идентитет и мерки за имплементација. Некои од најзначајните следни чекори во поглед на рамковниот договор претставува негова имплементација на локално ниво.

[7] http://ec.europa.eu/employment_social/social_protection/health_en.htm#studies
http://ec.europa.eu/employment_social/social_inclusion/docs/2006/study_croatia_en.pdf

процесот[8] на социјална заштита и социјална инклузија, усвоени од Европскиот Совет во Март 2006.

Основната цел на студијата е да придонесе за претстојниот процес на преговори за членството на земјата во ЕУ, во областа на социјалната заштита и социјалната инклузија, како и за Заедничкиот меморандум за инклузија. Резимето обезбедува краток преглед на студијата на англиски, македонски и албански јазик.

Економски, демографски и социјални трендови кои влијаат на системот за социјална заштита

Поранешната Југословенската Република Македонија го одпочна периодот на независност во 1991 година во мошне неповолна економска состојба. Во споредба со останатите држави од поранешна Југославија таа беше најслабо развиена, со висока стапка на невработеност (20%) и слабо развиена инфраструктура. Процесот на транзиција од затворена и централно планирана економија кон отворен и функционален пазарен систем беше соочен со многу внатрешни и надворешни шокови, кои постојано влијаеја врз отпочнатите политики и реформи.

Деценијата на бавен економски раст почна да се подобрува полека но постојано почнувајќи од 2001. Во 2002 реалниот БДП забележа раст од 0.9%, по што во 2003 достигна пораст од 2.8%, а од 2004 забележува раст од 4%. Пролетните предвидувања на Генералниот директорат за економски и финансиски прашања (2007) посочуваат релативно умерен раст од 3.1% во 2006, во споредба со 3.8% во 2005. Основната причина за овие релативно умерени резултати беше послабиот раст отколку очекуваното во областа на производството, земјоделството и градежништвото. На пример, индустриското производство забележа пораст од само 2.5% во 2006. Бруто домашниот производ по глава на жител во поглед на купувачката моќ изнесува 26% од просекот на ЕУ-25. Сепак, постојат забележливи регионални разлики во БДП по глава на жител во однос на стандардите на куповната моќ, кој е скоро два пати поголем во регионот на главниот град (приближно 50% од просекот на ЕУ, во споредба со националниот просек од околу 25% од просекот на ЕУ). Ова се должи на значителните разликите во инфраструктурните вложувања и приходите меѓу главниот град и руралните области. Според предвидувањата за 2007 год на Генералниот директорат за економски и финансиски прашања се проценува дека БДП ќе порасне до 4.3% во 2007 и 5.3% во 2008.

Просечната месечна бруто плата во 2006 изнесуваше 23,036 денари или 374.56 евра (вклучувајќи го персоналниот данок на приход и придонесите за социјална заштита на вработените). Просечната месечна нето плата за истиот перид изнесуваше 13,527 денари или 219.95 евра. Во 2006 просечната месечна нето плата се зголеми за 7.3% во споредба со 2005. Покрај ниските месечни плати, исто така постои голем број на вработени кои не добиваат редовни плати (во декември 2006, 13.3% од сите вработени не биле воопшто исплатени). Споредбено, просечната месечна плата е единствено поголема од онаа во соседна Бугарија (200 евра) и Албанија (170 евра).

[8] http://ec.europa.eu/employment_social/social_inclusion/docs/2006/objectives_en.pdf

Слабостите на пазарот на работна сила во поранешната Југословенска Република Македонија се должат на низа фактори, меѓу кои: губење на работни места поради економското реструктуирање, неповолното економско опкружување (Грчкото ембарго 1994-95, косовската криза во 1999 итн.), пречките за влез или нефлексибилноста на пазарот на работна сила проследени со почеста примена на пасивни отколку активни политики на пазарот на работна сила. Севкупната стапка на вработеност во поранешната Југословенска Република Македонија во основа останува статична на исклучително ниско ниво при што 39.6% од работоспособното население (на возраст од 15 до 64 години) во 2006 биле регистрирани како вработени (со стапка на активност од 62.2%). Ова е доста пониска стапка во споредба со стапките за вработеност (2006) во Хрватска-55%, Бугарија и Романија (58.6% и 58.8%), и посебно пониска од таа на ЕУ 27-63.4%.

Подобрувањата во однос на вработувањето на етничките заедници во поранешна Југословенска Република Македонија се поврзуваат со Охридскиот рамковен договор (2001). Принципот на еднаква застапеност, која е дел од Охридскиот рамковен договор**,** придонесе за пораст вработувањето на етничките заедници пред се во јавните институции. Од 31 август 2006 процентот на вработени во јавниот сектор (односно во министерствата и останатите државни институции, институциите од областа на судството и јавните претпријатија) според етничката припадност, изнесува: 74.19% Македонци, 8.93% Албанци, 1.74% Срби, 0.93% Турци, 0.55% Власи, 0.26% Босанци, 0.42% Роми и 0.91% останати.

Сивата економија е широко распространета, што предизвикува зголемување на некои од индикаторите на пазарот на работна сила (односно невработеноста). Според последниот извештај на ЕТФ за поранешна Југословенска Република Македонија (2007) сивата економија во земјата изнесува 33%-37% од БДП.

Податоците од Анкетата за работната сила укажуваат дека во 2006 стапката на невработеност (15-64) изнесуваше 36.3%, што е далеку повеќе во споредба со стапките на невработеност во Хрватска (11.8%), Бугарија (9%), Романија (7.3%) и во ЕУ-27 (7.9%). Дополнителен проблем претставува присутноста на долгорочната невработеност, со оглед на фактот дека процентот на долгорочно невработени лица (лица невработени подолго од една година) во 2005 изнесуваше 32.3% од севкупното работоспособно население. Стапките на невработеност во 2006 според родовата припадност (Анкета за работната сила) покажуваат дека стапката на невработеност кај припадниците од машкиот пол изнесувала 35.6%, а кај припадничките на женскиот пол 37.5%. Во двата случаи, бројките забележуваат пад од 2005 за 0,9% за двата пола.

Работниот пазар исто така се карактеризира со голем недостаток на вештини. Пресметките на ЕТФ во поглед на нивото на стекнување на образование кај возрасни лица од 25-64 години покажуваат многу ниски бројки, 41% со ИСЦЕД[9] 0-2 (двапати повисоко од 10те нови ЕУ земји членки), 45% со ИСЦЕД 3-4 и 14% со ИСЦЕД 5-6. Споредбено, резултатите на ИСЦЕД 0-2 се: во Хрватска-30%, Бугарија-28% и Романија-27%.

Според националниот попис во 2002, поранешната Југословенска Република Македонија има 2.022.547 жители. Етничката слика на државата е разновидна, со 64.18% Македонци, 25.17% Албанци, 3.85% Турци, 2.66% Роми, 1.78% Срби,

[9] Меѓународна Стандардна Класификација на Образованието (International Standard Classification of Education-ISCED).

0.84% Босанци, 0.48% Власи и 1.04% други националности. Стапката на фертилитет во 2005 беше 1.5, која е мошне пониска во споредба со нивото поставено од ЕУ 2.1 потребно за да се оддржи популацијата. Според демографските предвидувања од страна на Одделението за население при Обединетите Нации (2004), целосниот број на населението во поранешната Југословенска Република Македонија може да опадне од 2,034,000 во 2005 до 1,884,000 во 2050. Бројот на работноспособно население (15-64) се очекува да опадне од 69.3% во 2005 до 60% во 2050.

Социјална заштита

Социјалната заштита во поранешната Југословенска Република Македонија е составена од услуги и бенефиции од даночно финансираниот систем за социјална заштита (социјална превенција-која според законот за социјална заштита вклучува едукативно-советувалишна работа, развивање на формите на самопомош, волонтерска работа итн., институционална заштита, вон-институционална заштита и парична помош), како и од систем за социјално осигурување заснован на придонеси (пензиско и инвалидско осигурување, здравствено осиугурување и осигурување во случај на невработеност). Традицијата на универзална достапност до социјалната помош и Бизмарковото социјално осигурување полека отстапија место на поселективна и поиндивидуализирана социјална заштита, посебно како резултат на влијанијата од меѓународните финансиски институции (како Светската Банка).

Податоците за трошоците за социјална заштита според ЕССПРОС методологијата сеуште не се достапни. Според Државниот завод за статистика, социјалните издатоци во поранешната Југословенска Република Македонија се пресметувани според ЕСА 95. Според оваа методологија, социјалните трансфери како процент од БДП пораснаа од 13.6% во 1995 до 15.3% во 2004 и се намалија на 12.2% во 2005. Сумата на социјалните трансфери како процент од централниот буџет се зголеми од 52.7% во 1995 до 60.3% во 2003 и се намали на 58.8% во 2005. За истата година, трошоците на централниот буџет за здравство претставуваа 1.8%, за пензии-45.2%, трансферите на Агенцијата за вработување-11.3% и за заштита на децата-0.4%.

Административно, главната одговорност за организацијата на јавната социјална заштита припаѓа на Министерството за труд и социјална политика. Институциите одговорни за социјалната заштита се центрите за социјална работа, установите за социјална заштита (за институционална грижа), како и градинките. Правата и услугите од системот за социјално осигурување се остваруваат преку Фондот на пензиско и инвалидско осигурување, вклучувајќи и приватните пензиски друштва, Фондот за здравствено осигурување и Агенцијата за вработување.

Паричните надоместоци од системот за социјална заштита се составени од контрибутивни и неконтрибутивни бенефиции. Неконтрибутивните надоместоци и надоместоците кои зависат од проверка на средствата вклучуваат социјална помош (вклучувајќи ги сите подкатегории) и детски надоместоци, кои ги прераспределуваат центрите за социјална работа (социјална помош) и секторот за заштита на децата (детски надоместоци). Контрибутивните надоместоци вклучуваат: пензии, парични надоместоци за невработени, надоместоци на плата за време на отсуство од работа поради бременост, раѓање и мајчинство, како и надоместоци на плата за време на привремена спреченост за работа поради болест и повреда. Овие надоместоци се прераспределуваат од страна

на Фондот на пензиско и инвалидско осигурување (пензии), Агенцијата за вработување (парични надоместоци за невработени), како и од Фондот за здравствено осигурување (надоместоци на плата за време на отсуство од работа поради бременост, раѓање и мајчинство**,** како и надоместоци на плата за време на привремена спреченост за работа поради болест и повреда). За време на транзицискиот период, посебно во пердиодот по доцните 90ти, заедничка карактеристика за сите парични надоместоци од системот за заштита беше заострувањето на критериумите за достапност до бенефициите како и висината на бенефициите.

Во 2006, просечните месечни суми на надоместоците за социјална помош исплатени по лице беа: за постојана парична помош–3,046 ден. (49.79 евра), за социјална парична помош-2,154 ден. (35.21 евра), за паричен надоместок за помош и нега–3,390 ден. (55.42 евра), за еднократна парична помош –2,080 ден. (34 евра), за финансиски надоместок од плата за намалени работни часови поради нега за дете инвалид-6,590 ден. (107.73 евра), за надоместок на плата за скратено работно време поради нега на хендикепирано дете-3,567 ден. (58.31 евра) и за парична помош на лице кое до 18 години возраст имало статус на дете без родители и родителска грижа-3,567 ден. (58.31 евра).

Детските надоместоци се генерално ниски. Детскиот додаток е 691 ден. (11.3 евра) за деца до 15 годишна возраст и 1,174 ден (19.19 евра) за деца меѓу 15 и 18 годишна возраст доколку се вклучени во образовниот систем. Посебниот додаток наменет за семејства кои се грижат за хендикепирани деца изнесува 3,632 ден. (59.38 евра) месечно и помошта за опрема на новороденче може да изнесува меѓу 1.000 ден. (16.35 евра) и 3,500 ден. (57.22 евра) кои се даваат само на првороденче.

Во 2006, просечниот месечен број на примачи на социјална помош (сите подкатегории) изнесува 92,506 корисници, додека просечниот месечен број на корисници на детски надоместоци 22,362 семејства и 36,649 деца.

Надоместоците за социјално осигурување се финансирани од задолжителни придонеси за пензии и инвалидитет, невработеност и здравство. Овие придонеси изнесуваат до 32% од бруто платата на вработените и се исплатуваат од страна на работодавците. Високиот процент на придонесите за социјално осигурување, исплаќани само од страна на работодавците, претставува голем товар за трошоците за вработување, и претставува една од водечките пречки за поттикнување на вработувањето. Покрај придонесите од страна на работодавците, државниот буџет исто така во одреден дел придонесува кон трошоците на социјалното осигурување.

Паричниот надоместок за невработени се исплаќа само на оние кои работеле и плаќале придонеси постојано најмалку 9 месеци или 12 месеци со прекини, во последните 18 месеци. Посебни категории, како земјоделци, може да ги примаат овие надоместоци доколку нивната дејност била регистрирана и доколку ги исплаќале придонесите според горенаведените критериуми. Не постои минимална граница, додека максимумот не може да биде над 80% од просечната плата во земјата. Бројот на корисници на паричните надоместоци за невработени постепено се намалува, од 41,375 примачи во 2001 на 30,752 во декември 2006 (8.3% од вкупниот број на регистрирани невработени лица). Важно е да се истакне дека намалувањето на корисниците на паричните надоместоци за невработени се јавува како резултат на заострувањето на критериумите за квалификуваност, но исто така поради намалениот број на затворени претпријатија и претпријатија во стечај во овој период.

Надоместоците на плата за време на отсуство од работа поради бременост, раѓање и мајчинство постојано се исплаќаат за период од: 9 месеци (28 дена пред раѓањето), или 12 месеци во случај на повеќе од едно новороденче. Фондот за здравствено осигурување исплаќа надоместоци на плата за време на отсуство од работа поради бременост, раѓање и мајчинство 100% од просечната месечна нето плата исплатена на вработената (мајката) во период од шест месеци пред отсуство од работа поради бременост. Во однос на надоместокот на плата за време на привремена спреченост за работа поради болест и повреда, работодавачот го исплаќа надоместокот за работникот за првите 21 работни дена од неговите средства, додека после 21 ден се исплаќаат од страна Фондот за здравствено осигурување. Стапката на надоместок за работниците за време на привремена спреченост за работа поради болест и повреда се одредува од страна на работодавачот или Фондот за здравствено осигурување според општиот подзаконски акт во износ од најмалку 70% од основата за надоместок на работникот.

Паралелно со паричната помош, системот за социјална заштита исто така обезбедува социјални услуги, кои според Законот за социјална заштита се категоризирани како: (1) социјална превенција; (2) институционална заштита; и (3) вон-институционална заштита. Овие услуги најчесто се обезбедуваат и управуваат од страна на државата, но во последно време со појавата на трендовите на плурализација и деинституционализација, постојат и други форми на не-резиденцијална заштита кои се нудат од невладини и приватни организации. Процесот на децентрализација на центрите за социјална работа (социјалните услуги) сеуште не е започнат како резултат на неколку причини: 1) недостаток на законски одредби во Законот за локална самоуправа (член 22.7), кој не предвидува децентрализација на паричните трансфери, 2) непостоењето на второстепен орган (на локално ниво) во однос на одлуки по жалби, 3) недостаток на човечки ресурси во повеќето од центрите за социјална работа во справувањето со управувањето на социјалните трансфери и обезбедувањето на социјални услуги.

Сиромаштија и социјална исклученост

Во моментов, мерењето на сиромаштијата во поранешната Југословенска Република Македонија не се потпира на усогласени извори на податоци ниту постојат ЕУ компаративни индикатори кои се применуваат кога се оценува линијата на сиромаштија. Исто така, не постои национално прифатена или усвоена дефиниција за социјална исклученост, според која оваа состојба би се анализирала. Покрај недостатокот на формално прифатена дефиниција за социјална исклученост**,** Министерството за труд и социјална политика, во нивниот документ за Политиките за справување со проблемите на социјално исклучените лица (2004), дефинираше 4 групи во социјално исклученото население. Овие групи се составени од: (1) корисници на дроги и членови на нивните семејства, 2) деца на улица/улични деца и нивните родители, 3) жртви на семејно насилство, како и 4) бездомници. Одвојувањето на овие целни групи како посебен социјален ентитет е насочено кон овозможување на ефективен пристап на услугите на социјална заштита (МТСП, 2004, стр. 1). Сепак, оваа категоризација користи арбитрарен пристап кој не се потпира на претходно истражување земајќи ја во предвид големата застапеност на овие групи во вкупното социјално исклучено население. Исто така не вклучува други значајни групи, како Ромите, рурално сиромашните итн.

Во 1996, поранешната Југословенска Република Македонија ја усвои релативната линија на сиромаштија како национален стандард за пресметување на нивото на сиромаштија. Релативниот метод ја дефинира сиромаштијата на ниво од 70% од средната еквивалентна потрошувачка со примена на старата ОЕЦД скала (1.0/0.7/0.5). Како резултат на сивата економсија како и дознаките од странство, методологијата за статистичко пресметување на сиромаштијата се потпира на потрошувачката а не на приходот како показател на животниот стандард. Пресметките за периодот од 1997 до 2005 покажуваат пораст на стапката на сиромаштија од 19.0 во 1997 до 30.0 во 2005.

Лаекен индикаторите за социјална исклученост се сеуште во првобитна фаза на подготовка. Постојат некои проценки но овие индикатори треба внимателно да се толкуваат (посебно оние кои се однесуваат на невработеност) како резултат на големината на сивата економија во земјата како и некои прашања поврзани со квалитетот на Анкетата на работната сила, посебно во однос на активниот/пасивниот статус на категориите како: неисплатени семејни работници, самовработени и пензионери. Земајќи го ова во предвид, следниве се првите Лаекен пресметки превземени од Националниот извештај за милениумските развојни цели (2005): (1) процентот на лица во домаќинства без вработени во 2004 изнесувал 27.7%; (2) стапката на долгорочно невработени во 2005 била 32.3%; (3) процентот на долгорочна невработеност во 2005 изнесувал 86.7%; (4) самата стапка на долгорочна невработеност во 2005 била 28.4%; (5) Џини коефициентот/индексот за 2003 изнесувал 29.3%; (6) Животниот век при раѓање за периодот 2003/2005 изнесувал 73.62 за сите и 71.4 години за мажи и 75.8 за жени; (7) процентот на лица со ниско ниво на образование (ИСЦЕД ниво 2 или помалку) за 2005 изнесувал 41%.

Во однос на групите во ризик, Стратегијата за намалување на сиромаштијата во 2002 и последниот национален извештај за Милениумските развојни цели покажуваат дека нема поголема промена кај домаќинствата со профили на најголем ризик, што упатува дека домаќинствата со повеќе членови, домаќинствата без вработени членови, домаќинствата чии членови имаат ниско ниво на образование, како и домаќинствата со постари лица се во највисокиот ризик на сиромаштија.

Пензии

Во споредба со останатите форми на социјална заштита, пензискиот систем беше подлежен на најголеми промени уште од 1991. Промените беа од параметрички и парадигматичен карактер. Сепак, главниот аспект на промена претставува модернизација на пензискиот систем, со многу малку или без вистинска загриженост околу неговата одржливост и соодветност. Нашата студија покажува дека покрај општите и официјалните проценки околу високата покриеност на пензискиот систем, повеќе од 70,000 луѓе (или 31.1%) над 65 годишна возраст не се покриени со пензиски бенефиции. Дополнителен загрижувачки фактор претставува зголемувањето на првично планираните транзициски трошоци (2.2% од БДП во случај на 86,000 пристапувачи или 25% од осигураните лица). Бидејќи бројките на пристапувачи во вториот столб ги дуплираа очекувањата, тоа укажува дека транзициските трошоци исто така ќе се дуплираат, достигнувајќи го врвот од 4.5% од БДП во периодот од 2025 до 2030.

Во однос на структурата, пензискиот систем на поранешната Југословенска Република Македонија е трослоен составен од: Прв столб-задолжително државен пензиско осигурување според принципот на генерациска солидарност; Втор столб- задолжително капитално-финансирано пензиско осигурување и Трет столб-доброволно капитално-финансирано пензиско осигурување (чие спроведување е планирано за 2008 година). Квалификувани за старосна пензија се осигурениците со 64 години живот за маж и 62 години живот за жена и минимум 15 години пензиски стаж. Стапката на придонес изнесува 21.2% од бруто платата на осигурениците кои нема да пристапат во вториот столб и 13.78% од бруто платата на осигурениците кои ќе пристапат во вториот столб од пензискиот систем. Осигурениците вклучени во новиот систем плаќаат придонес од 7.42% од бруто платата за вториот столб.

Постојат две приватни пензиски друштва, кои ги собираат придонесите од вториот задолжителен столб. Надоместокот кој се наплаќа од пензиските друштва вклучува: (i) 7,9%-од придонесите; (ii) месечен надоместок од 0,05% од вредноста на нето средствата од пензискиот фонд, за да се покријат трошоците на пензиското друштво за управувањето со пензискиот фонд, и (iii) надоместок за сумата предвидена на сметката на членот на пензискиот фонд, во случај на трансфер на тие средства во друг пензиски фонд (кој сеуште не е одреден). Споредбено, административните надоместоци во поранешната Југословенска Република Македонија се високи (во Хрватска изнесуваат до 0.8%, во Унгарија 5-6% во просек, Полска-7% но предвидено е да опаднат на 3.5% за период од 10 години). Повисоките административни издатоци може значително да го намалат нивото на штедење за време на кариерата на работникот. Според проценките на ОЕЦД, месечно надоместоци еднакви на само 1% од средствата може да се очекува да го намалат штедењето на работникот со пензионирање до 20% за време на неговата, нејзината работна кариера.

Кон крајот на 2005 година, имаше 405,542 осигурани лица во државата. За време на истиот период, бројот на корисници на пензија (старосна и инвалидска пензија, семејна пензија) изнесуваше 265,152. Од 31 декември 2006 имаше 128,031 членови во вториот столб, кој преставува 31.5% од сите осигурани лица, или 14.35% од активното население. Според достапните податоци за бројот на осигуреници во приватните пензиски фондови, од вкупно 128,031 осигуреници до 31.12.2006 за 14,467 никакви придонеси не биле исплатени. Тоа преставува околу 11% од сите осигуреници во приватните пензиски фондови.

Просечната сума за пензии во 2005 изнесуваше: старосна пензија-8,517 ден. (139.2 евра), инвалидска пензија-6,542 ден. (106.93 евра) и семејна пензија-6,018 ден. (98.37 евра). Гарантираната минимимална пензија во поранешната Југословенска Република Македонија изнесува 3,918.59 ден. (64.06 евра).

Процентот за трошоци за пензиско и инвалидско осигурување за 2005 изнесуваше 10.5% од БДП и беше намалено во споредба со 2004 и 2003 година. Во 2006 година плаќањето на придонеси се зголеми за 10.5% во споредба со претходната година, од кои 7% се резултат на номиналното зголемување на приходот во државата, и 3.5% е проценето како резултат на подобреното плаќање на придонеси.

Здравство и долгогорочна нега

Поранешната Југословенска Република Македонија поминува низ долг и тежок процес на реформи во обезбедувањето и финансирањето на здравствените

услуги. Покриеноста на здравственото осигурување изнесува блиску до 100%, индикаторите за физичката достапност се импресивни, и основниот пакет на услуги е мошне широк покривајќи ги практично сите здравствени услуги. Оваа дарежливост на јавно финансираниот систем не е допуштлива и создава значајни проблеми поврзани со неефикасност. Таа се е карактеризира со корупција и се балансира преку намалување на трошоците кои влијаат врз системот на примарното здраство, како и врз одржувањето објектите кои се значајни за сиромашните. Квалитетот на здравството исто така се влоши како резултат на недостатокот на материјали и плати кои го завземаат најголемиот дел од буџетот за здравство. Постојат податоци од различни проценки на корисниците дека достапноста и квалитетот на здравствената нега се несоодветни за тие кои не можат си дозволат да платат за лекови, да платат со приватни средства или не се во можност да платат приватни доктори.

Иако набљудувањето на овој начин само по себе е неформално, комбинирањето на здравствените податоци со податоците за сиромаштијата во однос на приходите може да придонесе кон подобро разбирање на сиромаштијата и кон соодветно креирање политики. Во тој поглед состојбата со здравствениот сектор е полоша од останатите. Дополнително, во однос на домувањето и пристапот до вода и санитарни услови, многу сиромашни домаќинства живеат во небезбедни, нездрави средини, посебно во случај на супстандардни населби без пристап до основна физичка и социјална инфраструктура.

Сепак, здравствениот профил на државата се карактеризира со слични тенденции како и во останатите европски земји, со голема застапеност на кардиоваскуларните болести како причинители на смрт. Исто така постои тенденција за намалување на заразните болести како и смртноста кај деца и мајки . Но влијанието на реформите во здраството врз животниот стандард, посебно кај сиромашните сеуште треба да се истражува. Додека подобрувањата во системот за здраствена нега се клучни за обезбедување одржливост на системот, претстои дополнителна работа да се оцени до кој степен овие реформи допреа до сиромашните, и какви ефекти се појавија од заострувањето на буџетските ограничувања за пристап за одредени групи.

Меѓу останатите прашања во поранешната Југословенска Република Македонија, процесот на децентрализација се стреми да ја промени организациската структура и да го реформира доставувањето на услуги од страна на владата. Овој процес треба да го зголеми влијанието на локалните заедници, да создаде можности за граѓаните да ги изразат своите потреби; да доставува услуги кои ја промовираат социјалната вклученост на ранливите групи, да поттикне здравствени реформи кои се стремат кон подобрување на капацитетот и ефикасноста на примарната здравствена заштита, како и кон намалување на трошоците на лекување во болниците. Слично, како и во останатите држави од регионот, здравствените реформи во поранешната Југословенска Република Македонија беа започнати и промовирани од Светската банка преку два главни реформски проекти. Одреден број на сериозни предизвици сеуште претставуваат приоритет за земјата.

Клучни предизвици кои следат

Со цел да се обезбеди доследност, клучните предизвици се структурирани според ЕУ целите за социјална заштита и процесот на социјална инклузија усвоени од Европскиот Совет во Март 2006.

Предизвици кои се однесуваат на системот за социјална заштита:

- Насочување на бенифициите од системот на социјална заштита според побарувачката за социјална заштита**.** Ефикасноста на бенифициите од системот на социјална заштита треба да се фокусира или на (а) критериумите за достапност до услугите/бенифициите или на (б) должината и износот на надоместоците. Применување на ригидности и во двата аспекти може да ја загрози адекватноста, достапноста и социјалната кохезија во поглед на корисниците на социјална заштита.

- Обезбедување на бенифициите од социјална заштита и социјално осигурување преку институции посебно создадени за оваа намена. Моментално, забележливо е преклопување на улогите кај институциите, на пример во случај на обезбедување на бесплатно здравствено осигурување, кое може да се добие преку Агенцијата за вработување (институција која воопшто не е поврзана со здравствениот сектор). Ова преклопување води кон зголемување/дуплирање на бројот на регистрирани корисници, како и воведување на непотребни (нефлексибилни) критериуми, кои потенцијално ги оддалечуваат загрозените барателите на социјална помош од системот за социјална заштита.

- Децентрализација на центрите за социјална работа, во поглед на финансирање и нудење на социјална заштита. Треба да се изврши процена на локалните ресурси и потреби за да се оценат капацитети на локалните самоуправи. Децентрализацијата на центрите за социјална работа треба да води кон подобрен пристап и ефикасност на системот за социјална заштита.

- Транспарентност и надзор над системот за социјална заштита. Отворен и достапен систем за социјална заштита може да ја зголеми довербата кај корисниците на социјална помош. Преку воведувањето на построги одредби во случај на прекршување на законот за социјална заштита, како и преку давање на поголеми овластувања на постоечките тела за надзор во рамките на Министерството за труд и социјална политика може да се подобри постоечката јавна слика за професионалците вклучени во системот за социјална заштита.

- Зголемување на административниот капацитет на Министерството за труд и социјална политика, како и на останатите институции задолжени за управувањето и обезбедувањето на социјалните услуги на централно и локално ниво.

Предизвици поврзани со искоренувањето на сиромаштијата и социјалната исклученост:

- Проширување на постоечката произволно утврдена опфатеност на социјално исклучените категории, преку вклучување на: вработените со ниски приходи**,** рурално сиромашните, жените од етничките заедници кои живеат во руралните средини, Ромите, децата од поголеми семејства (3 и повеќе деца) посебно со невработени родители и деца кои живеат во институции.

- Обезбедување на нови подвижни, деинституционализирани услуги за повеќе категории на социјално исклучени групи (од постоечките) посебно за постарите лица, како и зголемување на бројот на дневни центри за згрижување бездомници како и за улични деца-деца на улица.

- Разграничување на мерки за различни сиромашни групи. Националната стратегија за намалување на сиромаштијата препознава три категории на сиромашни во поранешната Југословенска Република Македонија, но бидејќи потребите на овие групи се разликуваат, и мерките насочени кон нив треба да се разликуваат исто така, (i) треба посебно значење да се даде на обуки и советувалишни услуги за тие одредени како ново сиромашни, (ii) постои потреба од поголема достапност до финансиските трансфери за тие одредени како традиционално, хронично сиромашни.

- Зголемена достапност до ресурсите, правата и услугите потребни за учество во општеството на оние кои живеат во географски оддалечени региони. Ова може да вклучи подвижни услуги, здравствени прегледи, набавка на храна, овозможување на неопходните предуслови за учество во обуки и други активности.

- Активно социјално вклучување на невработени млади лица, кои не се опфатени со образование и обуки.

- Превенција на социјалната исклученост уште од раната возраст преку: проширување на претшколското образование за поголем пристап, зголемена достапност на основното образование за ранливи групи како Ромски деца, рурални девојчиња, деца со хендикеп и намалување на бројот на ученици кои ги напуштаат образовните институции преку зајакнување на вон-училишните активности на училиштата, соработка со локалните заедници и интерактивни методи кои подржуваат индивидуално учење кај децата и личен напредок.

- Подобро управување со системот за социјална заштита. Учество од релевантни владини и невладини актери како и сиромашни лица во подготовката и координацијата на политиките за социјална инклузија. Невладиниот сектор треба да биде поддржан да ги деконцентрира и релоцира услугите кои ги нуди во места каде што постои потреба но нема соодветен капацитет за обезбедување услуги за дневна грижа.

Предизвици поврзани со соодветни и одржливи пензии:

- Процена на стари лица кои не се покриени со пензиското осигурување. Оваа студија покажува дека постојат околу 70,000 лица над 65 годишна возраст кои не се покриени со пензиското осигурување. Старите лица од оваа група на кои им недостасува дополнителна поддршка од формалните и неформалните социјални мрежи треба да бидат вклучени во програмите за социјална инклузија.

- Процена на стапката на покриеност на пензискиот систем кај старите жени. Како што кај жените се забележува тенденција да живеат подолго, може да се очекува дека тие кои моментално не се вклучени во пензискиот систем се повеќето жени. Тие исто така треба да бидат вклучени за да можат да бидат корисници на системот за социјална заштита.

- Процена на останатите исклучени групи од пензискиот систем, стечајни работници, сопругите на руралните земјоделци, членови на одредени етнички групи (како Албанци) како и ранливи етнички групи (Роми) со несоодветно работно искуство.

- Соодветност на пензиските приходи. Индиректни решенија, како намалување или отстранување на учеството за лекови и здраствени услуги за старото население, посебно за оние над 70 годишна возраст, доколку имаат супстандардна пензија; проширување на позитивната листа на лекови и обезбедување доволно количини н лекови од позитивната листа во аптеките, како и друг вид на директна помош доколку се смета дека ќе овозможи доволен пензиски приход, соодветен за животниот стандард на старите лица.

- Финансиска оддржливост на пензискиот систем. Подобреното собирање на придонеси треба да биде приоритет бидејќи има значително влијание врз финансирањето и функционирањето на пензискиот систем. Најефикасните мрежи за собирање треба да ја превземат задачата и соодветна легислатива со јасни насоки треба да се спроведе. Информациски мрежи, бази на податоци и механизми за координација треба се создадат.

- Подобрување на транспарентноста на пензискиот систем, преку воведување на почести извештаи (од постојната пракса) од страна на приватните пензиски фондови до пензиските осигуреници. На овој начин секој неисплатен придонес од страна на работодавците може навремено да се забележи, што исто така може да се користи од страна на трудовата инспекција за надзор и да ги санкционира овие прекршувања.

- Трошоците на новиот систем-во поглед на структурата за наплата и како надоместоците ќе се се исплатуваат при пензионирање.

Предизвици кои се однесуваат на достапен, високо квалитетен и оддржлив систем за здраствена заштита и долгорочна нега:

Добро организиран и ефективен систем за здраствена заштита со примарна надлежност на Министерството за здраство треба да ги има следниве карактеристики:

- Ефективност: медицинските интервенции треба да се потпираат на докази за погодноста по здравјето**.**

- Ефикасност: услугите за здраствена заштита треба да се стремат кон најдобрите резултати за цената што општеството може да си ја дозволи, што во поранешната Југословенска Република Македонија е посебно ограничена.

- Еднаквост: сите граѓани треба да имаат еднаков пристап до услугите кои им се потребни без разлика на приходот и потеклото.

- Солидарност: во извлекувањето на фондовите за услугите на здраствена заштита, здравиот треба да придонесува за болниот, богатиот за сиромашниот, младиот за стариот.

- Понатамошно зајакнување на примарната здраствена заштита. Треба повеќе да се вложат напори во зајакнувањето на капацитетите на превентивните здраствени тимови, да се модернизираат стандардите и протоколите за клучните превентивни и промотивни интервенции (да се зајакне активноста на имунизација во локалните заедници**,** негата кај бремените жени и систематските прегледи на деца, посебно за најмаргинализираните деца, семејства и ранливи групи). Како посебна форма треба да се спомнат младинските пријателски услуги како ефективна стратегија за промовирање и здраствена превенција кај децата и младите луѓе.

- Во претходно споменатиот контекст, зајакнувањето на капацитетот на сисемот на патронажни стестри може да биде ефективна стратегија за имплементација на неколку програми за промоција и превенција. Исто така овој патронажен систем може да функционира како структура која ќе го намали товарот на секундарната и терцијарната здраствена заштита, односно негата и лекувањето на хронични и останати болести кое може да се направи на локално ниво со што ќе се намали болничкиот престој и трошоците на повисоко ниво на здраствена заштита

- Министерството за здраство треба да се стреми кон постоење на мрежа на различни видови на примарни и секундарни здраствени услуги во целата земја која ќе овозможи високо ниво на достапност, отсуство на удвојување и ефикасна и одржлива употреба на финансиски и човечки ресурси. Мрежата треба да функционира како систем, што претпоставува комплементарност на различните елементи кои ќе придонесуваат кон заедничката цел за обезбедување ефективни и ефикасни услуги за јавноста. Со цел да се обезбеди соодветна достапност, сите здраствени објекти треба да имаат лиценца од Министерството за здраство, со редовно релиценцирање, што претставува една од целите на постоечкиот процес на изготвување на здравствената мапа.

- Постои потреба за понатамошно надградување и хармонизација на постоечките јавни здраствени услуги и функции со меѓународно прифатените стандарди.

- Децентрализацијата треба да се испланира така што нема да навлегува во, или да ја ослабне, способноста на земјата да ги оствари сопствените цели на системот за здраство. Опасноста од зголемување на нееднаквоста во пристапот до неопходните услуги и/или квалитетот на услуги добиен во различни средини или кај различни групи на население претставува клучен предизвик во процесот на децентрализација. Зголемената независност на институциите за здраствена заштита ќе има потреба од формирање на соодветни регулаторни тела.

- Неопходно е да се преоцени постојниот пакет на загарантирани основни здраствени услуги споредувајќи го со меѓународни практики и имајќи ги во предвид демографските и епидемиолошките карактеристики како и прашањата поврзани со фискална оддржливост. Најголемиот дел од населението кое се соочува со економски и социјални проблеми треба да се одреди како примарна целна група за изземање од учество во плаќањето на услугите (партиципација).

- Во поглед на услугите во областа на долгорочната грижа, се очекува дека процесот на трансформација и деинституционализација на системот за здраствена заштита во поранешната Југословенска Република Македонија, ќе овозможи дисперзија на палиативната и здраствената заштита на менталното здравје на локално ниво и ќе ја зајакне домашната нега во земјата. Исто така, овој процес треба да ги поддржи условите за отварање на дневни болници и центри за палиативна и здраствена заштита на менталното здравје.

Rezyme

Mbrojtja sociale dhe Përfshirja sociale në Ish Republikën Jugosllave të Maqedonisë

Për studimin

Studimi ofron analizën më të re të sistemit ekzistues të mbrojtjes sociale në Ish Republikën Jugosllave të Maqedonisë me fokusim të veçantë në problemet të lidhura me përjashtimin social. Hulumtimi kontekstual është bazuar në analizën e trendeve ekonomike dhe gjeografike si dhe në trendet e pazarit të fuqisë së punës të cilat ndikojnë në sistemin për mbrojtje sociale. Gjithashtu, pasqyrim i detajuar është kryer për rolin e mbrojtjes sociale, sistemit shëndetësor dhe të pensionit, si dhe të sistemeve të mbrojtjes afatgjate. Studimi i hulumton strukturat themelore institucionale dhe ligjvënëse të sistemit të mbrojtjes sociale, si dhe reformat dhe synimet që vijojnë. Theks i veçantë në suazat e studimit është vendosur mbi aspektet të cilat i përfshijnë çështjet e gjinisë, bashkësive etnike, dhe grupeve të ndjeshme.

Gjithashtu, studimi i shqyrton proceset vijuese të decentralizimit si dhe ndikimin e Marrëveshjes Kornizë të Ohrit mbi organizimin e ardhshëm[10] dhe mbi rezultatet e sistemit për mbrojtje sociale. Këto dy procese janë të mbështetur prej bashkësisë ndërkombëtare dhe marrëdhënieve të ardhshme midis Ish Republikës Jugosllave të Maqedonisë dhe Bashkimit Evropian, midis të tjerash ato varen prej zbatimit të tyre të suksesshëm. Prej këndej, studimi me vëmendje i analizon synimet e mundshme dhe mundohet t'i përcaktojë kapacitetet dhe nevojat themelore në nivel lokal.

Ish Republika Jugosllave e Maqedonisë është bërë shtet i pavarur në vitin 1991. Deri atëherë sistemi ekonomik, politik dhe i mbrojtjes sociale për Ish Republikën Jugosllave të Maqedonisë ishte i përbashkët me Republikat Jugosllave të tjera, siç është Kroacia, (vend kandidat për anëtarësim në BE). Ngjashmëritë e tjera, sidomos në raport me synimet dhe trendet karakteristike për kapacitetet ekonomike dhe kapacitetet e fuqisë punëtore, janë gjithashtu të afërme me ato që vërehen në Bullgari dhe Rumani (vende anëtare të BE-së). Prej këndej, pjesa më e madhe e krahasime të të dhënave statistikore të studimit i përfshijnë Ish Republikën Jugosllave të Maqedonisë dhe shtetet e përmendura.

Edhe pse studimi e ndjek linjën e përgjithshme të kërkimeve që janë kryer më parë në vendet e tjera kandidate për anëtarësim në BE deri në vitin 2006[11], megjithatë studimi bazohet në synimet e reja dhe kornizë e re të procesit[12] të mbrojtjes sociale dhe përfshirjes sociale, të miratuar prej Këshillit Evropian në mars të vitit 2006.

[10] Marrëveshja Kornizë e nënshkruar në 13.8. 2001 i dha fund konfliktit të brendshëm në Ish Republikën Jugosllave të Maqedonisë. Qëllimi i tij është promovimi i zhvillimit të qetë dhe harmonik të shoqërisë, duke i respektuar identitetin etnik dhe interesat e të gjithë qytetarëve në vend. Në bazë t kësaj marrëveshjeje, u zbatua lista e ndryshimeve konkrete kushtetuese dhe reforma juridike në fushën decentralizimit, përfaqësimit të drejtë, procedura të veçanta parlamentare për mbrojtjen e bashkësive etnike që nuk janë shumicë, arsim, përdorim të gjuhëve, flamujve, shprehjen e identitetit etnik dhe kulturor dhe masa për implementim. Disa prej hapave më të rëndësishëm të mëtejshëm në aspektin e Marrëveshjes Kornizë përbën implementimi i saj në nivel lokal.

[11] http://ec.europa.eu/employment_social/social_protection/health_en.htm#studies
http://ec.europa.eu/employment_social/social_inclusion/docs/2006/study_croatia_en.pdf

[12] http://ec.europa.eu/employment_social/social_inclusion/docs/2006/objectives_en.pdf

Qëllimi kryesor i studimit është të kontribuojë në procesin e ardhshëm të bisedimeve për anëtarësim të vendit në BE në fushën e mbrojtjes sociale dhe përfshirjes sociale, si dhe për Memorandumin e përbashkët për përfshirje. Rezymeja siguron pasqyrim të shkurtër të studimit në anglisht, maqedonisht dhe shqip.

Trende ekonomike, demografike dhe sociale të cilat ndikojë në sistemin e mbrojtjes sociale

Ish Republika Jugosllave e Maqedonisë e ka marrë pavarësinë në vitin 1991 me kushte ekonomike mjaft të pafavorshme. Në krahasim me shtetet e tjera të ish-Jugosllavisë ajo ishte shteti i zhvilluar më dobët, me shkallë të lartë të papunësisë (20%) dhe infrastrukturë pak të zhvilluar. Procesi i tranzicionit prej një ekonomie të mbyllur dhe të planifikuar nga qendra drejt një sistemi tregu të hapur dhe fukcional është ballafaquar me shumë strese të jashtme dhe të brendshme, të cilat vazhdimisht ndikonin në politikat dhe reformat e filluara.

Dekada e rritjes ekonomike së ngadalshme filloi të përmirësohet ngadalë, por vazhdimisht duke filluar prej vitit 2001. Në vitin 2002 PBV shënoi rritje prej 0.9%, pas së cilit në 2003 arriti rritje prej 2.8%, kurse prej vitit 2004 shënon rritje prej 4%. Parashikimet pranverore të Drejtorisë së Përgjithshme për Çështje Ekonomike dhe Financiare (2007) tregojnë rritje relativisht të matur prej 3.1% në vitin 2006 në krahasim me 3.8% në 2005. Shkaku themelor për këto rezultate relativisht të matura ishte rritja më e dobët se sa pritej në fushën e prodhimtarisë, bujqësisë dhe ndërtimtarisë. Për shembull, prodhimtaria industriale shënoi rritje prej vetëm 2.5% në vitin 2005. Prodhimtaria bruto vendase për çdo banor në pikëpamje të fuqisë blerëse është 26% e mesatares të BE-së – 25. Megjithatë ekzistojnë dallime të dukshme rajonale të PBV-së për çdo banor në raport me standardet e fuqisë blerëse, e cila është pothuajse dy herë më e madhe në rajonin e kryeqytetit. (afërsisht 50% e mesatares së BE-së, në krahasim me mesataren nacionale prej afërsisht 25% të mesatares së BE-së). Kjo u detyrohet dallimeve të theksuara në investimet të infrastrukturës dhe të ardhurave në kryeqytet dhe zonat rurale. Sipas parashikimeve për vitin 2007 të Drejtorisë së Përgjithshme për Çështje Financiare dhe ekonomike llogaritet që PBV-ja do të rritet deri në 4.3% në vitin 2007 dhe 5.3% në vitin 2008.

Paga mesatare mujore bruto në vitin 2006 ka qenë 23,036 denarë apo 374.56 euro (duke e përfshirë tatimin personal të të ardhurave dhe të ardhurat e mbrojtjes sociale të të punësuarve). Paga mesatare neto për të njëjtën periudhë ka qenë 13,527 denarë apo 219.95 euro. Në vitin 2006 paga mesatare mujore u rrit për 7.3% në krahasim me vitin 2005. Përkrah pagave të vogla mujore, gjithashtu ekziston një numër i madh të punësuarish të cilët nuk marrin paga rregullisht (në dhjetor 2006, 13.3% prej të gjithë të punësuarve nuk kanë marrë rrogë). Në krahasim, paga mesatare mujore është më e madhe vetëm prej asaj të Bullgarisë (200 euro) dhe Shqipërisë (170 euro).

Dobësitë e pazarit të fuqisë punëtore në Ish Republikën Jugosllave të Maqedonisë i dedikohen një sërë faktorësh, midis të cilëve: humbja e vendeve të punës për shkak të ristrukturimit ekonomik, rrethanave të pafavorshme ekonomike (Embargoja Greke 1994-95, kriza kosovare në 1999 etj.), pengesat për futje apo jo fleksibiliteti i tregut të fuqisë së punës të ndjekura prej zbatimit më të shpeshtë të politikave pasive dhe jo atyre aktive në tregun e fuqisë punëtore. Shkalla e përgjithshme e punësimit në Ish Republikën Jugosllave të Maqedonisë në bazë mbetet e palëvizshme në një nivel jashtëzakonisht të vogël gjatë kësaj 39.6% e popullsisë së aftë për punë (në moshë prej 15 deri 64 vjet) në vitin 2006 janë regjistruar si të punësuar (me shkallë aktiviteti prej 62.2%). Kjo është një shkallë mjaft më e ulët në krahasim me shkallën e

punësimit (2006) në Kroaci – 55%, Bullgari dhe Rumani (58.6%, 58.8%) dhe sidomos mjaft më e ulët se ajo e BE-së 27 – 63.4%.

Përmirësimet në raport me punësimin e bashkësive etnike në Ish Republikën Jugosllave të Maqedonisë lidhen me Marrëveshjen Kornizë të Ohrit (2001). Parimi i përfaqësimit të barabartë, i cili është pjesë e Marrëveshjes Kornizë të Ohrit, kontribuoi për zmadhimin e punësimit të bashkësive etnike para së gjithash në institucionet publike. Prej 31 gushtit 2006 përqindja e të punësuarve në sektorin publik (përkatësisht në ministritë dhe institucionet e tjera shtetërore, institucionet nga fusha e gjykatave dhe ndërmarrjeve publike) sipas përkatësisë etnike, është: 74.19% maqedonas, 8.93% shqiptarë, 1.74% serbë, 0.93%, turq, 0.55% vllehë, 0.26% boshnjakë, 0.42% romë dhe 0.91% të tjerë.

Ekonomia e zezë është e përhapur gjerësisht, që shkakton rritje të disa ndikuesve të tregut të fuqisë së punës (përkatësisht papunësisë). Sipas planit të fundit të ETF-së për Ish Republikën Jugosllave të Maqedonisë (2007) ekonomia e zezë në vend përbën 33% -37% të PBV.

Të dhënat prej Hulumtimeve të Fuqisë së Punës tregojnë se në vitin 2006 shkalla e papunësisë (15-64) ishte 36.3% që është shumë më e madhe në krahasim me shkallën e papunësisë në Kroaci (11.8%), Bullgari (9%), Rumani (7.3%) dhe BE-27 (7.9%). Problem shtesë paraqet pranishmëria e papunësisë afatgjatë, duke pasur parasysh faktin se përqindja e personave të papunësuar për një kohë të gjatë (persona të papunësuar më shumë se një vit) në vitin 2005 ishte 32.3% e popullsisë së përgjithshme të aftë për punë. Shkalla e papunësisë në vitin 2006 sipas përkatësisë gjinore (Anketa për Fuqinë e Punës) tregojnë se shkalla e papunësisë tek përfaqësuesit e gjinisë mashkullore ishte 35.6%, kurse tek përfaqësuesit e gjinisë femërore 37.5%. Në të dyja rastet, numrat tregojnë rënie në krahasim me vitin 2005 për 0.9% për të dyja gjinitë.

Tregu i punës gjithashtu karakterizohet me një mangësi të madhe të aftësive. Llogaritjet e ETF-së në aspektin e nivelit të marrjes së arsimit tek personat në moshë madhore prej 25-64 tregon numra shumë të vegjël, 41% me ISCED[13] 0-2 (dy herë më e lartë në krahasim me 10 vendet e reja anëtare të BE-së), 45% me ISCDE 3-4 dhe 14% me ISCDE 5-6. Krahasuar, rezultatet e ISCED 0-2 janë: në Kroaci-30%, Bullgari-28% dhe Rumani-27%.

Sipas regjistrimit nacional të vitit 2002, Ish Republika Jugosllave e Maqedonisë ka 2,022,547 banorë. Paraqitja etnike e shtetit është e shumëllojshme, me 64.18% maqedonas, 25.17% shqiptarë, 3.85% turq, 2.66% romë, 1.78% serbë, 0,84% boshnjakë, 0.48 vllehë dhe 1.04% kombësi të tjera. Shkalla e fertilitetit në vitin 2005 ishte 1.5 që është mjaft më e ulët në krahasim me nivelin e vendosur prej BE-së 2.1 e nevojshme për mirëmbajtjen e popullatës. Sipas parashikimeve demografike të Sektorit të Popullsisë në suazat e Kombeve të Bashkuara (2004), numri i tërësishëm i popullsisë në Ish Republikën Jugosllave të Maqedonisë mund të bjerë nga 2,034,000 në vitin 2005 deri në 1,884,000 në vitin 2050. Numri i popullsisë së aftë për punë (15-64) pritet të bjerë nga 69.3% në vitin 2005 deri në 60% në vitin 2050.

Mbrojtja sociale dhe sistemi për ndihmë sociale

Mbrojtja sociale në Ish Republikën Jugosllave të Maqedonisë është e përbërë prej shërbimesh dhe beneficionesh të sistemit tatimor financiar për ndihmë sociale

[13] Klasifikimi Standard Ndërkombëtar i Arsimit (International Standard Classification of Education-ISCED).

(preventiv social – i cili sipas Ligjit për Mbrojtje Sociale përfshin punë edukative-këshilluese, zhvillim të formave të vetë-ndihmesës, punën vullnetare etj., mbrojtjen institucionale, mbrojtjen jashtë institucionale dhe ndihmën financiare) si dhe prej sistemit për sigurim social i bazuar në të ardhurat (sigurimi i pensioneve dhe invaliditetit dhe sigurimi në rast të papunësisë). Tradita e ndihmës sociale egalitare dhe sigurimi social sipas Bizmarkut ngadalë i lëshuan vendin mbrojtjes sociale më të qëndrueshme dhe më individuale, sidomos si rezultat i ndikimeve të institucioneve financiare ndërkombëtare (si Banka Botërore).

Të dhënat për shpenzimet për mbrojtje sociale sipas ESSPROS-metodologjisë ende nuk janë të kapshme. Sipas Entit Shtetëror të Statistikës shpenzimet sociale në Ish Republikën Jugosllave të Maqedonisë janë llogaritur sipas ESA 95. Sipas kësaj metodologjie transferimet sociale si përqindje e PBV-së janë rritur nga 13.6% në vitin 1995 deri në 15.3% në vitin 2004 dhe janë ulur në 12.2% në vitin 2005. Shuma e transferimeve sociale si përqindje e buxhetit qendror është rritur nga 52.7% në vitin1995 deri në 60.3% në vitin 2003 dhe është ulur në 58.8% në vitin 2005. Për të njëjtin vit, shpenzimet e buxhetit qendror për shëndetësi kanë qenë 1.8%, për pensione - 45.2%, transferimet e Agjencisë së Punësimit - 11.3% dhe për mbrojtje të fëmijëve – 0.4%.

Nga ana administrative, përgjegjësia kryesore për organizimin e mbrojtjes sociale publike dhe ndihmës i takon Ministrisë së Punës dhe Mbrojtjes Sociale. Institucionet përgjegjëse për ndihmë sociale dhe për dorëzimin e ndihmës janë qendrat për çështje sociale, institucionet për mbrojtje sociale (për kujdesje sociale) si dhe kopshtet. Të drejtat dhe shërbimet e sistemit për sigurim social realizohen nëpërmjet Fondit për Sigurim të Pensionit dhe Invaliditetit, duke përfshirë edhe kompanitë private të pensioneve, Fondin e Sigurimit Shëndetësor dhe Agjencisë të Punësimit.

Kompensimet me të holla prej sistemit për mbrojtje sociale janë të përbëra prej beneficionesh kontribuitive dhe jokontribuitive. Kompensimet jokontribuitive dhe kompensimet të cilat varen prej kontrollimit të mjeteve përfshijnë ndihmë sociale (duke përfshirë këtu të gjitha nënkategoritë) dhe ndihmën për fëmijët, të cilat i shpërndanë qendrat për ndihmë sociale (ndihmë sociale) dhe Sektori për Mbrojtjen e Fëmijëve (Kompensimet për fëmijë). Kompensimet kontribuitive përfshijnë pensionet, kompensimet me të holla për të papunësuarit, kompensimet për rroga gjatë kohës kur nuk janë në punë për shkak të shtatëzanisë, lindjes dhe lejës së lindjes, si dhe kompensime të rrogës gjatë kohës së mungesës së përkohshme nga puna për shkak sëmundjeje apo lëndimi. Këto kompensime shpërndahen prej Fondit për Sigurim Invalidor dhe Pensional (pensionet), Agjencia e Punësimit (kompensimet në të holla për të papunësuarit), si dhe Fondi për Sigurim Shëndetësor (kompensime për rrogat gjatë kohës së mungesës në punë për shkak të shtatëzanisë, lindjes dhe lejës së lindjes, si dhe kompensimet për rrogë gjatë mungesës së përkohshme nga puna për shkak sëmundjeje dhe lëndimi). Gjatë kohës së tranzicionit, sidomos në periudhën e viteve të fundit të 90-ve, karakteristikë e përbashkët për të gjitha kompensimet me të holla të sistemit për mbrojtje ishte thellësimi i kritereve për marrje të beneficioneve si dhe madhësinë e beneficioneve.

Në 2006, shumat mujore mesatare të kompensimeve për ndihmë sociale janë të dhëna për person ishin: për ndihmë në të holla të vazhdueshme-3,046 denarë (49.79 euro), për ndihmë sociale në të holla-2,154 denarë (35.21 euro), për kompensim në të holla për ndihmë dhe kujdesje-3,390 (59.42 euro), për ndihmë të njëfishtë në të holla-2,080 denarë (34 euro), për kompensim financiar për rrogë për orë pune të shkurtuara për shkak të kujdesje për fëmijë invalid-6,590 denarë (107.73 euro), për kompensim financiar për rrogë për orë pune të shkurtuara për shkak të kujdesje për fëmijë invalid – 3,567 denarë (58.31 euro) dhe për ndihmë në të holla personave të

cilët deri në moshën 18-vjeçare kanë pasur statusin e fëmijëve pa prindër dhe përkujdesie prindërore – 3,567 denarë (58.31 euro).

Kompensimet për fëmijë në përgjithësi janë të vogla. Shtesa për fëmijë është 691 denarë (11.3 euro) për fëmijë deri në moshën 15 vjeçare dhe 1,174 denarë (19.19 euro) për fëmijë në moshën midis 15 dhe 18 vjeç në qoftë se janë në sistemin arsimor. Shtesa e veçantë e dhënë për familjet që kujdesen për fëmijë të hednikepuar është 3,632 denarë (59.38 euro) në muaj dhe ndihma për pajisje të fëmijës së porsalindur mund të jetë prej 1,000 denarësh (16.35 euro) dhe 3,500 denarësh (57.22 euro) të cilat jepen vetëm për fëmijën e parë.

Në vitin 2006, numri mesatar i marrësve të ndihmës sociale (të gjitha nënkategoritë) është 92,506 shfrytëzues, kurse numri mesatar mujor i shfrytëzuesve të kompensimeve fëminore 22,362 familje dhe 36,649 fëmijë.

Kompensimet për sigurim social janë të financuara prej të ardhurave të detyrueshme për pensione dhe invaliditet, papunësi dhe shëndetësi. Këto të ardhura përbëjnë deri 32% të pagës bruto të të punësuarve dhe paguhet prej punëdhënësve. Përqindja e lartë e të ardhurave për sigurim social, të paguara vetëm prej punëdhënësve, përbën barrë të madhe për shpenzimet e të punësuarve, dhe përbën një prej pengesave kryesore për nxitjen e punësimit. Përveç të ardhurave prej punëdhënësve, Buxheti Shtetëror gjithashtu kontribuon në një pjesë të caktuar për shpenzimet e sigurimit social.

Kompensimi në të holla për të papunësuarit paguhet vetëm për ata të cilët kanë punuar dhe paguar të ardhurat vazhdimisht të paktën 9 muaj apo 12 muaj me ndalesa në 18 muajt e fundit. Kategori të veçanta, si bujqit, mund t'i marrin këto kompensime vetën në qoftë se veprimtaria e tyre ka qenë e regjistruar dhe në qoftë se i kanë paguar të ardhurat sipas kritereve të lartpërmendura. Nuk ekziston kufi minimal, kurse maksimumi nuk mund të jetë mbi 80% të rrogës mesatare në vend. Numri i shfrytëzuesve të kompensimeve për të papunësuar shkallë-shkallë po ulet, prej 41,375 marrë në vitin 2001 në 30,752 në dhjetor të vitit 2006 (8.3% e numrit të përgjithshëm personave të regjistruar si të papunësuar). Është e rëndësishme të theksohet se ulja e shfrytëzuesve të kompensimeve në të holla për të papunësuarit shfaqet si rezultat i thellësimit të kritereve për kualifikim, po gjithashtu, për shkak të numrit të zvogëluar të ndërmarrjeve të të mbyllura dhe ndërmarrjeve në falimentim në këtë periudhë. Kompensimet e rrogës gjatë kohës së mungesës nga puna për shkak të shtatëzanisë, lindjes dhe lejës së lindjes vazhdimisht paguhen për periudhë prej 9 muajsh (28 ditë para lindjes) apo 12 muaj në rast të lindjes të më shumë se një fëmije. Fondi për Sigurim Shëndetësor paguan kompensime të rrogës gjatë kohës së shkëputjes nga puna për shkak të shtatëzanisë, lindjes dhe lejës së lindjes 100% të rrogës neto mujore që i është dhënë të punësuarës (nënës) në periudhën prej 6 muajsh para shkëputjes nga puna për shkak të shtatëzanisë. Në raport me kompensimin e rrogës gjatë shkëputjes nga puna të përkohshme për shkak të sëmundjeve dhe lëndimeve, punëdhënësi paguan kompensimin për punëtorin për 21 ditët e para të punës prej mjeteve të tij, ndërsa pas 21 ditësh paguhen prej Fondit për Sigurim shëndetësor. Shkalla e kompensimit për punëtorët gjatë shkëputjes së përkohshme nga puna për shkak sëmundjeje dhe lëndimi përcaktohet nga punëdhënësi apo Fondi për Sigurim Shëndetësor sipas aktit të përgjithshëm nënligjor në shumë prej 70% të bazës për kompensim të punëtorit.

Paralelisht me ndihmën në të holla, sistemi për mbrojtje sociale gjithashtu siguron shërbime sociale, të cilat sipas Ligjit për Mbrojtje Sociale kategorizohen si: (1) preventiv social; (2) mbrojtje institucionale; (3) mbrojtje jashtë institucionale. Këto shërbime më shpesh sigurohen dhe administrohen prej shtetit por kohët e fundit me

shfaqjen e trendeve të pluralizmit dhe deinstitucionalizimit, ekzistojnë dhe forma të tjera të mbrojtjes jorezidenciale të cilat ofrohen prej organizatave joqeveritare dhe private. Procesi i decentralizimit të qendrave tëë punës sociale (shërbimeve sociale) ende nuk ka filluar si rezultat i disa shkaqeve: 1) mungesë e dispozitave ligjore në Ligjin e Vetqeverisjes Lokale (neni 22.7) i cili nuk parashikon decentralizim të transferimeve në të holla; 2) mosekzistimi i organit të shkallës së dytë (në nivel lokal) në raport me vendimet apo ankesat; 3) mungesa e resurseve njerëzore në shumicën e qendrave për punë sociale në përballimin me administrimin e transferimeve dhe sigurimin e shërbimeve sociale.

Varfëria dhe përjashtimi social

Në këtë moment, matja e varfërisë në Ish Republikën Jugosllave të Maqedonisë nuk bazohet në burime të përshtatura të të dhënave dhe as që ekzistojnë indikatorë komparativë të BE-së të cilat zbatohen kur vlerësohet linja e varfërisë. Gjithashtu nuk ekziston përkufizim i miratuar apo i përvetësuar nacional për përjashtimin social, sipas të cilit do të mund të analizohej kjo gjendje. Përveç mungesës së përkufizimit formal të pranuar për përjashtimin social, Ministria e Punës dhe Politikës Sociale, në dokumentin e vet për Politikat për ballafaqimin me Problemet e Personave Socialisht të Përjashtuar (2004) përcaktoi 4 grupe të popullsisë të përjashtuar nga ana sociale. Këto grupe janë të përbëra prej: (1) shfrytëzues të drogës dhe anëtarë të familjes së tyre, (2) fëmijët e rrugës dhe prindërit e tyre, (3) viktimave të dhunës familjare, si dhe (4) të pastrehët. Ndarja e këtyre grupeve të qëllimit si entitet i veçantë social është i drejtuar kah mundësimit të qasjes efektive të shërbimeve të mbrojtjes sociale (MPPS, 2004 fq. 1). Megjithatë ky kategorizim shfrytëzon qasje arbitrare e cila nuk bazohet në hulumtim të paraprak duke e marrë parasysh përfaqësimin e madh të këtyre grupeve në popullsinë e përgjithshme sociale. Gjithashtu nuk përfshin grupe të tjera të rëndësishme si romët, të varfrit ruralë etj.

Në vitin 1996, Ish Republika Jugosllave e Maqedonisë e miratoi linjën relative të varfërisë si standard nacional për llogaritjen e nivelit të varfërisë. Metoda relative e përkufizon varfërinë në nivel prej 70% të konsumueses ekuivalente mesatare me zbatim të shkallës së vjetër OECD (1.0/0.7/0.5). si rezultat i ekonomisë së zezë si dhe të dhënave nga jashtë, metodologjia për llogaritje statistikore të varfërisë bazohet në konsum dhe jo në të ardhura si tregues i standardit jetësor. Llogaritë për periudhën prej 1997 deri në 2005 tregojnë rritje të shkallës të varfërisë prej 19.0 në 1997 deri në 30.0 në 2005.

Indikatorët laeken për përjashtim social janë ende në fazën e fillimit të përgatitjeve. Ekzistojnë disa vlerësime, por këta indikatorë duhet të interpretohen me vëmendje (sidomos ata që kanë të bëjnë me papunësinë) si rezultat i madhësisë së ekonomisë së zezë në vend si dhe disa çështje lidhur me cilësinë e Anketës së Fuqisë Punëtore në vend, sidomos në raport me statusin pasiv/aktiv të kategorive si: punëtorë familjarë pa pagesë, të vetëpunësuar dhe pensionistë. Duke e marrë parasysh këtë, këto që vijojnë janë Llogaritjet Laeken të para të ndërmarra prej Raportit Nacional për Qëllime Zhvillimore të Mileniumit (2005): (1) përqindja e personave në amvisëritë me të papunësuar në 2004 ka qenë 27.7%; (2) shkalla e të papunësuarve afatgjatë bë vitin 2005 ka qenë 32.3%; (3) përqindja e papunësisë afatgjate në 2005 ka qenë 86.7%; (4) vetë shkalla e papunësisë afatgjate në vitin 2005 ka qenë 86.7%; (5) Xhini koeficienti/indeksi për 2003 ka qenë 29.3%; (6) shekulli jetësor gjatë lindjes për periudhën 2003/2005 ka qenë 73.62 për të gjithë dhe 71.4 vjet për burra dhe 75.8 për gra; (7) përqindja e personave me nivel të ulët të arsimit (nivel ISCED 2 apo më pak) për 2005 ka qenë 41%.

Në raport të grupeve në rrezik, Strategjia për Uljen e Varfërisë në vitin 2002 dhe raportin e fundit nacional për Qëllimet Zhvilluese të Mileniumit tregojnë se nuk ka ndryshim të madh tek amvisëritë me profile të rrezikut më të madh, që tregon se amvisëritë me më shumë anëtarë, amvisëritë me anëtarë të papunësuar, amvisëritë anëtarët e të cilave kanë nivel të ulët arsimi, si dhe amvisëritë me persona më të moshuar janë në rrezikun më të lartë të varfërisë.

Pensionet

Në krahasim me format e tjera të mbrojtjes sociale, sistemi i pensionit u është nënshtruar ndryshimeve më të mëdha që prej 1991. Ndryshimet kanë qenë me karakter parametrik dhe paradigmatik. Megjithatë, aspekti kryesor i ndryshimeve paraqet modernizim të sistemit të pensionit, me përkujdesje shumë të vogël apo pa përkujdesje të vërtetë në lidhje me qëndrueshmërinë e tij apo përshtatshmërisë së tij. Studimi ynë tregon se përkrah vlerësimeve të përgjithshme dhe zyrtare në lidhje me mbulimin e lartë të sistemit të pensionit, më tepër se 70 000 njerëz (apo 31.1%) mbi moshën 65 vjeçare nuk janë të mbuluar me beneficionet e pensionit. Faktor shqetësues shtesë përbën rritje e shpenzimeve të parapara të planifikuara tranzicionale (2,2% të PVB-së në rast të 86,000 të hyrësve apo 25% të personave të siguruar). Meqenëse numrat e hyrësve në shtyllën e dytë i dyfishonin pritjet, kjo tregon se shpenzimet tranzicionale gjithashtu do të dyfishohen, duke e arritur kulmin prej 4.5% të PVB-së në periudhën prej 2025 deri në 2030.

Në raport me strukturën, sistemi i pensionit në Ish republikën Jugosllave të Maqedonisë është i përbërë prej tri shtresash: Shtylla e parë – sigurim i detyruar i pensionit shtetëror sipas parimit të solidaritetit të gjeneratave; Shtylla e dytë – sigurim i detyruar kapitalo-financiar i pensionit dhe Shtylla e tretë – sigurim vullnetar kapitalo-financiar i pensionit (zbatimi i të cilës është planifikuar për vitin 2008). Të kualifikuar për pension nga vjetërsia janë të siguruarit në moshë 64 vjeçare për burra dhe 62 vjeçare për gra dhe minimum 15 vjet stazh pensional. Shkalla e kontributit është 21.2% e rrogës bruto të të siguruarve të cilët nuk do t'i bashkëngjiten shtyllës së dytë dhe 13.78% të rrogës bruto të të siguruarve të cilët do t'i bashkëngjiten shtyllës së dytë të sistemit të pensioneve. Të siguruarit të përfshirë në sistemin e ri paguajnë kontribut prej 7.42% të rrogës bruto për shtyllën e dytë.

Ekzistojnë dy shoqëri private të pensionit, të cilat i mbledhin kontributet e shtyllës së dytë të detyrueshme. Kompensimi i cili paguhet prej shoqërive të pensionit përfshin: (I)7.9% - të kontributeve; (II) kompensim mujor prej 0.05% të vlerës neto të mjeteve të fondit të pensionit, që të mbulohen shpenzimet e shoqërisë së pensionit për administrimin me fondin e pensionit dhe (III) kompensim për shumën e paraparë në llogarinë e anëtarit të fondit të pensionit, në rast të transferimit të këtyre mjeteve në tjetër fond pensioni (i cili ende nuk është përcaktuar). Krahasim, kompensimet administrative në Ish Republikën Jugosllave të Maqedonisë, janë më të larta (na Kroaci janë 0.8%, në Hungari 5-6% në mesatare, Poloni 7% por është paraparë të bien në 3.5% në periudhë prej 10 vjetësh). Daljet administrative më të larta mund ta ulin ndjeshëm nivelin e kursimit të kohës së punëtorit. Sipas vlerësimeve të OECD-së, në muaj kompensime të barabarta të vetëm 1% të mjeteve mund të pritet ta ulin kursimin e punëtorit me pensionim deri në 20% gjatë kohës së karrierës së tij të punës.

Nga fundi i vitit 2005 kishte 405,542 persona të siguruar në shtet. Për të njëjtën periudhë kohore, numri i shfrytëzuesve të pensionit (pension vjetërsie dhe invaliditeti, pension familjar) ishte 265,152. Nga 31 dhjetori 2006 kishte 128,031 anëtarë në shtyllën e dytë, që përbën 31.5% të të gjithë personave të siguruar, apo 14.35% të popullsisë aktive. Sipas të dhënave të kapshme për numrin e të siguruarve në fondet

private të pensionit, prej 128,031 të siguruarve deri në 31 dhjetor 2006 për 14,467 nuk janë paguar kontributet. Kjo përbën 11% të të gjithë të siguruarve në fondet private të pensionit.

Shuma mesatare për pensione në vitin 2005 ka qenë: pension vjetërsia-8,517 denarë (139.2 euro), pension invaliditeti-6,542 denarë (106.93 euro) dhe pension familjar – 6,018 denarë (98.37 euro). Pensioni i garantuar minimal në Ish Republikën Jugosllave të Maqedonisë është 3,918.59 denarë (64.06 euro).

Përqindja e shpenzimeve për sigurim pensioni dhe invaliditeti për 2005 ishte 10.5% të PVB dhe është ulur në krahasim me vitin 2004 dhe 2003. Në vitin 2006 pagesa e kontributeve u rrit për 10.5% në krahasim me vitin e mëparshëm, prej të cilave 7% janë rezultat e rritjes nominale të të ardhurave në shtet dhe 3.5% është vlerësuar si rezultat pagimit të përmirësuar të kontributeve.

Shëndetësia dhe kujdesi afatgjatë

Ish Republika Jugosllave e Maqedonisë kalon nëpër një proces të gjatë dhe të vështirë reformash në sigurimin e financimin e shërbimeve shëndetësore. Mbulimi sigurimit shëndetësor përbën afërsisht deri në 100%, indikatorët për qasjen fizike janë impresionuese dhe pakoja themelore e shërbimeve është mjaft e gjerë duke i mbuluar pothuajse të gjitha shërbimet shëndetësore. Kjo bujari e sistemit publik financiar nuk është e lejueshme dhe krijon probleme të theksuara lidhur me paefikasitetin. Ajo karakterizohet me korrupsion dhe balancohet nëpërmjet zvogëlimit të shpenzimeve të cilat ndikojnë në sistemin e shëndetësisë primare, si dhe në mirëmbajtjen e objekteve të cilat janë të rëndësishme për të varfrit. Cilësia e shëndetësisë gjithashtu përkeqësohet si rezultat i mungesës së materialeve dhe rrogat të cilat e zënë pjesën më të madhe të buxhetit për shëndetësinë. Ekzistojnë të dhëna të vlerësimeve të ndryshme të shfrytëzuesve se qasja dhe cilësia e kujdesit shëndetësor janë të pa përshtashme për ata të cilët nuk kanë të paguajnë për mjekimet, të paguajnë me mjete private apo nuk kanë mundësi të paguajnë doktorë privatë.

Edhe pse vëzhgimi në këtë mënyrë në vetvete është joformal. Kombinimi i të dhënave shëndetësore me të dhënat e varfërisë në raport me të ardhurat mund të kontribuojë në kuptimin më të mirë të varfërisë dhe në krijimin përkatës të politikave. Në atë aspekt gjendja në sektorin shëndetësor është më e keqe se në sektorët e tjerë. Në raport me banimin dhe qasjen e ujit dhe kushteve sanitare, shumë amvisëri të varfra jetojnë në mjedise të pasigurta, dhe jo të shëndetshme, sidomos në rastin e lagjeve substandarde pa qasje të infrastrukturës sociale dhe fizike.

Megjithatë, profili shëndetësor në shtet karakterizohet me tendenca të ngjashme si dhe në vendet e tjera të Evropës, me përhapje të madhe të sëmundjeve kardiovaskulare si shkaktues të vdekjes. Gjithashtu ekziston tendenca për uljen e sëmundjeve ngjitëse dhe vdekshmëria tek foshnjat dhe nënat. Por ndikimi i reformave në shëndetësi mbi standardin jetësor, sidomos tek të varfrit ende duhet të hulumtohet. Ndërsa përmirësimet në sistemin e kujdesit shëndetësor janë të rëndësishme për sigurimin e qëndrueshmërisë së sistemit, duhet bërë punë plotësuese që të vlerësohet se deri në cilën shkallë këto reforma kanë prekur tek të varfrit, dhe çfarë efektesh janë shfaqur prej thellimit të kufizimeve buxhetore për qasje për grupe të caktuara.

Midis çështjeve të tjera në Ish Republikën Jugosllave të Maqedonisë, procesi i decentralizimit synon ta ndryshojë strukturën organizuese dhe ta reformojë dhënien e shërbimeve nga ana e Qeverisë. Ky proces duhet ta rrisë ndikimin e bashkësive

lokale, të krijojë mundësi për qytetarët që t'i shprehin nevojat e tyre, të japë shërbime të cilat e promovojnë përfshirjen sociale të grupeve të lëndueshme, të nxisë reforma shëndetësore të cilat synojnë drejt përmirësimit të kapacitetit dhe efikasitetit të mbrojtjes primare shëndetësore si dhe drejt uljes së shpenzimeve në spitale. Ngjashëm, si dhe në shtetet e tjera të rajonit, reformat shëndetësore në Ish Republikën Jugosllave të Maqedonisë kanë filluar dhe janë promovuar prej Bankës Botërore nëpërmjet dy projekteve kryesore reformatore. Një numër i caktuar i nxitjeve serioze ende përbëjnë prioritet për vendin.

Nxitje kyçe që vijojnë

Me qëllim që të sigurohet konsekuencë, nxitjet kyçe janë strukturuar sipas qëllimet e BE për mbrojtje sociale dhe procesi i inkluzionit social të miratuara nga Këshilli i Evropës në mars të 2006.

Synimet të cilat kanë të bëjnë me sistemin e mbrojtjes sociale:

- Drejtim i beneficioneve të sistemit të mbrojtjes sociale sipas kërkesës për mbrojtje sociale. Efikasiteti i beneficioneve të sistemit të mbrojtjes sociale duhet të fokusohet ose në (a) kriteret e dhënies së shërbimeve/beneficioneve ose në (b) gjatësinë e shumës së kompensimeve. Zbatimi i rigiditeteve në të dy aspektet mund ta rrezikojë përputhshmërinë, qasjen dhe kohezionin social në aspektin e shfrytëzuesve të mbrojtjes sociale.

- Sigurimi i beneficioneve të mbrojtjes sociale dhe sigurimit social nëpërmjet institucioneve të krijuara veçanërisht për këtë qëllim. Momentalisht, vëzhgohet përputhje e roleve tek institucionet, për shembull në rastine sigurimit shëndetësor pa pagesë. I cili mund të sigurohet prej Agjencisë së Punësimit (institut i cili nuk është i lidhur aspak me sektorin shëndetësor). Kjo përputhje çon drejt rritjes/dyfishimit të numrit të shfrytëzuesve të regjistruar, si dhe vendosjen e kritereve të panevojshme (jofleksibile), të cilat potencialisht i largojnë kërkuesit e rrezikuar të ndihmës sociale prej sistemit të mbrojtjes sociale.

- Decentralizimi i qendrave të punës sociale, në aspektin e financimit dha ofrimit të mbrojtjes sociale. Duhet të kryhet vlerësim i resurseve dhe nevojave lokale që të vlerësohen kapacitetet e vetëqeverisjeve lokale. Decentralizimi i qendrave të punës sociale duhet të çojë drejt qasjes dhe efikasitetit të përmirësuar të sistemit të mbrojtjes sociale.

- Transparencë dhe mbikëqyrje e sistemit të mbrojtjes sociale. Sistem i hapur dhe i kapshëm i mbrojtjes sociale mund ta rrisë besimin tek shfrytëzuesit e ndihmës sociale.. Nëpërmjet futjes së dispozitave më të rrepta në rastin e shkeljes së ligjit për mbrojtje sociale si dhe nëpërmjet dhënie të kompetencave më të mëdha trupave ekzistues mbikëqyrës në suazat e Ministrisë së Punës dhe Politikës Sociale mund t përmirësohet pamja publike ekzistuese për profesionistët e për përfshirë në sistemin e mbrojtjes sociale.

- Zmadhimi kapacitetit administrativ të Ministrisë së Punës dhe Politikës Sociale, si dhe të institucioneve të tjera të detyruara për administrimin dhe sigurimin e shërbimeve sociale në niveli qendror dhe lokal.

Nxitje të lidhura me shkuljen e varfërisë dhe përjashtimit social:

- Zgjerim të përfshirjes ekzistuese prodhuese të përcaktuar t[kategorive sociale të përjashtuara, nëpërmjet përfshirjes të të punësuarve me të ardhura të vogla, të varfrit ruralë, gratë e bashkësive etnike të cilat jetojnë në mjedise rurale, romët, fëmijët familjeve më të mëdha (3dhe më tepër fëmijë) sidomos me prindër të papunë dhe fëmijë të cilët jetojnë në institute.

- Sigurim i shërbimeve të reja të lëvizshme të deinstitucionalizuara për shumicën e kategorive të grupeve sociale të përjashtuara (prej ekzistueseve), sidomos të personave më të vjetër si dhe rritje të numrit të qendrave ditore për strehimin e të pastrehëve si dhe për fëmijët e rrugës.

- Kufizim të masave për grupe të ndryshme të varfra. Strategjia nacionale për uljen e varfërisë njeh tri kategori të të varfërve në Ish Republikën Jugosllave të Maqedonisë, por meqenëse nevojat e këtyre grupeve dallohen, edhe masat përkundrejt tyre duhet të kenë dallime, gjithashtu, (I) duhet t'u kushtohet rëndësi e veçantë trajnimeve dhe shërbimeve këshillëdhënëse për ata që përcaktohen si të varfër të rinj, (II) ekziston nevoja e qasjes më të madhe në transferimet financiare për atë që përcaktohen si tradicionalisht të varfër kronikë.

- Zmadhim i qasjes në resurset të drejtat dhe shërbimet e nevojshme për pjesëmarrje në shoqërinë e atyre që jetojnë në rajone gjeografisht të largëta. Kjo mund të përfshijë shërbime të lëvizshme, vizita shëndetësore, furnizim me ushqime, mundësim të parakushteve të domosdoshme për pjesëmarrje në trajnime dhe aktivitete të tjera.

- Përfshirje sociale aktive të personave të rinj të papunësuar të cilët nuk janë të përfshirë me arsim dhe trajnim.

- Preventim i përjashtimit social që në moshë të hershme nëpërmjet: zgjerim të arsimit parashkollor për qasje më të madhe, qasje e zmadhuar e arsimit tetëvjeçar për grupet e lëndueshme si fëmijët romë, vajzat rurale, fëmijët me hendikep dhe zvogëlimin e numrit të nxënësve të cilët i lënë institucionet arsimore nëpërmjet shtimit të aktiviteteve jashtëshkollorë në shkollë, bashkëpunim me bashkësitë lokale dhe metodave interaktive të cilat e përkrahin mësimin individual tek fëmijët dhe përparimin vetjak.

- Administrim më i mirë me sistemin e mbrojtjes sociale. Pjesëmarrje e aktorëve joqeveritarë dhe qeveritarë relevantë si dhe persona të varfër në përgatitjen dhe koordinimin e politikave për inkluzion social. Sektori joqeveritar duhet të mbështetet, t'i dekoncentrojë dhe rivendosë shërbimet të cilat i ofron në vende ku ekziston nevoja, por nuk ka kapacitet përkatës për sigurimin e shërbimeve për kujdesi ditore.

Nxitje lidhur me pensionet përkatëse dhe të qëndrueshme

- Vlerësim të personave të vjetër të cilët nuk janë të mbuluar me sigurimin e pensionit. Ky studim tregon se ekzistojnë rreth 70,000 persona me moshë mbi 65 vjet të cilët nuk janë të mbuluar me sigurim pensioni. Personat e moshuar të këtij grupi të cilëve u mungon mbështetje shtesë prej rrjetave sociale formale dhe jo formale duhet të përfshihen në programet për inkluzion social.

- Vlerësim të shkallës së mbulimit të sistemit të pensionit te gratë e moshuara. Siç vërehet te gratë tendenca për të jetuar më gjatë, mund të pritet se ato të

cilat momentalisht nuk janë përfshirë në sistemin e pensionit janë shumica gra. Ato gjithashtu duhet të përfshihen që të mund të jenë shfrytëzues të mbrojtjes sociale.

- Vlerësim i grupeve të tjera të përjashtuara prej sistemit të pensionit, punëtorët në falimentim, bashkëshortet e bujqve ruralë, anëtarë të grupeve përkatëse etnike (si shqiptarët) si dhe grupet etnike të lëndueshme (romët) me përvojë pune jo përkatëse.

- Përshtatshmëri e të ardhurave të pensionit. Zgjidhje indirekte, si ulje apo heqje të pjesëmarrjes për barna dhe shërbime shëndetësore për popullsinë e moshuar, sidomos për atë me moshë mbi 70 vjet, n.q.s. kanë pension substandard, zgjerim të listës pozitive të barnave dhe sigurim të sasive të mjaftueshme të barnave të listës pozitive në farmaci, si dhe lloj tjetër të ndihmës direkte n.q.s mendohet se do të mundësohet e ardhur e mjaftueshme e pensionit, përkatës për standardin e jetës të personave të moshuar.

- Qëndrueshmëri financiare e sistemit të pensionit. Mbledhja e përmirësuar e kontributeve duhet të jetë prioritet sepse ka ndikim të theksuar në financimin dhe funksionimin e sistemit të pensioneve. Rrjetat më efikase për mbledhje duhet ta ndërmarrin detyrën dhe të zbatohet legjislacioni përkatës me drejtime të qarta. Duhet të krijohen rrjeta informatike, baza të dhënash dhe mekanizma për koordinim.

- Përmirësim i transparencës së sistemit të pensioneve, nëpërmjet futjes së raporteve më të shpeshta (se praktika ekzistuese) prej fondeve private të pensioneve për të siguruarit. Në këtë mënyrë çdo kontribut i papaguar prej punëdhënësve mund të vërehet në kohë, që gjithashtu mund të shfrytëzohet prej inspektimit të punës për mbikëqyrje dhe t'i sanksionojë këto shkelje.

- Shpenzimet e sistemit të ri – në aspektin e pagesës dhe si do të paguhen kompensimet gjatë pensionimit.

Nxitje që vendosen në sistem të qëndrueshëm, të kapshëm dhe me cilësi të lartë për mbrojtje sociale dhe kujdesi afatgjate

Sistemi i organizuar mirë dhe efektiv për mbrojtje shëndetësore me kompetencë primare të Ministrisë së Shëndetësisë duhet t'i ketë këto karakteristika:

- Efektivitet: intervenimet mjekësore duhet të mbështeten në dëshmi për përshtatshmëri për shëndetin.

- Efektivitet shërbimet për mbrojtje sociale duhet të synojnë rezultatet më të mira për çmim që shoqëria mund ta lejojë, që në Ish Republikën Jugosllave të Maqedonisë është e kufizuar.

- Efikasitet: të gjithë qytetarët duhet të kenë qasje të njëjtë në shërbimet të cilat u nevojiten pa dallim të të ardhurave dhe prejardhjes.

- Solidaritet në marrjen e fondeve për shërbime të mbrojtjes shëndetësore, i shëndetshmi duhet të kontribuojë për të sëmurin, i pasuri për të varfrin, i riu për të moshuarin.

- Përforcimi i mëtejshëm i mbrojtjes shëndetësore primare. Duhet të bëhen më tepër përpjekje në përforcimin e kapaciteteve të ekipeve shëndetësore preventuese, të modernizohen standardet dhe protokollet për preventimet kryesore dhe intervenimet promovuese (të përforcohet aktiviteti e imunizimit në bashkësitë lokale, kujdesi për gratë shtatzëna dhe vizitat sistematike të fëmijëve, sidomos për fëmijët, familjet dhe grupet e lëndueshme më të margjinalizuara). Si formë e veçantë duhet të përmenden shërbimet rinore shoqërore si dhe strategjia efektive për promovim të preventivit shëndetësor tek fëmijët dhe të rinjtë.

- Në kontekstin e përmendur më parë, përforcimi i kapacitetit të sistemit të infermiereve patronazhe mund të jetë efektive strategjia për implementim të disa programeve për promovim dhe preventim. Gjithashtu ky sistem patronazh mund të funksionojë si strukturë e cila do ta ulë barrën mbrojtjes shëndetësore sekondare dhe terciare, përkatësish kujdesin dhe mjekimin e sëmundjeve kronike e të tjera i cili mund të realizohet në nivel lokal me çka do të ulet qëndrim në spital dhe shpenzimet në nivel më të lartë të mbrojtjes shëndetësore.

- Ministria e Shëndetësisë duhet të synojë drejt ekzistencës së rrjetës të llojeve të ndryshme të shërbimeve shëndetësore primare dhe sekondare në të gjithë vendin e cila do të mundësojë nivel të lartë të qasjes, mungesës së ndarjes dhe përdorim efikas dhe të qëndrueshëm të resurseve financiare dhe njerëzore. Rrjeta duhet të funksionojë si sistem, që paraqet komplementaritet të elementëve të ndryshëm që do të kontribuojnë për qëllimin e përbashkët të sigurimit të shërbimeve efektive dhe efikase për opinionin. Me qëllim që të sigurohet qasje përkatëse, të gjitha objektet shëndetësore duhet të kenë licencë prej Ministrisë së Shëndetësisë, me rilicencim të rregullt, që përbën një prej qëllimeve të procesit ekzistues të përgatitjes së hartës shëndetësore.

- Ekziston nevojë për mbindërtim dhe harmonizim të shërbimeve dhe funksioneve ekzistuese shëndetësore publike me standardet ndërkombëtare të miratuara.

- Decentralizimi duhet të planifikohet në atë mënyrë që të mos futet në, apo ta dobësojë aftësinë e vendit që t'i realizojë qëllimet e veta në sistemin e shëndetësisë. Rreziku i rritjes së pabarazisë në qasjen e shërbimeve të domosdoshme dhe/apo cilësinë e shërbimeve të marra në mjedise të ndryshme apo në grupe të ndryshme të popullsisë përbën nxitje kyçe në procesin e decentralizimit. Rritja e pavarësisë së sistemeve të mbrojtjes shëndetësore do të ketë nevojë për formim të trupave përkatës rregullatorë.

- Është e domosdoshme të rivlerësohet pakoja e shërbimeve shëndetësore themelore të garantuara duke zbatuar praktika ndërkombëtare dhe duke marrë parasysh karakteristikat demografike dhe epidemiologjike si dhe çështjet lidhur me qëndrueshmërinë fiskale. Pjesa më e madhe e popullsisë e cila ballafaqohet me probleme ekonomike dhe sociale duhet të përcaktohet si grup qëllimi primar për lirim prej pjesëmarrjes në pagimin e shërbimeve (participimit).

- Në aspektin e shërbimeve nga fusha e kujdesisë afatgjatë, pritet që procesi i transformimit dhe deinstitucionalizimit të sistemit të mbrojtjes sociale në Ish Republikën Jugosllave të Maqedonisë, do të mundësojë dispersion (shpërndarje) të mbrojtjes paliative dhe shëndetësore të shëndetit mental në nivel lokal dhe do ta përforcojë kujdesin shtëpiak në vend. Gjithashtu, ky

proces duhet t'i mbështesë kushtet për hapjen e spitaleve ditore dhe qendrave për mbrojtje paliative dhe shëndetësore të shëndetit mental.

Chapter 1: Introduction - economic, demographic and social trends

1.1 Main factors that influence social protection

1.1.1 Economic and labour market indicators

The former Yugoslav Republic of Macedonia faced a prolonged and difficult process of transformation from a closed and centrally planned economy to an open and functioning market system. Although the country's separation from Yugoslavia in 1991 was not immediately followed by war or armed conflicts, unlike other ex-Yugoslav countries, the process of transition was challenged by many other internal and external shocks, which repeatedly hindered the initiation of policy reforms. Important internal factors have influenced increased economic uncertainty, including: a legacy of economic underdevelopment from the time of the Yugoslav federation; the breakdown of traditional production links and financial intermediation; the loss of preferential trading arrangements; a rise in inflation reaching 1,700 percent in 1992; and the ethnic crisis in 2001, which led to a decline in GDP by 4.5% in 2001 and pushed the public sector deficit to about 7% of GDP. Additional external factors have hindered economic growth including: the indirect effects of the sanctions imposed by the United Nations on Yugoslavia (1991-1995); the trading embargo imposed by Greece (1994-1995) due to the dispute regarding the country's name; the war in neighboring Kosovo (1999), which brought around 360,000 refugees into the country (around 17% of the total population of the former Yugoslav Republic of Macedonia) and which had a negative impact on the financial markets, leading to liquidity bottlenecks and pressure on the exchange rate.

After more than a decade of sluggish economic growth, the country's economic performance started to improve. The country's key industrial sectors are manufacturing (15% of GDP), trade (14% of GDP) and agriculture (11% of GDP). The main export commodities are textiles and steel. About 55% of total trade is EU trade.

In terms of GDP growth, there has been a slow but steady recovery since 2001. In 2002 real GDP grew by 0.9%, followed by 2.8% growth in 2003 and 4% growth since 2004 (Table 1.1). DG ECFIN spring forecasts (2007) point to a relatively moderate growth of 3.1% in 2006, compared to 3.8% in 2005. The main reason underpinning this was lower than expected expansion in manufacturing, agriculture and construction. In particular, industrial production increased by only 2.5% in 2006. Comparatively, the country's GDP represents about 0.04% of the GDP of the EU-25. Per capita GDP in terms of purchasing power is roughly at 25% of the EU-25 average. However, there is an evident regional difference in GDP per capita in purchasing power standards (PPS), which is nearly twice as high in the capital region (approximately 50% of the EU average), compared to the country as whole. This is a result of significant differences in infrastructural endowment and income levels between the capital and rural areas.

The increase in real GDP is due to growth in all economic sectors, excluding construction. The main driving force for the intensified economic activity in 2005 was industry with growth of 6.9%. Industrial growth is almost evenly distributed over all industrial branches, 70% of which showed positive results, with the most significant growth being recorded in the food processing industry, basic metals, construction materials, textiles, and the tobacco and chemical sectors. Relatively high growth rates were achieved in trade (6.8%), transport and communications (6.7%) and in hotels and restaurants (6.0%). Current national estimates for 2006 show a higher

increase in the real growth rate of GDP by 4.0% (according to DG ECFIN spring forecast this figure is 3.1%), making GDP equivalent to Euro 4,882 million and per capita GDP as Euro 2,358.

During the initial years of transition (after 1990), the economy was faced with enormously high inflation – 1,199% annually at the time of independence. Monetary policy has been guided by the principle of the fixed exchange rate, which has successfully delivered low inflation. The successful implementation of the stabilization program resulted in a substantial reduction in inflation in a relatively short period of time, successfully maintained at under 10% per annum from 1995 until now. Core inflation remains well under control, but according to the National Bank of Republic of Macedonia (NBRM) the average inflation rate increased to 3.8% in the period between January - November 2006, compared to an increase of only 0.5% in 2005. The main reasons for this relatively strong rise have been increases in excise taxes for alcohol and tobacco towards EU levels and higher energy prices.

The external balances continued to improve during the first three quarters of 2006. In September 2006, the current account balance has turned from a deficit of nearly 8% of GDP in 2004 and 1.4% in 2005, to a surplus of about 2% of (estimated) GDP. This was mainly achieved through a marked reduction in the trade deficit, high workers' remittances and a considerable increase in private transfers in the form of cash exchanges at foreign exchange offices. As a result, net private transfers amounted to Euro 856 million during the first nine months of 2006 (23% of GDP), compared to Euro 589 million a year before. The trade account registered a deficit of a similar size, amounting to Euro 840 million (22% of GDP). In the first quarter of 2006 there was a relatively high inflow of FDI amounting to about Euro 250 million (nearly 5% of GDP). A large part of this inflow was related to the privatization of the electricity distribution company ESM which was sold to a foreign investor. In the second and third quarters, FDI inflows fell back to 1.7% and 1.0% of GDP, respectively. Commodity exports increased markedly during the first nine months of 2006, increasing by 45% in Euro terms compared to the same period a year before. Nominal imports rose by 43%. The main factor behind this strong increase was increased trade in iron and steel, construction materials and textiles. Total external debt accounted for 35.6% of GDP at the end of 2006.

The general government debt declined from 40.9% of GDP in 2005 to 35.6% at the end of 2006. The main factor behind this strong decline was the early repayment of the country's Paris Club debt in early 2006.

Nominal wage growth appears to have been accelerating recently. After strong rises of nominal gross wages in the post-crisis period 2002-2004, wage growth moderated to 4.5% in 2005. However, nominal wages started to increase again towards the end of 2005. This trend continued during 2006, with a nominal increase of 6.0% in the third quarter. In absolute terms, the average monthly gross wage in 2006 was Denar 23,036 or the equivalent of about Euro 375 (inclusive of personal income tax and employees' social security contributions). The average monthly net wage for the same period was Denar 13,527 or the equivalent of Euro 220. In 2006 the average monthly net salary increased by 7.3% in comparison to 2005. Cumulatively, in 2006 nominal and real average salaries grew by 7.5% and 4.2% respectively. Comparatively, the average monthly net wage is higher than neighboring Bulgaria (Euro 200) and Albania (Euro 170), but lower than all other countries in the region. According to DG ECFIN spring forecasts (2007), wage growth in the former Yugoslav Republic of Macedonia is expected to remain largely in line with productivity developments. In addition to low wages, there is also a significant number of

employed persons who do not receive their salaries regularly (in December 2006, 13.3% of all employees did not receive a salary payment).

The labour market situation in the former Yugoslav Republic of Macedonia was already difficult when the country became independent, and has further deteriorated since then. Starting with more than 20% unemployment in 1991, the labour market continued to weaken as a result of a combination of factors, including, *inter alia*: loss of jobs due to economic restructuring, unfavourable economic surroundings (the Greek embargo 1994-95, the Kosovo crisis 1999 etc.), and barriers to entry or inflexibility of the labour market accompanied by the prevalence of a passive rather than an active labour market policy. All these led to unfavourable labour market indicators, making the former Yugoslav Republic of Macedonia comparatively much weaker than the other countries in the region.

The overall employment rate in the former Yugoslav Republic of Macedonia has basically remained static at an extremely low level, with 39.6% of persons of working age (15-64) being employed in 2006 (with an activity rate of 62.2%) (see table 1.2). This presents an increase of 1.7% compared to the previous year, but it is comparatively quite low when compared with the employment rates (2006) in Croatia (55.0%), Bulgaria (58.6%) and Romania (58.8%), and considerably lower than the rate for the entire EU27 which stands at 63.4%. In terms of gender, the employment trend shows that the male employment rate in 2006 decreased to 48.3% (from 50.6% in 2001), well below the male employment rate in the EU15 for 2006 (73.5%) and below the rate for the EU27 countries (71.6%). The female employment rate in 2006 was 30.7%, again low compared to the EU15 (58.4%) and the EU27 countries (57.1%). Ethnicity is also an important factor which contributes towards greater gender disparities in the labour market.

The data on employment trends in the former Yugoslav Republic of Macedonia are given according to the Labour Force Survey, which is conducted using a sample of 10,000 households (1.8% of all households). The non-response rate of the LFS in 2005 was 17.3%, which represents an increase of 5.9% compared to non-respondents in 2001. According to Djerf (2005) there are some specific groups needing further consideration in the LFS in relation to their non-standard labour market status, e.g.: the self-employed (when employed, unemployed or inactive), unpaid family workers (when employed, unemployed or inactive), women on parental leave (when employed or inactive) and pensioners (when employed or inactive). Some members of these groups may be regarded as inactive by the LFS when, in fact, their true status is that of employed or unemployed. Within the inactive population, which in 2006 decreased by 1.6% in comparison to the previous year, totaling 537,214 people (15-64), the majority are women, while those above 64 represent 26.1% of all those inactive.

Until recently, differences between data coming from the Employment Agency (administrative source) and the State Statistical Office (LFS) were more pronounced. The reasons for these differences, in addition to differences in methodology, were also a result of the number of persons registered as unemployed at the EA only in order to get health insurance, but who were not looking for a job. As explained by Causovska (2006), these differences have been reduced in 2006 because the EA has started to use the ILO and Eurostat definition of an unemployed person.

According to the ETF labour market review (Kjosev et al., 2005), there is a significant level of informal work in both agriculture and in family businesses. The share of agricultural employment in total employment grew until 2003 (22.0%), but then decreased to 19.5% in 2005. In the period of transition the agricultural sector

absorbed laid-off workers and served as a subsistence activity, a pattern familiar in other similar transition contexts. According to the same ETF study, the main part of the informal economy operates in the service sector, which suggests that services are underestimated in terms of their share in GDP and in employment. The share of services in employment increased from 39.7% in 2001 to 48% in 2005. Among the other sectors, industry is in constant decline, from a 29.2% share in 2001 to 25.8% in 2005.

According to the LFS in 2006, there were 70,789 self-employed persons, representing 12.4% of all those employed, while the number of unpaid family workers was 62,199 or 10.9% (tables 1.3 and 1.4).

Concerning undeclared work, the latest ETF country plan on former Yugoslav Republic of Macedonia (2007) suggests that the grey economy in the country represents an estimated 33–37% of GDP. However, these estimates are not accepted by the SSO, since the LFS covers undeclared employment. Still, there is no detailed statistical information and analysis on the magnitude of the issue, in particular on the characteristics of the unemployed – ethnicity, place of residence, position in the labour market, educational attainment levels, coping strategies and chances of finding formal employment.

The LFS does not collect data on activity or employment trends in relation to ethnicity. According to the 2002 Census, the ethnic Macedonian population has the highest activity rate of 63.2%, followed by Vlachs (62%), Serbs (59.8%), Roma (50.4%), Bosniaks (47.8%), and ethnic Turks (42.4%). Ethnic Albanians have the lowest participation rate of 32.3%, which is mainly due to the extremely low activity rate of females of Albanian ethnicity (Table 1.5).

Improvements regarding the employment of ethnic communities in the former Yugoslav Republic of Macedonia have been associated with the OFA (2001). The principle of equitable representation, which is part of the OFA, has led to developments in the employment of ethnic communities mainly in the public institutions. The Government has collected data from 175 state bodies on the level of equitable representation of non-majority ethnic communities, and has increased the amount in the 2007 Budget allocated to improvement of equitable representation threefold compared to the 2006 Budget, from Denar 47 million (Euro 768,266) to Denar 150 million (Euro 2,451,914). According to the data, as of 31 August 2006, the percentage employed in the public sector (i.e. ministries and other state institutions, judicial institutions and public enterprises) according to ethnicity, is: 74.19% Macedonians, 8.93% Albanians, 1.74% Serbs, 0.93% Turks, 0.55% Vlachs, 0.26% Bosniaks, 0.42% Roma and 0.91% others.

In contrast,, the participation of ethnic communities in the informal economy is quite high. As indicated in the EURAC study on minorities (2005), the main forms of activities are family business and small enterprises. Due to limited employment opportunities in public administration in the past, ethnic communities as well as other vulnerable communities tended to find employment in the private sector, mostly in services and trade gravitating around small and medium-sized enterprises (SMEs) and family businesses. Also, low skilled workers seem to rely more on employment in the grey economy in the former Yugoslav Republic of Macedonia, which is in line with the employment pattern in other transition economies (Rutkowski, 2005).

Migration and remittances are another important aspect especially in terms of their relevance for ethnic Albanians living in the former Yugoslav Republic of Macedonia. According to NBRM data in 2005 remittances were equal to US$155 million (Euro 131 million), which is much higher than the amount of FDI or more than twice the

level of foreign official assistance. Remittances amounted to 2.7% of GDP. World Bank calculations of workers' remittances and compensation of employees come to 5.5% of GDP, but when increased by the cash exchange it stands at 17.4% of GDP. As indicated by Markiewicz (2006), since cash exchange includes also payments for unrecorded trade and services, the real amount of migrants' transfers is somewhere between these two figures.

According to the LFS, in 2006 the unemployment rate (15-64 year olds) was 36.3%, which represents a decrease of 1.3% from 2005. In comparative terms, for the same period this rate is significantly above unemployment rates in Croatia (11.8%), Bulgaria (9.0%), Romania (7.3%) and the EU27 (7.9%). According to the EA, as of 31 December 2006, there were 366,551 registered unemployed persons, out of which 74,803 or 20.4% of the registered unemployed are only registered for the purposes of receiving free health insurance, and are not actively looking for employment (Table 1.6). An additional problem is the prevalence of the long–term unemployment, with the share of the long-term unemployed (those unemployed longer than 1 year) in 2005 standing at 32.3% of the total workforce. Long-term registered unemployment is also prevalent with 80.2% of those registered unemployed in 2006 waiting for employment longer than one year (Table 1.7).

There are also wide regional variations in unemployment (Table 1.8). According to the Census of population, households and homes in 2002[14] regional (NUTS 3) unemployment rates show that the highest unemployment rate was in the Polog region (49.9%), while the lowest was in the Skopje region (30.4%). The correlation is high between municipalities with significant minority population and high unemployment rates, but the problem seems rather to be one of inclusion of the ethnic communities in the labour market and integration of their economic activities in the formal economy. The regional mismatch might reflect an unbalanced regional development as well as low labour mobility. According to the EA (2006), registered unemployment in different Employment Centers in the country also shows differences, although the size of the municipality should be taken into consideration when making generalizations. Thus, from December 2006 data, the Skopje Employment Centre (according to the size of the city) had the largest number of registered unemployed – 23.5%, followed by Kumanovo – 8.3%, Tetovo – 7.9%, etc. Hence, registered unemployment in 2006 was more pronounced in the urban areas (67.4%) as compared to the rural areas (32.6%).

Concerning age cohorts, the group aged 15-24 years is the hardest hit, with an unemployment rate of 59.8% in 2006. The youth unemployment ratio (the proportion of all unemployed from the cohort group 15-24 in relation to the whole population at age of 15-24) is also high with 21.37% unemployed. Concerning registered unemployment, the participation of young people up to age 30 in overall unemployment is highest with 30.2% (2.7% aged 15-19, 13% aged 20-24 and 14.5% aged 25-29). In regional terms, the unemployment rate of young people is highest in the Vardar and Northeast regions (80.6% and 80.3% respectively), and lowest in the East region (65.4%).

The latest available information regarding the ethnic dimension of unemployment rates can be found in the 2002 Census. According to this data, the highest unemployment rate was evident among Roma with 78.5%, followed by Albanians with 61.2%, Bosniacs with 60.3%, Turks 58.2%, Macedonians with 32%, Serbs with

[14] As taken from the UNDP, "*Socio-Economic Disparities among the Municipalities in Macedonia"*, Skopje, 2004.

30.9% and Vlachs with 25.3%. Concerning registered unemployment among different ethnicities EA data are available. In December 2006, out of the registered unemployed population: 65.5% were Macedonians, 22.6% Albanians, 4.7% Roma, 3.7% Turks, 0.9% Serbs and 0.1% Vlachs (Table 1.9). Other ethnic groups account for 2.5% of overall registered unemployment. It can be observed that the structure of registered unemployment is proportionate to the total number of population for each ethnic group.

Gendered unemployment rates in 2006 (LFS) show a male unemployment rate of 35.6% and a female unemployment rate of 37.5%. In both cases, the figures have dropped since 2005 by 0.9 percentage points. These figures need to be understood in terms of ethnic factors, in particular, the low participation rate among ethnic Albanian and Roma women. These low participation rates are caused by a variety of factors, including early school drop our rates among ethnic Roma and to some extent Albanian women, as well as the lack of jobs available for ethnic communities in the formal sector before 1991. Also, specific cultural factors play a role. According to registered unemployment figures, in 2006 men accounted for 58.4% and women 41.6% in the overall registered unemployment figures.

According to the 2002 Census, 4.2% of the Macedonian population was lacking any education, 6.8% had not completed primary education, 35.1% had completed only primary school, 36.9% secondary school, 3.2% pre-university, college-level education and 13.8% higher education. This means that approximately two out of every five persons have low qualifications (ISCED 0–2), which points to a huge skills deficit. ETF calculations regarding the educational attainment level of adults aged 25-64 show quite low figures, with 41% with ISCED 0-2 (twice as high as in the 10 new EU member states), 45% with ISCED 3-4 and 14% with ISCED 5-6 (Table 1.10). Unemployment by level of education for 2006 shows that 51.3% of the unemployed were without any qualification (only a few percent are semi-qualified), 17.1% with secondary VET, 24.9% with general secondary education, 1.8% with post-secondary, non-tertiary education and 5.0% with tertiary education. According to the ETF report (2007), there is a clear link between educational attainment and the employment rate. In 2005 the employment rate of unqualified or low-qualified people (ISCED 0–2) was the lowest with 23.5%, while for those with medium qualifications (ISCED 3-4) it was 43.8% and with higher qualifications (ISCED 5 or higher) 73.3% (Table 1.11). Higher education levels can thus be seen as a safeguard against unemployment.

Unfavourable labour market indicators suggest that the socio-economic condition of the population in the former Yugoslav Republic of Macedonia is extremely poor. A coping strategy which has enabled the unemployed or impoverished population to survive has been the use of the subsistence economy. For example, a great number of unemployed (men) due to a lack of other skills have oriented towards taxi-driving; selling goods on the streets/markets is especially visible among older women (selling flowers, fruits, vegetables), seasonal (and undeclared) work in coffee shops, restaurants, boutiques and (recently) betting companies where primarily young people work. In addition, a large number of (low-skilled) people are working abroad, those from the western part of the country mainly in Germany and Switzerland, while from the eastern part of the country Italy has been a major destination. Those from the border regions have also benefited from buying/selling goods in the nearest cities of neighbouring countries, such as Bulgaria, although some of the recent visa restrictions have impaired the economic activities of these groups. However, in comparison to the past, there is a greater number of people on the streets (not only Roma), who try to satisfy their basic needs from garbage containers and through begging.

1.1.2 Demographic indicators

According to the 2002 Census, the former Yugoslav Republic of Macedonia has a population of 2,022,547. The share of the male population is slightly higher (50.20%) than the female population (49.80%). A constantly declining natural increase rate is evident since the early 1980s, from 11.3 in 1989 to 2.0 in 2005 (TransMONEE 2006). The crude birth rate, which was 19.1 (per 1,000 inhabitants) in 1989, fell to 11.0 in 2005, whereas the mortality rate remains rather constant over the whole period at about 8 deaths per 1000 inhabitants. The total fertility rate in 2005 was 1.46 (Table 1.12). In 2005, 14,500 marriages were registered in the former Yugoslav Republic of Macedonia, which represents an increase of 3.0% on the previous year. The total number of divorces in 2005 was 1,552, representing a decline from the previous year when the number of divorces was 1,645.

The ethnic picture of the former Yugoslav Republic of Macedonia is diverse and implies the existence of different ethnic communities (Table 1.13). According to the final results of the 2002 Census, there are 1,297,981 Macedonians (64.18% of a total of 2,022.547 inhabitants), 509,083 Albanians (25.17%), 77,959 Turks (3.85%), 53,879 Roma (2.66%), 35,939 Serbs (1.78%), 17,018 Bosniaks (0.84%), 9,695 Vlachs (0.48%) and 20,993 (1.04%) of other nationalities. The ethnic composition recorded in the 2002 Census shows a particular rise in the representation of the Albanian ethnic group compared to the last Yugoslav census of 1981 when 19.8% declared themselves as ethnic Albanians in the former Yugoslav Republic of Macedonia, and the first census after the country's independence in 1991, when 21.7% of the population declared themselves as Albanians (Table 1.14) Due to the proclaimed Albanian boycott of the 1991 census, the European Union initiated a new census in 1994, supervised by the international community. The results showed ethnic Albanian representation of 22.7%. According to confessional composition, in 2001 there were 64.7% Orthodox Christians, 33.3% Muslims, 0.35% Roman Catholics, 0.02% Protestants, and 1.52% of the population belonging to other confessions. There are no official statistics regarding other religious communities, but it is estimated that there are around 15,000 Macedonian Muslims (also known as Torbeshi or Poturs) and 5,000 Bekteshi, a separate religious entity, who ethnically are mainly Albanians.

Key demographic indicators show that the average age of the population grew from 32.8 years in 1994 to 35.9 years in 2005. Life expectancy at birth for both sexes has increased slightly from 72.13 years in 1991 to 73.62 years in 2005, with women expected to live longer (75.8) than men (71.4). Life expectancy in 2005 at 73.62 years was almost five years below the EU average of 78.49 years. The trend towards an ageing population can be observed in the former Yugoslav Republic of Macedonia as in many other countries: the 2002 Census showed that 22% of the population was under the age of 14 and 10% were above the age of 65. Specifically, from 1990 to 2003 the percentage of the population over 65 years of age increased from 7.97% to 10.7% (males 4.8% and females 5.8%) and the percentage of the population aged 0–14 years decreased to 21.1% (males 10.9% and females 10.2%). However, looking at these figures comparatively, they suggest that the trend towards an ageing population is far less pronounced than in most neighboring central and southeastern European countries (in 2003 only Albania had a younger population with 7.87% over 65 years) or in the EU (in 2003 the percentage of the population over 65 years on average amounted to 16.13%, in 2004 it was 16.42%).

In terms of the total number of families, this number rose from 539,555 to 574,159 in the period between 1994 and 2002, which is an increase of 6.4 percent. In 2002, the

average number of family members was 3.3, while at a regional level it was lowest in the Pelagonija and East regions (3.1) and highest in the Polog region (3.5). In 2002, one quarter (25.3 percent) of the total number of families in the country was childless married couples. The structure of families was and still is dominated by married couples with children: in 2002, this percentage totaled 64.5 percent which was slightly lower than that in 1994 (65.9%). Single parent families form 8.7% of the families in the former Yugoslav Republic of Macedonia, 6.9% being single mothers.

The contribution of international migration to population change - which has been the most important factor for many decades - has substantially decreased so that fertility is now the most important factor. External migration, however, continues to be underestimated in national records. There are signs from census data, not evident from previous periods that family migration (both spouses and children) is increasing as compared to migration of single persons without family members. The data on population growth and on the natural increase of population presented by UNDP (UNDP, 2004) suggest that there was a small decrease in population due to international migration, amounting to 1.4% of population, or 28,000 in absolute terms, over the six-year period 1996-2002. The IMF (2006) states that rough estimations give a figure of half a million Macedonians living abroad which would represent 20-25% of the population. According to data from the 2002 Census, emigrants are predominantly Albanian, and are typically male workers aged 20-39. The net external migration rate (number of migrants per 100,000 population) has declined from 164.4 in 1993 to 35.0 in 2004 (TransMONEE, 2006).

The degree of urbanization in the former Yugoslav Republic of Macedonia has remained relatively stable in the last decade, with the urban/rural distribution of population estimated at approximately 60/40 (UNDP, 2004), with a low level of internal migration. Inland migration flows in the former Yugoslav Republic of Macedonia are still following the pattern from rural regions (hill and mountain areas) to urban regions, mainly to the capital city of Skopje (UNDP, 2001). According to Kjosev et al. (2005) this has negative implications for both emigrant and immigrant regions: whereas the former suffer an ageing workforce and economic slump due to underutilization of arable land, the latter face excess labour supply and the formation of poverty ‘pockets’. According to the structure of internal immigrants identified in the 2002 Census, those who moved to another municipality accounted for 66.5 percent of the total number, while those who moved within the borders of the same municipality constitute 22 percent of the overall number of internal immigrants. These regional indicators show that inter-municipal migrations were most numerous in the Skopje (73.4 percent) and Pelagonija (70.4 percent) regions.

Possession of double nationality is also significantly present in Macedonia. According to the Bulgarian Ministry of Justice, from 2000 until mid-2006 there were around 30,000 applications for citizenship from Macedonia, although there are no official data on how many of the applicants were granted Bulgarian citizenship. Australia and Turkey are two countries with a majority of Macedonian immigrants having local citizenship (92% and 96% respectively). It indicates that this migration has long-term origins (Markiewicz, 2006).

The number of immigrants who moved into the country from other countries according to the UNDP study in 2004 (based on the population census of 2002) is 79,167, which is 3.9% of the total population in 2002. However, it should be taken into consideration that these numbers include those that have immigrated since 1945 among which are autochthonous population as well as people born in other countries. More than half of those immigrants moved into the Skopje region (41,391 immigrants or 52.3%), whereas somewhat less than a fifth (10.1%) moved into the

Northeast and the Polog (7.8%) regions. During the Census period 2002, there were 6,000 registered foreign immigrants who had stayed for up to one year in the former Yugoslav Republic of Macedonia.

1.1.3 Social transfers

One of the main problems in statistical measurement is finding relevant and comparable data on social transfers. Official figures on this matter are often confusing, with different sources (i.e. Ministry of Finance, Ministry of Labour and Social Policy and State Statistical Office) using very different accounting standards. Data on expenditures on social protection according to ESSPROS methodology are not yet available. According to the State Statistical Office, social expenditures in the former Yugoslav Republic of Macedonia are calculated according to the European System of Accounts 95, which includes transfers for pensions, unemployment, sickness, and child allowance as well as other benefits. According to this methodology, the total amount of social transfers as a proportion of GDP rose from 13.6% in 1995 to 15.3% in 2004 and then decreased to 12.2% in 2005 (Table 1.15) The amount of social transfers as a percentage of the central budget increased from 52.7% in 1995 to 60.3% in 2003 and then decreased to 58.8% in 2005.

The system of social contributions currently amounts to 32% of the gross wage, including 21.2% for the Pension and Disability Insurance Fund, 9.2% for the Health Fund, and 1.6% for the Employment Fund. These are paid by the employer alone – no contributions are made by individuals.

Expenditure on unemployment benefits fluctuated between 1998 and 2002, when it amounted to approximately 0.95% of GDP and 3.17% of total government expenditure. Both shares declined significantly between 1998 and 2002, particularly on terms of the share of government expenditure, which amounted to 4.86% in 1998. In 2002, benefits transferred from the Centers of Social Work accounted for almost 48% of all benefits, 1.28% of GDP and 4.3% of government expenditure.

MLSP calculations (based on the calculations from the MF) indicate that current expenditure on active labour market policies is 0.09% of GDP. This is particularly low in relation to the rate of unemployment in the country but also taking into consideration the increasing importance of active labour market measures in general.

According to the National Strategy for European Integration (2004), social expenditures should be reduced, consistent with the fiscal situation in the country. This is part of an overall endeavor for more targeted and less egalitarian social assistance, aiming at a higher level of benefits for a smaller number of beneficiaries who really need it. This is justified by the experience of 2003 when, due mostly to more rigorous inspections regarding eligibility, the number of households qualifying for the social cash benefit scheme was reduced by over 25 percent. However, this approach is not consistent with the current high demand and need for social protection on the one side, but also with the overarching European goal for promoting adequate and accessible social protection systems, on the other.

1.2 Forecasts and projections

1.2.1 Economic and labour force forecasts

The economic forecasts presented here are a combination of data from national administrative sources as well as according to the DG ECFIN spring forecasts (2007).

The (national) projected rate of GDP growth for the period 2007-2009 is between6.0% and 6.5% per year (Table 1.16). According to the DG ECFIN 2007 forecasts, GDP growth is estimated at about 4.3% in 2007 and 5.3% in 2008 (Table 1.17). In terms of the structure of GDP, growth is determined on the basis of the continued increase of industrial production at 6%, a rise in investments which is expected to grow by 10-15%, accompanied by an increase in private consumption by 6%. The rate of inflation for 2007 is estimated to remain relatively low, at about 3.5%, and to drop to 3% in the period 2008-2010. According to DG ECFIN forecasts, in view of year-on-year inflation below 1% during the first quarter of 2007, annual inflation is expected to reach around 2% in 2007, which could further rise to about 2.5% in 2008.

This decrease is expected on the base of the fading out of the impact of the rise in excise duties, and further reductions in import duties due to the country's commitments as a member of the WTO. The current account deficit in 2007 will increase to 3.4% of GDP, but is expected to shrink gradually to 2.6% (2008) and 2.1% (2009). The combination of strong economic growth, early debt repayments and relatively low deficits will lead to a further reduction of the debt ratio to 32% of GDP by 2008.

Regarding foreign trade, trade policy continues to put the highest priority on creating the conditions for increasing export of goods. In the next period, an average real annual increase in export of goods of approximately 8% can be expected, and an average real growth of import of goods between 6% and 6.5%. The achievement of these projections would produce a small decrease in the trade deficit which, according to the projections for the end of 2008, should reach 16.8% of GDP. In parallel to the stabilization of the trade deficit, a further decrease in the current account deficit is also expected. Fiscal policy will support the macroeconomic stability of the country through maintaining a low deficit level of the consolidated governmental budget at approximately 0.6% of GDP.

Employment growth has taken off, increasing by about 6 percent year-on-year in the third quarter of 2005. The employment for the period 2007-2009 is projected to rise by 4 % annually. Additional positive economic developments are expected to stem from active labour market measures, EU candidate status, the upgrading of the former Yugoslav Republic of Macedonia’s credit rating, and the successful launch of the inaugural Eurobond. However, unemployment is likely to remain high. As a result, the official unemployment rate might decline slightly from 36% in 2006 to about 34.7% in 2008. According to the National Strategy for Employment (2006), goals to be achieved by 2010 are: an increase in the general employment rate to 48%, an increase in the female employment rate to 38% and an increase in the employment rate for older workers (55-64 years) to 33%. Average wages in real terms are expected to grow at a rate of around 0.3% (2007) and 1.0% (2008, 2009).

Total budget expenditures in 2007 will be slightly higher - 1.4% compared to those in 2006. Current expenditures contribute 85.8%, while capital expenditures account for 14.2% of total spending. Social transfers in the 2007 budget absorb the largest share of total government expenditures, and amount to Denar 51.102.000 million or equivalent of 833.637 million Euro (or 44.4%).

1.2.2 Demographic projections

According to demographic forecasts from the UN Population Division (2004), the total number of the population could fall from 2,034,000 in 2005 to 1,884,000 in 2050 (Table 1.18). This medium variant calculation by the UN of the population growth rate shows a constant population decrease from 0.12 for the period 2005-1010 to 0.46 for the period 2045-2050. Total fertility rates are expected to rise from 1.45 in 2005 to 1.85 in 2050. The percentage of working age population (15-64) is projected to fall from 69.3% in 2005 to 60.0% in 2050. This is in line with national actuarial projections, which reveal that the ratio between the working age population (18-59) and the elderly population (above 60 years of age) will rise to 64.4% in 2060 and then will fall to 51.5% in 2100. This means that, in the future, one third of the population above 18 will be comprised of the elderly. The number of elderly persons will rise from 11.1% in 2005 to 24.9% in 2050, meaning that the old age dependency ratio will rise from 16% in 2005 to 41% in 2050.

According to the 2002 Census, life expectancy at birth for 2010 is projected at 75.3 years (women) and 70.8 years (men), while the same numbers for 2050 are over four years higher at 80.0 years (women) and 75.0 years (men). Continual rise in life expectancy is projected until 2050. Life expectancy at retirement for 2010 is forecast at 18.6 years (women) and 14.7 years (men), rising to 21.2 years (women) and 16.6 years (man) by 2050.

1.3 Conclusion

The analyzed economic, demographic and labour market indicators have an important influence on the overall system of social protection. However, the analysis in this chapter suggests that there is a great deal of relevant and comparable data lacking, necessary for creating policies, but also for concrete estimation of the magnitude and depth of some of the socio-economic problems. In this respect, further data and studies are especially needed concerning:

- The subsistence economy and under-reporting of the self-employed;
- Estimates about the nature and extent of remittances;
- More indicators within the LFS, such as ethnic affiliation of the active, inactive, employed and unemployed population;
- Use of harmonized data sources for educational attainment and literacy rates;
- Reliable estimates on migration trends;
- Use of harmonized data sources for calculation of social expenditures/social transfers (i.e. ESSPROS); and
- Labour force forecasts and projections.

These data and analyses are not only necessary for studies of this type, but also for the comprehensive and effective development of overall policy on social protection and social inclusion.

References for Chapter 1

Causovska, A. (2006) Information for Labour Market Survey with special review of the unemployment measuring, realized as part of the Twinning Project, subcomponent 3.4 Labour Market and Living Standard, Skopje.

Dietrich, C. Griffiths, M. Pivovarsky, A. Ross, K. Giustiniani, A. Gutierrez, E. Marsh, C. (2006) Former Yugoslav Republic of Macedonia – Selected Issues, International Monetary Fund

Djerf, K. (2005) Assessment of the Labour Force Survey (project component), Report from a mission to the State Statistical Office of the Republic of Macedonia, Project title: Improved Agricultural Statistics in Macedonia, funded by the Swedish International Development Cooperation Agency (SIDA), 21-25 November, Skopje.

ETF (2003), Key Indicators, Eurostat Structural Indicators, year of reference 2003, Turin: European Training Foundation

ETF (2004) Key Indicators 2003, ETF Key Indicators 2002 on vocational education, training and employment in new member states, candidate countries and South East Europe, Internal document, Turin: European Training Foundation

ETF (2006) Designing Adult Learning Strategies – The Case of South Eastern Europe, Turin: ETF

ETF (2007) Former Yugoslav Republic of Macedonia – ETF Country Plan 2007, http://www.etf.europa.eu

European Commission (2005) Candidate Countries' Economies Quarterly, Directorate General, Economic and Financial Affairs

European Commission (2007) Candidate and pre-accession Countries' Economies Quarterly, Directorate General, Economic and Financial Affairs

European Commission, Autumn Economic Forecasts 2006-2008: Solid Growth and Unemployment and Deficits Falling:
http://ec.europa.eu/economy_finance/about/activities/activities_keyindicatorsforecasts_en.htm

Government of the Republic of Macedonia (2002) National Strategy for Integration of the Republic of Macedonia in the European Union, Skopje: Government of the Republic of Macedonia

Ilievski, Z. (2005) Access to Education, Training and Employment of Ethnic Minorities in the Western Balkans, Country Report Macedonia, Bozen: EURAC Europäische Akademie

International Monetary Fund (2005) Former Yugoslav Republic of Macedonia: Letter of Intent, Memorandum of Economic and Financial Policies and Technical Memorandum of Understanding, International Monetary Fund

Kjosev, S., Blazevski-Mojsoska, N., Corcoran, T., Popova, N., Fetsi, A., Nikolovska, M., Nielsen, S., Zelloth, H. (2005) Labour Market Review of former Yugoslav Republic of Macedonia - Working Paper, ETF

Markiewicz, M. (2006) Migration and Remittances in Macedonia, Skopje: CEA Center for Economic Analyses

Ministry of Finance (2005) „Macroeconomic policy of the Republic of Macedonia for 2006", Skopje: Ministry of Finance

Ministry of Finance (2006) „Macroeconomic policy of the Republic of Macedonia for 2007", Skopje: Ministry of Finance

Ministry of Labour and Social Policy (2006) National Action Plan for Employment 2006-2008, Skopje: Ministry of Labour and Social Policy, Arbetsmarknadsstyrelsen, GVG

Ministry of Labour and Social Policy (2006) National Employment Strategy 2010, Skopje: Ministry of Labour and Social Policy, Arbetsmarknadsstyrelsen, GVG .

National Bank of Republic of Macedonia, Public Announcement: http://www.nbrm.gov.mk/defaultmk.asp?ItemID=1072FA415D39C94BAB2D3C5C25231DAC

Rutkowski, J. (2005) Enhancing Job Opportunities: Eastern Europe and the Former Soviet Union, Washington: The World Bank

State Statistical Office (2006) Average Monthly Gross-Wage Paid per Employee October 2006, Skopje: State Statistical Office

State Statistical Office (2006) Average Monthly Net-Wage Paid per Employee October 2006, Skopje: State Statistical Office

State Statistical Office (2007) Labour Force in the Republic of Macedonia - Results from the Labour Force Survey 3rd quarter 2006, Skopje: State Statistical Office

UNDP (2001) National Human Development Report 2001: Social Exclusion and Human Insecurity in the Former Yugoslav Republic of Macedonia, Skopje: UNDP

UNDP (2003) Macedonia Common Country Assessment, UN – 2003, Skopje: UNDP

UNDP (2004) National Human Development Report 2004 – Former Yugoslav Republic of Macedonia: Decentralization for Human Development, Skopje: UNDP.

UNDP, Ministry of Local Self Government and State Statistical Office (2004) Socio-economic Disparities among Municipalities in (former Yugoslav Republic of) Macedonia, http://www.undp.org.mk

United Nations (2004), World Population Prospects: The 2004 Revision, Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat: http://esa.un.org/unpp.

World Bank (2003) Memorandum of the President of the International Bank for Reconstruction and Development to the Executive Directors on a Country Assistance Strategy for the Former Yugoslav Republic of Macedonia, World Bank

World Bank (2005) Former Yugoslav Republic of Macedonia Poverty Assessment for 2002-2003: Document of the World Bank.

Statistical Annex for Chapter 1

Table 1.1 Main economic indicators

	2001	2002	2003	2004	2005	2006
Real Sector						
GROSS DOMESTIC PRODUCT						
GDP at current prices (million Euro)	3,839	4,001	4,105	4,324	4,523	4,882
GDP growth rate (at constant prices)	-4.5	0.9	2.8	4.1	4.0	4.0
GDP per capita (at current prices, Euro)	1,887	1,981	2,025	2,128	2,223	2,358
GDP per capita at PPP	5,000	5,200	5,400	5,700	6,000	n.a.
GDP per capita, EU-25*=100	24.0	23.9	24.6	25.1	25.8	n.a
PRICES, WAGES AND EXCHANGE RATE						
Consumer price inflation (CPI, average)	5.5	1.8	1.2	-0.4	0.5	3.8
Wages (monthly average, net)						
- Nominal growth	3.5	6.9	4.8	4.0	4.5	6.0
- Real growth	-2	5.1	3.6	4.4	2.0	2.2
Exchange rate (Denar/Euro, pa)	60.91	60.98	61.26	61.34	61.30	61.2
FOREIGN TRADE AND CAPITAL FLOWS						
Export of goods and services (% of GDP)	42.7	38.0	37.9	40.2	44.4	n.a.
Imports of goods and services (% of GDP)	56.6	58.2	54.8	60.5	63.8	n.a.
Current account balance (% of GDP)	-7.1	-9.5	-3.2	-7.7	-1.4	-1.3
Trade balance (% of GDP)	-15.3	-21.3	-18.4	-20.9	-18.8	-21
Foreign direct investment (million Euro)	493.2	82.6	81.4	127.2	79.4	n.a.
Foreign direct investment (net, as % of GDP)	12.8	2.2	2.0	2.8	0.5	1.7
GENERAL GOVERNMENT FINANCE						
Revenues (% of GDP)	n.a.	23.5	21.2	22.1	37.6	35.8
Expenditures (% of GDP)	n.a.	28.8	22.2	22.0	37.7	36.4
General government balance (% of GDP)	-2.5	-5.6	-1.1	0.0	0.3	-0.6
General government debt (% of GDP)	48.8	43.0	39.0	36.6	40.9	35.6

Sources: Ministry of Finance, European Commission – ECFIN

* Source: Eurostat, 2006. Country comparisons with the EU27 are not yet available.

Table 1.2 Labour market

	2001	2002	2003	2004	2005	2006
Employment						
Employment rate (15-64)	42.6	40.4	38.5	36.8	37.9	39.6
Employment rate (15-64) male	50.6	48.6	45.6	44.4	45.4	48.3
Employment rate (15-64) female	34.5	32.0	31.3	28.9	30.1	30.7
Employment rate of older workers (55-64)	27.7	25.8	28.5	24.5	26.2	n.a.
Economic activity rate (15-64)	61.8	59.8	61.3	58.8	60.7	62.2
Agriculture, forestry and fishing as a share of total employment	24.9	23.9	22.0	16.8	19.5	n.a.
Industry as a share of total employment	29.2	27.5	27.3	25.8	25.8	n.a.
Construction as a share of total employment	5.9	5.8	6.6	7.0	6.5	n.a.
Services as a share of total employment	39.7	42.6	43.8	50.1	48.0	n.a.
Unemployment						
Unemployment Rate	30.5	31.9	36.7	37.2	37.3	36.3
Unemployment rate, male	29.5	31.7	37.0	36.7	36.5	35.6
Unemployment rate, female	32.0	32.3	36.3	37.8	38.4	37.5
Unemployment rate of persons < 25	56.1	58.4	65.7	64.8	62.6	59.8
Long term unemployment rate	26.5	27.0	31.2	31.7	32.3	n.a.

Source: State Statistical Office, different years 2001-2006

Table 1.3 Employed by economic status and division of activities, 2006

Sectors and divisions of activities	Total	Employed	Employer	Self-employed	Unpaid family worker
TOTAL	570,404	403,564	33,853	70,789	62,199
Agriculture, hunting and forestry	114,485	12,106	7,873	37,679	56,827
Fishing	292	218	37	-	37
Mining and quarrying	3,861	3,835	25	-	-
Manufacturing	123,066	114,193	4,503	3,562	807
Electricity, Gas and water supply	15,955	15,955	-	-	-
Construction	43,203	33,605	2,249	6,649	700
Wholesale and retail trade, repair of motor vehicles, motorcycles and personal and household goods	73,015	47,257	10,998	12,067	2,694
Hotels and Restaurants	19,034	14,580	2,290	1,448	715
Transport, Storage and communications	30,000	23,289	1,645	4,860	207
Financial intermediation	7,081	7,023	-	59	-
Real Estate, renting and Business activities	15,376	11,553	1,792	1,936	94
Public administration and defense, compulsory social security	39,343	39,343	-	-	-
Education	33,394	32,666	616	113	-
Health and Social Work	32,584	31,052	1,002	531	-
Other activities of communal, cultural, general and personal services	18,290	15,760	824	1,590	117
Private households employers of domestic staff	464	168	-	296	-
Exterritorial Organizations and bodies	962	962	-	-	-

Source: Labour Force Survey, 2006

Table 1.4 Employed by economic status and gender, 2005

TOTAL	Economic status				Gender
	Employed	Employer	Self-employed	Unpaid Family worker	
545,253	391,651	31,276	65,487	56,840	Total
332,179	229,996	25,140	55,714	21,330	Men
213,074	161,654	6,136	9,773	35,510	Women
Structure by economic status in %					
100.0	71.8	5.7	12.0	10.4	Total
100.0	69.2	7.6	16.8	6.4	Men
100.0	75.9	2.9	4.6	16.7	Women

Source: LFS, 2005

Table 1.5 Activity and unemployment rates according to ethnic affiliation 2002 Census results

	Activity rate	Unemployment rate
All	54.6	38.1
Macedonians	63.2	32
Albanians	32.3	61.2
Turks	42.4	58.2
Roma	50.4	78.5
Vlachos	62	25.3
Serbs	59.8	30.9
Bosnians	47.8	60.3
Other	51.5	40.8

Source: State Statistical Office, Census 2002

Table 1.6 Registered unemployed persons by level of education, total number and % of all unemployed

Level of Education	31.12.2006		31.12.2005		31.12.2004		Index 31.12.06./ 31.12.05.	Index 31.12.06./ 31.12.04.
	Number	%	Number	%	Number	%		
Non qualified or semi-qualified	187,870	51.3	187,448	52.1	201,865	51.6	100.2	93.1
Secondary VET	62,626	17.1	62,378	17.3	69,850	17.9	100.4	89.7
General Secondary education	91,155	24.9	86,939	24.2	95,693	24.5	104.8	95.3
Post-secondary, non-tertiary education	6,569	1.8	6,577	1.8	7,252	1.9	99.9	90.6
Tertiary education	18,331	5.0	16,647	4.6	16,412	4.2	110.1	111.7
Total	366,551	100.0	359,989	100.0	391,072	100.0	101.8	93.7

Source: Employment Agency, 2006

Table 1.7 Duration of unemployment

Duration of unemployment	31.12.2006		31.12.2005		31.12.2004		Index 31.12.06./ 31.12.05.	Index 31.12.06./ 31.12.04.
	Number	%	Number	%	Number	%		
Less than 1 month	8,205	2.2	6,454	1.8	7,350	1.9	127.1	111.6
From 1-5 months	30,455	8.3	20,865	5.8	22,411	5.7	146.0	135.9
From 6-11 months	33,976	9.3	23,619	6.6	28,963	7.4	143.9	117.3
From 12-17 months	22,039	6.0	25,273	7.0	32,196	8.2	87.2	68.5
From 18-23 months	17,302	4.7	20,015	5.6	25,066	6.4	86.4	69.0
2 years	35,168	9.6	41,597	11.6	38,995	10.0	84.5	90.2
3 years	32,606	8.9	29,703	8.3	30,101	7.7	109.8	108.3
4 years	24,113	6.6	23,475	6.5	28,734	7.3	102.7	83.9
5 - 7 years	54,176	14.8	58,642	16.3	67,057	17.1	92.4	80.8
8 years and more	108,511	29.6	110,346	30.7	110,199	28.2	98.3	98.5
Total	366,551	100.0	359,989	100.0	391,072	100.0	101.8	93.7

Source: Employment Agency, 2006

Table 1.8 Regional (NUTS 3) disparities in employment and unemployment in 2002

NUTS 3	Unemployment rate	Unemployment rate men	Unemployment rate women	Unemployment rate young people	Share of employment in farming	Share of employment in industry	Share of employment in services	Long term Unemployment as % of total unemployment	Rate of activity of women
Pelagonia	39.9	36.2	45.0	75.0	18%	41%	41%	85.7%	55.6%
Vardar	43.9	38.8	51.4	80.6	13%	40%	47%	80.0%	50.3%
Northeast	48.6	45.6	54.0	80.3	8%	40%	47%	83.1%	38.6%
Southwest	42.4	41.5	44.0	75.4	4%	40%	52%	82.4%	35.0%
Skopje	30.4	31.8	28.4	67.6	1%	40%	66%	81.4%	45.3%
Southeast	34.4	31.9	38.2	67.2	36%	40%	36%	83.8%	53.2%
Polog	49.9	50.1	49.2	78.4	10%	40%	50%	86.9%	18.5%
East	34.5	34.5	34.6	65.4	12%	40%	38%	75.6%	50.3%

Source: Census of population, households and homes in 2002

Table 1.9 Registered unemployed persons by level of education and nationality

	Level of education										
	Total	%	Non-qualified	Semi-qualified	3-yr VET	4-yr VET	Gen sec educ.	Post sec non-tert.	Higher educ.	Master degree	PhD
Macedonians	243,434	65,5	79,950	8,759	53,469	9	78,244	5,960	16,897	138	8
Albanians	84,086	22,6	63,303	3,221	5,729	2	10,260	331	1228	11	1
Turks	13,926	3,7	11,340	477	907	0	1,045	38	118	1	0
Roma	17,397	4,7	15,679	395	813	0	471	10	28	1	0
Serbs	3,254	0,9	1,143	94	758	1	1,052	74	132	0	0
Vlachs	469	0,1	88	38	85	0	137	38	82	1	0
Others	9,250	2,5	6,032	449	1,124	0	1,427	60	154	4	0
Total	371,816	100	177,535	13,433	62,885	12	92,636	6,511	18,639	156	9

Source: Employment Agency, March 2007

Table 1.10 Educational attainment level of the population aged 25-64 (%)

Country/Territory	Year	Low (lower secondary or less, ISCED 0-2)	Medium (upper secondary, ISCED 3-4)	High (higher education, ISCED 5-6)
Croatia	2003	30	54	16
former Yugoslav Republic of Macedonia	2005	41	45	14
Bulgaria	2005	28	51	21
Romania	2005	27	62	11

Source: ETF, 2006

Table 1.11 Employment rates by educational attainment, 15-64 year olds, 2005, (%)

Level of qualification	Croatia	former Yugoslav Republic of Macedonia
Low (lower secondary or less, ISCED 0-2)	42.9	23.5
Medium (upper secondary, ISCED 3-4)	64.3	43.8
High (higher education, ISCED 5-6)	81.1	73.3

Source: ETF, 2006

Table 1.12 Demographic profile

	1991	1994	2002	2003	2004	2005
Population (in '000)	1,923	1,954	2,022	2,026	2,030	2,038
- men (in '000)	965	978	1,010	1,012	1,014	1,022
- women (in '000)	958	975	1,012	1,015	1,017	1,016
Birth rate (per 1000 inhabitants)	18.2	17.2	13.7	13.3	11.5	11.0
Mortality rate (deaths per 1000 inhabitants)	7.7	8.1	8.8	8.9	8.8	9.8
Natural increase rate (per 1000 inhabitants)	10.5	9.1	4.8	4.4	2.7	2.0
Fertility rate	2.30	2.08	1.59	1.54	1.54	1.46
Population by age groups (absolute no.)						
0-14	-	-	-	-	406,015	396,351
15-64	-	-	-	-	1,404,888	1,414,995
65 and over	-	-	-	-	221,641	226,272
Old age dependency (ratio 60+ to 15-59)	19.3	20.7	23.0	23.4	23.5	23.7
Average household size						
Households by size (absolute no.)	505,852	501,994	564,296	-	-	-
Single	30,697	44,637	53,861	-	-	-
2-4 members	324,382	317,870	374,885	-	-	-
5+ members	150,773	139,487	135,550	-	-	-
Life expectancy at birth (in years)	72.13	71.8	73.25	70.35	73.9	73.62
-men	70.1	69.6	70.8	71.2	71.4	71.44
-women	74.4	74.0	75.7	75.8	75.8	75.88

Sources: State Statistical Office, UN Population Division, http://esa.un.org/unpp; Trans - MONEE

Table 1.13 Total population composition according to ethnic affiliation and sex
2002 Census Results

	Total	Percent	Male	Female
All	2,022,547	100	1,015,377	1,007,170
Macedonians	1,297,981	64.2	648,178	649,803
Albanians	509,083	25.2	258,195	250,888
Turks	77,959	3.8	39,550	38,409
Roma	53,879	2.7	27,137	26,742
Vlach	9,695	0.5	5,146	4,549
Serbs	35,939	1.7	18,580	17,359
Bosniaks	17,018	0.8	8,634	8,384
Other	20,993	1	9,957	11,036

Source: State Statistical Office

Table 1.14 Comparison of population structure according to ethnic affiliation

	1991	1994	2002
All	100	100	100
Macedonians	65	66.2	64.2
Albanians	21.7	22.7	25.2
Turks	3.8	4	3.8
Roma	2.5	2.5	2.7
Vlach	0.4	0.4	0.5
Serbs	2.1	1.9	1.7
Bosnians	-	-	0.8
Other	3.4	1	1

Source: State Statistical Office

Table 1.15 Social transfers (D.621 according to ESS 95) in relation to GDP and the Central Budget in the period 2000-2005

	2000	**2001**	**2002**	**2003**	**2004**	**20051)**
Social transfers as % of GDP (total)	13.7	14.1	14.7	15.3	15.3	12.2
% of expenditure from the central budget (total)	56.1	47.9	50.2	60.3	68.1	58.8
Pension and disability insurance fund (as % of GDP)	9.5	10.3	10.3	10.8	10.7	9.4
Pension and disability insurance fund (as % of expenditure from the central budget)	38.8	34.9	35.2	42.3	47.7	45.2
Agency for Employment, financial transfers for unemployed, as % of GDP	2.0	1.8	2.3	2.4	2.7	2.4
Agency for Employment, financial transfers for unemployed, (as % of expenditure from the central budget)	8.2	6.0	7.9	9.3	11.9	11.3
Health Insurance Fund, sickness benefits (as % of GDP)	0.3	0.3	0.3	0.4	0.4	0.4
Health Insurance Fund, sickness benefits (as % of expenditure from the central budget)	1.2	1.1	1.2	1.5	1.6	1.8
Transfers to Ministry of Labour and Social Policy (as % of GDP)	1.7	1.6	1.6	1.6	1.4	-
Transfers to Ministry of Labour and Social Policy (as % of expenditure from the central budget)	6.8	5.3	5.4	6.3	6.1	-
Child protection – child supplement (as % of GDP)	0.3	0.2	0.2	0.2	0.2	0.1
Child protection – child supplement (as % of expenditure from the central budget)	1.0	0.7	0.7	0.9	0.8	0.4

Source: State Statistical Office, 2006

Table 1.16 Macroeconomic forecasts

	2007	2008	2009	2010
GDP growth rate (at constant prices)	6.0	6.5	7.0	7.0
Employment growth	4.0	4.0	4.0	n.a.
Consumer price inflation (cpi, average)	3.5	3.0	3.0	3.0
Average real wage growth	1.5	2.0	1.0	1.0
Current account balance (in % of GDP)	-3.4	-2.6	-2.1	n.a
Export (f.o.b.)	6.3	7.7	7.8	9.1
Import (f.o.b.)	6.3	6.1	6.1	6.5

Source: Ministry of Finance, 2006

Table 1.17 Macroeconomic SPRING forcasts, ECFIN

YEAR	GDP at constant prices	Employment	Unemployment rate	Current account balance	General government balance	General government gross debt
	Annual percentage change					
2007	4.3	3.3	35.8	-2.0	-1.2	32.9
2008	5.3	3.6	34.7	-2.6	-1.5	31.8

Source: ECFIN, 2007

Table 1.18 Population and working age participation projections

	2005	2010	2020	2030	2040	2050
TOTAL POPULATION						
Population (in '000)	2 034	2 046	2 057	2 027	2 000	1 928
Population growth (%, average per year)	0.12	0.09	0.02	-0.20	-0.33	-0.46
Fertility rate						
WORKING AGE POPULATION						
Working age population(15-64)(thousands)	1 410	1 447	1 419	1 342	1 255	1 130
Working age/ total population (in %)	69.3	70.7	69.0	66.2	63.8	60.0
Population aged 65+(thousands)	225	243	301	365	416	469
Population aged 65+(in %)	11.1	11.9	14.6	18.0	21.1	24.9

Source: UN Population Division, http://esa.un.org/unpp

Chapter 2: The Social Protection and Social Welfare System

2.1 Current structure

2.1.1 Overview of the Social Protection System

The main responsibility for the administration and organization of public social welfare rests with the Ministry of Labour and Social Policy. The wide scope of its professional competencies is managed by 10 departments, out of which 7 are in charge of professional maters in the field of social policy and social welfare, such as: labour, pension and disability insurance, social protection, child protection, social inspection, equal opportunities and international cooperation (see Graph 2.1). In addition, there are two other administrative bodies within the MLSP - the Office for Veterans and War Disabled Affairs and the State Labour Inspectorate. The Ministry is also in charge of supervising the work of: the Employment Agency, the Pension and Disability Insurance Fund and the Agency for Supervision of Mandatory Fully Funded Pension Insurance. The Social Protection Department within the Ministry is in charge of administering and supervising the work of the Institute of Social Affairs; the Centers for Social Work and the Social Protection Institutions. Apart from the central role of the MLSP in the planning and supervision of social welfare policies, other ministries also contribute in the coverage of supplementary needs and risks in social protection. These include the Ministry of Health (which is in charge of health care as well as supervision of the Health Insurance Fund), the Ministry of Local-self Government, the Ministry of Education, the Ministry of Justice and the Ministry of Finance.

The Institute for Social Affairs is another important link in the social protection network. It was formed in 1961, and its activities have been defined in the Law on Social Protection. The main tasks of the Institute involve the control and evaluation of social protection policies, analytical research on social problems, programming of social protection development, supervision of the professional activities in the Centers of Social Work (CSW), as well as other public welfare institutions. Although there were sporadic initiatives (corresponding with periods of governmental change) to transform the Institute into an independent institution, it still functions as a part of the organizational structure of the MLSP.

The Centers of Social Work are the main units for social welfare provision. They were created in the early 1960s, and since then function as the key public providers of professional services in social work (with individuals, groups and families), as well as administrators of social assistance payments. Currently, there are 27 inter-municipal SWCs, dispersed in all bigger cities in the country with 660 employees (Tables 2.1 and 2.2). In the capital Skopje, there are 6 sub-offices of the SWC, located in different territorial units, with 158 employees. The process of decentralisation has not yet resulted in transfer of the responsibilities of the SWCs to the local level. Thus, SWC still represent deconcentrated units of central government. According to the representative of the MLSP working group on decentralization, the process of decentralization of SWCs cannot yet be initiated for several reasons, such as: 1) lack of provisions in the Law on Local Self- government (article 22 paragraph 7), which does not envisage decentralization of financial transfers; 2) non existence of a second instance body (at the local level) regarding decisions on complaints; 3) lack of human resources in most of the SWCs in dealing with both administration of social transfers and social service provision.

Social protection institutions are providers of care services and their legal status corresponds to bodies of public law, supervised by the MLSP. They are distinguished according to the target group they cover, which include the following: (1) children and youth without parents or lacking parental care; (2) children and youth with educational and social problems and behaviour disorders; (3) children and youth with intellectual development impediments; (4) children and youth with physical disabilities; (5) elderly and adult disabled persons; (6) elderly; and (/) adults with moderate and severe intellectual development impediments.

Kindergartens are also part of the social protection system, and the Child Protection Department within the MLSP has responsibility for their supervision. Those employed in kindergartens are paid by the MLSP. There are 51 public kindergartens, dispersed in 184 educational buildings/sites. The total capacity of the public kindergartens is 25,000 children, which is 11% of the generation up to age of 7.

The units of local self-government, under the Law on Local Self-government (2002) have gained competencies related to social protection issues. This in practice mainly involves the establishment of child nurseries and homes for the elderly (ownership, financing, investments and maintenance), social care for the disabled (day care centers), as well as other types of non-residential care activities directed at vulnerable groups. The execution of these competencies is in compliance with the National Program for the Development of Social Protection adopted each year.

Four other institutions that are important for the functioning of the social welfare network include: the Pension and Disability Insurance Fund, the Agency for Supervision of Mandatory Fully Funded Pension Insurance, the Employment Agency and the Health Insurance Fund. These institutions are responsible for the management and delivery of social rights derived on the basis of social insurance. Competencies of the PDIF mainly focus on provision of pension rights related to the mandatory public pillar based on the pay-as-you-go principle, while MAPAS is in charge of the management and supervision of pension rights within the second pillar, which is fully funded. Within its scope of activities, the EA monitors employability, employment and unemployment on the national and local levels, provides training and consultations for the unemployed, acts as a mediator in the employment process between the employer and the unemployed, and also carries out payments for financial assistance to the unemployed, i.e. to those who fulfill the specified criteria. The main responsibility of the HIF is connected to rights and obligations with regard to compulsory health insurance.

Although all these funds function as independent public institutions, they still fall under the supervision of the relevant ministries (PDIF, MAPAS and EA are under the supervision of the MLSP, while the HIF is under the supervision of the Ministry of Health).

The positive aspect of the institutional set up of the social welfare provision in the former Yugoslav Republic of Macedonia is its wide geographical distribution, which enables good and timely access. However, there are also many system challenges that include poor targeting and more profoundly the lack of efficient supervision and control. Chosen means testing criteria have not always succeeded in reaching those most in need. Also, the discretionary powers given to social workers and other professionals in the SWCs and others connected with administration and delivery of social assistance payments seem to have been abused in certain instances by issuing documents with false names or with names of deceased recipients of social welfare. The unlawful and illegitimate use of professional discretion and authorities

should be more directly dealt with through legal and financial sanctions and supervision.

2.2 Financial benefits and allowances

Social protection benefits form the most important part of the social protection system, providing many people with their only source of existence. Those which are non-contributory and mean-tested, include: social assistance (including all sub-categories) and child benefits, which are managed through the SWCs (the social assistance) and the Child Protection Department of the MLSP (child benefits). Contributory benefits include: pensions, unemployment benefit, maternity benefit and sickness benefit. These are managed through the PDIF (pensions), EA (unemployment benefit) and the HIF (maternity and sickness benefit).

2.2.1 Non-contributory benefits

2.2.1.1 Social assistance

According to the Law on Social Protection, there are several categories of social assistance benefits: (1) permanent financial assistance - for persons who are unfit to work and/or are socially not provided for; (2) social financial assistance - for persons who are fit to work but are socially not provided for; (3) financial reimbursement for assistance and care; (4) one-off financial assistance; (5) reimbursement of salary for shortened working hours due to care of a disabled child and (6) financial reimbursement for children without parents and parental care - between 18 and 26 years of age.

In 2006, the average monthly amount of the social assistance benefits paid per person were: for permanent financial assistance – Denar 3,046 (Euro 49.79), for social financial assistance – Denar 2,154 (Euro 35.21), for financial reimbursement and care – Denar 3,390 (Euro 55.42), for one-off financial assistance – Denar 2,080 (Euro 34.00), for reimbursement of salary for shortened working hours due to care of disabled child – Denar 6,590 (Euro 107.73) and for financial reimbursement for children without parents and parental care – Denar 3,567 (Euro 58.31).

The amount of the permanent financial assistance is adjusted according to the increase of the average paid salary in the country. In 2006, the ceilings for this benefit were: for a single person – Denar 2,459 (Euro 40.20) for a couple – Denar 3,442 (Euro 56.27) and for families with three or more members – Denar 4,917 (Euro 80.38). On the other hand, the amount of the social financial assistance has been regulated in 1997, and its ceiling amount has not been changed since. Actual ceilings for this benefit are: Denar 1,700 (Euro 27.79) for a single person, Denar 2,200 (Euro 35.96) for couples, Denar 2,800(Euro 45.77) for three member families, Denar 3,600 (Euro 58.85) for four member families and Denar 4,200 (Euro 68.66) for five and more member families. These ceilings have been determined according to the available central budget resources and according to the poverty thresholds in the country. However, these limits indirectly discourage large families, among which members of ethnic groups such as Roma and Albanian who have families with many children are particularly affected.

The amount of the financial reimbursement and care depends on the average income of the family, as well as on the scope of need and care, and at the end of 2005 it ranged from Denar 1,413 (Euro 23.10) to Denar 3,835 (Euro 62.69). The one-off financial assistance could amount to a maximum of two average net salaries on the

national level. The reimbursement of salary for shortened working hours due to care of a disabled child is calculated as 30% of the average national salary, while the amount of the financial reimbursement for children without parents and parental care amounts to 25% and 35% (for those in regular education) of the average salary.

The means testing procedure involves selection based on the documentation checklist, as well as estimation of household income and needs, which is realized upon a household visit.

In 2006, the average monthly number of social assistance beneficiaries was 92,506, out of which: for permanent financial assistance – 4,988 persons, for social financial assistance – 64,749 households, for financial reimbursement and care – 21,499 persons, for one-off financial assistance – 1,139 persons, for reimbursement of salary for shortened working hours due to care of disabled child – 42 persons and for financial reimbursement for children without parents and parental care – 89 persons (Table 2.3).

The structure of social assistance beneficiaries by certain characteristics (ethnicity, age, etc.) is currently available only for the social financial assistance for 2005. According to this data, the average number of social financial assistance beneficiaries in 2005 was 65,117 households. Out of this number, in December 2005 according to the ethnicity of the household head, Macedonians were represented with 39.4%, Albanians with 28.9%, Roma with 14.9%, Turks with 7.5%, Vlachs with 0.1%, Serbs with 0.9% and 8.3% belonged to other or unknown ethnicities. According to age structure of the household head in December 2005, there were 20.9% of beneficiaries in the age group 0-30, 35.6% beneficiaries in the age group 31-40, 28.7% beneficiaries in the age group 41-50, 11.9% of beneficiaries in the age group 51-60 and 2.9% of the beneficiaries above 61 years of age. Registered unemployed people comprised the largest share of these beneficiaries– 96.3%, while according to educational attainment those with no qualification represented the greatest share - 35.6%, followed by those with lower education -24.9%[15].

According to some of the numbers presented it can be estimated that the coverage of social protection does not reach many categories in need, such as the unemployed and the elderly. Comparing only the numbers of unemployed people (321,029 in 2006) with the numbers of social assistance recipients (those of social financial assistance and one-off financial assistance – total of which in 2006 were 65,888 recipients) it seems that almost 80 percent of those who are unemployed are not covered by the social protection system[16]. In addition, the elderly also seem to lack coverage in the social protection system, as according to the age structure of the household head for social financial assistance, only 2.9% were beneficiaries above 61 years of age. The total numbers of permanent financial assistance beneficiaries (4,988 in 2006) also does not significantly increase the numbers of elderly in receipt of the social assistance.

2.2.1.2 Child benefits

The Law on Child Protection defines four different financial benefits aimed at contributing to child welfare and child well-being. These include: (1) child allowance; (2) special allowance; (3) first born baby allowance and (4) participation.

[15] Data from the Unit for Analysis, Planning, Coordination and Evaluation of Policies of the MLSP (2005)

[16] The numbers of social financial assistance recipients are households, where more than one unemployed can benefit from the allocated social assistance to the household head. Hence, this percentage might be less, but even if adjusted for numbers of unemployed in one household that is recipient of social financial assistance, the percentage will remain high ???? not very clear.

The child allowance is the major form of child benefit in the former Yugoslav Republic of Macedonia and it is granted to children living in families with low incomes. It is dependent on the child's age and household income. However, the means-testing procedure used for assessment of the household income for child allowance is confined to a set of documents, which according to some researchers (Verme, 2003) contributes to a failure in targeting and selection of poor families. The income threshold for exercising the right to child allowance is 16% of the average salary paid per employee in the first half of the previous year for couples and 32% of the same amount for single parents. The total sum for child allowance can amount to a maximum of Denar 1,800 (Euro 29.42) per month.

Special allowance is granted for disabled children and a special commission establishes the disability status for children up to the age of 26. The sum of the special allowance represents 27% of the average salary paid in the first half of the previous year.

First born baby allowance is a universal benefit provided once and only for the first born babies to all mothers.

Participation is a form of public contribution to the costs for caring and education of the children in public institutions. Although this benefit is stipulated in the Law, it is rarely provided in practice.

Child benefits are generally low. Child allowance is Denar 691[17] (Euro 11.30) per child below the age of 15 and Denar 1,174 (Euro 19.19) per child between the age of 15 and 18 if in education. Special allowance which is offered to support families caring for disabled children is Denar 3,632 (Euro 59.38) per month and allowances for new born babies can vary between Denar 1,000 (Euro 16.35) and Denar 3,500 (Euro 57.22). These amounts can make a difference only to the poorest among the poor, a target group which is not reached by benefits at present.

In 2006, the average monthly number of child benefits beneficiaries was 22,362 families and 36,649 children. According to specific type of child benefit, in 2006 the average monthly number of beneficiaries was: (1) child allowance – 17,195 families and 31,591 children; (2) special allowance – 4,655 families and 4,536 children and (3) first born baby allowance – 512 families and 522 children (See table 2.4).

2.2.2 Contributory benefits

2.2.2.1 Unemployment benefit

The right to cash compensation in case of unemployment is part of the social insurance system and is given to an unemployed person that has been working and paying contribution continuously at least 9 months or 12 months with interruptions in the last 18 months. Labour market new entrants are excluded *a priori* from unemployment insurance although they may register as unemployed and claim health insurance.

[17] Calculated according to the average paid salary in October 2006 – Denar 13,812 (Euro 225.78)

According to the Law Amending the Law on Employment and Unemployment Insurance[18] (Article 5), the duration of receiving unemployment benefit is:

- three months if the unemployed person was insured continuously at least 9 months or with interruptions 12 months within the last 18 months;
- four months if the unemployed person was insured continuously at least 24 months or with interruptions 36 months within the last four years;
- six months in the case of being insured for more than 5 and less than 10 years;
- eight months in the case of being insured for more than 10 years and less than 15 years;
- 12 months in the case of being insured for more than 15 years.

In the case that the unemployed person was insured for more than 15 years and lacks not more than 5 years to fulfill the criteria for receiving a pension (57 years of age - women and 59 years of age – men), then the length of receiving the unemployment benefit is extended permanently until retirement age.

The benefit level is set at:

- 50% of the average monthly net wage calculated over the last 12 months of employment for a person that has the right to a cash compensation up to 12 months;
- 40% of the average monthly net wage for a person that has a right to compensation longer than 12 months.

In any case, unemployment benefit cannot be higher than 80% of the average wage in the country. The minimum amount of the unemployment benefit is not set.

Rights to unemployment insurance have been reduced on a number of occasions since 1997. For example, before 1997 there was no maximum level of the unemployment benefit, while the minimum was set at (then 100 Deutche Marks) 50 Euro. The duration of the unemployment benefit in 1997 was set at maximum 18 months (for those with between 20-25 years of work record). Until 2004 the unemployment benefit was calculated as an average amount of the salary received in the last 12 months of insurance, while since 2004 it is calculated as an average of the salaries received in the last 24 months. Also since changes from April 2006 to the Law on Employment and Unemployment Insurance, the right to pension and invalidity insurance is granted only to those that are insured less than 15 years and lack 5 years to fulfill the criteria for receiving a pension.

As presented in Table 2.5, the number of beneficiaries of unemployment benefit has been slowly decreasing, from 41,375 recipients in 2001 to 30,572 in December 2006 (8.3% of the total number of registered unemployed). It is important to emphasize that the reduction of unemployment benefit recipients is a result of the tightening of the eligibility criteria, but also of the smaller number of closures of companies in this period. The decreasing trend has been also evident in the 'retirement' scheme category from more than 40% in 2003 (according to the World Bank Report) to 33.21% in 2006 (according to the EA report for 2006). The number of beneficiaries that receive unemployment benefit for a permanent period (retirement scheme category) in 2006 was 15,202 (out of which 11,322 are men over 59 years of age and 3,880 are women above the age of 57).

[18] "Official Gazette of the RM" no. 14/2005

After the use of unemployment benefit is terminated, unemployed people most commonly apply for and use social financial assistance. Currently, there is no real communication/cooperation between the SWCs and the EAcenters.

Some of the problems associated with access to unemployment benefits arise from the need to prove ownership of land, required by the EA to determine whether potential unemployed benefit recipients have arable land which can be used for economic purposes. This is required from those that are registered without any educational certificate. Since many of the unemployed (mainly Roma and Albanian) do not have settled property rights, they cannot fulfill this criterion and are prevented from fully realising their social rights. These problems can be resolved with improved coordination between the EA (centers for employment), SWCs, revenue offices and cadastre (land registry) offices. A mutual data base could resolve the problems of requiring unnecessary documents, and improve the efficiency of delivering these services. Also on the client side, it would be less time consuming and less costly to obtain the needed service.

2.2.2.2 Maternity benefit

Maternity benefit as a financial compensation is provided through compulsory health insurance and administered through the HIF. The right to maternity benefit can be claimed if the woman was insured at lest 6 months before the start of maternity leave. Women in agriculture can claim the maternity benefit only if their agricultural activity is registered as an independent economic activity. There is a trend of increased registering by agricultural families of their economic activities, not because of claiming particular benefits, but mainly due to the possibility of using bank loans and credits. Maternity benefit is continuously paid for: 9 months (28 days before anticipated delivery), or 12 months in case of a multiple birth. A female employee may begin her maternity leave 45 days before childbirth if authorized by a competent medical commission.

To promote earlier return to the labour market, a female employee may return to work 6 months after the birth, during which time (until the end of the 9th month of her maternity leave) she will receive both the maternity benefit and the regular salary. The HIF pays maternity benefits in the amount of 100% of the average monthly net wage paid to the employee (mother) in the six months before the maternity leave (monthly payment).

2.2.2.3 Sickness benefit

Workers' compensation is paid from the first day of work incapacity and lasts for the whole period of the sickness leave. The benefit is paid for the working days for which the worker would have received salary pursuant to the labour regulations. In cases of temporary incapacity for up to 12 months the Medical Committee of the HIF refers the insured person to the competent body for assessment of the permanent incapacity pursuant to the regulations on pension and disability insurance. The employer pays worker's compensation for the first 21 working days from his funds, whereas after 21 days it is paid by the HIF. The workers' compensation rate during sickness leave is specified by the employer or the HIF by general by-law in the amount of at least 70% of the basis of the workers' compensation.

2.3 Social services provision

In parallel with financial assistance, the system of social welfare also provides social services, which according to the Law on Social Welfare are categorized as: (1) social prevention; (2) institutional care; and (3) non-institutional care. These services are predominantly organized and administered by the state, but recently with the trends of pluralization and de-institutionalization, there are many other non-residential forms of protection offered also by NGOs and private organizations.

2.3.1 Social prevention

The measures of social prevention, as stipulated in the Law on Social Welfare, are undertaken by the SWCs and they are directed towards individuals, groups and families with an aim to prevent social risks. This involves educational and advisory work, development of self-assistance forms, volunteering work with personal engagement and without remuneration and implementation of other methods, which conform to the needs of social welfare beneficiaries. In general, this activity, as currently performed by the SWC, is probably least offered, due to greater demand for other social services. The SWC need flexible working hours in terms of providing services for emergency situations since currently they work in one shift only, from 08.30 to 16.30, Monday to Friday. The budget for undertaking social prevention measures is not mentioned in the Annual Programs for Social Protection

2.3.2 Institutional care

The services provided through institutional protection are divided into two categories: (a) the right to training, working and productive activity (in the case of moderate and severe mentally disabled) and (b) the right to placement in a Social Protection Institution. This is provided through a network of public and non public institutions (Table 2.6), which currently involves the following:

- Public institutions for children without parents and parental care. There are two institutions giving shelter and care to this category of children. Currently they accommodate around 200 children from 0-18 years of age. These are predominantly children without parents, but also many of them have some form of disability;

- Public institutions for children and youth with educational and social problems and behavioral disorders. Two such institutions, both located in Skopje, accommodate 120 children (April 2006). The age of the children is between 7-18 years;

- Public institutions for persons with learning (intellectual) and physical disabilities. Three such institutions provide care and accommodation to 550 users (in 2006);

- Public homes for elderly. There are four (registered) institutions for adults, accommodating a total of 550 persons (April 2006).

Apart from the public network, there are also private institutions that mainly provide accommodation and care for the elderly. Currently there are 4 private homes for the elderly, accommodating 142 users.

A non–profit organization, SOS children's village, which is part of the umbrella organization SOS Kinderdorf International, also provides residential services to around 83 children without parents and parental care.

Non-governmental organizations also contribute towards sheltering particular categories in need. There are 6 day-care centers for persons with intellectual disability organized by the NGO Poraka and 1 Shelter Center for victims of family violence (located in the premises of the Public Institution for Children and Youth with Educational and Social Problems) by the NGO Shelter Center.

Until recently (to 2000), institutional care was the most dominant form of accommodation in comparison to other non-residential, day care or other forms of shelter provision. Its quality was poor, due to low funding, lack of staff and large numbers of residents. Some of the social protection institutions have improved their conditions due to external funding and donations, but some of them are still of very poor quality. One such extreme case is the Special Institution for Children, Youth and Adults with Learning (intellectual) and Physical Disabilities, situated in Demir Kapija. Despite recent efforts to improve the conditions in this institution, it still does not provide humane and decent living conditions for its residents. Institutional care is currently in the process of transformation according to the goal of de-institutionalization.

According to the draft Strategy for Deinstitutionalization (2007-2014), the process of transformation of institutions is perceived to last seven years and to encompass three phases. Phase one will be focused on transformation of three institutions: Demir Kapija (Special Institution for Children, Youth and Adults with Learning/Intellectual and Physical Disabilities), Bitola (Home for babies and children without parents and parental care 0-3 years of age) and Banja Bansko – Strumica (Institution for rehabilitation of children and youth with physical invalidity). The second phase will be focused on the transformation of two other institutions: the Home for children without parents and parental care (11 Oktomvri -Skopje) and the Institute for protection and rehabilitation of children and youth in Skopje. The third phase will involve the remaining two institutions: Public institution for children and youth with educational and social problems in Skopje and Institute for accommodation, upbringing and education of children and youth Ranka Milanovik – Skopje. The reform will be follow two directions: (1) assessments of the current network of all types of accommodation and giving priority to the development of the accommodation network of foster families and small housing units; and (2) assessment of the type and quality of accommodation services given in the social protection system. Throughout the transformation, the MLSP will finance, train and support the formation and effective functioning of the following services within the local communities and the SWC: preventive services, services for temporary accommodation, services for reintegration and small family homes. The successful implementation of this Strategy requires prior assessment of the capacities of the local communities in terms of professional staff to be involved in the planned services for accommodation.

2.3.3 Non-institutional care

There are several types of non-institutional care. These include: primary social service for users of social protection, assistance to individuals and assistance to families. These three categories involve advice and counseling to overcome social problems. Other forms of non-institutional care comprise of:

Home care and assistance: This covers support and services to elderly and disabled people, who are not able to care and provide for themselves. This support is provided regardless of the person's family status (single or living with family).

Day care centers: This form of care is used for the protection of people with different social risks, including: (1) children with special needs - according to SWC statistics, there are 1,600 registered children with moderate and severe intellectual disabilities in the country. They all suffer a form of exclusion from access to public nurseries, schools and other forms of organized social activities. Therefore, starting from 1994, but more actively since 2001, a trend towards community-based care has occured. This resulted in the opening of 18 day care centers, dispersed throughout the country, which provide services to approximately 270 users; (2) drug abusers - 2 such centers; (3) victims of family violence - 6 centers; (4) street children – 1 centre; (5) homeless people – 1 centre.

Foster care: This form of protection in the former Yugoslav Republic of Macedonia has been used for more that 30 years, although not in all cities (or not administered by all CSWs). Currently there are 106 foster families where 174 children between 3 and 26 years have been placed. The majority of these children are without parental care. In the last few years, through the de-institutionalization process, this form of protection has covered many children with special needs. It should be mentioned that CSWs also place children without parents or parental care with close relatives (grandfather, grandmother, aunt, uncle and so on), who are also considered to be foster families. Each foster family receives a monthly contribution of Denar 5,000 (Euro 81) per child from the MLSP.

Adoption: This is also a much used way of protecting children without parents and parental care. The CSWs are in charge of administering this procedure, which involves obtaining consent from the biological parents, and working with the adoptive parents. Children can be adopted after their 3rd month and with complete documentation, with the consent of both biological parents. The upper age limit for the adoptive parents is set at 45 years of age, or the difference between the age of the child and the age of the parent should not be more than 45 years. The number of children adopted each year varies, from 164 in 2001(Transmonee, 2006) to 191(October 2005 to October 2006, according to the MLSP).

Under the amendments to the Law on Social Protection of 2004, a special commission was formed within the MLSP, which also administers the adoption procedure. Although this has been done to assure and strengthen control over adoptions, anecdotal evidence suggests that this has not prevented, but on the contrary has reinforced, the existing ‘adoption market’ through which adoptive parents are asked to pay a significant sum of money (between Euro 2,000 and 5,000 per child) to complete the adoption procedure. This implies a need for urgent political and legal action to investigate these problems further in order to put an end to potential human rights violations as well as corruption within the social welfare field.

Non-institutional care in the former Yugoslav Republic of Macedonia (with the exception of more traditional forms of service, such as foster care) lacks a clear and precise legal framework for certification, accreditation and quality control. The mentioned Strategy for Deinstitutionalization emphasizes the need for standards and licensing, but it does not mention who will be responsible for their supervision and execution. On the other hand, capacity building for non-institutional care is more pronounced, as more actors, such as the MLSP, the Institute for Social Affairs (which is part of the MLSP), the Faculty of Social Work and Social Policy as well as the National Association of Social Workers frequently organize seminars, workshops and trainings contributing towards improvement of the skills and qualifications of social work professionals.

2.4 Decentralization and pluralization

The process of decentralization in the social welfare involved mainly the transfer of responsibilities from central to local level concerning the elderly and child protection. More specifically, it encompassed the transfer of responsibilities from central to local level of 4 public homes for the elderly and 51 kindergartens. Also, all municipalities and the city of Skopje were given the possibility to provide social services though their own developmental plans and programs regarding the specific problems of the population in their community, to be financed through their own resources.

The process of decentralization has not transferred additional responsibilities to the municipalities. Fiscal decentralization only encompasses financial transfers for the elderly and kindergartens, due to currently unresolved problems explained in section 2.1.1 above. However, depending upon municipal resources, additional services can be provided by the municipality itself such as shelters, public kitchens, day care centers, and so on. In 2006, the total revenues of the municipalities increased by 29% compared to 2005. In 2006, the total revenues of local government represented 7% of the total revenues of the central government, or nearly 2.5% of GDP. However, due to differences among municipalities' own resources, regional disparities become and important and enduring challenge.

The consultations and interviews carried out for the purposes of this study with representatives of the municipalities of Veles, Chair, Saraj and Gjorce Petrov, indicate an obvious trend towards an increase in local social policy activities in relation to: (1) the opening of day care centers; (2) projects for improvement of employment opportunities; (3) cooperation with the private and NGO sectors in search of joint solutions for increased employability of citizens; as well as (4) humanitarian assistance and educational courses.

In addition to local authorities, other actors such as the private sector and NGOs were given the legal possibility to contribute to social service provision. Currently there are 6,000 registered associations of citizens in the country, out of which only 23 are registered in the MLSP database. This database is comprised of organizations that have satisfied the Ministry criteria for professionalism, competence and quality, and only they can apply for tender calls that are announced by the MLSP. According to the NGO the Macedonian Centre for International Cooperation the NGO index (ratio of number of NGOs per 1,000 inhabitants) is 2.5. For comparative illustration, this index in Croatia is 9.5 NGOs per 1,000 inhabitants. The sources of financing of non-governmental organizations include the central budget, the budget of individual ministries, the resources acquired from the lottery and similar entertainment games and recently in the context of EU integration, the budgetary allocations of the Secretariat for European Affairs, as well as CARDS. Other NGO resources are mainly from international donors.

Although the trend towards pluralization has improved, in terms of the overall participation of NGOs and other non-state actors in the process of creation of social policy strategies, the evidence from some of the NGOs given in the interviews for this study, reveal that when drafting important national strategies, there is a lack of cooperation, as well as a lack of final outcomes/effects in terms of accepted proposals etc. However, it can be observed that the impact of the NGO's in the former Yugoslav Republic of Macedonia has been mostly evident in activities where there is a lack of governmental action. For example, many of the civil society organizations, with the support of international donors, have been very active in providing educational support (for formal and non-formal education) for ethnic communities, i.e. mainly to Roma children and families, as well as activities in the area of day-care centers for disabled persons. While the government seems to favor

a social service provision approach that covers all those eligible by Law, the activities of the non-profit social service providers are more targeted and directed towards specific vulnerable groups. This give the latter a possibility for a better effectiveness and more prompt responses in realization of their clients needs.

Private sector participation in social services provision is still not that prominent. This is mainly due to a lack of precision of legal provisions, and implies a need for more incentives for its promotion within the social welfare sector. As already described above in terms of institutional services, the main focus of the private sector has been in the domain of elderly care, i.e. private homes for elderly.

2.5 Financing of the social protection system

As already indicated, the social protection system comprises both contributory and non-contributory benefits. Social insurance benefits comprise the contributory part of the scheme. These include compulsory contributions for: pensions and invalidity – 21.2% of the gross salary (out of which 13.78% in the first pay as you go public pillar and 7.42% in the second private capital financed pillar), unemployment benefits – 1.60% of the gross salary, and health insurance (health care, sickness, maternity benefits) – 9.20% of the gross salary. Therefore, the total rate of contributions towards social insurance is 32% paid by employers only, out of the gross salary of the employees.

Non-contributory benefits are financed through the central budget. According to the Central Budget for 2007, Denar 51,102,000 (Euro 835,409) will be allocated for social transfers.

According to the 2007 Annual Program for Social Protection, the financing of social protection will consume a total of Denar 3,340,790,000 (Euro 54,614,843 Euro) from the central budget. The earmarked budget is dived into three categories: (1) for non-institutional care – Denar 287,450,000 (Euro 4,699,198); (2) for institutional care – Denar 210,340,000 (Euro 3,438,613) and (3) for financial transfers Denar 2,843,000,000 (Euro 46,477,031).

According to the Operational Plan for Active Employment Policies for 2007[19] which are indicated in the Program for the Work of the Government 2006-2010, the implementation of the planned active employment policies in 2007 will consume a total of Denar 297.6 million (Euro 4,865,130). These costs will be financed by employment contributions (Denar 71.5 million / Euro 1,168,874), by the EA budget for 2007 (Denar 50 million / Euro 817,394, plus Denar 4 million / Euro 65,392 already provided from the 2006 budget), by the Special Fund for persons with invalidity (Denar 71.5 million / Euro 1,168,874), with support from UNDP (Denar 33 million / Euro 539,480), as well as by the local (Denar 9.6 million / Euro 156,940) and central government (Denar 69 million / Euro 1,128,004) budgets.

2.6 Evaluation of recent and planned reforms

Despite initial delays, reforms in the social protection sphere gained momentum in the late 1990s. Economic and political instability resulted in delayed government reforms in a number of areas particularly relevant for labour market functioning and social protection. The main laws on employment, unemployment compensation, labour relations, social protection and others were introduced only after 1997. The

[19] Ministry of Labour and Social Policy, November 2006.

period between 1997 and 2004 can be particularly associated with the adjustments supported by the World Bank, which included the transformation of the PAYG pension towards a multi-pillar pension system, a focus on activation and workfare in employment and social welfare policies, a reduction of public spending and stricter targeting of social transfers. Since 2004, the Government has been very active and focused on the acceptance of international standards, especially those coming from the European Union.

Currently, there is an ongoing process of changing the Law on Social Protection, which should be finalized by the end of 2007. Planned amendments focus on a number of levels, including: (1) improvement and standardization of the conditions, means and procedure for acquiring the rights to social protection, especially different social assistance benefits. Among other things, this envisages the introduction of conditional social transfers. It presumes giving social assistance benefits only to families which accept the offered conditions, such as receiving benefits only if their children are enrolled and attending school, or if they are subject to regular health check-ups etc.; (2) introducing greater means-testing and conditionality. This involves a change of the criteria for acquiring the right of financial reimbursement for assistance and care, which until now was more or less a universal benefit for people with certified disability who needed additional assistance and care in the family. Now this reimbursement will be allocated only to people with low or no incomes; (3) broadening the scope of social protection to new risk groups, such as asylum seekers; (4) introduction of the EU directives for equal treatment among people, i.e. the Directive 2000/43/EC implementing the principle of equal treatment among persons irrespective of racial or ethnic origin; and (5) specifying and broadening the rights deriving from the decentralization of social protection, according to the financial possibilities of the municipalities.

It seems that the innovations planned in the changes of the Law on Social Protection focus more on stricter targeting and reducing the previous universal character of social assistance benefits. This is also supported by the World Bank, which has especially contributed to the idea of conditional social transfers, based on its experience with countries from Latin America, where the human development index is much lower than in the former Yugoslav Republic of Macedonia. Therefore, it is questionable whether this approach has sufficient arguments to be introduced in the former Yugoslav Republic of Macedonia, as it might be potentially dangerous for the main socially deprived groups such as Roma, who might be further distanced from the social protection system.

Other strategic documents planned to be implemented include: National Program for De-institutionalization and National Program for the Fight against Family Violence.

Additional planned activities for 2007 in the field of social welfare include a subsidy for the employment ofsingle parents, people with disabilities and children without parents and parental care. The planned financial support consists of employment support for 500 single parents and 100 children without parents and parental care, which will involve public financial assistance in the amount of Denar 11,200 (Euro 183) monthly for a period of 6 months.

The strive towards European Union accession has also contributed towards EU minded policy papers, such as the: National Strategy for Integration in the EU (September 2004); the development of the first National Action Plan for Employment (NAP) 2004-2006, and the second NAP for Employment for 2006-2008; as well as the development of the National Strategy for Employment – 2010 (in 2006). The latter three documents try to correlate the EU goals and recommendations on the labour

market with three horizontal priorities (increasing employment, improving quality and productivity of work, as well as strengthening social cohesion and inclusion) and the ten employment guidelines of the European Employment Strategy. Although all of them seem to lack a more precise matrix of instruments and means for realization of the planned priorities, still they present an important contribution towards systematic, measurable and transparent social policy making.

Unlike these documents, the chapter on social issues of the National Strategy for Integration in the EU gives a confusing picture of the social policy reform tendencies and their correlation with EU common approaches. In the section that elaborates adequate provision and targeted social protection in order to eliminate negative social consequences from the transition, the document, in a quite contradictory way notes that:

> "The system of social protection which is robust and egalitarian and that offers a relatively high degree of protection needs to be transformed to prevent endangering the balance of the public finances, as well as companies' competitiveness." (p.133, 2004)

Yet, it acknowledges the difficult economic conditions, which necessitate the need for more inclusive social protection, so in the continuation it argues that:

> "The system must be transformed quickly, without damaging social inclusion in the society and without causing greater social tensions." (p.134, 2004)

However, it is difficult to imagine that these two, mutually exclusive, goals (reduction of the egalitarian nature of the system without damaging social inclusion) can be achieved quickly, and without social tensions. What is also interesting is that this Strategy suggests social reforms based on individual responsibility, reduction of social transfers in line with budgetary capabilities, and enabling the social sector to perform its tasks in the context of the needs of a market economy (p.134, 2004). This is in sharp contrast with the EU goals and priorities concerning social cohesion, sustaining adequate social transfers and maintaining market competitiveness through universal social security and protection.

It is obvious that the latter stage of social protection planning in the country is mainly influenced by EU goals and recommendations, which can be seen through the initiatives of creating working groups for drawing up the Joint Inclusion Memorandum, putting an emphasis on social inclusion and social prevention, as well as on anti-discrimination higher on the political agenda. However, this must be followed by real actions in practice, including all relevant stakeholders, so that all activities have broad support and relevance. The experiences of the past show that the approaches used in creating strategic plans were not very efficient, since many of the stakeholders' suggestions have not been considered in the process of policy making. The MLSP should reinforce its role as a coordinating body and incorporate different stakeholders' ideas and proposals into the planned strategic documents.

Other assistance to the social protection sphere in the country involves the World Bank's Social Protection Implementation Loan - SPIL (US$ 9.8 million, 2004 - / Euro 7,204,143). In 2007, this Project aims to continue the analysis of the laws and by-laws from the aspect of determination of a unified methodology for estimation, calculation and payment of different types of social benefits, so that in the next period a software application can be created, which will be applied in all SWCs, and they can be mutually connected with the MLSP, EA and other partners involved in the social benefits administration.

Other active World Bank loans include: Public Sector Management Adjustment Loan (PSMAL) (US$ 30 million, 2004 -/ Euro 22,053,499), which supports public administration reforms to tackle corruption and reforms in health care and social assistance, increasing the efficiency of the health care services and ensuring that subsidies are effectively targeted to the poor; Health Sector Management Loan (US$ 10 million, 2004 - /Euro 7,351,166), that focuses on capacity building of the Ministry of Health and HIF, as well as upon development and implementation of an efficient scheme of restructuring hospital services with a emphasis on day-care services and shifting to primary care; and the Education Modernization Project (US$ 5 million credit/ Euro 3,675,583 and US$ 10 million grant/ Euro 7,351,166, co-financing by the Government US$ 3 million / Euro 2,205,350, 2004-), which is designed to improve the quality and standards in all sectors of education, and to build management capacities within schools.

Among the interesting assistance projects is the Social Institutions Support Program with an office in Skopje. This program is a joint CARDS project, mainly funded by the European Commission, and co-funded and managed by the Council of Europe's Directorate General of Social Cohesion (DG III). The program is a spin-off of a previous activity, carried out within the Initiative for Social Cohesion of the Stability Pact for South East Europe, which contributed to the creation of a network of social security professionals and set the basis for regional cooperation in the field of social security coordination. Their initial activities were by and large of academic and/or networking character, but currently their more prominent engagement in analysis of the functioning of social insurance seems to have more impact on the policy making level.

Other donors in the social welfare field include: UNICEF (baseline surveys and studies on the situation of children and women conducted to fill data gaps and to further understanding on emerging issues; Dev Info and Child Info System, which identifies socially excluded groups and influences government pro-poor policies); UNDP (with a focus on local human development and good governance at national and local level and poverty reduction policies in line with national MDGs targets); USAID (local community participation, training managers and principals in 50 schools); as well as WHO, GTZ, less prominently DFID, and others such as OSCE, the governments of Greece, Italy, Japan, the Netherlands (Trust fund), Norway (Gender issues, Norad), Sweden/SIDA, and Switzerland.

Donor influence in social policy creation and implementation is of great concern in the former Yugoslav Republic of Macedonia. The most prominent contributors were the international financial organizations, mainly the World Bank. Their influence is most evident in pension reform and the ongoing social protection reform (SPIL project), while in health care their impact was less pronounced. The effects can be seen through more 'means-testing' policies, greater restrictions in eligibility criteria, as well as through redirecting the emphasis from 'egalitarian' to a 'safety net' social policy. Other donors, such as UNICEF and UNDP had less impact on a policy level, although their activities have contributed towards the establishment of programs that might have a small, but long-term effect (UNDP active employment programs, UNICEF immunization programs etc.). Without donor support, the former Yugoslav Republic of Macedonia would have faced greater challenges than those existing, especially in the first years of the country's independence. However, it must be emphasized that there is a greater need for systematic approach towards donor supported programs, in order to avoid duplications and correlate a variety of projects with the current national priorities.

2.7 Conclusions

The system of social protection in the former Yugoslav Republic of Macedonia since 1991 was faced with many challenges, such as the increased number of social risks needing to be covered, increased demand for social welfare, reduced financial possibilities, as well as lack of timely, unified and comparative social statistics as a basis for the creation of properly targeted social policy. Some of these challenges are still pertinent and have been accompanied by other new specific problems, all of which require adequate attention and action. Our own conclusions regarding current system capacities is summarised in the following SWOT analysis.

Strengths	**Weaknesses**
- Well dispersed network of social services (SWCs) - Wide scope of covered social risks	- Incompatibility between targeting of social benefits and demand for social welfare - State Monopoly of services - Lack of quality criteria, standards and accreditation for social services - High degree of politicization of public administration - Lack of transparency - Inefficient human resources - Corruption and illegitimate use of discretionary power
Opportunities	**Threats**
- EU conditionality policy and requirements - Ongoing technical and expert support by international organizations - De-institutionalization - Decentralization - Increased emphasis on plural social protection (welfare mix)	- Increased impoverishment of the population - Deepening of 'classic' social problems and appearance of new social problems - Demographic, social and financial sustainability of the social protection system

Below is a more comprehensive analysis of the weaknesses and threats, given that the strengths and opportunities have been already assessed in the previous sections of this chapter.

Weaknesses:

(a) Current targeting of social welfare benefits (i.e. unemployment benefit, social financial assistance) has literally been translated into a policy of major cut backs in eligibility, duration and amount of social welfare benefits. In the context ofhigh unemployment rates, irregular wages and high demand for social welfare, this policy does not provide adequate and accessible social protection for all. This is accompanied by problems of the misuse of social benefits by its administrators and professionals. This implies a need for a more fundamental change in social welfare benefits, both in terms of their targeting direction (i.e. either less recipients but higher social benefits, or more recipients with n average amount of social benefits) and also in terms of authorization of their issuance and delivery.

(b) Monopoly of services within one institution: There is an evident trend of increasing the authority and duties of existing public social services providers (SWCs), which prohibits their effective functioning in domains where they have already established a tradition and practice. This can be exemplified in a recent announcement that the SWC will engage in opening 'public kitchens', as well as in their engagement in running and managing some of existing day care centers. Instead of increasing the competencies of SWCs, room should be given to other actors, such as NGOs and/or private sector, which can provide these services in a more timely and innovative manner. Greater coordination is also needed between public and non-public bodies in order to avoid overlaps and reduce the bureaucratization of the system.

(c) Lack of quality standards, licensing and accreditation for social services: Currently there is no obligatory requirement for participation in ongoing professional development and continuous training for professional staff working in social service delivery. This contributes towards a lack of required competencies, especially in dealing with specific social problems, such as homelessness, family violence, human trafficking etc. Also, there are no practice guidelines, which leads to improvisations and ad hoc decisions in social service delivery. Lack of accreditation and licensing also negatively impacts the further development of social service provision, especially in the process of pluralization and decentralization of social welfare.

(d) Instead of a professionalisation of social services, we are constantly witnessing a process of politicization of social welfare administration. This is expressed through extensive political interference in recruitment and advancement procedures and in the prevalence of party or other interests (rather than professionalism) in the operation of social administration. Also, frequent political changes at the ministerial level interrupt previously initiated processes of planning and implementation in social welfare. In addition, the politicization of the administration leads to a lack of professionalisation in public services. The social sector administration is weak and few personnel have the required skills to write project proposals or to set priorities. Ministries are weak in the monitoring of projects and in report-writing skills; they lack ability to prioritize needs in the short, medium and long term, as well as knowledge of the requirements of the Social *Acquis*.

(e) Lack of transparency, which is evident at all levels of social policy-making (creation, implementation and supervision), contributes toward increased mistrust and low support among clients and other stakeholders in the system. Reforms in social policy seem to be constantly prepared and decided with international financial organizations, where only fiscal needs and capabilities are being considered. This has contributed towards a situation where many important policy proposals and ideas have been rejected, such as those coming from the trade unions (for example during the time of introducing pension reform). Social services provision also needs more transparency, so that different client groups can have a more effective take up of services and benefits in the system. More transparent promotion is needed, for example a more energetic campaign regarding recruitment of foster families, employment of people with disabilities in terms of benefits for employers, etc.

(f) Human resources in the social sector are insufficient. Although SWCs and social welfare institutions differ in size according to their clients and the area they serve, still there is an evident lack of professional staff dealing with social services' delivery. In some SWCs, due to the limited numbers of staff, there is a practice that the same social workers are dealing with both financial assistance and social service provision. In the process of decentralization, this problem becomes even more evident. Hence,

careful planning based on local municipality resources and needs should be undertaken in order to improve the current client-staff ratio.

(g) Corruption and abuse of discretionary powers: As indicated elsewhere in this report, there have been many reported (and unreported) cases of misuse of professional authority and power in the social sector. These have included: misuse of social assistance benefits by managers or professionals in SWCs, accepting bribes for offering services (for example through the Commission for Categorization of Disabled People, Commission for Determination of the Capacity to Work, Employment Centers through issuing provisional documents for employment status i.e. M1 and M2 documents, needed for visa purposes etc.), as well as anecdotal evidence regarding informal payments for adoptive children. Independent bodies should review all of these, so that approporiate (and non politicized) action can be undertaken to prohibit and sanction these illegal behaviors further.

Threats:

(a) The process of impoverishment of the population, which has been noticed since the early 1990s, has rapidly accelerated in the period since 1997 resulting in a poverty rate of 30% in 2005. This condition affects the negative motivation and participation rates both generally in the society and in the labour market, and stimulates deviant and anomalous behavior.

(b) There is an evident trend of a deepening of the 'classical' social problems, such as social deprivation, family dysfunction, delinquency and addictions. These have been complemented with a growing number of new social risks and problems, such as human trafficking, family violence etc. The social protection system should be flexible and adaptable and enable absorption of these categories in the formal system of social rights.

(c) Demographic, social and financial sustainability of the social protection system: According to the last Census there is an increased number of the elderly population, increased number of divorces as well as use of counseling services, greater demand for social welfare, increased number of social financial assistance recipients as well as an increased number of provided social services. This calls for innovations in the system and its correlation with an accurate picture of needs and risks in the society.

References for Chapter 2:

Amitsis, G. (2004) System of Social Protection in the R.M., Skopje: Ministry of Labour and Social Policy

Bartlett, W. and Baagoe, U. (2005): Cards Social Sector Study: Country Report The Social Sector Administration in the Former Yugoslav Republic of Macedonia (unpublished report).

Government of the Republic of Macedonia (2002) National Strategy for Integration of the Republic of Macedonia in the European Union, Skopje: Government of the Republic of Macedonia

Government of the Republic of Macedonia (2002) National Strategy for Poverty Reduction in the Republic of Macedonia, Government of the Republic of Macedonia, Skopje

Joshua, L. (2003) From Benefits to Work: Options for Establishing Welfare-To-Work Policies in Macedonia: A Discussion Paper Prepared Under the Framework of Preparation for the Social Protection Investment Loan (SPIL)

Law on Child Protection, "Official Gazette of the Republic of Macedonia" no. 98/2000 (in Macedonian)

Law on Gender Equality, “Official Gazette of the Republic of Macedonia” no. 66/2006

Law on Labour Relations, “Official Gazette of the Republic of Macedonia” no. 80/2003, 62/05 (in Macedonian)

Law on Social Protection, "Official Gazette of the Republic of Macedonia" no. 50/1997 (in Macedonian)

Poot, H. and de Voogd, J. (2003) Policies and programs for reducing poverty and unemployment: Former Yugoslav Republic of Macedonia: Policy Support and Advice to the Ministries of Finance and Labour, ECORYS-NEI (unpublished report).

Taylor, A. (2004) Stage Inception Report on Social Protection Program Administration Analysis and Design, Macedonia Social Protection Implementation Project (SPIL), World Bank Document

World Bank (2003), Former Yugoslav Republic of Macedonia Country Economic Memorandum Tackling Unemployment, Report No. 26681-MK.

World Bank (2004) Project Appraisal Document on a Proposed Loan to the Former Yugoslav Republic of Macedonia for a Health Sector Management Project, Report No. 27760-MK

World Bank (2004) Social Protection Implementation Project, Report No.27880-MK

World Bank (2004), Public Sector Management Adjustment Loan, PID, Report No. 27487

Annex for Chapter 2

Graph 2.1 Organizational structure of the Ministry of Labour and Social Policy

					Minister				
					Deputy Minister				
					State Secretary				
State Adviser		**State Adviser**	**State Adviser**	**State Adviser**	**State Adviser**	**State Adviser**	**State Adviser**	**State Adviser**	
Depart. for Labour	Depart. for Equal Opport.	Depart. for Pension and Disability Insur.	Depart. for Social Protect.	Depart. for Social Inspection	Department for Protection of Children	Depart. for European Integr.	Depart. for Budget, Finances and Account.	Depart. for Legal and Gener. Issues	Depart. for Coord. and Technical Assist. to the Minister
Unit for Work relations and Employment	Unit for Gender Equality	Unit for Pension and Disability Insur.	Unit for Social and Legal Protect. of Children and Family	Unit for Inspection Supervision to Provision of Social Assistance	Unit for Provision of the Rights to Child Protection	Unit for Coordination of Realization of Programme for Adoption of Acquis Communautaire and Negotiat. for Accession	Unit for Budget, Finances, Account. and Internal Control	Unit for Normative-legal and Gener. Issues	Unit for Coord. and Tech. Assist. to the Minister
Unit for Wages	Unit for Prevention and Secur. from all Types of Discrimination	Unit for Funded Pension Insur.	Unit for Protect. and Placem. of Disabled, Employment of Invalids and Protect. of Persons with Social Problems	Unit for Inspection Supervision to Provision of Social Protect. Services	Unit for Provision of Right to Placement, Upbringing, Vacation and Recreation of Children	Unit for IPA Coord. and Implementation	Unit for Budget, Finances, Account. for Social Protect.	Unit for HR Management	Unit for PR

						and Elderly												
Unit for Social Partnership						Unit for Protect. and Placem. of People with Development Impediments, Placem. of Refugees and Asylum Seekers						Unit for Monitor. and Evaluat. of Activities for EU Accession				Unit for IT		Unit for Policy Analysis, Planning, Evaluat and Coord.
						Unit for Provision of Rights to Social Protect.						Unit for International Cooper.				Unit for Invest. Issues		Unit for Internal Audit
						Unit for Public and Private Institution for Social Protect.												
						Unit for Protect. and Placem. of Socially Excluded												

Source: Ministry of Labour and Social Policy, 2006

Table 2.1 Administrative capacities in Centers of Social Work

City	Total number of employed	Professional staff	Technical staff
Berovo	10	7	3
Bitola	31	25	6
Makedonski Brod	10	4	6
Vinica	8	3	5
Gevgelija	26	17	9
Gostivar	25	17	8
Debar	13	10	3
Delchevo	13	11	2
Kavadarci	15	11	4
Kichevo	26	19	7
Kochani	21	18	3
Kriva Palanka	12	8	4
Krushevo	9	7	2
Kumanovo	38	27	11
Negotino	11	9	2
Ohrid	18	15	3
Prilep	29	27	2
Probistip	20	15	5
Radovis	12	11	1
Resen	17	12	5
Sveti Nikole	12	9	3
Struga	21	16	5
Strumica	18	14	4
Tetovo	44	27	17
Veles	26	19	7
Shtip	17	13	4
Skopje	158	86	72
Total	660	457	203

Source: Institute for Social Affairs, 2005

Table 2.2 Employees in Centers of Social Work according to educational qualifications

City	Social workers	Pedagogues	Psychologists	Lawyers	Sociologists	Economists	Other profess. staff	Tech. staff	Total
Berovo	3	1	1	1	0	1	0		10
Bitola	11	2	3	5	0	2	2	6	31
Makedonski Brod	2	0	1	1	0	0	0	6	10
Vinica	1	0	1	1	0	0	0	5	8
Gevgelija	7	2	1	3	2	1	1	9	26
Gostivar	11	1	1	1	3	0	0	8	25
Debar	4	1	1	1	1	0	2	3	13
Delchevo	3	1	1	4	1	1	0	2	13
Kavadarci	6	1	1	1	1	1	0	4	15
Kichevo	7	1	1	3	3	1	3	7	26
Kochani	6	2	2	2	3	3	0	3	21
Kriva Palanka	5	1	1	1	0	0	0	4	12
Krushevo	4	1	0	2	0	0	0	2	9
Kumanovo	10	3	2	7	3	1	1	11	38
Negotino	3	1	1	2	1	0	1	2	11
Ohrid	8	2	1	2	0	1	1	3	18
Prilep	10	2	2	4	3	6	0	2	29
Probistip	9	1	2	1	1	1	0	5	20
Radovis	4	1	1	3	1	1	0	1	12
Resen	4	1	1	4	0	2	0	5	17
Sveti Nikole	4	1	1	2	0	1	0	3	12
Struga	6	1	2	4	1	2	0	5	21
Strumica	7	1	1	2	0	0	3	4	18
Tetovo	13	2	4	3	2	2	1	17	44
Veles	10	2	2	3	1	1	0	7	26
Shtip	5	1	2	3	0	2	0	4	17
Skopje	47	10	11	9	3	2	4	72	158
Total	210	43	48	75	30	32	19	203	660

Source: Institute for Social Affairs, 2005

Table 2.3 Average number of beneficiaries and average amount of social assistance in 2006

	Social financial assistance (no. of households)	Permanent financial assistance	One-off financial assistance	Financial reimbursement for assistance and care;	Reimbursement of salary for shortened working hours due to care of disabled child	Financial reimbursement for children without parents and parental care - between 18 and 26 years of age
Average no. of recipients (monthly)	64,749	4,988	1,139	21,499	42	89
Average amount per person (monthly)	Denar 2,154 Euro 35.21	Denar 3,046 Euro 49.79	Denar 2,080 Euro 34.00	Denar 3,390 Euro 55.42	Denar 6,590 Euro 107.73	Denar 3,567 Euro 58.31

Source: Ministry of Labour and Social Policy, 2006

Table 2. 4 Numbers of beneficiaries of child benefits in 2006

	Child allowance		Special Allowance		First born baby allowance	
Month	Families	Children	Families	Children	Families	Children
January	11,994	22,190	7,508	4,079	386	402
February	13,502	24,754	3,724	3,903	408	413
March	15,900	29,546	4,564	4,938	587	619
April	17,896	33,433	4,398	4,557	442	447
May	20,620	29,212	4,370	4,526	488	494
June	19,842	37,875	4,430	4,601	483	490
July	18,504	34,497	4,427	4,591	484	494
August	18,483	35,027	4,489	4,664	540	546
September	14,811	28,158	4,485	4,647	613	622
October	17,916	34,009	4,467	4,626	600	610
November	18,238	35,053	4,470	4,628	596	603
December	18,638	35,338	4,529	4,675	511	520
TOTAL	206,344	379,091	55,861	54,435	6,138	6,260
Average-monthly	17,195	31,591	4,655	4,536	512	522

Source: Ministry of Labour and Social Policy, 2006

Table no 2.5 Recipients of unemployment and health insurance benefit through the Agency for Employment

Year (situation as of December in every year)	Unemployment benefit users	Health insurance users acquired as unemployment right
2001	41,375	220,883
2002	46,772	230,444
2003	47,324	238,123
2004	45,867	252,612
2005	40,124	244,935
2006	30,572	252,566
2007 (February)	29,300	250,985

Source: Agency for Employment, www.zvrm.gov.mk

Table no 2.6 Institutional social protection (as of April 2006)

Type	Number of institutions	Number of residents
TOTAL	16	1,645
STATE HOMES	11	1,420
Public institutions for children without parents and parental care	2	200
Public institutions for children and youth with educational and social problems and behavior disorders	2	120
Public institutions for persons with learning (intellectual) and physical disabilities	3	550
Public homes for elderly	4	550
NON-STATE HOMES	5	225
Homes for children without parental care	1	83
Homes for older people	4	142

Source: Ministry of Labour and Social Policy, 2006

Chapter 3: Poverty and Social Exclusion

3.1 History of researching and measuring poverty and social exclusion in the former Yugoslav Republic of Macedonia

Although the former Yugoslav Republic of Macedonia has been depicted as the most impoverished country of all ex-Yugoslav Republics, the problems of poverty and social exclusion were never explicitly placed on the policy agenda in the previous socialist system. As in all other transitional countries, the previous regime did not allow for public recognition of these problems, so the focus was mainly placed on 'traditional' or visible social problems such as people with disabilities, children without parents and parental care and alcohol addiction. Hence, the problems of poverty and social exclusion might be defined as 'new' social problems in the country, phenomena which were first studied systematically only in the post-independence period.

It can be said that the first research and analysis connected with poverty (and not social exclusion) in the former Yugoslav Republic of Macedonia came under the initiative of the World Bank. Their Social Reform and Technical Assistance Project in 1995 emphasized that the country needed to establish a poverty line based on a minimum (rather than the then existing average) consumption basket. The poverty line was seen as the basic foundation for 'identifying and targeting the poorest households in the economy as well as for establishing social assistance minimum benefits and making them consistent across cash benefit systems'. (p. 9, 1995). Hence, the project contributed towards developing a poverty line based on the following: "(i) using the household budget survey data to construct upper and lower national, regional and urban/rural poverty lines for the economy based on a minimum consumption basket that takes into account both food and non-food consumption; (ii) constructing three basic measures of poverty for the economy based on the poverty line -- the head count index, the poverty gap index and the poverty severity index -- and then using the poverty line to gauge the targeting effectiveness of the social assistance program; and (iii) evaluating the social assistance program to identify measures to improve efficiency and equity in the system" (p. 14, 1995).

In the same period - 1996, and with World Bank technical support, the State Statistical Office started measurement of the population's welfare in the country, through preparation of poverty data for the period of 1994-1996. These calculations, which were treated as experimental, used a poverty rate determined as 60% of median equivalent expenditure by households. They showed that the poverty rate in 1994 was 9.0%, in 1995 – 16.2% while in 1996 – 18.3%. Since 1997, the threshold for measuring poverty was changed and determined as 70% of median equivalent expenditure. Anecdotal evidence suggests that this change has been introduced as a result of expert estimations that were realized as part of the previously mentioned World Bank Project, but also due to the need to correlate the poverty threshold with the increased demand for social assistance. Calculations for the period 1997 to 2005 show an increase of the poverty rate from 19.0% in 1997 to 30.0% in 2005 (Table 3.1).

The period after 1998 and especially after 2000 showed an increase in academic interest and research on poverty and exclusion. A number of texts addressed the definition of poverty and possibilities of its measurement (Dimitrievska, V., 1998); the qualitative analysis of poverty (Novkovska, B., 1999); focus on different excluded categories i.e. Roma children (Lakinska, 2000), street children (Institute of Social Work and Social Policy, 2001) as well as a more recent and explicit focus on social

exclusion and inclusion in general, (Donevska, M., 2003; Jakimovski, J., 2003) and specific concern of social inclusion of children and youth in economically under-developed regions (Donevska, Kirandjiska, Lazarevska, 2005).

The first and only governmental strategic document aimed at combating poverty was the National Strategy for Poverty Reduction, prepared in 2000-2001(interim version), and published in 2002 (final version). This document, which was mainly created for the purposes of the Poverty Reduction and Growth Facility arrangement with the International Monetary Fund and the World Bank, represented the first multi-sector and multi-disciplinary analysis of the poverty problem. The goals of the Strategy were to be achieved in the period 2002-2005. However, despite some of its concrete shortcomings, such as lack of quantitative and measurable goals, which prohibited its implementation and efficiency, the NSPR in the former Yugoslav Republic of Macedonia proved less significant because of other particular domestic factors. The timing of the NSPR creation coincided with the 2001 ethnic crises in the country. This contributed towards a major change and reorientation of political priorities and diversion of funds from economic towards national stability measures, hence putting poverty issues off the then current agenda. Another factor that also made the Poverty Reduction Strategy process marginal was the political change that occurred which disrupted the assigned responsibilities, actors and plans.

In 2005, the World Bank published its country Poverty Assessment for the period 2002-2003. According to this report, consumption poverty (measured by the cost-of-basic-needs methodology) is estimated at 21.7 percent, non-monetary dimensions of poverty (in particular, poor housing conditions and low education) affect another 30 percent of the population, while the poverty rates in Skopje, secondary urban centers, and rural areas are similar ranging between 20 percent and 22 percent (p. viii, 2005).

The latest available analysis of poverty was realized as part of the Millennium Development Report (2005), within the chapter Reducing Poverty and Social Exclusion. Here, it is noted that for the period 2004, the human poverty index (measured through life expectancy, literacy rate, educational attainment and GDP per capita) shows that, on average, 55.1 percent of the total population is suffering from various forms of human poverty. The high human poverty rate is a result of the high rate of long-term unemployment and the high percentage of the population illiterate in functional terms.

It can be concluded that poverty research and measurement in the former Yugoslav Republic of Macedonia, since its beginning in 1996, has become an important aspect of analysis which has been mainstreamed in all recent national strategies and programmes. However, the period since 1996 has been used mainly for testing and analyzing poverty conditions according to the national standards and possibilities, which were not comparable with EU methodology. The applied methodology for the calculation of poverty was also influenced by World Bank experts, who have contributed towards the initiation of those measurements and consequent follow ups. Yet, this trend is expected to change in the following period according to the needs of EU accession, by applying EUROSAT poverty thresholds and methodologies, which differ from those currently employed.

3.2 National definitions and profiles on poverty and social exclusion

Currently, poverty measurement in the former Yugoslav Republic of Macedonia is not based on harmonized data sources nor are there EU comparative indicators applied

when estimating the poverty line. Concerning the poverty definition, the State Statistical Office in its Report on Poverty in the country for the period 2003-2005, emphasizes that the EUROSTAT definition of poverty[20] is used as a 'starting definition'. There are no other national concepts, definitions and operationalisations in place in addition to the 'EU definition'.

Similarly, there is no nationally accepted or adopted definition of social exclusion, according to which this condition can be analyzed. According to Donevska, exclusion can be analyzed from many aspects, but most importantly from the economic, health, education, ethnic, geographic and cultural aspects (2003, p.216). Despite the lack of a formally accepted definition of social exclusion, the MLSP, in its Policy paper (2004) for tackling the problems of the socially excluded, has defined four target groups in the socially excluded population. These comprise: (1) drug users and members of their families; 2) street children and their parents; (3) victims of family violence and 4) homeless people. Separation of these categories as specific social groups is aimed at enabling their effective access to social protection services (MLSP, 2004, p. 1). Yet, this categorization suggests an arbitrary approach which is not based on prior statistical research considering the prevalence of these groups in the overall socially excluded population. It also does not include other important vulnerable groups, such as Roma, the rural poor etc.

As already mentioned, since 1996, the former Yugoslav Republic of Macedonia has adopted a relative poverty line as the national standard for calculation of poverty rates. The relative method defines poverty at the level of 70% of the median equivalent consumption, applying the old OECD equivalent scale (1.0/0.7/0.5) to adjust for household size and composition. After defining the poverty threshold, the percentage of households living under the poverty line is established. Because of the subsistence economy and remittances, the methodology for statistical calculation of poverty is based on consumption rather than on income as an indicator of the standard of living. The basic poverty profiles are determined at a national level, at the level of Skopje, other urban and rural areas. These poverty profiles are disaggregated by several fundamental features of the households and their members: household size, level of education and age of the head of the household, economic status of the household members, etc. The Household Budget Survey is the main source of data for the calculation of the poverty line and the number of households included in the survey has increased from 1,025 to 5,040 households.

By measuring and monitoring poverty according to the double method (relative and subjective poverty), as well as according to the information obtained though interviews with 154 poor households and also by using the data on the basic structures of welfare beneficiaries, the National Strategy for Poverty Reduction (2002) has identified three main groups of poor households: 1) the traditional poor, who are made up of rural, farming households; (2) the new poor, who are non-agricultural households with low-paid workers and the unemployed; and (3) the chronic poor, who are pensioners, elderly without pensions, the disabled, or others without permanent income (p.23). Also, according to this Strategy, the main risk groups include (i) employed without education, with low education and low-skilled; (ii) long-term unemployed (iii) poor households from rural areas and small urban areas; (iv) disabled people; (v) institutionalized persons; and (vi) the elderly (pp. 41-42).

[20] "The poor shall be taken to mean persons, families and groups of persons whose resources (material, cultural and social) are so limited as to exclude them from the minimum acceptable way of life in the Member State in which they live" (EEC, 1985).

The latest available national report on the MDGs (2005) shows that there has been no great change in households with the highest risk profiles thus indicating that multi-member households, households with no employed members, households whose members have a low level of education and households of elderly people are at the highest poverty risk (p. 21).

3.3 Laeken indicators of social exclusion

The former Yugoslav Republic of Macedonia is still in the early stages of preparation of the data concerning the Laeken indicators on social exclusion. Due to the country's commitment to achieve the UN MDGs, an initial analysis of some of the Laeken indicators, i.e. those that are within the scope of the MDGs as well, have been presented in the National Report on MDGs (2005). This report analyses 7[21] of the 18 Laeken indicators, according to the available data (Tables 3.2 and 3.3). However, it must be emphasized that due to the size of the grey economy in the country, due to certain issues related with the quality of the LFS (especially in connection to the activity/inactivity status of the categories, such as: unpaid family workers, self-employed and pensioners), these figures should be interpreted cautiously.

The „persons living in jobless households" is a Laeken indicator which shows the number of persons aged 0-65 living in eligible households where none of the members is working as a percentage (proportion) of the total population aged 0-65 who are living in eligible households. The share of the persons living in jobless households in 2004 was 27.7 percent. The poverty rate in households with no employed members in 2003 was 36.1 percent.

The data concerning 3 Laeken indicators on long-term unemployment rate, long-term unemployment share and the very long-term unemployment rate are also available. These figures are quite high according to all of the three indicators. The long-term unemployment rate is the total number of long-term unemployed (at least 12 months) as a percentage of the total active population aged 15-64. The rate of long-term unemployed in 2005 was 32.3, while in 2004 it was 31.7. The long-term unemployment share is the total number of long-term unemployed (at least 12 months) as a percentage of the total number of unemployed. In 2005, this share was 86.7, while in 2004 it was 85.4. The very long-term unemployment rate is the total number of very long-term unemployed (at least 24 months) as a percentage of the total active population. This rate in 2005 was 28.54, while in 2004 it was 27.6. These figures confirm that general unemployment in Macedonia is not only extremely high, but it is also of a long-term character. Hence, unemployment rather than low income has become one of the key factors of poverty and social exclusion.

The Gini coefficient is used to measure income inequality, but can be used to measure any form of uneven distribution. For 2003, the Gini coefficient/index was 0.293. According to an earlier analysis (Novkovska, Donevska, Saveska, 2002) the Gini coefficient for the period 2000 was 0.347. Disaggregated among different types of households, the Gini coefficient in 2000 was 0.259 among agricultural households, 0.359 among non-agricultural households and 0.308 among combined households. This showed that agricultural households were in a better position compared to other household types due to their capability of self-employment.

[21] The Laeken indicators are still not available, nor calculated by the SSO. The data given in this study present a combination of the Laeken indicators calculated in the Millennium Development Report (2005), ETF calculations (re ISCED) as well as the team own calculations.

Life expectancy at birth is another EU indicator that is included as an indicator measuring progress under the poverty reduction goal. Though the indicator relates to health and gives an indication of the efficiency of the healthcare system, it also predicts the future ability of society to fight poverty and social exclusion, and largely depends on the general development level of the society. This indicator is defined as the number of years a person may be expected to live, starting at age 0, if subjected through their lives to the current mortality conditions. For the former Yugoslav Republic of Macedonia, this indicator for the period 2003/2005 was 73.62 for all and 71.4 years for men and 75.8 years for women.

The Laeken indicator which is defined as the percentage (proportion) of the total population of 25-64 years who have achieved ISCED level two or less represents persons with low educational attainment. While this number (ISCED 0-2) is around 19 in the new member states, the respective figure in the former Yugoslav Republic of Macedonia for 2005 is twice as high – 41 (for comparison it is 30 in Croatia, 28 in Bulgaria and 27 in Romania). Analyzing how educational attainment relates to employment, it shows that the employment rate for unqualified or low qualified people is considerably lower - 23.5 (ISCED 0-2) than that for people with higher level qualifications – 43.8 (ISCED 3-4) and 73.3 (ISCED 5-6).

The process of estimation of other Laeken indicators has been initiated. Currently the SSO with expert assistance from Hungary is preparing to calculate Laeken indicators concerning poverty, according to the 60% of median income and with the application of the new OECD scale (1.0/0.7/0.5). Also the launching of SILC (statistics on income and living conditions) is planned to be initiated in 2008, which will improve some of the indicators for non-monetary poverty. Still, due to the particularities of the labour market in the former Yugoslav Republic of Macedonia (i.e. the size of the grey economy), application and use of some of the harmonized sources, such as SILC, will not significantly improve the reliability of the data. Consequently, expenditure rather than income will be still a more reliable source for poverty calculation.

3.4 Policy Challenges and Policy Responses (including non-monetary poverty key indicators)

3.4.1 Participation in the Labour Market

Negative trends, such as low economic growth, strict and inflexible labour legislation and lay-offs due to enterprise restructuring have been among the leading factors that have contributed towards problems associated with labour market participation. The grey economy, youth unemployment and long-term unemployment have been identified as leading problems in the labour market. Therefore, unemployment has become one of the key factors of poverty and social exclusion, while the unemployed and those who receive wages on an irregular basis have become some of the highest risk groups.

The poverty rate in households with no employed members in 2005 was 41.5 percent. Households with two or more employed members were in a more favorable situation with a poverty rate of 16.8 percent; this, however, is still high, as a considerable number of the employed members receive wages on an irregular basis or receive minimum wages (Table 3.4).

Disparities in participation and access to/in the labor market may be a result of the influence of several factors, but educational level, age, and place of residence may

be considered as the most important ones. According to the statistical data given in the Chapter 1, more vulnerable groups in regard to their labor market participation include: Roma people, women, people from the Polog region, long-term unemployed, older workers as well as those with no or lower educational qualifications.

The situation of the youth (15-24) in the labor market is also unfavorable as in 2006 the youth unemployment was 59.8%, and the youth unemployment ratio - 21.37% (Table 3.5). This is twice the rate of any EU country. There are no great gender differences in this age group, as the unemployment rate for men in this age group is 59% and for women it is 61% (Table 3.6). The reasons for this particular labour market condition among youth include: (i) mismatch between labour market needs and the educational and training system; (ii) specific employers' needs for people with working experience; as well as (iii) the massive upsurge of the grey economy, thus, many young people are actually employed although officially they are registered as unemployed.

The lesser inclusion of women in the labor market in the former Yugoslav Republic of Macedonia can be attributed to the traditional role of women in the family. During the last several years, the increase in the number of employed women can be seen as a positive trend. Among other reasons, this increase is due to their employment as unpaid family workers in the agricultural sector. However, even though there is a trend towards increased employment, women's situation on the labour market cannot be perceived as favorable, yet. Some of the differences between man and women's employment rates can be attributed to the lower activity of women from Albanian, Roma and Turkish ethnic communities. It is expected that with the increase of their participation in the educational system this difference will be gradually reduced.

In combating these challenges, the current Governmental strategy encompasses a few soft law regulations i.e. the National Action Plan for Employment– 2006-2008 and the National Strategy for Employment - 2010 as well as a few concrete measures based on active employment measures, targeted towards particular 'risk' groups.

EU induced soft regulations, such as the second NAP for the period 2006-2008 as well as the NSE –2010 have put forward quantitative targets for improvement of employment participation, which are to be realized in the period until 2010. These include: (1) overall employment rate at 48% (which is significantly lower than the EU Lisbon target for 2010 of 70%); (2) employment rate for women of 38% (again, lower than the European target rate - 60% employment, because it is adjusted to the specific national conditions); (3) employment rate for older workers (55-64) of 33%; (4) combating long-term youth unemployment through new start – training of all the young unemployed before they reach 6 months of unemployment; (5) 15% of long-term unemployed should participate by 2010 in an active measure in the form of training, retraining, work practice, or other employability; (6) decrease the difference between the legal and effective average exit age from the labour market in line with the increase of the average life expectancy by 2010 (effective average exit age women 57, men 61.7 in 2005 according to PDIF). The emphasis on qualitative targets is a new and needed approach in social policy planning in the country, but it is questionable whether the delivery of these results will be achieved, having in mind the previous declarative status of the first NAP 2004-2006. Therefore, a constant and ongoing evaluation and supervision of the undertaken activities should go along with these planned tasks.

Additional concrete steps regarding at-risk groups and their participation in the labour market have already been initiated through the following 5 Governmental projects: (1) financial (non-returnable) assistance for initiation of family businesses for 500 persons mainly directed at the long-term unemployed from underdeveloped regions and also support for training and financial assistance for 600 young persons up to 27 years of age for a period of three months; (2) employment of 2000 persons (800 in 2007), including single parents (500), children without parents (100) and people with disabilities (200). This measure includes subsidy by the state in an amount of Denar 11,200/ Euro 182 (plus paid social contributions) for a period of 6 months, after which period the employer will be responsible to keep the person in employment for at least the following 18 months; (3) public and other works in the local community – for which 1000 persons are planned to be employed through this measure in 2007; (4) employment of persons from underdeveloped regions for work on construction and ecological projects, through subsidizing of costs for food, travel and work in amount of Denar 3,200/ 52 Euro for a period of three months; and (5) training, counseling and participation for re-training of 3,000 unemployed persons in 2007.

Proposed policy initiatives in regard to improvement of labour market participation seem to be focused only on certain vulnerable groups, excluding others from these measures. For example, improving the participation and employment of women, especially those that are members of ethnic communities is not put in any of the proposed actions. Thus, the proposed policy initiatives can only have a symbolic or minor impact on the general improvement of critical labour market indicators. Also, the proposed initiatives do not differ significantly from previous governmental measures where budget resources were used for a limited time to target groups which have not succeed permanently to enter and stay in the labour market.

3.4.2 Education

The inclusion of children within the educational system in the former Yugoslav Republic of Macedonia varies between different levels of education, as well as between different categories of children. While there are high enrolment rates for primary (92.5%) and secondary education (88.9%), the enrolment rates for pre-school is significantly lower (11%). The number of enrolled students in tertiary or higher education is also comparatively low with 2,212 students per 100,000 inhabitants.

Pre-school education, which starts from 6 months of age and lasts until the age of 5 1/2 years or until the official age for entering primary education, is being provided through 52 public pre-school institutions, operating at 178 different sites. These institutions work with a capacity of approximately 25,000 children, or 11% of all children up to age seven. Out of this 11%, in urban areas 82% of eligible children are enrolled in kindergartens and 61% in infant schools, but in rural areas these figures drop to 18% and 39% respectively (Bartlet and Baagoe, 2005). There are also four private pre-school facilities, all situated in Skopje. The main problem for pre-school education is the serious shortage of facilities, with only 40 (out of 84) municipalities in the whole country having their own kindergartens. The number of children included in pre-school education shows a continuous decrease, which can be attributed to declining birth rates and migration. Costs for public kindergartens (approximately Denar 1,500 / Euro 24.5 per child), are another factor for low coverage especially for those that are unemployed or with incomes below the average. The total spending for pre-school is much higher when transport, clothing and other costs are calculated. Low pre-school attainment among Roma and some of the Albanians can also be

attributed to their culture and tradition that favors informal and home-based child care.

Primary education, which lasts for nine[22] years, is universal, compulsory and free, accounting for almost 60% of the education budget. The gross inclusion rate in primary education is 97.1 percent; the net inclusion rate in primary education is 92.5 percent, while the annual drop-out rate in primary education is 1.71 percent. The system of own-language teaching is most developed in the primary school sector: out of the 1,043 regular schools, 801 include teaching in Macedonian, 282 teaching in Albanian, 55 in Turkish, and 14 in Serbian. Of the total number of pupils in the primary education, the share of Macedonians is 56.39%, that of Albanians is 33.18%, Turks comprise 4.20%, Roma 3.49%, Serbs 1.00%, Vlachs 0.18%, and others 1.55%. The percentage of pupils who completed their primary education (for the school year 2003/04) is 88.09%. The largest percentage of early school drop-outs can be traced in the transition period from primary into secondary education – 16.65%.

Secondary education that takes up 2, 3 to 4 years will also be obligatory[23]. Public secondary education is free, although access is granted on the basis of grades obtained in primary school, with even the earliest years' grade counting, so revision of the system of pupil assessment in primary school has important implications for later education. Access to secondary school may also be affected by the difficulty of transport from rural areas and by a variety of economic factors. The gross participation (scope) of pupils in the secondary education is 69.5%. Compared to primary education, vertical efficiency in secondary education is much higher. So, out of the total number of students that enroll in secondary education, the completion rate has increased from 86.34% in 1997/98 to 91.26% in 2003.

Higher i.e. university education, takes between 2 to 6 years depending on the program and consists of undergraduate studies, post-graduate studies and doctoral studies. The number of students per 100,000 inhabitants is 2,212, which is very low, or at the very bottom compared to the EU countries. According to the Country National Report for the purposes of the Bologna Process (2006), the number of enrolled students in the academic year 2006/07 within the five Universities (3 public and 2 private) was 22,179. According to the SSO, the number of students who graduated in 2006 at the two public Universities in Skopje and Bitola was 6,213, out of which 64.8% were female students.

According to international studies measuring learning achievements - such as the Progress in International Reading Literacy Study (PIRLS) concerned primarily with literacy rates and the Third International Mathematics and Science Study (TIMSS) – the former Yugoslav Republic of Macedonia shows performances under the international benchmarks. Outdated curricula, lack of standards to monitor learning achievements, lack of systematic investment in teacher training, weak teacher incentives, poor learning environments (both in terms of infrastructures and teaching methods) are all contributing to the poor learning achievements of Macedonia's children.

[22] According to the amendments of the Law on Primary Education, Official Gazette no. 51/2007, compulsory primary education was extended from grade 8 to grade 9. This change will be implemented from 1st of September 2007.

[23] According to the amendments of the Law on Secondary Education, Official Gazette no. 49/2007, secondary education becomes obligatory from September 2008 (for the generation that will enrol in secondary education in September 2008/09).

In order to widen the access to higher education amongst socially disadvantaged groups the Ministry of Education and Science grants student scholarships for talented students with a grade point average of 8.5[24] and student credits for students with a grade point average of 7.5; also the state finances a quota of students in all state universities; for students admitted in the state quota, the state covers part of their participation; the state grants quotas for ethnic communities in higher education institutions under beneficial conditions; The social aspect of the state assistance in education includes the possibilities of using dormitories/restaurants, transportation under reduced prices, then libraries, labs and computers in the faculties free of charge.

According to the MF report (2004), the expenditure for education as a percentage of GDP in 2003 was 3.49%. This presents a decrease of 0.77% since 1996. However, according to the National Strategy for Employment, there is a planned increase of the budget funds for education to 5% of GDP by 2010.

The ratio of girls and boys in primary, secondary and higher education shows a relative equality at the national level. The share of girls is the highest in higher education, followed by primary, with secondary education lagging slightly behind. Disparities appear when vulnerable groups overlap with gender.

As indicated before, the share of female students by level of education, shows that Roma girls and to a certain extent, ethnic Albanians, are at the highest risk of being excluded from the educational system at an early stage. This is mainly a result of the highly restricted inclusion of Roma girls in primary education and a high percentage of drop-outs during schooling. Anecdotal evidence suggests that participation of Albanian girls in the educational system seems to be improving at all levels. This has happened due to opening of schools in their own language, but also due to identification and opening of secondary schools with particular specialization, i.e. medical schools etc. Some of the reasons that prevent their participation into next level of education include: conservative attitudes within families and lack of financial resources.

The educational structure of the population is worrying as there is a large number of individuals in the country older than 15 years who have no education (3.85%), incomplete primary education (10.77%), or only completed primary education (34.77%). The Roma population is in the most unfavorable situation; in the case of Roma, 33% have not completed primary education, and of the remaining 67%, 93% have completed primary education only.

The literacy rate in the former Yugoslav Republic of Macedonia (defined as percentage of persons aged 15 and over who can read and write) in 2002 was 96.38% (table 3.7). According to the data, there are 63,562 (3.62%) illiterate individuals in the country, who are older than 15, which is a decline in the illiteracy rate identified during the 1994 census, when the number of illiterates was 87,749 – 5.96%. The rate is lowest among Macedonians (2.33%), who are followed by the Serbs (3.79%), the Albanians (4.80%), and the Turks (7.34%), while it is the highest among the Roma (20.63%). Out of the total number of illiterate people at the age of 15 and over - 76.41% are women. In 2002, the illiteracy rate of female Macedonians was 3.62%, Serbian females 6.86%, female Albanians 7.54%, female Turks 10.66% and female Roma 28.55%. Women are obviously at a higher risk of not attending and

[24] The grading system in higher education is consisted of marks from 5 (failure) to 10 (highest/distinction).

completing primary education, as well as in terms of employment opportunities, in particular among ethnic Albanians, Turks and Roma.

An additional worrying factor is the number of young people aged 15 to 19, who are not included in education, employment or training. The percentage of young people belonging to this category shows that there is a high prevalence of social exclusion amongst the young generation. According to the SSO calculations and from Census 2002 information, there were 55,611 young people or 33.9% of the total number of persons aged 15 to 19 that belong to this category. Comparatively, this is much higher than in the EU member states, where this figure is around 10%. However, according to EU standards young people at age of 19 are still considered as potential which can be included in training and further employment, so the focus should be placed on those above 24 years of age which are not included in training or employment.

There is a considerable mismatch between the educational system and the skills needed on the labour market, making education and training decisive tools for the longer-term economic development of the country and especially for employment. According to the preliminary results from the LFS the life-long learning rate was 2.4% in 2005, whereas the average for the EU25 is above 19% and for the post-communist new members 7%. This discrepancy between the educational system and market needs can be partly attributed to the inherited (socialist) educational system that produced only generic knowledge, which was not connected with labour market needs. On the other hand, problems arise because of the current lack of official projections of the needed qualifications for the labour market and their correlation with the educational system curricula.

An additional problematic aspect of the educational system in the former Yugoslav Republic of Macedonia is the limited access of children with disabilities to mainstream education. This contributes both to school segregation, as well as to discrimination and denial of the right to basic education.

The NSE - 2010 as well as the National Program for Development of Education 2005-2015 have set the following objectives and targets: (i) a rate of no more than 10% early school leavers; (ii) increased child coverage in the pre-school year to 100%; (iii) increase higher education coverage to 3,500 students per 100,000 citizens by 2015 (2,212 students per 100,000 in 2005); (iv) increase life-long learning and informal education to 8 -10% for adults (age group 25-64) by 2010; (v) improve the educational level by increasing secondary education coverage aiming at a target of at least 75% of 22-year olds in the country to complete secondary education by 2010. The relevant EU target is 85%.

3.4.3 Child Protection

According to the SSO, couples with children and other households with children represent 66.6% of the poor in the country in 2005 (Table 3.8). Poverty rates are higher among households with children (33.6% in 2005) than in households that without children (27.1%). Concerning age groups, the poverty rate is higher for children from 7-14 years of age - 33.2% (Table 3.9), while among children living in families where the head of the household is unemployed the poverty rate is highest among those aged 15 to 19 - 59.2% (Table 3.10).

UNICEF study on child poverty in South Eastern Europe and Commonwealth of Independent States (2006) signaled that child poverty has become more concentrated. Most affected children include: children in large or non-nuclear

families, children living in institutions, in rural areas and disadvantaged regions, and children belonging to vulnerable communities. This study indicated that the percentage of children living on less than US$ 2.15 (Euro 1.72) a day in 2003 in the former Yugoslav Republic of Macedonia was 6%. Comparatively, this percentage in Bulgaria was 8%, while the rate of child poverty in Romania and Albania was 21% and 30%, respectively.

Research on the 'ethnic' dimension of child poverty has been mainly focused on Roma children. A major research on Roma child vulnerability was carried out through a joint study by UNICEF and the World Bank in 1999 (Lakinska, 2000) in the municipality of Šuto Orizari in Skopje, the largest Roma settlement in Europe and home to many of Skopje's street children. This confirmed that the picture for these children is indeed bleak: (i) 27% live in temporary or makeshift houses with minimal facilities; (ii) 53% of families share their living space with at least one other family and 61% live in just one or two rooms; (iii) nearly half are without indoor toilet (48%) or running water (42%); (iv) 45% of women had their first child by the age of 18, and 3.5% had given birth by the age of 14; (v) 55% of mothers never completed primary school, and 31% of the children do not attend school at all; (vi) 64% of family heads have no regular income, and 59% of families reported a total family income equivalent to about half of the "dollar a day" international poverty standard. There are no newer studies concerning Roma children, although it may be estimated that their living conditions have not changed much since then.

Policies aimed at improving child and family support include cash transfers (maternity benefit, child allowance, reimbursement of salary for shortened working hours due to care of disabled child); services (day care centers, foster families, institutional placement) as well as time allowed for family functions (maternity and parental leave).

Governmental activities in this area comprise of amendments to the Law on Child Protection to improve targeting of child benefit and participation towards poor families with children, where the risk of social exclusion is greatest. This is emphasized both in the Governmental Program for the period 2006-2010, and also in the Poverty Reduction Strategy Paper. Other planned measures in this field include transposition of EU directives (such as Council Directive 2000/43/EC) implementing the principle of equal treatment between persons irrespective of racial or ethnic origin, as well as legal provisions concerning protection of children against any type of violence.

Concerning budget resources for 2007, it is planned that 50,000 children from 32,000 families will use financial assistance. Out of this, 38,000 children from 20,500 families will use the right to child supplement, 4,700 children from 4,500 families will use the right to special allowance, and 7,300 children from 7,000 families is planned to use the first born baby allowance.

3.4.4 Housing

The post-communist transformation of the housing sector started with the Law on Selling Social Housing Units that became effective in 1992. Over 52,000 families acquired the right to ownership of a housing unit, and 90% of the social housing stock has been sold.

Apartment housing: The total number of apartments in the former Yugoslav Republic of Macedonia increased from around 436,000 units in 1981 to 580,000 in 1994, an increase of 33%. Out of the total number of apartments in 1971, only 10% were

socially owned with an increase to 15% in 1989. In 1994, as a result of the national policy to sell public apartments to occupiers, the number of socially owned apartments decreased to 4.14% and remains almost unchanged until 2001. Privately owned apartments represent 95% of the total number. While most apartments (93%) are occupied by a single family, 18,437 (4%) apartments are shared between two families, and 2,384 (40%) are shared between three or more families. Most such multi-family housing units are occupied by rural migrants, since it is the norm in their village culture.

Informal urban settlements: It is estimated that there are about 100 informal urban settlements in Macedonia, where about 15-25% of the total urban population live. Typically the population in these settlements faces problems of unemployment, high crime rate, families with social problems, juvenile delinquency, and has high illiteracy rates. Typically, most households do not own the land on which their houses are built and do not have building permits. Most houses are built on land owned by the municipalities which complicates the procedure of clearing land ownership status. It has been noted that the poorest housing conditions are found among the Roma population living in the urban peripheries. According to official data, 95% (47,408) of the Roma population in Macedonia live in the cities. In spite of many studies available about the Roma population in Macedonia, there is a scarcity of reliable information regarding their housing environment in the informal settlements.

The number of illegal buildings among some ethnic communities (especially Roma and Albanians) is high. Types of illegal buildings include: constructions for which there are no certificates of ownership; buildings for which a construction permit is not issued, illegal heightening of buildings and illegal extension of buildings. Main reasons for existence of illegal buildings include: delayed issuing of technical documentation by the authorities, unresolved issues in inherited property matters, high communal taxes, demographic factors (high birth rate among Roma and Albanians accompanied with the multigenerational type of families leads to constant need of enlargement of their living space) and ethnic factors.

The practice of customary law in terms of the pattern of land inheritance which is generally male, decreases the instances of female inheritance (especially among Albanian women, but among Roma as well). Albanian women are rarely joint owners of land or property. Roma women appear more often as owners, due to their better employability than men in the past and accordingly improved access to housing credits. New generations of women tend to avoid the customary law; however land registration is still more in favor of men.

A particular issue specific to the former Yugoslav Republic of Macedonia is the existence of segregated settlements, which are formed mainly according to ethnic lines. For example, in the capital city of Skopje, Albanians mostly occupy the northern part of the city, while there are also some almost pure ethnic settlements such as that in municipality of Saraj (91.5% are Albanians), and the municipality of Aracinovo (90.7% Albanians). Roma also tend to be territorially concentrated in their ethnic communities, i.e. the biggest Roma settlement in the country is that in the Skopje municipality of Shuto Orizari, where out of 22,017 inhabitants 76.5% are Roma.

Following the 2001 crisis, a number of donors, including the EU through ECHO and CARDS and a number of bilateral donors, provided emergency assistance for the reconstruction of damaged houses and buildings. According to the SEI Brief Information of Projects, a project for social flats, financed by the Council of Europe

Development Bank and implemented by the Ministry of Transport and Communications is underway.

The Government in the past few years has strengthened the activities for allocating 'social flats' to people in need, such as social assistance recipients, children without parents and parental care, single mothers etc. However, these initiatives have been clouded by political interference concerning eligibility criteria and political affiliation of the applicants.

3.4.5 Anti-discrimination policies

The recent phase of social policy creation in the former Yugoslav Republic of Macedonia has been associated with a greater emphasis on the promotion of anti-discrimination policies, with a particular focus on access to rights and services of people with disabilities, ethnic communities and gender issues. Although this trend has been mainly encouraged though the international organizations and regulations, still it represents a positive trend towards a more inclusive social policy. This does not suggest that social inclusion policies are focused on these groups only, but rather that the anti-discrimination concept has been practiced through measures and policies targeted towards these groups.

3.4.5.1 People with disabilities

Although there are no precise estimates on the number of disabled people in the country, according to those registered for receiving social services, their number is 13,063, out of which 6,676 are children and 6,387 adults. In addition, according to the EA, in January 2007 there were 2,223 people with disabilities registered as unemployed, out of which 760 are women. Concerning the educational status of unemployed disabled people 1,116 are without any qualification. Concerning the type of disability, the majority of the registered unemployed disabled people – 749 are with a mental disability, followed by those disabled as a result of work injury, with 558 registered as unemployed.

In legislative terms, the former Yugoslav Republic of Macedonia does not lack legal acts that regulate the status of people with disabilities. There are 26 laws and many other additional by-laws which are regulating this matter. These laws range from fragmented mention of the disabled (such as the Custom Law) up to the existence of a separate Law for Employment of Disabled People, as a *lex specialis* of the Labour Law. There are also many international conventions which are signed and ratified, such as the United Nation's Universal Declaration for Human Rights, UN Resolution of Standard Rules on the Equalization of Opportunities for Disabled Persons (1993 Resolution 48/96), European Convention for Human Rights (of 1950). Also there is a National Strategy for Equalization of the Rights of Disabled People (2001), as well as a Declaration for Protection and Promotion of the Rights of Disabled People, adopted by the Parliament in 2003. Currently, there is a citizen initiative for adoption of a Law on Protection of the Rights and Dignity of Persons with Disabilities, a legal instrument that will cover horizontally all of the legislation and will serve as a reference point for disability issues.

Aiming at depicting the real conditions and possibilities for inclusion of disabled people within the society, the Inter-parliamentary lobby group for protection of people with disabilities in cooperation with 23 NGOs that work on disability issues in 2005 conducted a survey among 1,670 persons, among which 9% were people with disabilities. The results have shown that 69% of all respondents consider that

according to the place and status in the society, disabled people are totally marginalized, while 57% of them thought that they do not achieve their citizen rights and that they are second class citizens. Among the 9% of disabled respondents, 88% of them thought they needed additional resources in order to equalize their possibilities with others in the society. Out of all respondents, 71% thought that there is a need for a separate law for protection of the rights and dignity of the disabled, while only 4% indicated that the state is capable of actively caring for the disabled persons' rights and dignity.

Since 2001, the MLSP has developed a dispersed network of 17 day care centers for children with special needs. Three other day care centers are planned until the end of 2007. A large number of these centers have been financially supported by UNICEF.

Some of the main problems associated with the social inclusion of disabled people include: (i) lack of day care centres in the local communities for children with developmental impediments, (ii) lack of adequate psycho-social support for their families; (iii) physical barriers for their free movement and communication, (iv) lack of support for inclusion of children with special needs in regular schools, with separate educational programmes; (v) lack of rehabilitation and integration services as well as lack of awareness raising campaigns for promoting the rights of people with disabilities in the social protection system.

3.4.5.2 Ethnic communities

According to the 2002 Census, along Macedonians, there are other ethnic communities which made up 35.8% of the total population. Among them, the largest ethnic community is Albanian, who make up 25.2% of the total population, while others make up around 10 percent of the total population.

Although equal treatment, rights and access to services is guaranteed regardless of gender, ethnic, religious, political or social affiliation, still ethnicity as a factor in some cases can be an obstacle for obtaining equal access to social welfare services. For example, the attainment of citizenship status[25] (which is among the basic requirements for acquiring social welfare service/benefit) can be problematic, due to the legal pre-condition of having a 'permanent source of income'. Having in mind the huge rate of unemployment in Macedonia, which among some ethnic communities is even greater (78.5% among Roma, 61.2% among Albanians according to the 2002 Census), this requirement prevents many of them from establishing their basic social rights. According to Erduan Iseini (mayor of the Roma local community - Shuto Orizari) in 1997 there were 4,356 Roma without citizenship and 7,407 Roma with unidentified citizenship.

Some of the other more general problems associated with the unequal access of ethnic communities to labour/social welfare rights might be attributed to reasons such as: the concentration of the main employment capacities in the bigger cities where many of the ethnic communities (with the exception of Roma in Skopje) are less settled; investments and employment related to ethnic preferences; and the lack of training and re-training customized to the language and needs of particular ethnic groups.

Roma as a vulnerable ethnic group face a variety of problems in terms of low rates of participation in the labour market, low educational attainment, as well as high

[25] Law on Citizenship, article 7, paragraph 3, Official Gazette of the R.M. No. 45/04 from 07.07.2004.

reliance on social assistance. A study by the European Centre for Minorities Issues shows that some 70 percent of Roma in the country have never had full time registered jobs. According to the analysis of the Institute for Sociological, Political and Juridical Research (2004) 30 percent of Roma live from income, while 44.3 percent of them live from social assistance. Exclusion from education is especially emphasized among Roma students. According to the European Roma Rights Center "There is a higher level of illiteracy among Romano women than among Romano men. A higher number of Romano girls drop out of school, usually after the fifth grade. Compared to Romano boys, Romano girls experience more barriers to attend school from within the family (www.errc.org). A UNICEF Report on Social Exclusion with Special Focus on Roma Children in South East Europe (2006) identifies that in the former Yugoslav Republic of Macedonia unemployment among Roma aged 15-55 was 71%, while the drop our rate for Roma children according to a needs assessment for the Roma Education Fund in 2004 was 48%.

Although ethnic Albanians share some of these problems, still there are differences between these two groups. A particular specific for the Albanian population is the financial support which they receive from external remittances. This enables many of those not registered for social assistance or other types of social benefits, to maintain a living standard without ever participating in the labour market. Due to this trend, it can be speculated that there is a large group among the Albanian population, especially women, who have neither access to or the right to receive social benefits (i.e. pension, unemployment benefit, social assistance). Remittances for this group of people represent their only available financial support, although anecdotal evidence suggests that new trends among the (young) Albanian population working abroad differs, as they spend more where they work and send less to their families.

Additionally specific among the Albanian population is their stronger organization (than that of Roma) in groups of interest, such as political parties, religious communities, etc. Due to that, they have been able to proclaim and put forward more explicitly their particular ethnic needs and problems. Hence, with the Constitutional amendments (adopted on 16 November, 2001) according to the OFA, the Albanians have been the major beneficiaries of the implementation of the principle of equitable representation. They have succeeded to gain more jobs in the public institutions in comparison to other ethnic groups, although according to their political representatives these numbers are still low in comparison to their overall numbers in the population.

It must be emphasized that the main research and policy action in relation to different ethnic communities in the former Yugoslav Republic of Macedonia have been undertaken mainly in regard to Roma and to some extent Albanians. Other ethnic groups have not been a focus of either research or political interest, due to which there are no real data or analysis of their social problems. These groups face dual problems, i.e. on the one side problems within their own ethnic/religious communities and on the other problems with the official institutions. For example, the Macedonian Muslim Religious Community[26] and the Bektashi Community since 1999 had problems with the official registration of their organization with the Ministry of Interior, while they also faced problems within the Muslim community itself, the biggest among them being the unequal distribution of power among the different ethnic groups in favour of the Albanian ethnic community and the consequent domination of

[26] Macedonian speaking Moslems are born in Macedonia, while the Bosniacs are Moslems that have comed from Sandjak (Serbia) and Bosnia. Gorani are also Macedonian speaking Moslems who have come from the region of Prisren and Dragas (Kosovo).

Albanian-language services in the mosques (Centre for Documentation and Information on Minorities in Europe - Southeast Europe, 2000)

The Governmental approach towards the inclusion of ethnic communities within the labour market and more broadly into the social protection system is comprised of: (i) political agreements, i.e. OFA; (ii) soft legislation i.e. National Action Plans for Roma Education, Employment and Housing; (iii) quotas, i.e. stimulating the equal participation of different ethnic groups in higher education; as well as (iv) decentralized social services, in the language of the ethnic communities where they represent more than 20% of the population. National reconciliation was also strengthened with donor support in the area of democracy (e.g. support for the Census, the SEE University in Tetovo and funds to deliver rapid rebuilding of areas affected by the internal conflict in 2001) which has contributed to the stability of the country.

3.4.5.3 Gender Equality

The position of women on the labour market is weaker than that of men. The female employment rate in 2006 was 30.7%, while the female unemployment rate was 37.5%. According to the LFS (2005) the share of women in the total inactive population is 61.6%, while the share of men 38.4%. The share of women in the economically inactive population is higher than that of men among all age groups, with the exception of the age group 15-19. The significant difference in the employment and participation rates is due to the lower activity of women from Albanian, Roma and Turkish nationalities. According to the National Millennium Development Report (2006) women tend to be mostly represented in the lower-paid sectors such as health, social care and education. Also lots of women are working in the informal sector, mainly in the agricultural subsistence economy.

Participation of women in the spheres of decision-making and public life both at the national and local levels is still marginal. Despite an increase in the participation of women in Parliament from 4.2% in 1990 to 17.5% in 2002, women are still largely underrepresented.

Problems of family violence and human trafficking have become prominent in the last few years. The size of family violence in the former Yugoslav Republic of Macedonia cannot be traced, as such cases are rarely reported by victims. According to some NGO researches (in Tozija et al., 2006) 8 out of 10 women were victims of family violence, however only 20% of these cases have been reported to the police. The SWC have undertaken research on family violence in the period from January to June 2006, which has encompassed 218 households. This research indicated that 221 persons were family violence assaulters, mainly aged between 41 and 55 (43%), out of which most were Macedonians and Roma. According to Ministry of Interior statistics in 2005, the reasons for family violence were mainly alcohol addiction (1,485 reported cases), mental health problems (1,019 reported cases) and drug addiction (44 reported cases).

The problem of human trafficking in the former Yugoslav Republic of Macedonia has worsened in the last 7 years (Tozija et al., 2006), due to problems such as border insecurity, the Kosovo crisis, the increased presence of international organizations/personnel, as well as continued high unemployment and impoverishment of the population. According to police records, women victims of violence are imported mainly through the border with Serbia and Bulgaria. Trafficked women are mainly of Moldavian, Ukrainian or Romanian origin and they transit to

Macedonia and leave the country through the border with Albania (Struga) and Greece (Dojran). In the transit center for trafficked women (established through cooperation between the International Organization for Migrations, the Ministry of Interior and local non governmental organizations) in 2004 there were 38 sheltered persons, out of which 11 were identified as victims while 27 were sheltered due to other reasons.

In the last few years the Government is pursuing a more active approach towards gender equality, which includes: the Law on Equal Opportunities for Men and Women (2006), a separate Department for Equal Opportunities within the MLSP, a Parliamentary Commission for equal rights among women and men, as well as legal provisions in separate laws, such as the Labour Law, Law on Pension and Disability Insurance etc. which enhance women's rights.

3.4.6 Conclusion

Although poverty and social exclusion prove as widely present problems in the country, still they remain under-researched and without precise statistical data. These prohibit the creation of a realistic and representative social inclusion policy. Based on the analyzed situation in the field of poverty and social inclusion, the following shortcomings can be summarized:

(i) partial and arbitrary treatment of the vulnerable and excluded groups, which can be traced to the current governmental measures towards social inclusion, which do not take into considerations the problems of: rural poor, redundant workers, women from ethnic communities living in rural areas, Roma etc.;

(ii) lack of analysis and comparative statistical data on poverty, as well as non-coordinated use of classifications regarding different beneficiary groups among the SSO, the MLSP and the MF;

(iii) lack of non-residential capacities for work with specific socially excluded groups, which contributes towards domination of the day care centers focused only on two or three vulnerable groups;

(iv) Lack of a strategic approach towards work with socially excluded groups according to different types. The socially excluded population differs in its needs and possibilities and cannot be encompassed by one unified policy approach. There is a need for diversified action regarding different categories of the socially excluded;

(v) Isolation of rural areas and groups from the campaigns for inclusion of vulnerable groups, i.e. location of information centers for citizens regarding employment, training, health etc. only in the bigger cities in the country.

References for Chapter 3:

Centre for Documentation and Information on Minorities in Europe - Southeast Europe (2000) Minorities in Southeast Europe: Muslims of Macedonia www.greekhelsinki.gr/pdf/cedime-se-macedonia-muslims.PDF

Dimitrievska, V. (2002), "Qualitative analysis of poor households in the Republic of Macedonia", South East Europe Review for Labour and Social Affairs, Special Issue, 81-88

Donevska, M. (2003) 'Social exclusion – problems in defining the concept' in Jakimovski, J. (ed.) Social Status of the Population in Macedonia: Poverty, Exclusion and Participation in the Society (in Macedonian), Skopje: Friedrich Ebert.

Donevska, M., Kirandjiska, S. and Lazarevska, S. (2005) Social Inclusion of Children and Youth (eds.) Skopje: Foundation for educational and cultural initiatives – Step by step.

Donevska, M., Novkovska, B. and Saveska, S. (2002) 'Poverty Profiles' prepared for the needs of the National Strategy for Poverty Reduction (working paper).

EEC (1985), On Specific Community Action to Combat Poverty (Council Decision of 19 December 1984), 85/8/EEC, Official Journal of the EEC, 2/24.

Eftimovski, D. (2002) "Measurement of Poverty and Inequality in the Republic of Macedonia", Economic Development - Journal of the Institute of Economics, Skopje

Government of the Republic of Macedonia (2002) National Strategy for Poverty Reduction in the Republic of Macedonia, Government of the Republic of Macedonia, Skopje

Government of the Republic of Macedonia (2005) Report of the Republic of Macedonia on Millennium Development Goals, Skopje: Government of the Republic of Macedonia

Institute of Social Work and Social Policy (2001) (Eds.) Street Children/Children on the Streets (in Macedonian), Skopje: Faculty of Philosophy

Jakimovski, J. (2003) 'Poverty and fragmentation' in Jakimovski, J. (ed.) Social Status of the Population in Macedonia: Poverty, Exclusion and Participation in the Society (in Macedonian), Skopje: Friedrich Ebert

Lakinska, D. (2000) Vulnerability of Roma Children in the Dispersed Roma Communities, Study Project, Skopje: UNICEF& World Bank

Lakinska, D. (2000) Vulnerability of Roma Children in the Municipality of Shuto Orizari, Study Project, Skopje: UNICEF& World Bank

Ministry of Education and Science (2006) National Program for Development of Education in Republic of Macedonia 2005-1015, with associated program documents (in Macedonian), Skopje: Ministry of Education and Science

Ministry of Education and Science (2006) National Report regarding progress in Bologna Process (unpublished material)

Ministry of Labour and Social Policy (2006) National Action Plan for Employment – 2006-2008, Skopje: MLSP

Ministry of Labour and Social Policy (2006) National Strategy for Employment - 2010, Skopje: MLSP

Ministry of Labour and Social Policy (2004) Policies for Tackling Problems of Socially Excluded Population, www.mtsp.gov.mk

National Human Development Report 2001, Social Exclusion and Insecurity of People in the Republic of Macedonia, UNDP, Skopje, 2002, p.182

Novkovska, B. (2006) Socio-economic status of the family as a factor for social exclusion from education and employment of persons aged 15 to 19 (in Macedonian language), Skopje: Faculty pf Philosophy (unpublished master thesis).

Novkovska, B., (1999) "Qualitative Analysis of the Poverty in the Republic of Macedonia" Bulletin of the International Statistical Institute, t. LVIII, Book 2, ISI 99: Helsinki.

Polio Plus (2005) 'Review of conditions and possibilities of inclusion of people with disabilities in society life – To ask ourselves: analysis of the survey', Skopje: Polio Plus.

State Statistical Office (2006), Poverty in the Republic of Macedonia 2003-2005, Report 4.1.6.50, July 2006.

Tozija, F., Gjorgjev, D. and Cicevalieva, S. (2006) Report for Violence and Health and Guide for Prevention, Skopje: Ministry of Health.

UNDP (2001) National Human Development Report – Social Exclusion and Human Insecurity in Former Yugoslav Republic of Macedonia, Skopje

UNICEF, Innocenti Social Monitor 2006: Understanding child poverty in South-Eastern Europe and the Commonwealth of Independent States. Florence: UNICEF Innocenti Research Centre, 2006.

World Bank (1994) Social Reform and Technical Assistance Project

World Bank (1999) Former Yugoslav Republic of Macedonia-Focusing on the Poor, Volume I – Main Report, Report No. 19411-MK, Human Development Sector Unit, Washington DC

World Bank (2005) Former Yugoslav Republic of Macedonia Poverty Assessment for 2002-2003: Document of the World Bank

Statistical Annex for Chapter 3

Table 3.1 Poverty rates in former Yugoslav Republic of Macedonia

1994*	1995*	1996*	1997	1998	1999	2000	2001	2002	2003	2004	2005
19.0	20.7	21.0	19.0	20.7	21.0	22.3	22.7	30.2	30.2	30.0	30.0

* 1994-1996 poverty rate determined as 60% of medial equivalent expenditure on households; 1997 onwards poverty rate is determined as 70% of medial equivalent expenditure
Source: State Statistical Office, 2006

Table 3.2 Currently available Laeken indicators

Laeken Indicator	2003	2004	2005
Share of the persons living in jobless households	n.a.	27.7	n.a
Long-term unemployment rate	31.2	31.7	32.3
Long-term unemployment share	85.1	85.4	86.7
Very long-term unemployment rate	27.9	27.6	28.5
Distribution of income (Gini coefficient)	29.3	n.a.	n.a
Persons with a low educational attainment (ISCED 0-2)			41
Life expectancy at birth (2003-2005)	73.21 (all)		
	Male	female	
	70,8	75,7	

1 - ETF Labour Market Review in Former Yugoslav Republic of Macedonia, Turin, 2005.
Source: ETF Key Indicators database
Source: Millennium Development Report, 2006
* State Statistical Office does not yet have any official data on Laeken indicators

Table 3.3 Laeken indicators for EU member states and EU candidate countries

Countries	Share of the persons living in jobless households	Long-term unemployment rate	Very long-term unemployment rate	Distribution of income (Gini coefficient)	Persons with a low educational attainment (ISCED 0-2)	Life expectancy at birth (2005)	
						Man	Women
EU 27	9.8 (EU25)	3.6	2.1	4.9 (EU25-2005)	30.0	n.a	n.a.
Bulgaria	11.6	5.0	3.6	4 (2004)	24.5	68.7	75.8
Romania	9.7	4.3	2.2	4.6 (2004)	25.8	68.7	75.5
Croatia	12.5	7.4 (2005)	4.9	4.9 (2005)	27.2 (2005)	70.6	76.9
Former Yugoslav Republic of Macedonia	27.7 (2005)	32.3 (2005)	28.54 (2005)	29.3 (2003)	43	71.4	75.8

Source: Eurostat, 2006
http://epp.eurostat.ec.europa.eu/portal/page?_pageid=1996,45323734&_dad=portal&_schema=PORTAL&screen=welcomeref&open=/sdi_ps/sdi_ps_oth&language=en&product=sdi_ps&root=sdi_ps&scrollto=161

Table 3.4 Poverty rate according to economic status of the household's members

	1997	1998	1999	2000	2001	2002	2003	2004	2005
Unemployed	26.0	29.0	31.2	32.6	35.5	37.5	36.1	39.0	41.5
1 Employed	19.2	22.1	21.2	22.2	21.0	28.0	29.3	27.8	28.2
2 and more employed	9.8	7.3	7.3	6.8	9.9	18.7	18.9	18.1	16.8

Source: State Statistical Office, 2006

Table 3.5 Employment rate for the population over 15 years by gender and age

Age	2005			2006		
	total	men	women	total	men	women
Total	33.9	41.2	26.6	35.2	43.5	27.0
15-24	12.3	14.1	10.3	14.4	17.2	11.4
25-49	49.8	58.6	40.5	52.0	61.9	41.6
50-64	36.0	46.2	26.1	36.4	47.9	25.3
65 and more	4.7	6.6	3.1	3.8	5.6	2.3
15-64	37.9	45.4	30.1	39.6	48.3	30.7

Source: Labour Force Survey, 2006

Table 3.6 Unemployment rate for the population over 15 years of age by gender and age

Age	2005			2006		
	total	men	women	total	men	women
Total	37.3	36.5	38.4	36.0	35.3	37.2
15-24	62.6	62.9	62.2	59.8	59.0	61.0
25-49	35.9	34.2	38.2	34.0	32.8	35.9
50-64	27.9	30.2	23.5	28.4	30.0	25.1
65 and more	2.6	3.6	0.9	3.2	3.7	2.2
15-64	37.6	36.9	38.8	36.3	35.6	37.5

Source: Labour Force Survey, 2006

Table 3.7 Literacy Rate (percentage of persons aged 15 and over who can read and write)

	1994			2002		
	total	male	female	total	male	female
Total	94.04	97.19	90.94	96.38	98.29	94.47
Macedonians	96.02	98.20	93.86	97.67	98.96	96.38
Albanians	90.21	95.31	85.35	95.20	97.89	92.46
Turks	88.21	93.65	82.80	92.66	95.91	89.34
Roma	74.50	85.44	63.48	79.37	87.17	71.45
Serbs	92.51	97.07	87.19	95.86	98.49	92.86
Vlachs	94.35	98.44	90.27	96.21	99.10	93.14
Other	93.68	97.73	89.96	95.69	98.27	93.27

Source: Millennium Development Report, 2006

Table 3.8 Relative poverty by type of household, 2003-2005 (70% of median equivalent expenditure, with old OECD equivalence scale)

	2003			2004			2005		
	Head count index	Poverty gap index	Composition of poor	Head count index	Poverty gap index	Composition of poor	Head count index	Poverty gap index	Composition of poor
Total	30.2	9.4	100.0	29.6	9.4	100.0	30.0	9.7	100.0
Elderly	23.3	6.1	11.6	18.2	5.3	3.5	22.2	5.9	3.2
Couple with children	30.2	9.2	9.5	28.2	8.7	13.6	24.8	7.8	8.8
Other households with children	38.0	12.8	42.4	35.1	11.9	52.3	33.6	11.1	57.8
Households without children	26.4	8.0	36.6	25.2	7.3	30.7	27.1	8.8	30.1

Source: State Statistical Office, 2006

Table 3.9 Poverty status of children, by age group

	Poor children in households		Head count index	
	2004	2005	2004	2005
Total	100.0	100.0	32.7	32.4
From 0-6 years	32.1	28.9	35.72	32.4
7-14 years	39.8	42.1	31.6	33.2
15-19 years	28.1	29.0	32.2	33.0

Source: State Statistical Office, 2006

Table 3.10 Poverty status of children in the households where head is unemployed, by age groups

	Poor children in households		Head count index	
	2004	2005	2004	2005
Total	100.0	100.0	47.4	50.8
From 0-6 years	36.5	26.0	49.7	44.2
7-14 years	37.0	38.6	43.0	54.1
15-19 years	26.6	35.4	50.9	59.2

Source: State Statistical Office

Chapter 4: Pensions

4.1 Modernization of the pension system

4.1.1 Parametric reforms

The PAYG pension system in the former Yugoslav Republic of Macedonia since the beginning of the transition continuously faced funding challenges, due to the huge rate of unemployment, lowering of the fertility rates, intensified process of demographic aging as well as generally low economic growth in the country. This contributed towards PDIF insolvency, which was manifested with high deficits and non regular pension payments.

Hence, parametric changes were introduced with a purpose to improve solvency of the PDIF, as well as to tighten eligibility criteria. These included:

(i) several restrictive measures, introduced with the Law on Pension and Disability Insurance, that entered into force on January 1, 1994 regarding: retirement eligibility criteria, by instituting higher retirement age, i.e. from 60 to 63 years of age for men and from 55 to 60 years of age for women; estimation of the pension base by the average of all wages of all years of service, instead of the 10 most favorable ones; lowering of the replacement rate from 85% to 80%; as well as repeal of the possibility to “buy” years of contributions as an option for fulfilling the eligibility criteria for retirement.

(ii) Another set of restrictive changes of the Law were introduced in 1995, revoking from the pension and disability insurance system the social elements of the system. Those changes included: the right to a money allowance for care and support of others; right to using social standard funds by the beneficiaries and the right to the funds for improvement of the protection of the disabled. The same Law put the money allowance for the workers with a decreased working ability at the expense of the employer; regulated the adjustment of the pensions to be done in concordance to the wage increase in the non-economic sector; expenses for the payment of the pensions to be covered by the beneficiaries, etc.

(iii) Amendments to the Law in 1996 introduced: calculation of valorization coefficients, minimum pensions, calculation of maximum pensions according to the wages of the non-economic sector in order to provide compatibility of all factors that have effect on the pension level.

(iv) Amendments to the Law on financial working in 1997 had the biggest effect on improvement of the financial balance of the PDIF. It provided payment of big parts of the unpaid past contributions with 70% discount or in installments. Also, more efficient mechanism was established regarding the payment of the current contribution for pension and disability insurance on 25 of the month for the previous month at the latest.

All the measures that were undertaken since 1993 created positive effects in a direction of the financial consolidation of the Fund, i.e. lowering the imbalance between its current revenues and expenditures. The flow of new beneficiaries and level of pensions were reduced, which lowered the expenditures for the pension and disability insurance. The payment of pensions was made on a regular basis. The payment of a delayed pension finished which shortened the period of pension

payments. Thus the Fund started with regular payment in the current month for the previous month, the same way as the wages of employed are paid.

Paradigmatic reforms

Despite parametric reforms, the actuarial projections showed that if the system does not reform more radically, the Fund will be faced with problems of collecting decreased number of contributions for financing the pensions of the increased number of old people, for a longer period of time (see table 4.1). Hence, the introduction of a paradigmatic pension reform, with three pillar system has been initiated, with the technical and financial support of the World Bank.

The reform introduced a multi-pillar system with the following general structure:

First pillar - Mandatory defined benefit reformed pay-as-you-go system
Second pillar - Mandatory defined contribution and
Third pillar – Voluntary defined contribution

The first pillar is mandatory pay-as–you-go public pension system based on the intergeneration solidarity. It is based on the current financing of pension expenditures and in-advance defined benefits[27]. It covers the risk of old-age, disability and survivors pensions, as well as minimum amount of benefit. It encompasses all employees and all other beneficiaries covered by the pension scheme, including self employed and agricultural workers. The current mandatory pension scheme changed regarding the retirement age for old –age retirement, replacement rate adjustment and some other characteristic. A person is entitled to an old-age pension when 64 (man) or 62 (women) and minimum 15 years of service. The age limit gradually rises to meet the stipulated age as presented in the Table 4.2. In addition to these criteria, there is a transitional period that allows those contributors which have at least 33 years of service (men) i.e. 28 years of service (women) by 1 September 2000, to realize the right to an old age pension when accomplishing 40 years of service (men) i.e. 35 years of service (women), regardless of the age. This condition will be in force until 1 of September 2007. The retirement allowances are financed through the contribution of employers (from the gross salary of employees), while expenditures not covered by the contribution are financed by the government budget. The manner of adjusting pensions was changed, so that the pensions are adjusted twice a year for 80% living costs and 20% of the index of the growth salaries. According to the Law there is temporary adjustment, twice a year for 40% living costs and 20% of the index of the growth salaries.

The second pillar is a mandatory individual capitalized savings system. The second pillar commenced on 1st of January 2006, pursuant to the Law on Mandatory Fully Funded Pension Insurance[28]. This insurance provides right from pension insurance in case of an old age, i.e. payment of old age benefit. This type of insurance is based on the principle of collecting the funds through payment of contributions on individual (personal) accounts, and subsequently these funds will be invested and together with the return will be accumulated in the accounts. After retirement (which is at the same age as in the first pillar) accumulated funds will be taken out in a form of annuities or scheduled withdrawals. Mandatory fully funded pension insurance covers persons that started working for the first time after January 1, 2003, i.e. younger generations,

[27] Law on Pension and Disability Insurance, “Official Gazette of the Republic of Macedonia" nos. 3/94, 14/95, 71/96, 32/97, 24/2000, 96/2000, 5/2001, 50/2001, 85/03, 50/04, 4/05, 84/05, 101/05 and 70/06).
[28] “Official Gazette of the Republic of Macedonia” nos. 29/02, 85/03, 40/04 and 113/05.

which provides gradual introduction of this system. Agricultural workers are not covered with the second pillar since their contributions are registered according to their cadastral income, which is too low, and can not be divided in the two pillars.

In addition to the mandatory entrants in the new pension system, there is a possibility for voluntary entrance of current contributors already covered by the pension and disability insurance. For the contributors who will decide to switch to the new system contribution will be 14.2% (of gross wage) for the first pillar and 7% (of gross wage) for the second pillar. The total amount of contribution (21.2% of gross wage) is paid in the Fund. Within the framework of the reformed pension system, contributors who will decide to remain in the old system will be entitled to the same rights as before. The contributors who will decide to switch to the new system can realize a part from the old age benefit, disability, survivor and minimum pension from the first pillar, and the remaining part of the old age benefit from the second pillar.

While the two pillars are fully functional, the third pillar is in process of design/creation. Its implementation is planned for 2008. This step will mark the full completion of the pension reform. Third pillar will cover all persons that want to provide higher financial security than the mandatory insurance, and all citizens which are not covered under the mandatory insurance can also be included (i.e. unemployed, for whom the contributions can be paid by a third party).

4.1.3 Institutional framework of the new pension system

The reformed pension system introduced private pension companies. They have been chosen on an international public tender, which was published on 9 and 10th of July 2004 in national daily newspapers (Macedonian and Albanian), as well as in the international financial journals - Financial Times and Economist[29].

Private pension companies within the second pillar currently include:

1) New Pension Fund, managed by the Shareholding Company for managing pension funds New Pension Fund - Skopje. The founders of this Fund are Nova Ljubljanska Banka DD, Ljubljana, Republic of Slovenia, which holds 51% of the Pension Company capital and NLB Tutunska Banka AD, Skopje, former Yugoslav Republic of Macedonia, which holds 49% of the Pension Company's capital. The founding capital of the Pension Company is Euro 2 million.

2) KB First Pension Fund, managed by the KB First company for managing of pension funds AD Skopje. The founders are Prva pokojninska Druzba DD, Ljubljana, Republic of Slovenia, with 51% of the Pension Company capital and Komercijalna

[29] Some of the terms of the tender included: (i) each founder must have minimum paid-up capital of 20 million Euros or more, (ii) must have been in existence for 3 or more years (iii) must be solvent (iv) experienced and competent management (v) minimum investment grade rating from reputable agency (non-Macedonian companies only); (vi) legal entity can only be shareholder in one Pension Company (vii) 51% of share capital must be held by banks, insurance companies, or other financial institutions (viii) each Pension Company manages one Pension Fund; each member may choose only one Fund (ix) share capital not less than 1.5 million Euros; (x) additional 1 million Euro of share capital is required for every 100 million Euro increase in assets; (xi) own capital must always exceed 50% of share capital (xii) share transactions require Supervisory Agency MAPAS consent; (xiii) Pension Company can not merge, separate, or reorganize.

Banka AD, Skopje, former Yugoslav Republic of Macedonia, with 49% of the Pension Company's capital. The founding capital of the Pension Company is Euro 1.5 million.

The licenses within the mandatory fully funded pension insurance were granted to two pension companies on April 4, 2005. Their approvals for pension fund management are granted for a 10-year period.

The fees that are charged by the pension companies, according to the Law on Mandatory Fully Funded Pension Insurance include: (i) 8.5% - fee on the contributions; (ii) monthly fee of 0.05% of the Pension Fund net assets value, to cover costs of the Pension Company for the management of the Pension Fund; (iii) fee on the amount standing to the account of a Pension Fund Member, in case of transfer of those assets to another Pension Fund has still not been determined. Brokerage fees related to transactions for acquisition or transfer of a Pension Fund's assets are paid from the Pension Fund's assets. Since July 2007, all the public institutions involved in the second pillar (MAPAS, the PDIF and the National Bank) have decided to reduce the fees that are charged from the Pension Companies for 0.6% percentage points. In relation to this, the pension companies have decided to reduce the previous contribution fee from 8.5 to 7.9%. However, this insignificant decrease signals that the pension companies have not reduced their part of the fee.

Pension Companies invest pension fund assets mainly in government debt securities (continuous bond, bond for denationalization, bond for settlement of claims by citizens on the basis of foreign currency deposits and 3, 6, 12-month short-term treasury bills), bank deposits[30] and shares.

The assets of a Pension Fund can only be invested in accordance with the provisions of the Law and in order to maximize the return resulting from the investment solely for the benefit of Pension Fund Members, subject to ensuring the following: the security of Pension Fund assets; diversification of investment risk and maintenance of adequate liquidity.

Legal investments limits are confined: to investments in the former Yugoslav Republic of Macedonia: bank deposits, bonds and other securities - NBRM and the Republic of Macedonia, certificates of deposit, commercial notes, bonds and mortgage backed securities – banks, shares, commercial notes, bonds - joint stock companies, participation units and shares of investment funds Investments abroad - EU, Japan and the US bonds and other securities – foreign governments and central banks, shares and debt securities – foreign investment funds.

Maximum investment limits by instruments can be seen in Table 4.3.

Maximum investment limits in one company or in one instrument include: maximum of 10% of each security (except securities of the former Yugoslav Republic of Macedonia); maximum of 5% of the pension fund's assets in one security of non

[30] Pension Fund assets can be invested in bank deposits, if they are deposited in a bank which meets the following requirements: has capital in amount of at least Euro 10 million in Denar counter value according to the middle exchange rate of the NBRM; its capital adequacy ratio should be maintained at a level higher than 10% from the moment of purchase onward and has audit report prepared by at least one international audit company. These criteria have been defined in cooperation with national and international experts in the pension field.

state entity and maximum of 15% of pension fund's assets in one bank. The Pension Fund assets may not be invested in the following instruments:

- shares, bonds and other securities that are either unlisted or not publicly traded;
- instruments that are legally prohibited;
- commodities that are not frequently quoted on organized markets and have uncertain valuation, for example antiques, works of art, and motor vehicles;
- real estate;
- shares, bonds and other securities issued by any shareholder of the managing Pension Company, the custodian and affiliated entities;
- derivatives.

According to the MLSP representative, it is too early to make assessment of the likely or projected returns from these investments. Last year pension funds earned rate of return of around 6% (net value).
Other institutions involved in the creation, management and supervision of the pension system, include:
MLSP – in charge of ensuring legality of work of institutions where rights from the pension and disability insurance are provided;
PDIF – providing pension and disability insurance, including contribution collection for both pillars and allocation of contributions between all funds;
MAPAS - supervision of pension companies and pension funds and protection of interests of the members;
Custodian – a bank or specialized depository institutions responsible for keeping securely any securities and keeping records, executing investments orders according to the Law, etc. (in the first 5 years the NBRM will perform the role of the Custodian)

Probably the best benefit of the undertaken pension reform can be seen in the improved institutional functioning, in terms of transparency of the institutions involved, as well as the contribution collection. The private pension companies are sending regular slips by post to all that have switched into the second pillar, which gives possibility to those people whose employers have not paid their contribution to react promptly. Also, the electronic database of the PDIF both in terms of the payment of contribution and the general public access to information has influenced the improved contribution rate and increased awareness about current pension conditions. Unfortunately, positive outcomes of the new pension system are not visible in the other aspects of the reform.

4.1.4 Benefits

Rights from pension and disability insurance include:

- Right to an old age pension benefit;
- Right to a disability pension benefit;
- Right to survivors pension benefit;
- Right to a minimum pension benefit;
- Right to relocation to another relevant job, right to appropriate employment, right to vocational retraining or additional training and right to appropriate monetary allowances;
- Right to allowance for physical impairment.

(a) The old age pension benefit is determined based on the average of all adjusted monthly wages of the contributor during his/her total years of service (pension base),

but not earlier than January 1, 1970, and in percentage determined according to the length of pension service.

Additional rules regarding the calculation of the benefits are as follows:
For the contributors which will be employed for the first time after January 1, 2003 and will join the new two pillar system the percentage will be 0.75% (for man), i.e. 0.86% (for woman) for each year of pension service, and for pension service shorter than one year, but at least 6 months this percentage is 0.375% (for man), i.e. 0.43% (for woman). This will apply after the split of contributions between the first and second pillar will start.

For the contributors which until January 1, 2003 have been employed and will decide to switch to the new two pillar system, this percentage, for each year of pension service until the day of switch to the new system is 2.33% (for man), i.e. 2.60% (for woman), and for pension service shorter than one year, but at least 6 months is 1.165% (for man), i.e. 1.30% (for woman), but maximum 11.65% (for man), i.e. 13.00% (for woman). For each following year of pension service completed after switching into the new system, percentage is 0.75% (for man), i.e. 0.86% (for woman), and for pension service shorter than one year, but at least 6 months it is 0.375% (for man), i.e. 0.43% (for woman).

For the contributors who have been covered by the pension and disability insurance, and shall not decide to switch to the new two pillar system, but have at least 15 years pension service, this percentage will be determined in the same way as before (pursuant to the table in Article 33 from the Pension and Disability Insurance Law). Namely, for 15 years of pension service the percentage is 35% for man, and 40% for woman. For men, for each additional 6 months of pension service the percentage is increased by 0.9%. For women, for each additional 6 months of pension service until 20 years total service the percentage is increased by 1.3% and for the service more than 20 years the percentage is increased by 0.9%. The percentage for full service (40 years for men, i.e. 35 years for women) is 80%. For every year of pension service, which is above 40 years of pension service (for men) and above 35 years of pension service (for women), the pension basis is established in percentage from additional 1.8 for each year pension service after 1 September 2007.

For the contributors which have been included in the pension and disability insurance, and will not decide to switch to the new two pillar system, but have less than 15 years of pension service, this percentage for each year of pension service until September 1, 2001, is 2.33% (for men), i.e. 2.60% (for women), and for pension service shorter than one year, but at least 6 months it is 1.165% (for men), i.e. 1.30% (for women). For each additional year of pension service after September 1, 2001 this percentage is 1.80% (for men), i.e. 2.05% (for women), and for pension service shorter than one year but at least 6 months it is 0.90% (for men), i.e. 1.025% (for women).

Contributors that will join the two-pillar system shall receive one portion of the pension benefit from the first pillar and another portion from the second pillar. Assets accumulated in the individual account in the second pillar can be received in form of pension annuities or as scheduled withdrawals, which will be regulated in detail by a separate law.

(b) Eligibility criteria for disability pension benefit
The contributor who has lost the ability to work, as well as the one with decreased working ability who has reached certain age, and therefore is not able to get

vocational retraining or additional training in order to be relocated to other appropriate job, is eligible to receive disability pension benefit, if:

- the disability is a result of a workplace injury or professional illness, regardless of the years of pension service; or
- the disability is a result of injuries not related to the workplace or illness, provided that prior to the disability occurrence the beneficiary has had pension service equivalent to at least one third of the period calculated starting from 20 years of age until the day of disability occurrence (working years), counting working years at full ages.

The disability pension benefit referred to in item 1 above is determined based on the pension base with a maximum percentage (for pension entitlement until 2015: 80% and for pension entitlement after 2015 the maximum percentage will gradually decrease and in 2040 it will be 72%). The disability pension benefit referred to in item 2 above is determined based on the pension base depending on the length of the pension service and the age, according to the calculation of the old age pension benefit. For these pension benefits, a minimum percentage is provided, and if disability occurred before fulfilling the criteria for an old age pension benefit, the disability allowance is also provided in case the pension benefit is lower than the pension benefit that is used by the disability pensioners due to workplace injury or professional illness.

Contributors that will join the two-pillar system will receive full amount of disability pension benefit from the first pillar only, and assets accumulated in the individual account in the second pillar will be transferred to the first pillar. In case the accumulated assets are higher than the amount needed for payment of disability pension benefit, the member can choose to buy pension annuity or scheduled withdrawal.

Since the introduction of the parametric reforms, which tightened the eligibility criteria for the old age pension, there is an increasing trend of people receiving disability pension. The greatest change can be seen in the years 1997 and 1998, when the numbers of disability pension beneficiaries increased from 48,909 to 51,208 respectively. In 2005 the number of disability pension beneficiaries was 50,180

(c) Eligibility criteria for survivors pension benefit
Eligible for the survivors pension benefit are the members of the family of the deceased contributor: the spouse, children and parents that had been dependent on the beneficiary under legal conditions.
The members of the family are eligible to receive survivor pension benefit if the deceased beneficiary:

- had at least 5 contributory years or at least 10 years of pension service, or
- fulfilled the eligibility criteria for obtaining an old age or disability benefit, or
- was an old age or disability pension beneficiary.

The amount of the survivors pension benefit is determined as a percent of the pension that had been received by the late beneficiary, as follows: 70% for one family member, and additional 10% for each additional family member, but not more than 100%.

Beneficiaries of the old age pension from contributors that will join the two-pillar system shall receive full amount of survivors pension benefit from the first pillar only,

and assets accumulated in the individual account in the second pillar will be transferred to the first pillar. In case the accumulated assets are higher than the amount needed for payment of survivors pension benefit, the beneficiary can choose to buy pension annuity or scheduled withdrawal.

(d) Right to a minimum pension benefit
The minimum amount of an old age pension benefit realized as a sum of the pensions from the two pillars cannot be lower than the average salary of all employees in the former Yugoslav Republic of Macedonia in the previous year, as follows:

- 41% for the beneficiaries with over 35 pension service (for men) and over 30 years pension service (for women);
- 38% for the beneficiaries with over 25 pension service (for men) and over 20 years pension service (for women);
- 35% for the beneficiaries with up to 25 years of pension service (for men) and up to 20 years of insurance (for women)

Further on, this pension will be adjusted with the same percentage of adjustment as other pensions. The structure of the pension beneficiaries by groups of amounts of pensions is given in Table 4.4.

4.2 Sustainability of the reformed pension system

The reformed pension system was introduced after several types of actuarial projections. These only focused on projections of transitional costs, replacement rates in the future, demographic projections, as well as projections regarding the amount of pension for switchers and non switchers in the reformed system. According to the projections regarding the economic costs, it is expected that during the first half of the transition the PYGO system shall face fiscal pressure due to the drop of the average contribution rate, but in the second half of the reform this pressure shall decrease, since the average replacement rate will decrease and the reform will reach maturity. After the initial switching process is completed, the average contribution rate will continue to fall, but slowly, eventually reaching a steady-state level of 14.2% around the year 2030. This decrease of the average contribution rate will increase the fiscal pressure experienced by the PAYG system. During the second half of the transition, between the 25-th and 50-th year of the reform, the average PAYG replacement rate will commence to decrease, the same way as the average contribution rate will decrease in the first half of the reform. The fiscal pressure will disappear the same way as the average replacement rate will decline and as the reform will attain maturity. The transitional deficit will be higher than initially projected, due to the higher number of contributors that entered into the second pillar (see Table 4.5). The transitional costs will be met by the Central Government budget. According to the initial calculations, projections made on the basis of estimated switchers of around 25% i.e. 86,000 insured persons (this number was exceeded for 20%, i.e. as of December 2006 in the second pillar there were 128,031 insured persons), implied that the transitional costs will be at their peak in 2025-2030 and it will amount to 2.2% of the GDP. As the numbers of switchers in the second pillar doubled the expectations, it implies that the transitional costs will also double, peaking to 4.5% of the GDP in 2025-2030.

The main financial input for the financing of the pension system comes from pension contributions provided by the employers. The contribution rate in the first pillar is 21.2% of the gross salary for contributors that will remain in the mono-pillar system and 13.78% of the gross salary for the contributors that will switch to the new two-

pillar system. Contributors that will be included in the new system will pay contribution of 7.42% of the gross wages into the second pillar.

The share of the costs for pension and disability insurance for 2005 is 10.5% of the GDP and it has decreased compared to 2004 and 2003. In 2006 the payment of contribution increased for 10.5% in comparison to the previous year, out of which 7% are a result of the nominal increase of the income in the country, and 3.5% is assessed as a result of the improved payment of contributions.

The main fear for the sustainability of the reformed pension system comes from the shortage of financial instruments in which the pension funds could invest. Judging from the currently low economic potential of the country, lack of foreign direct investments, the high rate of unemployment, as well as risky geographical surrounding (Kosovo), it is questionable whether the projected gains from the investments of the funds in the second pillar can materialize. The optimists, including those from the MAPAS Supervisory Agency, dismiss these fears with explanation that the pension reform has served as an incentive for the reviving of the market, for example that of the government debt securities, which have started to be issued in a greater amount. The optimists' arguments also point to the fact that the portion of investment in equities is also increasing, as well as to the initiated trend of investing abroad.

4.3 Adequacy of the reformed pension system

The actuarial projections regarding the new reformed pension system did not involved the projections regarding the adequacy of the new multi-pillar system in terms of current and future poverty rates among pensioners, neither its influence on different groups in the society (ethnic, gender, age-groups etc.) Therefore, it is extremely difficult to assess its adequacy, although some conclusions can be drown from the existing legislative solution and statistical data.

The average paid amount of pension in 2005 was: for old-age pension – Denar 8,517 (Euro 139), for disability pension – Denar 6,542 (Euro 107) and for the survivors pension – Denar 6,018 (Euro 98). The guaranteed minimum pension level in the former Yugoslav Republic of Macedonia is Denar 3,918,50 (Euro 64).

According to the Law on Pension and Disability Insurance, the pension coverage in the former Yugoslav Republic of Macedonia is broad and applies to all employees, self-employed persons, and farmers.

At the end of 2005, there were 405,542 insured persons in the country. For the same period, the number of pension beneficiaries (old-age, disability and survivor pension) was 265,152. According to the latest available information from the MLSP for the period of May 2007, this number has increased to 269,819 pensioners. In addition to this number, in May 2007 there were 3,731 beneficiaries of minimal agricultural pension, as well as 2,628 beneficiaries of pension for serving in the military. Hence, the total number of pensioners in May 2007 was 276,178 beneficiaries.

As of December 31, 2006 there were 128,031 members into the second pillar, out of which 60,473 voluntary and 67,558 mandatory members (see table 4.6).

The Law on Pension and Disability Insurance also provides an option for voluntary insurance for persons whose mandatory pension insurance has terminated. They may insure themselves under the so-called complementary insurance scheme. This option applies to persons who are:

- participating in training and retraining in the country or abroad with approval by the employer;
- staying abroad as a spouse of an employee that was posted to work abroad;
- unemployed, after termination of the right to monetary allowances.

Data on the total number of people that are not covered by pension insurance is difficult to be assessed. However, below are some examples of groups that are not covered by pension insurance. The first example is the result of the Law on Pension and Disability Insurance which regulates general conditions for the old-age pension insurance – the age limits for men (64) and women (62) and the work period limit (15 years), as well as conditions for retirement according to the pension service – men (40) and women (35). Those who do not fulfill the above conditions are not able to be included in the pension insurance. According to our estimations based on the PDIF data for the end of 2005, there were 114,029 pension beneficiaries above 65 years (out of which 94,336 - old age pension and 19,693 – invalidity). Additional pension beneficiaries are using survivors pension, whose number are not given exactly, but our estimations (according to the suggestions from the PDIF that 1/3 of the survivors pension beneficiaries are children and additional 10% are below 65 years of age) indicate that this number is around 40,883 survivor pension beneficiaries. In total, our estimation shows that pension beneficiaries above 65 years of age are around 154,912. Having in mind the estimations of the total number of population aged 65 and above (225,000 in 2005), this suggests that more than 70,000 (or 31.1%) people above the age of 65 are not covered with pension benefit. This does not imply that they are not covered with any other social benefit, such as social assistance. They also might continue to work, or rely on their families. However, this group of people not in receipt of social assistance, or not working or having family support is the most exposed to the risk of poverty. It can be speculated that among this group there is a large number of women, especially those belonging to ethnic communities, who have no work experience.

A second example is that the disability and survivors pensions are not provided in the second pillar. In case of activation of a disability or a survivors pension, an individual or his/her successors are entitled to draw the higher of the two benefits: the regular first pillar or a combined basic pension and annuity. If the regular PAYG disability and survivors benefit exceeds the combined pillars benefit, the total accumulation in the second pillar is transferred to the Pension Fund in exchange for a pension that would be received by an individual that participated only in the first pillar.

The number of contributors based on the data by the PDIF, that is the number of employees for which the contribution is paid is 348,500 employees. The correlation between the number of contributors and the pension beneficiary is 1.3 employees per 1 user of pension and it is not changed compared to 2004. The number of pension beneficiaries at the end of the year and the employees by years is given in Table 4.7. Although since 2003 the number of employees for which the contributions are paid is increasing, their correlation with the pension beneficiaries is still the same (1.3 : 1). According to the available information on the number of contributors to the private pensions funds (MAPAS and PDIF, 2006), out of 128,031 contributors, until 31.12.2006 no contribution has been paid for 14,467. That represents around 11% of all contributors in the private pension funds.

Additional vulnerable groups in relation to the pension insurance access include: unemployed people, redundant workers (laid-off workers), those working only with short-term employment contract for which the employees pay only personal tax, but

not the pension-disability insurance, those working on the grey market, including particularly the ethnic community groups (Roma, Albanians) who are far less likely to be in registered work, leading to increased risks of poverty in old age. Also, very frequent condition in the private sector (especially in the small and medium sized companies) is the underreporting of salaries, which contributes towards payment of the pension contribution to the minimally calculated base (and not on the real paid salary). This will have an effect on future pensions of huge number of people, who will retire with below the average or minimal pensions.

Due to the trends of working abroad, many people now get pensions mainly from Germany, Switzerland, but also ex-Yugoslav Republics. Exact figures on the numbers of those pensioners receiving pensions from abroad are not available. Multilateral agreements and contracts have been concluded with many countries (see list of agreements, Table 4.13). However, in meeting the requirements of the EU Directive on Mobility of Workers (1408), a review of the requirements and implementation will be needed.

The correlation of the average pension (paid in December 2005 and the average income for December 2005 in the country) is 56.9%. The average income and the average pension by types in the period of 1991 till 2005 (December) is given in Table 4.8. Participation of pensions compared to the average income is given in Table 4.9.

4.4 Public awareness and acceptance of the multi pillar pension reform

Throughout the campaign period (2002-2006) there were several public opinion surveys on the new pension system and pension reform. According to the World Bank's Social Assessment (as part of the SPIL project), focus groups which included employers and public officials were positive towards the planned reform. The focus groups of pensioners were skeptical of the reform, mainly because of the previous negative experience with 'private pyramidal schemes', as well as the prevailing trust towards the state as pension provider rather than private sector (Tetragon, 2004).

The MLSP has conducted a public awareness campaign under the name "Inform yourselves about your rights – The decision is yours" in 2006. The campaign informed the public (members of the second pillar) about their rights in the reformed pension system. The campaign was implemented through broadcasting of TV commercials, publishing ads, newspaper banners and billboards and dissemination of informative brochures for employees and leaflets for employers in both languages, Macedonian and Albanian. The media campaign was followed by PR activities, such as organizing press conferences to inform the public about the reformed pension system and the effects in the long run, its recent successful implementation and promotion of the benefits of the two pillar pension system for the individuals and for the society, "open event" aimed to bring the government institutions close to the citizens and where the citizens could check the paid pension contributions through the clients' software. In the framework of the campaign there were several interviews with the Minister of Labour and Social Policy, the Director of the PDIF and the Director of MAPAS. A presentation was organized in the Macedonian Chamber of Commerce for the employers about their obligations related to the reformed pension system and the payment of contributions.

However, it must be noted that the public campaign did not involve an expert-based debate regarding the social risks and possible solutions in the new reformed pension system. Lack of such debate reduced the space for alternative country based

solutions in regard to the pension specifics and characteristics. The prevailing general impression was that the reform was 'imposed', without taking into consideration the social concerns of the population. Among the few who challenged this reform were the trade unions, but their impact can be described as 'too little, too late'. According to a representative of the Union of Trade Unions in the former Yugoslav Republic of Macedonia "the characteristics of the new pension system in Macedonia are the worst in comparison to other neighboring countries". She named the following problems, which the Trade Union considered as worrying: "(i) lack of economic pre-conditions for successful and effective operation of the second pillar (as the low number of new employees accompanied with the low level of salaries – 60% of the workers have salary less than Euro 60); (ii) high administrative cost of 8.5% (and according to some experts it should not exceed 3%); (iii) the small investment market in the country.[31]" Because of this, she noted that the Trade Unions were in favor of a voluntary, rather than mandatory second pillar.

Despite trade union efforts to point out these problems by organizing a general strike in 2000, their activities did not have an impact on the political will and decisions. Jankulovska noted: "The Government openly told us that the pension reform is an obligation that they have to fulfill because of the IMF and WB arrangements"[2].

This study believes that the reform should not have been undertaken without sufficient projections of the pension reform outcomes on different client groups, their future level of living standard, as well as its impact on different gender, ethnicities and economic sectors. Without these estimations, the pension reform confirms the general impression as being imposed, without relevant risk factors being considered. Therefore, the major problem underneath the paradigmatic pension change is not whether the reform would have been better if it introduced voluntary instead of the mandatory pillar, but rather the lack of analysis of the major gainers and losers of this reform. Thus, the pension system seems to lack solutions in terms of providing adequate and sufficient resources for everyone.

4.5 Political and policy direction of future reforms

The next step in the pension system reform concentrates on implementation of the third pillar. A Steering Committee on voluntary fully funded pension insurance was established that plans to do an analysis of the national system's situation at present and a comparative analysis of the voluntary pension in other countries. That will help to give recommendations and suggestions for the design of the model of the third pillar, most appropriate for the national pension system. Pursuant to the plan of activities, the third pillar will start in June 2008. The voluntary pension insurance will mean access to pensions to all persons who have income and are not covered by the mandatory pension insurance on any ground. Voluntary pension insurance is good opportunity for those persons who can afford higher pension for the old age period.

Reforms are also necessary in the area of the disability insurance. New definition of the invalidity or total incapability for work is required. Instead of the current definition of the invalidity as total incapability of the employee to work at the job that he/she had prior to the appearance of the invalidity, the invalidity should be assessed in relation to any job in accordance with the professional education of the employee. Special emphasis will be given to the professional rehabilitation as a right and obligation of the workers with remaining working capability, prior to the acquisition of the right to an invalidity pension. This will lead to reduction of the number of the

[31] Interview with Ms. Liljana Jankulovska , representative of the Union of Trade Unions in Macedonia, dated 25.01.2005

disability pensioners, i.e. disability pension will be given only the persons fulfilling the conditions. Also, this will mean wider access to the labour market of the workers with the remaining working capability through improved working conditions and professional rehabilitation.

Changes are necessary regarding the part of the insurance under favorable conditions. The work positions under special treatment because of the difficult conditions for their performance need to be revised. The revision should be done while having into account the world trends, development of the technology and improvements in the protection at work. At present, the determination of these jobs as such is done by a decision of the Management Board of the PDIF on the base of experts' opinion. To avoid decisions for the determination of the work positions under favorable conditions, the list of these work positions should be determined in the law. Jobs not listed in the law would be additionally determined. This new way of determination of the jobs under favorable conditions would mean realistic, objective assessment of those jobs considered as jobs that are performed in difficult conditions and require favorable treatment.

The implementation of the second and third pillar requires new payment legislation. Preparation of a new law on annuities and withdrawals i.e. payments from the fully funded pension insurance is planed. According to the plan, the law should be adopted in mid 2008.
Additional needed reforms include the need for strengthening the effectiveness and efficiency of collection of social contributions to support essential government expenditures, and reduce the administrative burden on businesses. For this purpose the Government is aiming to achieve harmonization of the bases for social security contributions, according to the identified key parameters for harmonization of social contribution bases, including a single and simple minimum contribution base based on the average wage, use of gross wages in rate calculations, common definitions of employer and employee, common lists of beneficiaries and a common definition of employment income.

4.6 Conclusions

The pension system in the former Yugoslav Republic of Macedonia seems to be more focused on the aspect of modernization, rather than on adequacy and sustainability. This can be explained though existence of variety of economic, financial and demographic projections, but none in terms of pension reform effect on the coverage of the pension for different categories in need, as well its sustainability vis-à-vis the limited employment and economic growth in the country. Hence, below is a summary of the conclusions concerning the main problems associated with the current system which is further elaborated in the final chapter as challenges ahead.

- Lack of information concerning coverage rate of the pension system, especially in relation to agricultural workers, as well as women with no employment record.
- Adequacy of the pension amount for those staying in the first pillar, assuming the gradual decrease of the replacement rates in the first pillar.
- Legal provisions in relation to adequacy of pensions for those who have not made sufficient contributions, or those on low earnings.
- To bear the burden of the transitional costs in the pension system which in the environment of high rate of unemployment and increased number of switchers to the second pillar can jeopardize the sustainability of the whole

pension system as well as gradually threaten the country's fiscal sustainability.

- Shortage of financial instruments in which the pension funds could invest**.** At the moment, bank deposits are almost the only available financial asset. This reduces the possibility for effectuating greater pension gains from the second pillar.
- The entitlement conditions for categorical pension schemes should be revisited in the light of eliminating overlapping between different schemes. Especially the disability assessment scheme should be rationalized.
- Evasion of contributions is a priority issue since it has a severe impact on the financing and the viability of the pension system. The most efficient collecting networks should undertake the task and relevant legislation with clear functions must be enforced. Information networks, databases and coordination mechanisms should be put in place.
- Legal stipulations in the second pillar in regard to investment restrictions and their compatibility with the *Acquis*. The fund investing restrictions differentiates between investing in the own or other EU countries.
- Cost of the new system to individual's funds and more clarity as to how these funds will be converted into income in retirement.

References for Chapter 4

Agency for supervision on fully funded pension insurance (2006) Latest developments in the mandatory fully funded pension insurance - Annual Statistical Report, Agency for supervision of fully funded pension insurance, http://www.mapas.gov.mk

Annual Report of Pension and Disability Insurance Fund for 2005 (published 2006), http://www.piom.com.mk

Feasibility Study/Capacity documentation of pension contribution process (April, 2001)

Law on Mandatory Fully Funded Pension Insurance (Official Gazette no. 29/02, 85/03, 40/04 and 113/05)

Law on Pension and Disability Insurance (Official Gazette no. 80/93, 3/94, 14/95, 32/96, 20/00, 96/00, 5/01, 50/01, 85/03/ 40/04, 4/05,101/05 and 70/06)

Law on Personal Records (Official gazette no. 16/04)

Ministry of Labour and Social Policy /Pension Steering Committee and Actuarial Unit within the Pension Fund (July 1999) Proposal for the reform of the pension system of the Republic of Macedonia

PDIF and MAPAS (2006) Public Information on number of members in the private pension funds for whom the contribution has not been paid, www.piom.com.mk

Sansier, F. (2006) Regional assessment report on social security financing issues, CARDS/Social Institutions Support Program (unpublished report)

Schmidt-Hebbel, K. (2003) Pension Funds and Capital Markets in Macedonia (unpublished report)

Technical assistance to the Pension and Disability Insurance Fund –Disability and increased service credit (Callund consulting) 2006

Tetragon (2004) Final report/ Social Assessment for the purposes of the Social Protection Implementation Loan (World Bank) (unpublished report)

Statistical Annex for Chapter 4

Table 4.1 Evolution of old age dependency ratio (% people above 65 years compared to people between 15 and 64 years)

2000	2005	2010	2015	2020	2025
14.94 %	16.20 %	17.35 %	18.93 %	22.01 %	25.10 %

Source: Sansier, F., 2006

Table 4.2 Gradual increase of retirement age for women

2002	2003	2004	2005	2006	2007	2008	2009
59.5	60.0	60.5	61.0	61.5	62.0	62.0	62.0

Source: Mapas, 2006

Table 4.3 Maximum investment limits – by instruments

Investments abroad (EU, Japan, USA)	20%
Securities guaranteed by NBRM or RM	80%
Bank deposits, certificates of deposit, commercial notes, bonds, mortgage backed securities	60%
Bonds and commercial notes of Macedonian joint stock companies	40%
Shares of Macedonian joint stock companies	30%
Participation units and shares of investment funds	20%

Source: Mapas, 2006

Table 4.4 Structure of the pension beneficiary by groups of amounts of pensions

Groups of amounts	Beneficiary	Structure	Cumulative beneficiary	Cumulative structure
to 3,918.50	21,577	8.1	21,577	8.1
3,918.51 - 4,218.00	10,987	4.2	32,564	12.3
4,218.01 - 5,252.00	54,937	20.7	87,501	33.0
5,252.01 - 6,000.00	38,859	14.7	126,360	47.6
6,000.01 - 10,000.00	89,991	33.9	216,351	81.5
10,000.01 - 15,000.00	36,608	13.8	252,959	95.4
15,000.01 - 20,000.00	8,371	3.2	261,330	98.5
20.000,00 - 24,896.50	2,738	1.1	264,068	99.5
up 24,896.50	1,084	0.4	265,152	100.0

Source: Ministry of Labour and Social Policy, 2006

Table 4.5 Transitional costs

Transitional costs				
			Denar	Euro
Month	Number of employee	Contribution for pension and disability	Assets	
2006				
January	99,102	1,480		
February	100,547	1,480	148,809,560	
March	101,992	1,480	150,948,160	
April	103,437	1,480	153,086,760	
May	104,882	1,480	155,225,360	
June	106,327	1,480	157,363,960	
July	107,772	1,480	159,502,560	
August	109,217	1,480	161,641,160	
September	110,662	1,480	163,779,760	
October	112,107	1,480	165,918,360	
November	113,552	1,480	168,056,960	
December	114,997	1,480	170,195,560	
Total			1,754,528,160	28,682,820
2007				
January	116,180	1,536	178,452,480	
February	117,363	1,536	180,269,568	
March	118,546	1,536	182,086,656	
April	119,729	1,536	183,903,744	
May	120,912	1,536	185,720,832	
June	122,095	1,536	187,537,920	
July	123,278	1,536	189,355,008	
August	124,461	1,536	191,172,096	
September	125,644	1,536	192,989,184	
October	126,827	1,536	194,806,272	
November	128,010	1,536	196,623,360	
December	129,193	1,536	198,440,448	
Total			2,261,357,568	36,968,408
2008				
January	130,376	1,602	208,862,352	
February	131,559	1,602	210,757,518	
March	132,742	1,602	212,652,684	
April	133,925	1,602	214,547,850	
May	135,108	1,602	216,443,016	
June	136,291	1,602	218,338,182	
July	137,474	1,602	220,233,348	

August	138,657	1,602	222,128,514	
September	139,840	1,602	224,023,680	
October	141,023	1,602	225,918,846	
November	142,206	1,602	227,814,012	
December	143,389	1,602	229,709,178	
Total			2,631,429,180	43,018,296
2009				
January	144,572	1,674	242,013,528	
February	145,755	1,674	243,993,870	
March	146,938	1,674	245,974,212	
April	148,121	1,674	247,954,554	
May	149,304	1,674	249,934,896	
June	150,487	1,674	251,915,238	
July	151,670	1,674	253,895,580	
August	152,853	1,674	255,875,922	
September	154,036	1,674	257,856,264	
October	155,219	1,674	259,836,606	
November	156,402	1,674	261,816,948	
December	157,585	1,674	263,797,290	
Total			3,034,864,908	49,613,616
Remark	The calculation of the pension and disability contribution is planed in accordance with the increase of the wages as follows: for year 2006 3, 50%.; for year 2007 3, 8%; for year 2008 4, 3% and for year 2009 4, 5%. The number of the employees in the second pillar is calculated on the base of the data from the new employments for the period 2003-2005 (approximately 14.200 new employments per year or approximately 1.183 new employments per month).			
Skopje: 25.01.2006				

Source: Ministry of Labour and Social Policy, 2006

Table 4.6 Distribution of the Pension Fund Membership by their Status

Pension Fund	Voluntary	Mandatory				Total
		With contract	Allocated	Temporary allocated *	Total	
31.12.2006						
NPF	27,638	22,205	8,437	3,127	33,769	61,407
KB Prv /	32,835	21,292	8,770	3,727	33,789	66,624
TOTAL	60,473	43,497	17,207	6,854	67,558	128,031

Source: Mapas, 2006

Table 4.7 Relation between pension beneficiary and employees

Year	Number of employees	Number of pension beneficiaries	Number of beneficiaries of pension to 1000 employees	Number of employees to 1 pension beneficiary
1991	534,887	180,749	338	3.0
1992	531,083	193,294	364	2.7
1993	503,010	210,537	418	2.4
1994	468,632	216,834	463	2.2
1995	427,658	219,307	513	2.0
1996	403,820	222,727	552	1.8
1997	381,723	227,099	595	1.7
1998	370,869	232,216	626	1.6
1999	374,025	235,839	631	1.6
2000	367,162	241,221	657	1.5
2001	351,009	247,200	704	1.4
2002	332,728	249,421	750	1.3
2003	321,105	254,267	775	1.3
2004	348,212	260,075	747	1.3
2005	348,500	265,152	761	1.3

Source: Ministry of Labour and Social Policy, 2006

Table 4.8 Average income/average pension by types 1993-2005 (December)

Year	Income	Old-age pension	Disability pension	Survivors pension	Total pension
1993	Denar 6,315.00 XBA 955 220.5	Denar 5,327.00 XBA 955 186	Denar 3,912.00 XBA 955 136.6	Denar 3,742.00 XBA 955 130.7	Denar 4,634.00 XBA 955 161.8
1994	Denar 8,424.00 XBA 955 163.3	Denar 6,140.00 XBA 955 119.02	Denar 4,500.00 XBA 955 87.23	Denar 4,374.00 XBA 955 84.78	Denar 5,350.00 XBA 955 103.7
1995	Denar 8,435.00 XBA 955 173.18	Denar 6,438.50 XBA 955 132.83	Denar 4,735.00 XBA 955 97.01	Denar 4,623.50 XBA 955 94.72	Denar 5,609.00 XBA 955 114.91
1996	Denar 8,931.00 XBA 955 177.48	Denar 6,558.00 XBA 955 130.33	Denar 4,872.50 XBA 955 96.83	Denar 4,707.00 XBA 955 93.54	Denar 5,715.00 XBA 955 113.57
1997	Denar 9,096.00 XBA 955 174.52	Denar 6,634.00 XBA 955 172.28	Denar 4,969.50 XBA 955 95.35	Denar 4,733.50 XBA 955 90.82	Denar 5,773.00 XBA 955 110.76
1998	Denar 9,694.00 XBA 955 158.27	Denar 6,607.00 XBA 955 107.87	Denar 5,007.50 XBA 955 81.76	Denar 4,717.00 XBA 955 77.01	Denar 5,751.00 XBA 955 93.89
1999	Denar 10,019.00 Euro 165.28	Denar 7,188.00 Euro 118.57	Denar 5,439.00 Euro 89.72	Denar 5,132.00 Euro 84.66	Denar 6,251.00 Euro 103.12
2000	Denar 10,526.00 Euro 173.15	Denar 7,394.00 Euro 121.63	Denar 5,563.00 Euro 91.51	Denar 5,281.00 Euro 86.87	Denar 6,431.00 Euro 105.79
2001	Denar 10,592.00 Euro 173.75	Denar 7,498.00 Euro 123	Denar 5,672.00 Euro 93.04	Denar 5,354.50 Euro 87.84	Denar 6,535.00 Euro 107.2
2002	Denar 11,550.00 Euro 189.13	Denar 7,982.00 Euro 130.7	Denar 6,060.00 Euro 99.23	Denar 5,673.00 Euro 92.89	Denar 6,955.00 Euro 113.88
2003	Denar 11,955.00 Euro 195.06	Denar 8,421.00 Euro 137.4	Denar 6,425.00 Euro 104.83	Denar 5,971.00 Euro 97.42	Denar 7,346.00 Euro 119.86
2004	Denar 12,534.00 Euro 204.44	Denar 8,492.00 Euro 138.51	Denar 6,509.00 Euro 106.17	Denar 6,023.00 Euro 98.24	Denar 7,428.00 Euro 121.15
2005	Denar 13,125.00 Euro 214.53	Denar 8,517.00 Euro 139.21	Denar 6,543.00 Euro 106.95	Denar 6,018.00 Euro 98.37	Denar 7,463.00 Euro 121.98

Source: Ministry of Labour and Social Policy, 2006

Table 4.9 Participation of pensions compared with the average income

Year	Old-age pension	Disability pension	Survivors pension	Total
1991	69.8	52.4	49.6	66.2
1992	89.6	64.7	61.6	77.1
1993	84.4	61.9	59.3	73.4
1994	72.9	53.4	51.9	63.5
1995	76.3	56.1	54.8	66.5
1996	73.4	54.6	52.7	64.0
1997	72.9	54.6	52.0	63.5
1998	68.2	51.6	48.7	59.3
1999	71.7	54.3	51.2	62.4
2000	70.2	52.8	50.2	61.1
2001	68.0	51.5	48.6	61.7
2002	69.1	52.5	49.1	60.2
2003	70.4	53.7	49.9	61.4
2004	67.7	51.9	48.1	59.3
2005	67.6	51.9	47.8	59.2

Source: Ministry of Labour and Social Policy, 2006

Table 4.10 The condition of the number of the pension beneficiary at the end of 2005 year

Ordinal numeral	Type of pension	Pension beneficiary 31.12.2004	Pension beneficiary 31.12.2005	Increase/ decrease	Index 2005/2004
1	Old - age	137,840	142,827	4,987	103.6
2	disability	51,589	50,180	-1,409	97.3
3	survivors	70,646	72,145	1,499	102.1
4	total	260,075	265,152	5,077	102.0

Source: Ministry of Labour and Social Policy, 2006

Table 4.11 The number of pension beneficiary by years

Year	Old-age	Disability	Survivors	Total
1991	94,676	38,206	47,867	180,749
1992	102,021	41,030	50,243	193,294
1993	113,799	43,867	52,871	210,537
1994	116,617	45,472	54,745	216,834
1995	116,241	46,509	56,557	219,307
1996	117,041	47,431	58,254	222,726
1997	118,148	48,909	60,042	227,099
1998	119,194	51,208	61,814	232,216
1999	120,574	52,060	63,205	235,839
2000	124,210	52,549	64,462	241,221
2001	128,322	52,619	66,259	247,200
2002	129,648	52,514	67,259	249,241
2003	133,008	52,237	69,022	254,267
2004	137,840	51,589	70,646	260,075
2005	142,827	50,180	72,145	265,152

Source: Ministry of Labour and Social Policy, 2006

Table 4.12 Age structure of pension beneficiaries

Age (years)	Old-age pension	Structure	Disability pension	Structure	Total	Structure
Up to 45	19	0.02	1,569	3.13	1,588	0.83
45-50	371	0.26	3,197	6.37	3,568	1.85
50-55	4,012	2.83	6,311	12.57	10,323	5.34
55-60	12,693	8.88	8,645	17.23	21,338	11.06
60-65	31,396	21.98	10,765	21.45	42,161	21.84
65-70	37,394	26.18	9,709	19.35	47,103	24.40
70-75	30,974	21.66	5,731	11.44	36,705	19.02
75-80	16,934	11.85	2,779	5.53	19,713	10.22
Above 80	9,034	6.34	1,474	2.93	10,508	5.44
Total	142,827	100.0	50,180	100.0	193,007	100.0

Source: Pension and Disability Insurance Fund, 2005

Table 4.13 List of Bilateral agreements for Social Insurance

1.	Macedonian-Austrian Convention for Social Insurance (in force since 1st of April 1998)	Official Gazette, International agreements no.28/1997
2.	Agreement between (former Yugoslav) Republic of Macedonia and Republic of Croatia for social insurance (in force since 1st of November 1997)	Official Gazette, International agreements no.34/1997
3.	Agreement for social insurance between (former Yugoslav) Republic of Macedonia and Republic of Turkey (in force since July 2000)	Official Gazette no. 7/1999
4.	Agreement for social insurance between (former Yugoslav) Republic of Macedonia and Republic of Slovenia (in force since 1st of April 2001)	Official Gazette no. 13/1999
5.	Convention between (former Yugoslav) Republic of Macedonia and the Swiss Confederation for Social Insurance (in force since 1st of January 2001)	Official Gazette no. 44/2000
6.	Agreement for social insurance between (former Yugoslav) Republic of Macedonia and the Kingdom of Denmark	Official Gazette no.37/2000
7.	Agreement between (former Yugoslav) Republic of Macedonia and Federal Republic of Yugoslavia for social insurance (in force since 1st of April 2002)	Official Gazette no. 13/2002
8.	Agreement for social insurance between (former Yugoslav) Republic of Macedonia and Republic of Bulgaria (in force since 1st of August, 2003)	Official Gazette no.31/2003
9.	Agreement between the Government of (former Yugoslav) Republic of Macedonia and the Government of the Federal Republic of Germany for social insurance (in force since 1st of January 2005)	Official Gazette, International agreement no. 70/2003
10.	Agreement between (former Yugoslav) Republic of Macedonia and Bosnia and Herzegovina for social insurance (in force since 1st of April 2006)	Official Gazette no. 82/2005
11.	Agreement between (former Yugoslav) Republic of Macedonia and the Czech Republic for social insurance	Official Gazette no. 20/2006
12.	Agreement between the Government of (former Yugoslav) Republic of Macedonia and the Government of the Kingdom of Netherlands for social insurance	Official Gazette, no. 20/2006
13.	Agreement between (former Yugoslav) Republic of Macedonia and Romania for social insurance	agreed in Bucharest on 27.02.2006

Chapter 5: Health and Long-Term Care

5.1. Current structure

5.1.1 Health profile – socioeconomic determinants of health

Health outcomes are influenced by various factors that operate at individual, household and community levels such as diet, health behavior, access to clean water, sanitation and health services. Underlying socioeconomic determinants of health are education, income and employment. There is an income gradient affecting health, the poor generally suffer worse health and die younger than people with higher incomes (better able to afford goods and services that contribute to health). In 2003 the gross national income in the former Yugoslav Republic of Macedonia adjusted for PPP was Euro 4,995, just below the Euro B+C average (WHO – HFA, 2006).

According to WHO estimates, total health expenditure as a percentage of GDP in the former Yugoslav Republic of Macedonia amounted to 6.8% in 2002 and 7% in 2004. This represents a significantly lower figure than that of most of the other ex-Yugoslav republics and the EU. In 2002 the health care expenditure (with PPP) per capita amounted to Euro 252, with 84.7% of health expenditure coming from public sources.

Since the early 1990s, the former Yugoslav Republic of Macedonia has made important progress on several of the MDGs. The share of population below the minimum level of dietary energy consumption has been reduced, primary completion rates are now near universal, infant and child mortality rates have fallen significantly, as has the incidence of tuberculosis. Related to middle income countries and the ECA region as a whole, the former Yugoslav Republic of Macedonia is also doing relatively well in many aspects of health and education (Government of RM, Report on MDGs, June 2005).

In 2003, an estimated 22% of the population of the former Yugoslav Republic of Macedonia or about 445 thousand persons lived in poverty. Of these persons, 113 thousand (6 percent of the population) had consumption expenditures below the amount needed to purchase the minimum food basket indicating that they suffered from extreme deprivation and most likely were malnourished. The concentration of poverty in Skopje, secondary urban centers, and rural areas were remarkably similar ranging between 20 - 22 percent of their population. Furthermore, poverty was not particularly shallow as the poverty gap in 2003 was 7 percent indicating that the average consumption of the poor would need to rise significantly to reach the poverty line. The Gini index for the former Yugoslav Republic of Macedonia for 2000 was 34.74 compared to Gini index for 15 Euro B+C countries for 2000 to 2002 range from 26.1 for Bosnia and Herzegovina (2001) to 45.6 in the Russian federation (2000) (World Bank, the former Yugoslav Republic of Macedonia Poverty Assessment, 2005).

The vast majority of the population in the former Yugoslav Republic of Macedonia has adequate access to essential physical infrastructure. This is true of access to water, sanitation, and electricity. A significant share of the population in rural areas lacks access to sewerage facilities within their dwelling, but this is a common phenomenon in developed and developing countries due to the high cost of providing this service in a cost effective manner to a dispersed population. Ninety three percent of the population of the former Yugoslav Republic of Macedonia is living in households with sanitary means of excreta disposal. There are some disparities in use of flush toilet between the households population from the Albanian ethnic group

(only 34 percent use this type of sanitation facility) and Roma population (81 percent). Analysis of infrastructure services as reported by businesses gives some insight into quality issues. It appears that there are problems, though relatively modest with reliability of services such as water and electricity. Though one cannot extract much information on the quality of the housing stock from the surveys, it does appear that a small, although significant share lacks some basic amenities, such as bathrooms and kitchens (7 percent of urban households and 24 percent of rural households lack a kitchen and/or bathroom).

Roma population is one at most risk. The discrimination and feeling of inferiority and less value very often is a reason for leaving the education process or not using some of the available public services, including the health services. Lack of information, knowledge, low level of health culture, are reason for low use of health services when needed, or disobeying the recommendations from health professionals, as well as the rights form health insurance, preventive health programs and social care. Introducing the principles of positive discrimination, ceasing the participation fees and free basic health services, might increase the financial access and use of health services by the Roma population. Insufficient and poor infrastructure in settlements where Roma population lives – educational, social and health facilities, influences the socio-economic status of the Roma. The process of decentralization and transfer of some authorities to local level might give possibilities for solving some of the existing problems, especially poverty among Roma population.

Reforms in some sectors should be intensified and adjusted to the needs of this population and their living conditions. Reforms in the health care system should be in light of quality improvement, accessibility, efficiency and rational use of the health care. Employment of more Roma health workers will contribute to the increase of the access to health services and rights for health insurance. At the moment only 0.8% of Roma population works in the health sector.

The Government allocates more than half of its total expenditures to social protection transfers. The Government spends a significant share of its resources – 58.8 of total expenditures or 12.2% of GDP on current transfers (excluding payment of debt). The majority of these transfers are for pensions with the remainder for various types of social welfare transfers, including the so-called health vertical programs. The resources allocated towards social transfers are a heavy burden on the public finances and take resources away from other important and higher return expenditures, including investments in infrastructure, which for example in the health sector practically does not exist. It also limits the amount of additional resources the Government can allocate towards redistribution.

The former Yugoslav Republic of Macedonia is beginning to see a pattern of morbidity that is characteristic for wealthier economies of Europe (cardiac and cerebrum-vascular diseases, cancer, mental health problems, injuries and violence, and respiratory diseases represent the most prominent causes of morbidity and mortality), but it is exacerbated by risk factors such as high-fat diet, lack of exercise, smoking and alcohol consumption, and also stress and economic dislocation associated with transition. Recent health survey showed that obesity is on the rise. At the same time, a quarter of the observed children are found to have iron deficiency disorders. There is also considerable drug use in the country (Euro Observatory, WHO – Health Systems in Transition, former Yugoslav Republic of Macedonia, 2006).

Life expectancy at birth for both sexes in the former Yugoslav Republic of Macedonia has increased slightly from 72.13 years in 1991 to 73.53 years in 2003. However, this figure is still much lower than in Western Europe and was five years below the EU

average of 78.49 years in 2004. In parallel a trend towards an ageing population can be observed: the 2002 Census showed that 22% of the population was under the age of 14 and 10% were above the age of 65. Specifically, from 1990 to 2005 the percentage of the population over 65 years of age increased from 7.97% to 11.1% and the percentage of the population aged 0-14 years decreased to 19.5%. However, figures also suggest that the trend towards an ageing population is far less pronounced than in most neighboring Central and Southeastern European countries (Table 5.1).

Several public health and health care indicators show that the country is outperforming those of central and Southeastern Europe and its EU neighbors in some areas. For example, owing to a number of policy interventions, there is evidence of a decreasing trend in communicable diseases and in the period 2001–2002 infant mortality was decreased to 10.8 per 1,000 live births. The Tuberculosis rates have significantly decreased between 1990 and 2005. The TB incidence in the country varies between 35 and 40 per 100,000 (32.3 in 2005) and thus is lower compared to the countries in the CIS region, similar to Albania and Bosnia, but high compared to the countries in other parts of Europe. The TB prevalence rate shows a decreasing trend within the period 1971-2005. In 2005 the prevalence was 52.8 per 100,000 with higher prevalence in the western part of the country (RIHP Health Map, 2006). The mortality rate is slightly decreasing, but is still much higher than in the European Union where it was 0.73 in 2001 (Tables 5.2, 5.3).

The burden of disease in population is the gap between the current health status and ideal situation of good health free of illness, disability and mortality. Circulatory diseases and neuropsychiatry conditions are the leading causes of burden of disease among both sexes in the former Yugoslav Republic of Macedonia in 2002, intentional injuries are third cause among males, while malignant neoplasm among females. The top risk factors with their relative contributions in descending order to burden of disease in male population in the former Yugoslav Republic of Macedonia are tobacco, high blood pressure, alcohol, high BMI, high cholesterol, low fruit and vegetable intake. High blood pressure is main risk factor for females, followed by high BMI, tobacco, high cholesterol, physical inactivity, low fruit and vegetable intake etc. (WHO 2006) (Table 5.3).

Circulatory diseases are the leading cause of death in the former Yugoslav Republic of Macedonia, accounting for nearly 57% of all deaths in 2003. The standardized death rate (SDR) per 100,000 inhabitants for circulatory diseases has increased from 527 in 1991 to 599 in 2003, which is more than double than that of the EU average of 262.38 in 2003 (Table 5.2). Overall mortality from malignant neoplasm as the second most significant cause of death has also increased over the past 10 years, from SDR 140 per 100,000 inhabitants in 1991 to 165 per 100,000 inhabitants in 2003, which is still lower than the EU average of 184 in 2004. External causes (injuries and poisoning) are the third leading cause of death (the SDR in 2000 was 37.9). For example, injuries are responsible for 33 deaths per 100,000 inhabitants, and there are 7 deaths from suicide and self-inflicted injuries per 100,000 inhabitants. Respiratory diseases rank fourth, with bronchitis, emphysema and asthma accounting for more than 60% of these deaths. Diseases of the endocrine and digestive systems - with a substantial proportion (approximately 40%) of the latter attributed to chronic liver diseases and cirrhosis - represent the fifth and sixth most significant causes of death, respectively (WHO, 2006). The structure of the leading causes of death in the former Yugoslav Republic of Macedonia has been changed in 2005, with respiratory diseases as third cause of death, endocrine disease as fourth and injuries as fifth (RIHP 2006). Neuropsychiatry disorders account for 19.4% of the diseases burden and 1% of all deaths.

According to the national data and the Joint United Nations Program on HIV/AIDS (UNAIDS) database, up to 2005 a total of only 16 HIV-positive and 59 AIDS cases were registered in the former Yugoslav Republic of Macedonia, with the first HIV-positive case being recorded in 1987 and the first AIDS case diagnosed in 1989. As most of the cases had been registered at a late stage of the HIV infection or after the patient had already developed AIDS, 46 out of the total of 59 people have died. In 2005 eight new AIDS cases were diagnosed. The male-to-female ratio in 2005 was 2.1 to 1, compared to a 1.02 to 1 ratio some years ago. Investigations into transmission methods revealed that heterosexual intercourse accounted for 56%, and homosexual for 13%. An additional 13% was attributed to intravenous drug use and 8.7% to hemophilic treatment. In 4.3% of cases, transmission from mother to child had occurred and for 5% the transmission method remains unknown, but may also be attributable to homosexual practices. For a variety of reasons, including cultural, religious or social traditions and irrespective of their ethnic origin, it is still very difficult for people to speak openly about their sexual behavior.

5.1.2 Health Profile of vulnerable groups and other disparities

Any attempt to assess the health of population out of the regular statistics faces major obstacles: data is often unreliable or simply missing. The situation is compounded by the limited capacity to undertake a meaningful analysis of health data. In certain areas, health information is available from nongovernmental sources. Multilateral and bilateral donor organisations, as well as national and international NGOs, have undertaken a number of important studies looking at health and socio-economic conditions. However, critical problem is that still very little is known about the most vulnerable groups of the population.

The number of live births has decreased from around 35,000 in 1990 to around 22,482 in 2005 with 98.9% of the children born in obstetric departments. Despite reduced public service investment throughout the transitional period, most indicators of child well-being show positive trends, mainly due to the implementation of well established governmental vertical preventive programs. One of the very positive developments in the former Yugoslav Republic of Macedonia in the last decade concerns the infant mortality rate that continued to fall and has halved, from 28.25 infant deaths per 1,000 live births in 1991 to 12.8 in 2005. However, this figure is still three times higher than the EU average of 4.75. These indicators reflect the social, economic and environmental circumstances in which children live and which have an impact on their health status, including health care. There are variations in the under-five mortality rate in different geographical areas and urban-rural settings, as well as between different socio-economic groups, such as Roma children that are at a higher risk of malnutrition. Some 82.5% of the Roma population cannot buy enough food, which results in poorer health and can lead to death before the age of five. The under-five mortality rate is usually higher among boys (59 %). The most common diseases among children from 0-5 are respiratory infections, anemia and acute diarrhea diseases. In the survey on health and nutritional status of children and mothers a mild and moderate anemia was observed in 26% of the observed children (6-59 months). The prevalence of anemia was significantly higher in children from rural areas. About 2% of children under age of five in the former Yugoslav Republic of Macedonia are moderately underweight and 0.3% is classified as severely underweight. Nine percent of children are stunted or too short for their age and two percent are wasted or too thin for their height.

Children in the South West region are more likely to be underweight, while the children in the South East and North East regions are more likely to be stunted than other children. Those children whose mothers have secondary education are the

least likely to be underweight and stunted compared to children of mothers with no education.

The official data says that the level of compulsory immunization coverage is high (between 90-95%). However, field data point to the existence of gaps with non-immunized children in poor rural and suburban communities. According to 2006 UNICEF MICS, approximately 93% of children aged 18-29 months received a BCG vaccination by the age of 18 months and the first dose of DPT was given to 89%. The percentage declines for subsequent doses of DPT to 87% for the second dose, and 80% for the third dose. Similarly, 90% of children received Polio 1 by age of 18 months and this declines to 75% by the third dose. The coverage for measles vaccine by 18 months is 75%. The percentage of children who had all eight recommended vaccinations by 18 months of age is 59%. In regard to this it must be emphasized that the births of 94% of children under five years old in the former Yugoslav Republic of Macedonia have been registered. There are no significant variations in birth registration across sex, age, or socio-economic categories (UNICEF, MICS, the former Yugoslav Republic of Macedonia, 2006).

The same survey presents that in the former Yugoslav Republic of Macedonia, 74% of under-5 children with suspected pneumonia during the two weeks prior to the survey had received an antibiotic. The percentage of under-5 children with suspected pneumonia who received antibiotics varies among groups and it is higher among the second quintile. This percent is also higher for boys than for girls, among children whose mothers/caretakers have at least secondary education, and among the children that belong to the Roma ethnic group.

Furthermore, about 14% of the births in the year prior to the MICS survey were delivered with assistance of a nurse/ midwife. Doctors assisted with the delivery of 84% of the births. This percent is lower among the women of Roma population (70% and women with no education 78%). About 1% of births were delivered with the assistance of relative or friend, and less than one percent with the assistance of traditional birth attendant.

More than 50% of mothers of children that do not live to one year have only primary or less than primary education.

Infant-mortality rates vary between municipalities and between rural and urban areas. Rural and suburban mortality is higher than urban mortality, mainly due to the low socio-economic status. Infants among some ethnic groups such as Roma are at higher risk of malnutrition, poorer health and higher infant mortality (16.8 in 2000 to 13.9 in 2003) (Map 5.1). According to field surveys, more than 60% of Roma families with more than five children live with regular incomes of up to only Euro 70.

Maternal mortality in the former Yugoslav Republic of Macedonia is decreasing, from 11.5 in 1991 to 3.7 in 2003. The 2001 rate was still higher than the EU average of 5.42, but is consistent with pertinent data from other countries from the CEE region (11-15 cases in 100,000 live births), while the 2002 rate is still among the lowest in Euro B+C (WHO, 2006). There is lack of awareness among mothers for the need to use the health services, requiring information and health promotion activities for pregnant women and mothers, especially in rural and poor urban communities. In these communities other factors, such as poor environmental conditions for health, widespread poverty, low education levels and conservative cultural behavior are additional obstacles that need to be addressed at the same time in order to further reduce maternal mortality. Roma mothers often do not have health insurance and can not afford the co-payment and informal costs linked to regular antenatal visits, delivery and postnatal visits, even for

the health services that are free and subsidized by the vertical preventive programs. However, it is obvious that maternal mortality is significantly influenced by socio-economic status, poverty, the level of education, hygiene, by culture, cultural accessibility, religion and tradition (early marriages, frequent pregnancies), lifestyle and risk-taking behavior (smoking, nutrition, drug addiction, alcohol), as well as inadequate health care (antenatal, delivery, prenatal and post neonatal). Public health interventions can directly address these issues and thus emphasize preventive instead of curative activities especially in the primary health care.

In the Interviews with the women NGOs a concern could be noticed for present discrepancy in the health system accessibility (information and services) between urban and rural areas, improper functioning of the health services in the field of reproductive health promotion and rights, especially in the rural areas and in vulnerable groups, such as poor people, low-educated people and Roma population (centers for family planning, consultation units for women, pregnant women, etc.) There is inadequate coverage for women health protection in some regions (insufficient coverage with gynecological offices, mammography). According to their opinion the state does not provide additional measures for motherhood support, as well as providing of proper nutrition during the pregnancy and breastfeeding. If the woman (pregnant or breast feeder) is not insured, she pays all the health services irrelevant of her financial status. There are no legal acts that secure adequate nutrition during the pregnancy or breastfeeding. Abortion is conducted in public health organizations exclusively and in those fulfilling legal requirements, but the costs are very high and they amount up to Euro 75, which is 40% of the average net salary in the country.

In 2005 and 2006 the Government has adopted a Program that estimates 20% of the female population aged 19-65 to receive gynecologic check-up and PAP test free of charge. Field information shows incomplete implementation of the program and problems with expenses settlement for the realized check-ups, further complicated with the ongoing privatization of the health protection system in the country, which results in truncation of the free gynecological check-ups.

Within the “Women and health” program, some NGOs run a Women info center for three years now, providing women counseling and information regarding their reproductive and sexual health free of charge. The NGOs are also concerned about the family planning activities in the country. There is no adequate register and control of contraceptive measures (apart from condoms, all others are women-controlled methods), and those are financially unavailable to a part of the female population in reproductive period.

There is a legal protection in the former Yugoslav Republic of Macedonia which does not allow while official evidence and identification is done, Roma, as well as other ethnic groups, to be registered as minority groups in the national health statistic. These technical problems and limitations do not allow for monitoring of the health situation and health protection of the Roma, as well as monitoring of intervention programs (Government of Republic of Macedonia, MLSP, 2004 - Information about Decade of Roma inclusion).

Therefore, the evaluation of the health status of Roma is done according to the data from relevant directed researches undertaken in Roma population, not from the routine data collected from the health sector.

Most of the researches undertaken so far, show that the overall health situation with Roma is worse than the other population: decreased life expectancy, highest infant mortality rates (twice the average one). Overall mortality in Roma is higher than the

national, which is 8.9%, where mortality in Suto Orizari in 2003 is 11.3%o. Health risks in Roma population should be associated mostly with nutritional deficiency, hepatitis, TBC and posttraumatic syndrome. In addition, general practice in the Roma populated districts noted hypertension at 55% of the Roma patients at age 45. This situation is due to the poor socio-economic status of the population where 90% of the patients are unemployed and 90% have no insurance coverage.

Health condition of Roma children is worse than the one in adults, for low coverage of the children with preventive measures. Mentioned preventive measures, even though are free and provided through the preventive vertical programs are not enough used and implemented within this population, because of lack of information. Immunization coverage is lower than that of other children in the former Yugoslav Republic of Macedonia. Diarrhea, respiratory infections and other contagious diseases are highly predominant in child pathology. Roma children are often victims in traffic accidents, participating with 4.1% in all injured at the same age.

5.1.3 Organization of the Health Care System

The Law on Health Care has established the organizational structure of the system with the Ministry of Health and the Government in charge of health policy formulation and implementation, the Health Insurance Fund responsible for the collection and management of funds and the health care institutions responsible for service delivery (Health Care Law 1993, Health Insurance Law 2000) (Graph 5.1).

Health care is delivered through a system of health care institutions, covering the country's territory relatively evenly (Map 5.2). This makes it possible for around 90% of the population to get a health service in less than 30 minutes. The health facilities range from health care stations and centers at PHC level and specialty-consultative and inpatient departments at secondary level, to university clinics and institutes at tertiary level, with the latter also carrying out research and educational activities. In general, smaller rural settlements are served with general medicine services only. The services of PHC centers at municipal level also include emergency and home treatment, pharmacies, laboratories, X-ray and echo cabinets, preventive TB services, including "polyvalent patronage" nursing services (for details see section on preventive health care below), and dental care. At present the system performs well in some areas (e.g. immunization and antenatal care) and less well in others (non-rational prescription, high referral rates, lack of coordination between different levels of care) (CRPM-Rationalization of Health Care services in the former Yugoslav Republic of Macedonia, 2007).

5.1.3.1 Accessibility of the Health Care Services

The access to and quality of the health care services are problematic in some districts populated with Roma population. In some settlements with inadequate infrastructure of health organizations, health services are difficult for access because of lack of health facility, or work of the medical professionals in one shift only, or only one day in the week, or there is a health facility which can not be used by the patients because of lack of health insurance. This is very important in situation of emergency cases, during pregnancy and delivery.

The quality of health services sometimes is very low because of the poor conditions of the health facility where services are provided, lack of equipment, lack of drugs, insufficient personnel, etc.

All recent analyses of the health sector have indicated that the functional division between the different health care levels is not working well. On the other hand, all reform efforts focus mainly on primary health care level. None of the reforms have addressed the rationalization of the health care services and their equal distribution on regional level. Since the system does not offer any incentive for the doctors or the staff to provide more and better services to patients, many practitioners in the primary and secondary level used to refer the patients to the tertiary health institutions. As a result, the main state hospital complex, the Skopje Clinical Center is overburdened with patients. On the other hand, the regional hospitals delivering mainly primary and secondary health services are underutilized.

Recently the medical centers at municipal level have been functionally and legally divided into primary health care on the one hand and specialist consultative and hospital care on the other. Recent years have seen substantial growth of the private sector, especially in the field of primary health care. General dentistry services have been almost completely privatized (with only preventive dental services still offered in the publicly-owned health centers) and the privatization of specialist dentistry services is under way. However, private primary care physicians do not offer comprehensive care, including all preventive services and emergency care after office hours. This is in line with an amendment to the Law on Health Care in 2005 stating that some services, such as emergency medical and dental care, emergency home treatment, preventive check-ups of pre- school and school children, as well as some patronage services should remain in the public domain.

The situation in 2007 is quite confusing. According to the Ministry of Health sources, in 2005, 607 out of 1,722 primary care physicians (most of them general physicians, pediatricians and gynecologists) were working in private practice. There were 1,937 private primary health care organizations in 2005, out of which around 90% in urban area (RIHP, 2006).

In 2007, the privatization seems to be over (Ministry of Health, 2006). However, the data are scanty and confusing. In fact, the Republic Institute has no reliable information on this. Last set of complete data are from 2005 and they are very unreliable regarding private practice, both in terms of the number of professionals and their activity. Moreover, this data are only of historical interest as the situation in 2007 is completely different. The process of total privatization of the pharmacies is also close to the end.

In 2005 hospital health care was delivered by 67 public hospitals, specialized hospitals, institutes, and specialized departments (clinics) in the Skopje Clinical Centre, as well as by four private hospitals (Graph 5.2, Table 5.4). The general hospitals deliver care in at least five specialty fields: internal medicine, surgery, pediatrics, obstetrics and gynecology and anesthesiology. Some of these hospitals include additional departments, such as ophthalmology, ENT and psychiatry, among others. The hospitals provide emergency services, as well as diagnosis, treatment, rehabilitation, accommodation, nursing and catering services and 24-hour specialist supervision for inpatients. The number of beds in acute hospitals in the former Yugoslav Republic of Macedonia is still lower than in the EU and the majority of the neighboring countries (Table 5.5).

Hospital admission rates are considerably higher than one might expect. In 2005 the average length of stay in hospitals was 7 days in the acute hospitals and 11.1 in all hospitals. These figures are higher than the EU averages for that year. The occupancy rate was 53.7% in the acute hospitals and 64% in all hospitals, figures that are much lower than the EU averages. While the EU countries have been recording a constant

decrease in the number of hospital beds in recent years, in the former Yugoslav Republic of Macedonia the number has been relatively static (475 per 100,000 inhabitants), but at a lower level than the EU average. More than half of the hospital beds in the former Yugoslav Republic of Macedonia are to be found in specialized or tertiary care institutions and the capital Skopje, which shows a pronounced oversupply of beds in this sector.

Specialized hospital care is delivered in six specialized hospitals and seven rehabilitation centers, accounting for 33.6% of the total number of hospital beds in the secondary health care sector. The average length of stay is longer than in general hospitals and ranges from 31.2 days in the specialized hospital for orthopedics and trauma in Ohrid, to 421.1 days in the psychiatric hospitals in Demir Hisar, 136.1 in Skopje, and 143.6 in Gevgelija in 2005 (RIHP, 2006) (Tables 5.6, 5.7, 5.8).

Tertiary health care is delivered in the Clinical Centre in Skopje and specialized hospitals, most of them also located in Skopje. All tertiary health care institutions have taken on board educational functions and are pursuing scientific research activities, alongside delivering secondary health care. Access to tertiary health care institutions is facilitated through referrals issued by doctors in primary health care.

The Clinical Centre in Skopje is the most sophisticated health care facility in the former Yugoslav Republic of Macedonia, providing tertiary health care in a number of specialties. It comprises 22 clinics and institutes, with almost 2,050 beds (Graph 5.2). More than half of the patients come from outside the capital, the average length of stay in the centre is 9.1 days and the bed occupancy rate is 64%.

The total number of beds in all other tertiary units is 1,353. The average length of stay ranges between 3.7 days in the hospital specialized in gynecology and obstetrics in Cair, and 182 days in the Skopje Psychiatric Hospital.

Studies point to a surplus of health personnel. However, there are discrepancies in the numbers among specialties and the ratio of doctors to health professionals. The relative surplus of general practitioners in urban settings can be attributed to better working conditions in urban environments. Rural units very often offer poor facilities, lacking basic equipment. This may be one of the reasons why patients, especially in rural areas, aim to bypass primary care. The official data shows that the capital has more doctors per capita than the other cities. For example, Tetovo a city in the western part (with predominantly ethnic Albanian citizens) has four times less doctors per capita than the capital city. Yet, analyzing the policy of referrals, we can assume that the situation should be favorable for the patients in the small municipalities as the specialists working at primary health care level are supposed to be skilful to treat the patients and thus not need to refer them to secondary level.

Accordingly, the sector experiences difficulties in employing all qualified personnel and there is therefore unemployment among doctors and nurses. Current figures show slightly more than 2 medical doctors per 1000 inhabitants (Graph 5.3, Map 5.4). However, national data suggest that the picture might be distorted and the actual figure is probably more than 3 per 1000 inhabitants, a ratio approaching the average for the EU Member. Some of the municipalities pointed out the unsatisfactory representation of ethnic communities among the stuff in the health sector.

Health care delivery services deteriorated due to lack of managerial skills, as well as the concept of allocation of funds based on pre-defined uses, insufficient needs assessment, centrally controlled procurement procedures, the lack of best practice protocols and drug registries, etc., all of which stem from the previous system.

Although health care institutions are managed by directors, their role is more administrative than managerial. However, in October 2006 the new Government has established a training course for health management and leadership as required qualifications for the future top managers. In parallel with the latest amendments to the Law on Health Care a new managerial system has been introduced with two top managers in the health care institutions (for the medical and economic aspects of the management).

An integrated approach to service delivery with close cooperation between primary- and tertiary-level services is also missing.

5.1.3.2 Public health infrastructure

The prevention of diseases at all levels of care is given special attention in the former Yugoslav Republic of Macedonia. As mentioned above, the health system has very successfully built up preventive health care services, which among others is reflected in very good immunization coverage of the population.

Specialized preventive health care is organized and provided in accordance with the provisions of the Law on Health Care in the Republic Institute for Health Protection in Skopje, the subordinated 10 regional institutes for health protection and 21 Hygienic-Epidemiologic-Sanitary units (Map 5.5).

Since 1993 the regional institutes for health protection have been independent legal entities. The provisions of the Law on Local Self-government of 2002 provide options for these institutes to further extend or modify their roles at local level. The Republic Institute for Health Protection is the top-level scientific institution providing highly specialized preventive health care services. It develops public health guidelines, specifically for social medicine, hygiene and occupational medicine, which also forms the basis of the Medical Faculty's training curricula. Owing to these capacities, the Ministry of Health and the HIF very often draw on the expertise of the RIHP in the field of health policy to develop and take on public health control functions. For example, the RIHP has revised the programme for public health, which could serve as the basis of the "Strategy for Public Health" to be drawn up jointly with the Ministry of Health and to be accompanied by new EU-oriented legislation regulating the public health sector. In cooperation with the regional institutes, the RIHP is responsible for the collection and analysis of health status and care-related data, including the performance of environmental health risk assessments. Surveillance of communicable and non communicable diseases such as HIV/AIDS, cancer, drug and alcohol addiction and injuries play an important role in this context and registries have therefore been established. Special efforts are also devoted to health promotion and health education.

Patronage (visiting nurse) services, as a form of specialized nursing care, also include a series of public health functions. Similar to visits at home, this service is based on family needs, including postpartum visits to mothers and their infants. Unfortunately, there are discrepancies in the number of the patronage visits during the pregnancy and postpartum between the regions. Only 75% of the mothers are covered by this kind of patronage services. Some rural areas where the delivery is still out of the health care institutions are especially at risks. Most of those cases are under registered and can make confusion in the vaccination program. This could be referred also to the situation among the Roma population. In certain regions patronage services have been extended to include preventive and therapeutic interventions related to ischemic heart disease, TB and carcinoma, with these services being termed "polyvalent patronage" (Institute for Health Protection of

Mother and Child, 2005). More emphasis should be put on the improvement of the current patronage services. The patronage nursing system could function as a structure to lessen the burden of the secondary and tertiary health care, i.e. care and treatment for chronic and other diseases can be done at the community level, thus shortening the hospital stay and reducing the costs of higher levels of health care. There is an existing positive experience in the UNICEF projects with the Youth Friendly Services as an effective strategy to carry out health promotion and health prevention activities.

Specific occupational health care activities are pursued by the Institute of Occupational Health, a WHO Collaborating Centre and by occupational health units mainly within the health centers. The latter are currently more oriented towards curative medicine rather than modern preventive occupational health and safety activities. Moreover, most employers are not interested in investing in modern occupational health and safety measures, and many activities at enterprise level have been discontinued and so-called "occupational dispensaries" are closed. Despite the precarious overall situation in occupational health, efforts continue in order to establish the basis for a new model for occupational health services, taking the inter-sector approach into account.

5.1.3.3 Long term care

Social services are provided for vulnerable population groups, such as the elderly, children lacking parental care, individuals with specific needs, minors with behavioral problems, minor offenders, etc. Care is provided in specialized institutions or in ambulatory settings. Traditionally, care of the elderly is provided by their families at home. There are cases, however, where the family is not able to provide such care, especially in certain periods of the year. Care is then provided in specialized hospitals providing beds for prolonged stays to elderly patients. So far only a small number of homes for the retired exist.

In regard to the palliative care system, total number of deaths from malignant neoplasm (2004) is 3,194, out of which male 1,908 and female 1,286. Patients die in health institutions (28.2%), at home (68%) and other places (3.8%).

Major conditions for organization of palliative care in the former Yugoslav Republic of Macedonia have been met in 1998 with the establishment of the first hospice Sue Ryder Care in Skopje, in accordance with the needs and the National plan for development of palliative care in the former Yugoslav Republic of Macedonia. This hospice is specialized institution for palliative care. The provision of services within this institution covers: two specialized institutions for palliative care; two specialized daily hospitals; two specialized ambulatory services; two specialized units for home palliative care; two daily hospitals within the clinic hospitals (oncology, hematology, pediatric, geriatric, centre for pain treatment).

Hospice Sue Ryder Care in Skopje was opened in 1998. This highly specialized institution has four specialized multi professional interdisciplinary teams. In the period of April 1998 to September 2005, a total number of 1,860 patients was covered, with average age of 61.8 years. 80% of the patients treated had malignant neoplasm, 20% chronic progressive diseases. Average time of treatment was 23 days. 60% of the patients died in the hospice, 40 in their homes. Hospice Sue Ryder Care in Bitola, as a specialized institution for provision of palliative care, has been established in 2005. In the period of March 2005 to September 2005, a total number of 162 patients were treated, out of which 70% with malignant neoplasm and 30% with chronic

progressive diseases. Average time of stay was 13 days. 50% of the patients died in the hospice, 50% in their homes.

Home palliative care includes two specialized units, which have started working in February 2005. In the period of February - September 2005, 81 patients were treated, with average length of the treatment of 25.3 days. Malignant neoplasm covered 64% of the deaths and chronic progressive disease 63% of total mortality.

It is expected that the process of transformation and deinstitutionalization of the health care system in the former Yugoslav Republic of Macedonia will enable dispersion of the palliative care on community level and enhance home palliative care throughout the country. Also, this process should support the conditions for establishment of daily hospitals and centers for palliative care.

Care of people with psychiatric illnesses is provided mainly in publicly-owned psychiatric departments with a total number of 1,307 hospital beds in the current three special hospitals in the country (Tables 5.6, 5.7, 5.8). The average length of stay in these hospitals is between 143 and 421 days and the utilization rate is 61-100%. There is a National Program for treatment of the people with mental disorders. In addition, the Government has introduced four more treatment centers out of the hospitals where 370 patients have been treated. There are also uninsured people among these patients. Even though there are improvements in the existing facilities, the situation is still very bad. The ongoing intensive process of implementation of the National Mental Health Strategy (Ministry of Health, 2005) offers possibility for improvement of the situation. The Ministry of Health supported by WHO mental health program, had introduced community mental health centers distributed in various parts of the country. The main aim was the re-socialization of the mental ill patients, as well as their re-integration in the society instead of long term inefficient treatment in the hospitals. In addition to opening of new facilities, the present units of the psychiatry hospitals located outside of the hospitals had been used for this purpose. Currently there are 8 centers in total (3 in Skopje, 2 in Strumica, and one in Tetovo, Gevgelija and Prilep). The day care department of the Psychiatric Hospital in the Clinical Center is also acting as such center. The organization of the service provided in these community centers is through the daily hospital, shelter home as temporary home, social clubs and mobile team for home treatment. In a period of three years, a continuous rehabilitation for about 240 users on day hospital treatment was provided, less than 2% of which have been re-hospitalized.

5.1.4 Decentralization in the health care system

The former Republic of Macedonia represents a case study of a system moving from highly decentralized to more centralized structures. However, at present the political aim is to move back to a decentralized system. The system in place in the Socialist Federal Republic of Macedonia (pre-1991) was highly autonomous and decentralized, with health service provision and financing controlled and managed at municipal level. With the transition to an independent country, there was a need for central health planning and for this purpose the Ministry of Health was established in 1991. The Law on Health Care was adopted in the same year, setting out a process to centralize the financing and stewardship functions, at the same time aiming to preserve some autonomy for the provider structures at local level. Against a background of limited resources, the need for an effective central planning infrastructure took precedence over the development of a management role at regional level. The establishment of the Health Insurance Fund contributed to the further strengthening of the central strategic and operational planning.

However, amendments to the Law on Health Care of 1995 acknowledged the importance of local involvement in decision-making and therefore proposed the establishment of management boards in the health care institutions. Initially, the latter were composed of representatives of the employees and representatives appointed by the Parliament of the former Yugoslav Republic of Macedonia. In 2004, the boards for PHC facilities were extended to accommodate municipal representation.

The central challenge in this process is how to harness the potential power of decentralization as a means to help achieve existing Ministry objectives for the Macedonian health care system. Decentralization needs to be designed in such a way so that it does not interfere with, or weaken, the ability of the country to achieve its central health system goals. A major issue will be ensuring that decentralization does not increase inequities in access to necessary services and/or in the quality of services received between different localities or between different population groups.

The current proposed decentralization in the health sector is in the outpatient services – primary, outpatient specialist, and emergency care – provided in the Health Houses, located in many municipalities in the former Yugoslav Republic of Macedonia. The hospital sector in the former Yugoslav Republic of Macedonia is currently not an attractive management possibility to the municipalities. Moreover, most municipalities presently do not have adequate managerial personnel or expertise to take on the additional burden of managing the hospitals. Lastly, it is well known that hospitals present a much greater danger because, if they are inadequately managed, they can build up high debt levels that will require substantial additional funds from the national level (a financial dilemma that primary care generally does not present).

However, hospitals have recently started to receive annual budgets, thus providing for greater independence of the directors and management boards of the respective institutions. Furthermore, for contracted hospitals a set of performance indicators has been introduced to support monitoring functions.

Increased autonomy of health care institutions will require adequate regulatory structures to be put in place. In addition, the institutions will need to be granted some degree of autonomy in the planning of human resources, i.e. the right to hire new staff or to end contracts.

According to the interviews conducted during the study, currently only some preventive public health activities are managed by the local governments (disinfection etc.). In the absence of clear legislation, the municipalities are cautious about taking on health sector responsibilities, especially in the area of care provision. They are still trying to digest their newly acquired management responsibilities in the education sector, and worry that health care is too large and too expensive for them to be able to manage it effectively. Yet, they want better quality health services to be provided for their inhabitants, and some municipalities would like to shift some resources currently going to primary care into needed specialized services.

A series of related concerns can be raised as well as pre-conditions to be fulfilled in order the new decentralization plan to be successful. There should be a way the municipalities to be encouraged to help make decentralization in the health sector successful. The proposed decentralization of the PHC institutions should be structured in a manner that can minimize constant disputes between municipalities and the national government over the adequacy of national funds transferred to the municipalities for this purpose. The proposed decentralization of the Medical Centers

to the municipalities should be structured to reinforce and strengthen the ongoing privatization of primary care physicians and of their offices inside the Medical Centers. Decentralization offers a major opportunity to the Ministry to structure the future relationship between the municipalities and the newly private general practitioners. The new health sector decentralization should synchronize its approach to municipal responsibilities so that the MH requirements can piggyback on the existing management control systems that the international agencies have helped develop and put it into place. The proposed decentralization of the Health Houses should be structured to help reduce the rates of unnecessary referrals from primary care to hospital (both emergency and outpatient specialist services). The outcome of the new relationship between the municipally run Health House and the private general practitioners should be one in which patients are encouraged to visit and also willing to receive more of their health services from their GP (by creating an inviting environment in the Health Houses, ensuring good building cleaning and maintenance, etc). The Ministry should strengthen existing monitoring and evaluation personnel to ensure that the municipalities conform to the terms of the signed contracts for operating the Health Houses. Decentralization requires stronger regulation and enforcement than direct ownership of health facilities, with well-trained and well-motivated inspectors to ensure compliance by independent municipal decision-makers.

Apart from municipalities being involved in the management of local health care facilities, the Law on Local Self-government also envisages municipalities having more competencies, especially in the areas of health promotion, preventive activities, and occupational and mental health, as well as in the provision of healthy living environments. To this end the MH plans to empower local representatives to play a more proactive role in problem assessment and analysis, priority-setting and health promotion activities. Such initiatives include, for example the newly established training course (jointly between the Ministry and the Medical Faculty) for the health managers and leadership, the Healthy Communities Project, the decentralized governance and management of the Medical Faculty and the Open Society Institute's joint health project, the Health, Environment and Safety Management in Enterprises (HESME) initiative, the Environmental Health Action Plans, etc.

5.1.5 Financing of the Health Care System

Following independence at the beginning of the 1990s, former Yugoslav Republic of Macedonia set up an insurance-based health care system with the Government and the MH providing the legal framework for operation and stewardship, and the HIF being responsible for the collection of contributions, allocation of funds and the supervision and contracting of providers.

Equity, solidarity and reciprocity, as well as the provision of universal coverage for the population, have been defined as its core values. Payroll-dependent contributions are collected and the funds are managed by the HIF. Together with the MH, the HIF steers the sector and agrees contracts with service providers. Health insurance coverage is universal and the benefits package comprehensive. A decision has been made this package to be revised and put in line with the available funds, as well as to transfer some of the financing responsibilities to other sectors.

The costs of acute hospital treatment for insured patients are covered by the compulsory health insurance, as well as by patients' co-payments in accordance with the legal provisions.

The MLSP covers the health insurance of financially deprived and socially vulnerable people, individuals with specific needs and population groups such as war veterans and their families. Via the pension funds the MLSP also indirectly covers pensioners' contributions. For treatment in specialized facilities, such are specialized geriatric institutions, for example, patients have to cover certain costs by themselves, such as those related to accommodation and catering. Depending on the financial resources of the individual in question, these payments can represent a significant financial burden. Socially vulnerable individuals may have their costs covered by the MLSP. Long term care for about 1,500 individuals in psychiatric institutions is covered by the HIF, as well as by the state budget through a special Program.

The funds generated by the collection of contributions represent the main source of financing of the health sector in the compulsory health insurance system (Graph 5.4). In 2005 the contributions accounted for more than 95% of the public resources available for health care delivery and other health insurance-related benefits and activities. In the same year, the revenue generated from contributions, specifically the share coming from gross salaries and allowances, was highest (around 59.5% of the total revenue), followed by contributions from pension and disability insurances (22.6%), contributions for temporarily unemployed people (13.2%), and finally contributions from the MLSP, providing insurance coverage for war veterans, social beneficiaries, etc, with a share of less than 1%. Co-payments by insured people and transfers from the state budget (to finance a number of preventive programs) constituted additional, though rather small, sources of revenue. Other revenue, including donations, is not available on a regular basis and in 2005 did not exceed 5%. The data shows that contributions from salaries and allowances as a share of the total revenue were declining (from 70% in 1995 to 59.5% in 2004), while contributions for temporarily unemployed people were rising (from 2.26% in 1994 to 13. 2% in 2005) (Table 5.9 and 5.10). The predominant contributions from the salaries are coming from the public sector. The contributions from the private companies and agricultural sector are rather symbolic (Table 5.10). These trends reflect the difficulty to follow and control the labour market in terms of records of employed, which does not reveal the real state of affairs in the private and agricultural sectors. Even though the contributions for unemployed people constitute a financial burden for the central budget, political support remains strong for having payroll-dependent contributions into a single health insurance fund, representing the main source of health system financing.

As stated by the Director of the HIF, the HIF of the Republic of Macedonia has repaid all its debts presenting the Fund's financial results in the first half of the year. After decade-long debts, it took several months for the Health Insurance Fund to repay the debts, mainly toward suppliers of medicines and medical equipment. Fund's Director added that Fund's overall debt was cut down for more than 6 million euros. The overall debt of health sector, including the public health-care institutions, was cut down for Euro 26 million.

The people contribute a quite significant proportion to healthcare costs through out-of-pocket payments. These out-of-pocket payments take the form of co-payments, unofficial payments, payments for services that are listed in the statutory package but are not available, or services that are outside the existing benefits package. According to some analysis the combined HIF and out-of-pocket expenditure on healthcare therefore is approximately Euro 300 million of which the out-of pocket expenditure is some 25%, which is a relatively high figure when compared to most western European countries.

5.1.5.1 Coverage

Insurance coverage encompasses nearly the entire population. The numbers of insured persons is increasing. Accordingly, in 2006, 1,938,760 insured people were registered, but it is estimated that at present approximately 150,000 citizens of the former Yugoslav Republic of Macedonia are for one reason or another not covered by social health insurance. Of the registered insured inhabitants, over 86% pay contributions; most of the remaining 14% are unemployed. In the structure, 54% are active insured persons and almost 46% are members of the families (Table 5.11). As stated above, contributions are payroll-dependent and insured individuals can be grouped into seven categories. General coverage includes employed and self-employed individuals (21.83 %), people working in the agricultural sector (0.93%), temporarily unemployed people (14.13%), pensioners (16.16%), disability insurance-related beneficiaries, war veterans, social welfare beneficiaries, etc. It is indicative that the most visible increase is among pensioners – 16,072 new pensioners in 2006 compared to 2005. The number of new unemployed insured persons is also bigger with 5,786 new persons in 2006. Representatives of some ethnic communities, as well as other vulnerable groups are among the uninsured. Aiming to provide basic health care services to some vulnerable groups (approximately 2,880 pregnant women, and that many infants, approximately 5,000 uninsured children, approximately 8,000 uninsured persons older than 65 and approximately 5,000 uninsured persons without prejudice of their age who were diseased by serious diseases), the Government, through a special program provides resources from the Budget to cover the health care costs of this group. However, in practice those funds provided by the Government are insufficient to fulfill the commitment (MH annual preventive programs).

The revenue of the HIF is insufficient, in view of the necessary expenditure, on items such as expensive treatment procedures or expensive drugs. However, many working citizens fraudulently register themselves as unemployed in order to receive free health care (upon registration as unemployed the individual receives a set of coupons which form the basis for health service delivery). The current plan in the reforms is all citizens to be entitled to one basic benefits package financed via compulsory social health insurance organized by the HIF. That means that the presently non-insured citizens will be included in the social health insurance system, starting from 1 January, 2008. Although precise numbers are missing, it is more or less known who these non-insured persons are: citizens who have left the country with or without informing the civil registry in their place of residence; employees for whom the employer has not paid the contributions, either permanently or temporarily; self-employed or otherwise independent persons who have managed to escape the payment of their compulsory contribution; persons without proper documentation.

Data on out-of-pocket patient payments and the financial burden they might constitute are neither detailed nor precise. However, there is some evidence that direct cash payments are also increasingly taking place in public facilities, and this should be monitored closely, perhaps through household budget surveys, as this might allow an assessment of the discrepancy between reported co-payments and actual household expenditures.

To be entitled to use the full range of benefits, the insured has the right and the obligation to select a doctor in the PHC sector, i.e. a GP, as a gatekeeper.

5.1.5.2 The Basic Benefit Package

The basic package of health services currently includes the following items:

(a) In primary health care: health status check-up; medical measures and procedures to improve the health status of the individual, including the implementation of preventive, therapeutic and rehabilitation measures; provision of emergency medical aid, including ambulance transportation when necessary; treatment at the beneficiary's home; health care related to pregnancy and child delivery; prevention, treatment and remedy of oral and dental diseases; drugs included in the positive list of drugs.

(b) In specialized and consultative health care (based upon referral from the selected PHC doctor): anamnesis and diagnosis of diseases and injuries; specialized therapeutic and rehabilitative procedures; prostheses and other appliances, auxiliary medical devices and materials and dental prosthetic devices, according to indications.

(c) In hospital health care (based upon referral from the previous levels): diagnosis and treatment of diseases and injuries, rehabilitation services, nursing services, accommodation and catering for the hospitalized; drugs included in the positive list, as well as auxiliary materials; up to 30 days accommodation and catering for an escort of a hospitalized child up to three years of age.

Especially in the context of hospital care, insured individuals and their family members are entitled to reimbursement for travel and subsistence expenses (if necessary including a professional escort), the latter only applying, however, to cases when patients are required to use health care services outside their place of residence, for example for dialysis, or for sight, hearing or speech outpatient rehabilitation, or treatment abroad.

As mentioned above, health promotion and disease prevention measures and activities represent an important part of the BBP. The programs covered include: prevention, detection and elimination of communicable diseases; comprehensive health check-ups for children, pupils and students; women's protection in pregnancy, child delivery, nursing and family planning; infants' and young children's health care; health promotion; and programs aiming to prevent substance abuse and drug addiction.

In addition to the coverage of health care services as grouped in the BBP, compulsory health insurance provides financial compensation (e.g. for sick leave, pregnancy and maternity leave). Over the years, these items have represented substantial budgetary expenses for the HIF (6-10%). To this end, recent reform initiatives aim to alleviate this problem and limit HIF expenditure.

The current benefit package is considered very comprehensive and very costly. In view of the low level of revenue, it is felt necessary to review the package by comparing it to international practices and taking into account demographic and epidemiological characteristics, as well as fiscal sustainability issues. The revision process is ongoing and currently the design of one universal type of package is being considered: an essential package for all citizens (including preventive check-ups, immunization, coverage of part of the positive list of drugs and treatment of a range of communicable diseases). There will be also a clear definition of the negative list, i.e. health services that will not be provided under social health insurance. For such services the patients will have to pay user fees. However, all citizens will have the opportunity to purchase voluntary private insurance for these services and to cover the cost of co-payments.

5.1.5.3 Co-payments and exemptions

Co-payments have been introduced to counteract any excess use of health services or consumption of drugs, as well as to provide additional resources for financing the health care system. While originally not part of the National Health Plan, co-payments were introduced in 1992 by a ministerial decree. The co-payment regulations were reviewed in 2000 and in 2001 a new decree on co-payments was issued. Co-payments have to be made by insured people for the use of health services and drugs at all levels of care and a list specifies the services and drugs concerned. The maximum co-payment is set at 20% of the total cost of the health services or drugs in question, at 20% of the total cost of approved treatment abroad and at 50% of the cost for prostheses and orthopedic appliances. Co-payments are set in fixed amounts as inverse variations of the prices for health care services, i.e. the co-payments for more expensive services are fixed at a proportionally lower percentage and vice versa.

While assessing the scale of co-payments, an individual's social status is taken into account. For example, insured individuals with a family income below the average net salary are entitled to pay lower co-payments. Special conditions and/or exemptions also apply for children under five years, youths from 5 to 18 years and insured people over the age of 65. Exemption from co-payments applies to the following population groups: children of families below a certain annual threshold income; beneficiaries of regular financial support, and those accommodated in social welfare institutions or foster families; mentally ill individuals; insured individuals in need of prostheses for upper and lower extremities, hearing prostheses, orthoptic appliances, wheelchairs, or medical appliances supporting the function of physiological ingestion and excretion.

Some services, such as a medical examination by a general practitioner or a call to the emergency services, are exempt from co-payments.

A number of preventive programs are also exempt from co-payments, including: mother and infant health programs and health care services, drugs and other expenditure incurred at delivery or for treatment of children up to one year of age; comprehensive health check-ups for school students of all age groups; compulsory immunization programs; treatment of a number of non-infectious and infectious diseases; medical examinations and treatment of patients with TB, brucellosis and AIDS; inpatient treatment of drug addicts in acute condition (up to 30 days) , blood donation program and alcohol and drug addicts treated in walk-in centers (up to 30 days).

Furthermore, the treatment of dialysis patients, drugs for the treatment of patients after organ transplantations, treatment of malignant diseases (including chemotherapy, radiotherapy and surgery), treatment against diabetes, hormone treatment for child growth and treatment of hemophilia are also exempt from co-payments.

Co-payments are usually used to discourage excessive use of health services and to generate revenues for the health care system. Co-payments are often criticized because they may limit access to needed health services, especially for the poorer segments of the population. Therefore, they usually require exemptions for vulnerable groups which may be difficult to administer. However, the MH and HIF are confident that they can manage a just exemption system in the country's social health insurance by targeting the right people and calculating the correct deductions and exemptions. Usually, the most socio economically deprived population is seen as the primary target group for exemptions, but sometimes other groups (for example

the elderly) are also proposed. For an exemption policy to work, the total exempted population should not exceed a certain percentage of the beneficiaries. Apart from vulnerable persons, there is also a possibility of exempting the treatment of certain diseases, such as some communicable diseases.

When there is insufficient public funding for the BBP, co-payments cannot be avoided. The alternative would be to add services to the negative list for which user fees must be paid or private insurance must be purchased. Regular adjustment of co-payments and of the negative list will be used to maintain the sustainability of the BBP.

The present co-payment situation is regulated by articles 32-36 of the Health Insurance Law and a General Act of the HIF. For many services and drugs, approximately 10% co-payment is required, with a certain maximum per year and with certain exemptions. Co-payment revenues should be transferred by the provider to the HIF. The HIF could possibly expect roughly Euro 15 million per year from co-payments, but in reality only half of this amount is received. It seems that some co-payments are either not collected or not transferred to the HIF. At present, co-payments account for only 3% of HIF revenues.

It is open for discussion for which services under the future BBP co-payments will be charged, and at what level. A suggestion could be: all drugs and the more sophisticated diagnostic tests in primary care, and all diagnostic and therapeutic services in secondary and tertiary care, including drugs, with certain exemptions and with a maximum per patient per year. The co-payments can be expressed as amounts in Denar or as percentages of the costs of services. The financial analysis of BBP services to be carried out during May-September 2007 will provide more insight into the required level of co-payments and the size of the negative list.

There appears to be agreement that from 2008 onwards the provider will collect and keep the co-payments, to be used for the facility and its staff. This will be an incentive for proper collection of co-payments. Such revenues for the facility will be subject to income tax. The HIF will reimburse the provider for the cost of the treated patient with deduction of the co-payment.

The MH is responsible for a total of 13 special programs that are actually a mix of individual prevention, collective prevention (public health) and medical (curative) care. The total cost of these programs in 2006 was estimated to be around Euro 15 million, of which only 65% is allocated for 2007 from the regular budget of the MH. However, the MH has received no revenues from the promised tobacco tax, and it has also not provided all required funds from the regular budget. It is not clear to what extent the 13 programs have been implemented, but it appears that the immunization rate of children has not suffered from the lack of funds. Apparently, some funding has been provided by other means, but it is obvious that the financial foundation of some of these “preventive programs” is insecure.

The beneficiaries of the 13 programs are: uninsured patients (to cover the cost of treatment of specific diseases), insured patients (to cover the co-payment for specific services), and the whole population (for public health activities).

The health sector is faced with ever rising costs and consumer expectations. This is contrasted by a volume of revenue from the collection of contributions that is not expected to rise in the near future. The HIF has already accumulated a significant deficit. There is also fragile financing of the preventive programs and the insufficient resources for capital investment. The HIF has submitted an official request to the

Government to improve the transfer of funds.

In the last few years the low living standard influenced the health of poor people. The recipients of social benefits, who are registered in the EA as unemployed, receive health insurance, but the costs that should be born for their health treatment would be huge burden of their already modest family budget. This is especially the case for the chronically ill people who need expensive medicaments. Despite the benefits from the current regulation, such as the Health Insurance Law, by-law of co-payment and preventive program for uninsured persons, there is a need to secure better accesses for poor people to the health services. This refers to prescription drugs or to partial financing of the costs that restrict the access to necessary treatment.

Roma population face several difficulties when using the rights for health insurance and protection: lack of information and knowledge of the rights; Macedonian citizenship (according to the last Census, about 23% of the people without citizenship are Roma); need for at least finished primary school to have the status of unemployed person and the right for health insurance; difficulties in achieving the right for social protection; members of the family of the insurer are covered by health protection only if in official marriage; distance of the services of the HIF and difficult access to the services.

A major feature of the economic transition in the country has been the shift in the burden of health care costs from the state to families and individuals. This has happened formally, through introduction of co-payments for health services and drugs, and informally, by informal, under-the-counter payments. Both formal and informal payments have increased dramatically. Reduced access to health care has been especially great in rural areas, where the migration of health professionals to cities, coupled with inadequate investment in equipment and facilities, has led to the loss or deterioration of services. The withdrawal of subsidies for drugs has hit hard many people, in particular those with chronic diseases, whose illnesses often prevent them from working.

5.1.5.4 Payments of the health care services

In the past, the payment system failed to exert proper financial control over health institutions: the planning of health services and their financial resources and the procurement of drugs and medical materials were jeopardized as the limited availability of financial resources on the one hand, and insufficiently developed information systems on the other, prompted the health institutions to present more services for reimbursement than were actually delivered.

Owing to these developments, the payment system has been replaced over the years by a system based on transfers of funds to cover salaries and allowances for employees, drugs and other medical materials, as well as part of the running costs, thus providing the financial resources required to cover the minimum needs of the health care institutions. Despite the fact that in the majority of cases the level of transferred resources does not directly reflect the type and volume of health care services delivered, many health care institutions continue to submit invoices with high figures for reimbursement. Financial planning is further aggravated by the provision of a scale and volume of health services that had not been anticipated beforehand and/or the financing of services and hospital departments that lack sufficient utilization. With needs assessment only carried out to a limited extent, different activities are established for different regions and staff is employed without taking appropriate account of the real needs.

This is contrasted by the fact that health care institutions have to cope with increasingly poor working conditions, in which basic infrastructure and consumables for the appropriate treatment of patients are lacking, and very limited funds are available to procure new equipment.

In 2001 a separate act on the introduction of capitation-based payment for health services in the PHC sector was prepared and adopted. Implementation of the act started in July 2001 with the agreement of contracts with a number of private primary care physicians. The calculation of capitation fees for the individual physician was based on the number of insured people who had registered with the respective practice, as well as a point system taking different categories of insured people into account. Additional incentives have been offered to physicians working in PHC facilities in remote rural areas. Payments are made monthly, in the current month for the preceding one, and cover 70% of the calculated capitation fee. The remaining 30% is billed at the end of each quarter, based on quarterly reports on the activities performed to achieve the agreed goals. The payment method described does not facilitate assessment of whether payments have been fair, nor whether services have been provided in an efficient or high-quality manner. However, initial analyses indicate that patients are paid greater attention, efficiency of work is stimulated and better control is exerted over expenditure in health care institutions. Fees have been defined for preventive check-up services, rational prescribing, referrals and the issuing of sick-leave certificates.

In 2005, the capitation-based payment system was extended to PHC-based dentistry services with a dentist-to-population ratio of 1 to 2,000 in urban areas and 1 to 1,600 in rural settings.

Capitation-based payment for health services in public primary care facilities is expected to commence in the near future, following the implementation of a law amending and supplementing the Law on Health Care.

In 2003, new regulations on the payment of secondary-level care, i.e. health services in specialty-consultative and hospital health care were developed and adopted. The regulations envisage the introduction of a system based on diagnosis-related groups. In 2005 the pilot phase of the new payment system was initiated in a selected group of contracted hospitals.

The new reimbursement system is expected to improve the motivation of health professionals, as well as the efficiency and quality of services. The accomplishment of targets will be monitored, based on an agreed set of clinical performance indicators. New Clinical Guidelines prepared by the Macedonian Medical Association have been also introduced. Full implementation of the system is expected by 2008. During the transitional period (2004-2008) a combined system of fund allocation for health care institutions is in operation and an agreement between the individual health care institutions and the HIF constitutes the basis for payment. The calculation of the actual volume of funds transferred to the individual facility is based on the expenditure and the health services provided to insured individuals in the course of the preceding three years, as well as the types and volume of health services to be delivered and the goals agreed. The structure of compensation is specified for each transition year, with a basic level of compensation, i.e. a fixed share that is not dependent on the volume of services delivered, gradually decreasing over time.

The implementation of the diagnosis-related groups-based payment system will be hampered by the facilities' deteriorated infrastructure, owing to the long absence of capital investment. Furthermore, the enhancement of staff performance may depend

on willingness to grant managers the right to reward staff and/or to make employment decisions in general.

The new changes in the payment policy and introduction of the annual budget approach are intended to represent a mechanism to stop the growth of hospital debts and to generate performance accountability. However, efficiency gains in individual health care institutions are hampered by the fact that facilities are not empowered to provide financial incentives to staff, or to make human resources planning decisions. Moreover, at present approaches to, and examples of, more cost-effective models of ambulatory care delivery at secondary care level, such as day surgery, day care for the elderly and the chronically ill, rehabilitation programs, patient hotels, etc., are scarce. Underinvestment in technologies to support some of the more cost-effective treatment regimes, such as minimally invasive surgery, is also a problem.

5.2 Evaluation of recent and planned reforms

5.2.1 Public awareness about the health care system and reforms

There were several public opinion surveys performed in the country - the first one was in 2001. The poll was conducted among a representative sample group of 1,600 persons in the country (Institute for Sociological and Political-legal Research, 2001).

The reforms in primary health protection services have been positively evaluated by only 10% of those polled. More critical against this issue are the older groups, as well as those of higher education and the agrarians.

The cost and the availability of medicines have been positively evaluated by only 10% of the respondents. The most dissatisfied categories are: the persons suffering chronic diseases, those of lower education and the pensioners.

Specialist's checkups have been positively evaluated by 1/5 of those polled, whereas over 30% of the respondents evaluate them as average. Greater dissatisfaction is evident among: pensioners, unemployed and respondents from the Albanian ethnic community.

The majority of the respondents share the opinion that the health services shall be improved if the outpatient departments are made private.

There are a particularly great percentage of polled persons that have already chosen a personal physician (about 90%).

The institution "personal physician" has mainly been positively evaluated (over half of the respondents), particularly by the older and more educated groups.

The answers to the question "Where savings can be made in health services?" are mainly about prevention and acceleration of administrative procedures.

The greatest number of respondents (36%) considers that all the health services must be made available without participation in their cost. Among other answers, the following are distinguished: preventive checkups and treatment of chronically ill persons.

The greater number of respondents follows the reforms in health services (only 12% declare that they are not interested). The most interested are: the older persons, the more educated and the chronically ill.

Less than one third of the respondents declared that they know about their rights as health insurers. Better informed are the older, as well as the more educated respondents.

The results from the focus groups have revealed women's dissatisfaction about not existence of specialized family planning counsel units. Women usually get the information from busy gynecologists, those not having enough time to spend with them and provide adequate and quality information. Some of the women have received such information within pre-marital counseling, but they still believe that main source for such information should be the gynecologist. Deficient accessibility to health services and information was especially anticipated by women coming from the rural areas. At the same time, the lack of health insurance has been addressed as a problem, especially in Roma and agriculture women.

The second polling was conducted during 2006. Only 56% of the respondents (including the rural population) are completely satisfied with the services of the selected PHC doctor. The majority has negative impressions from the quality of the hospital services, much more common the rural areas or smaller cities (60% of the respondents), especially the food quality, lowest level of hygiene, generally bad conditions, bad behavior and attitudes of the staff. The bad quality of the services and bad conditions in the institutions, as well as the corruption are among the most frequently emphasized problems, followed by shortage of drugs from the positive list, insufficient organization and efficiency of the services provided in the state owned health sector. Some of the respondents mentioned the bad management and low salaries in the health sector, as well as insufficient information of the providers and patients, as equally important problems which leads toward bad impressions about the system.

5.2.2 Recent Health Care Reforms

Since the independence, the former Yugoslav Republic of Macedonia has embarked on a number of reform initiatives in the field of health care. All reforms have been undertaken with the aim of sustaining access for the whole population to a comprehensive health system, as well as improving the quality of health services and enhancing the financial sustainability. At present these reform priorities still hold true: the objectives are to improve the health of the population by improving access to and quality of basic health services; to increase the efficiency of service delivery, thereby enhancing cost-effectiveness and fiscal sustainability; and to improve patient choice within the health system.

A number of reforms have been very successful and brought about positive changes in the health sector. Preliminary surveys regarding the introduction of capitation-based payment systems for primary care, for example, have highlighted that job satisfaction for physicians, and service delivery, could be improved. Furthermore, the MH focus on improving the quality of neonatal and prenatal health care services by providing training to doctors and nurses on the use of evidence-based protocols and the provision of adequate equipment resulted in a remarkable 21% reduction in neonatal deaths. In the pharmaceutical sector, training on the rational prescription of drugs in the PHC sector has been conducted, a Drug Information Centre has been established and international tendering processes for the purchasing of drugs have been carried

out, which has led to a significant reduction in prices for the drugs in question (WB Health Sector Transition Project, 2002).

Despite these improvements, substantial challenges remain. The political and economic uncertainties since the early 1990s have had a strong negative impact on the health status of the population, as well as on the health care system in the former Yugoslav Republic of Macedonia in general. The current system has yet to overcome the legacies of the system that existed until 1991, including oversupply of medical staff, especially in the PHC sector; strengthening continuing medical education and addressing low morale among staff; the as yet remaining rationalization of health care facilities in order to redistribute limited resources more effectively and thereby improve the infrastructure of facilities; the low quality of PHC services, leading to low levels of patient satisfaction and high referral rates to higher levels of care; high expenses for drugs and hospital care; the limited solvency of the sector and the HIF altogether, with the latter facing a substantial deficit. Decentralization is an important policy priority for the Government. So far the impact on the health sector has been limited, although the Law on Local Self-government essentially mandates the representation of local authorities on the boards of health facilities and provides the local communities with some responsibility for the design of health promotion and disease prevention programs.

All players in the field need to improve performance and enhance transparency and accountability. Performance measurements of the doctors and the services at all levels should be introduced to ensure efficiency of the human resources and utilization of the equipment and the available technology.

There are three key development challenges and opportunities for the health sector:

- achieve sound public expenditure management, especially through an increased emphasis on extra budgetary institutions which includes the HIF;

- assure undisrupted delivery of health services in the context of decentralization;

- guarantee the quality, efficiency and access to health services;

In order to meet the demands for high quality accessible health and long-term and expensive care, the National Health Strategy recently adopted by the Government has launched the following basic priorities in the health sector: improvement of the population health status, increased efficiency and efficacy of the health care system through institutional and structural reforms in the health care provision, modernization of public health care system according to the EU standards, improved planning of the human resource base in the health sector and introduction of quality assurance system, and last but not the least, reforming healthcare financing by introducing stronger accountability and transparency and linking the financing to better healthcare outcomes.

5.2.3 Ongoing and Planned Health Care Reforms

The former Yugoslav Republic of Macedonia has received a Specific Investment Loan from the World Bank in amount of US$ 10 million for the Health Sector Management Project.

The objectives of the project are: (i) to upgrade MH and HIF capacity to formulate and effectively implement health policies, health insurance, financial management

and contracting of providers; and (ii) to develop and implement an efficient scheme of restructuring of hospital services with emphasis on developing day-care services and shifting to primary care. The project comprises the following components:

- **Component 1: policy formulation and Implementation:** to assist the MH in implementing critical functions, such as policy and strategy formulation, monitoring and evaluation of health reforms and public information and communication. The component includes three sub-components: (i) support to overall health policy and strategy development, (ii) public relations and communications, and (iii) improving MH management and business processes;

- **Component 2: strengthening HIF governance and management:** to improve governance and management of the HIF as the organization responsible for purchasing health care services for its beneficiaries under the compulsory health insurance scheme. The component includes three sub-components: (i) eligibility criteria and revenue collection, (ii) HIF management, and (iii) purchasing functions;

- **Component 3: improving service delivery:** to improve the quality and efficiency of health care providers by supporting development of staff skills, introduction of new management methods and instruments and essential upgrades of units selected to implement well defined sub-projects. These improvements will enhance the management and operational capacity of health care providers, putting them in a better position to respond to the challenges and incentives of new contracting arrangements with HIF. The component includes two sub-components: (i) hospital management and primary care, and a (ii) Grant Facility for Improving Service Quality and Efficiency;

All other policy changes in the sector are directly or indirectly linked with these main areas of activities.

Recently the Government decided to transform the Skopje Clinical Center, the biggest health facility in Macedonia, which will break up into 30 separate public healthcare facilities. The decision envisages forming of four institutions, while the remaining facilities will include the clinics, a public facility and joint services that will be in charge of the logistics of the newly formed institutions. As stated the newly formed facilities will start operating with cleared debts. The joint Service will take over all liabilities and the funding of the new institutions will be carried out through the Health Insurance Fund and from own incomes.

The Government also promised a new investment of Euro 40 million in medical equipment for the purposes of the state owned health care facilities. The Prime Minister specified that 75 percent of the funds will be provided by the HIF and the rest will be covered through allocation from the State Budget. The equipment will be procured on the basis of a tender, scheduled for announcement by the end of July. As stated, as many as 32 hospitals will be supplied with the latest technology, the most up-to-date in the region.

There are also plans for transformation of the current Military Hospital into the public health care system in accordance to its size, capacity and the skills of the personal.

5.3. Conclusions

Since independence in 1991, the former Yugoslav Republic of Macedonia has been facing various structural, economic and political challenges, in light of which the preservation of the publicly-funded health system is a success in itself. The coverage

of the established compulsory health insurance system is in effect universal and the current benefit package comprehensive, but also very costly.

At present the system is facing a number of challenges, including the need to overcome the legacies of the health system that was is place until 1991. These include: strengthening of human resources planning and training, the rationalization of health care facilities to redistribute limited resources more effectively and thereby to significantly improve the infrastructure of facilities, as well as the quality especially of primary care services. In this context the reorganization of medical centres at primary health care level, very ambitious privatization trends on the same level and reforms regarding the remuneration of providers – with the introduction of a capitation-based system at primary health care level and an annual global budget allocation for inpatient care based upon performance indicators – represent important developments.

The Conditional Cash Transfer project, supported by the World Bank will aim at alleviating poverty, while working towards improving the future opportunities of recipients. This can be done through conditioning existing cash benefits on behaviors that build human capital, such as pre-school and primary school attendance, take-up of primary health care, especially during the pre- and peri-natal phases, and attendance of parenting classes. Target groups are benefit recipients, such as the economically vulnerable (currently receiving the so-called temporary social assistance), and parents of children with special needs (receiving the so-called special allowance). Through this targeting, the Project de facto benefits the marginalized, including rural populations, those with special needs and vulnerable communities (such as Roma). Those groups will be stimulated to properly use the essential health care services, which will significantly improve the health profile of such groups.

Overall, sustainable health financing will need to be secured, including adequate funding for the public health services; population based preventive programmes and capital investments. Another challenge is the decentralization process which is in the very early stage. To this end, the MH will need to strengthen its policy formulation, implementation and monitoring capacities, while the HIF has started to enhance its budget planning, monitoring and reporting instruments. So far the quality of the information system has not sufficiently supported this process. However, in a few strategic documents the country has put a special emphasis to provision of and improving health care services of some vulnerable groups. The strengthening of the health promotion activities, as well as proper transparency of the changes will be also among the challenges in this process.

References for Chapter 5

European Health for All Database (HFA-DB) [online database]. Copenhagen, WHO Regional Office for Europe, 2005 and 2006 (http://www.euro.who.int/hfadb)

Center for Research and Policy Making- Rationalization of Health Care services in the former Yugoslav Republic of Macedonia, 2007

Government of the Republic of Macedonia, Ministry of Labour and Social Policy - Information about Decade of Roma inclusion, 2004

Government of the Republic of Macedonia - UNDP, Report on Millennium Development Goals, June 2005.

Government of the Republic of Macedonia, Ministry of Health, Mental Health Strategy, draft paper, 2005

Government of the Republic of Macedonia, Ministry of Health, Health Care Strategy, draft paper, 2006

Government of the Republic of Macedonia, Ministry of Health, Information about the progress in the privatization process in the health care system, 2006

Health Insurance Fund (www.fzo.org.mk)

Institute for Health Protection of Mother and Child, Annual Report 2005

Institute for Sociological and Political-legal Research, Public opinion survey about the reforms in the health care services, 2001

Law on Health Care, "Official Gazette of the Republic of Macedonia" nos. 38/91, 46/93, 55/95, 10/04, 84/05

Law on Health Insurance, "Official Gazette of the Republic of Macedonia" nos. 25/2000, 34/2000, 96/2000, 50/2001, 11/2002, 31/2003.

Ministry of Health (www.zdravstvo.gov.mk)

PRISTOP - Ministry of Health, Public opinion survey about the reforms in the health care system, 2006

Republic of Macedonia, Republic Institute for Health Protection (RIHP), Annual Report, Health Map2006

State Statistical Office of the Republic of Macedonia, Statistical yearbook of former Yugoslav Republic of Macedonia 2005, Skopje, State Statistical Office, 2006.

UNICEF Findings from the Macedonia Multiple Indicator Cluster Survey, Preliminary Report, 2006

World Bank, The former Yugoslav Republic of Macedonia Poverty Assessment, for 2002-2003, November 2005

World Bank, Health Sector Transition Project, the former Yugoslav Republic of Macedonia, Implementation Completion, (Report No. 25735). Washington, DC, World Bank, 2003

World Bank (2004), Project Appraisal Document on a Proposed Loan to the former Yugoslav Republic of Macedonia for a Health Sector Management Project, Report No. 27760-MK

Statistical annex for Chapter 5

Table 5.1 Demographic, vital and some health indicators in former Yugoslav Republic of Macedonia, 2003, 2004, 2005

	2003	2004	2005
Area Km2	25,713	25,713	25,713
Population places	1,753	1,753	1,753
Municipalities	123	123	84
Population per 1Km2	78.82	79.05	79.21
Population			
Total	2,026,773	2,032,544	2,036,855
Male	1,017,274	1,019,903	1,021,772
Female	1,009,499	1,012,641	1,015,083
Urban	1,207,848	1,211,514	1,215,140
Rural	818,925	821,030	821,715
0-6 age	174,136	170,418	167,164
7-19 age	411,441	404,975	397,289
20 +	1,441,196	1,457,151	1,472,402
20 - 64 age	1,224,459	1,236,642	124,7537
65 +	216,737	220,509	224,865
female 15-49 age	524,156	525,682	526,456
female 15 +	805,991	813,769	820,675
Vital indicators			
Natality per 1.000	13.3	11.5	11
Mortality per 1.000 population	8.9	8.8	9
Natural increase per 1.000 population	4.4	2.7	2
Infant mortality per 1000 live births	11.3	13.2	12.8
Maternal mortality	7.4	12.8	13.3
Health care personnel			
Physicians	4,448	4,490	4,392
Dentists	1,132	1,134	706
Pharmacists	319	322	205
Health care personnel with higher level qualification	756	762	753
Health care personnel with mid	9,773	9,749	8,967
Number of population per one:			
Physician	455.7	452.7	463.8
Dentist	1,790.4	1,792.4	2,885.1
Pharmacist	6,353.5	6,312.2	9,935.9
Hospital beds			
Total number	9,743	9,699	9,569
Hospital beds per 1,000 population	4.8	4.8	4.7
Hospital beds per 1,000 population	4.8	4.8	4.7

Source: Republic Institute for Health Protection Annual Report 2006

Table 5.2 Morbidity and mortality indicators, 1991, 1995, 2000, 2004 (or latest available year)

	1991	1995	2000	2004	EU average	EU-15 average	EU-10 average
SDR, diseases of the circulatory system per 100 000	527.53	603.83	582.18	599.06 (2003)	262.38	233.2 (2003)	447.99
SDR, malignant neoplasms per 100 000	139.51	149.19	163.6	165.07 (2003)	184.23	177.94 (2003)	220.90
Tuberculosis incidence per 100 000	35.19	39.98	31.63	31.72	11.85	9.68	23.12
SDR external causes of injury and poisoning per 100 000	40.88	30.83	37.88	32.9 (2003)	42.83	37.81 (2003)	71.24
Clinically diagnosed AIDS incidence per 100 000	0.00	0.25	0.2	0 (2003)	1.58	1.79	0.50
Cancer incidence per 100 000	142.46	276.39			463.76 (2002)	468.17 (2000)	437.88 (2002)
New HIV infections reported per 100 000	0.05	0.31	0.35	0.30	5.34	6.75	2.79

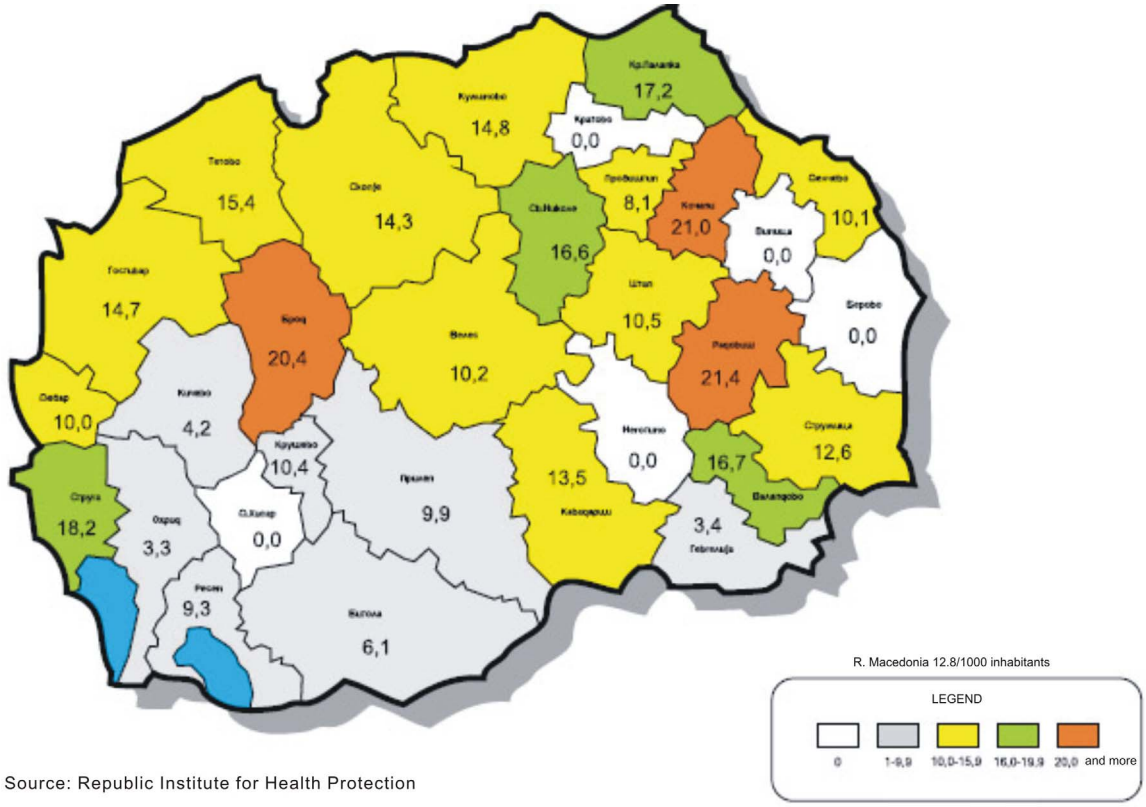
Source: WHO Regional Office for Europe health for all databases, January 2006
Note: EU: European Union; EU-15: Member States before 1 May 2004; EU-10: New Member States per 1 May 2004

Table 5.3 Lifestyles 1991, 1995, 2000, 2004 (or latest available year)

	1991	1995	2000	2004	EU average	EU-15 average	EU-10 average
Persons injured in road traffic accidents per 100 000	113.59	129.25	83.50	95.47 (2003)	296.39 (2003)	318.52 (2003)	181.94 (2003)
Average number of calories available per person per day (kcal)	2460	2529	2638	2655 (2002)	3494 (2002)	3522 (2002)	3335 (2002)
% of total energy available from fat	22.68	23.98	28.15	25.63 (2002)	37.47 (2002)	38.51 (2002)	31.75 (2002)
Average amount of cereal available per person per year (in kg)		144.5	127.1	132.3 (2002)	120.68 (2002)	117.32 (2002)	139.74 (2002)
Average amount of fruits and vegetables available per person per year (in kg)		250.1	291.8	304.6 (2002)	226.53 (2002)	235.74 (2002)	153.15 (2002)
% of regular daily smokers in the population, age 15+					28.84 (2003)	28.41 (2003)	30.34 (2003)
Pure alcohol consumption, litres per capita	2.64	2.69	2.60	1.85 (2002)	9.3 (2003)	9.38 (2003)	8.88 (2003)

Source: WHO Regional Office for Europe health for all databases, January 2006
Note: EU: European Union; EU-15: Member States before 1 May 2004; EU-10: New Member States per 1 May 2004

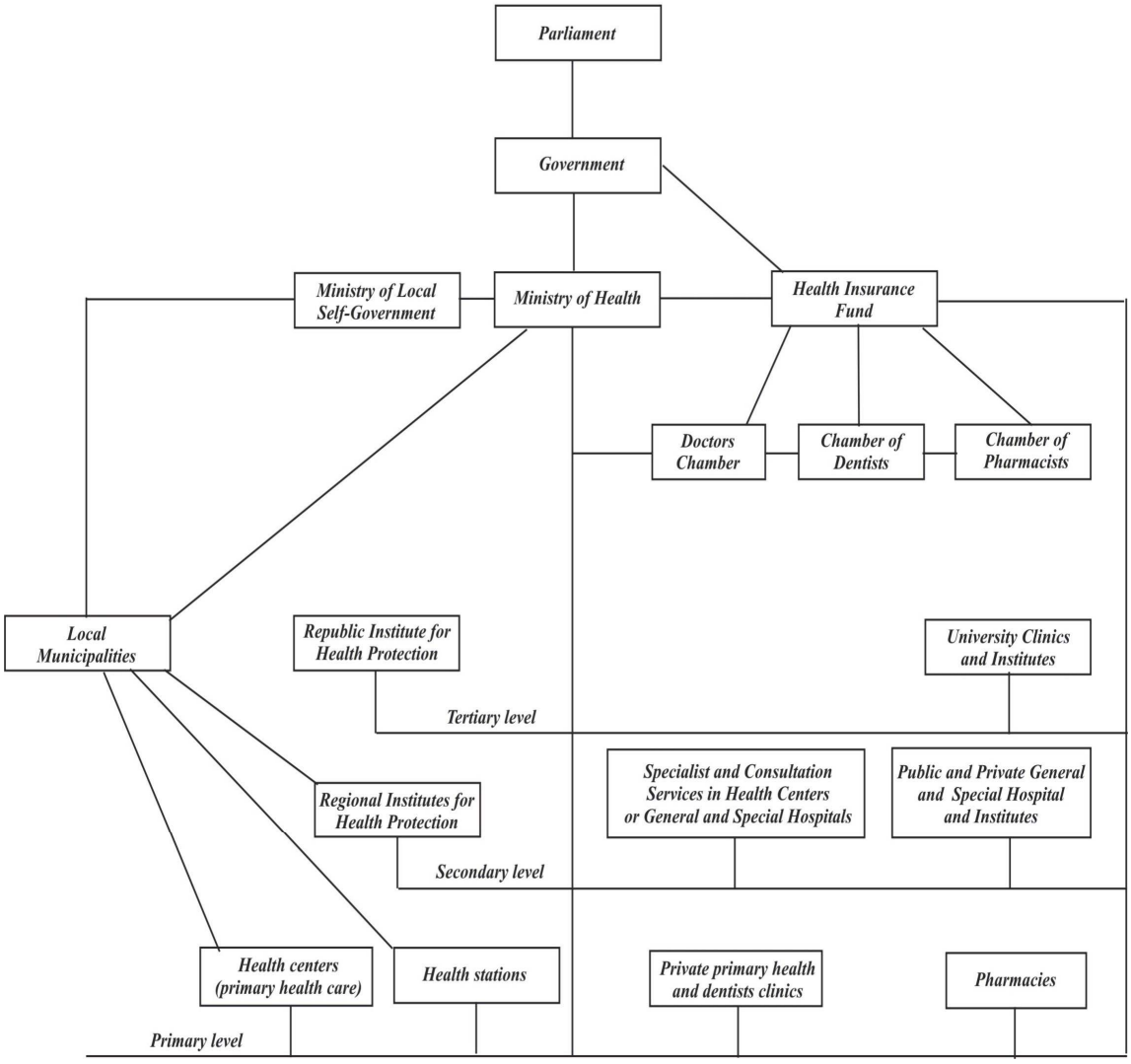
Map 5.1 Infant mortality (deceased infants per 1000 live-birts) by health regions in former Yugoslav Republic of Macedonia in 2005



Source: Republic Institute for Health Protection

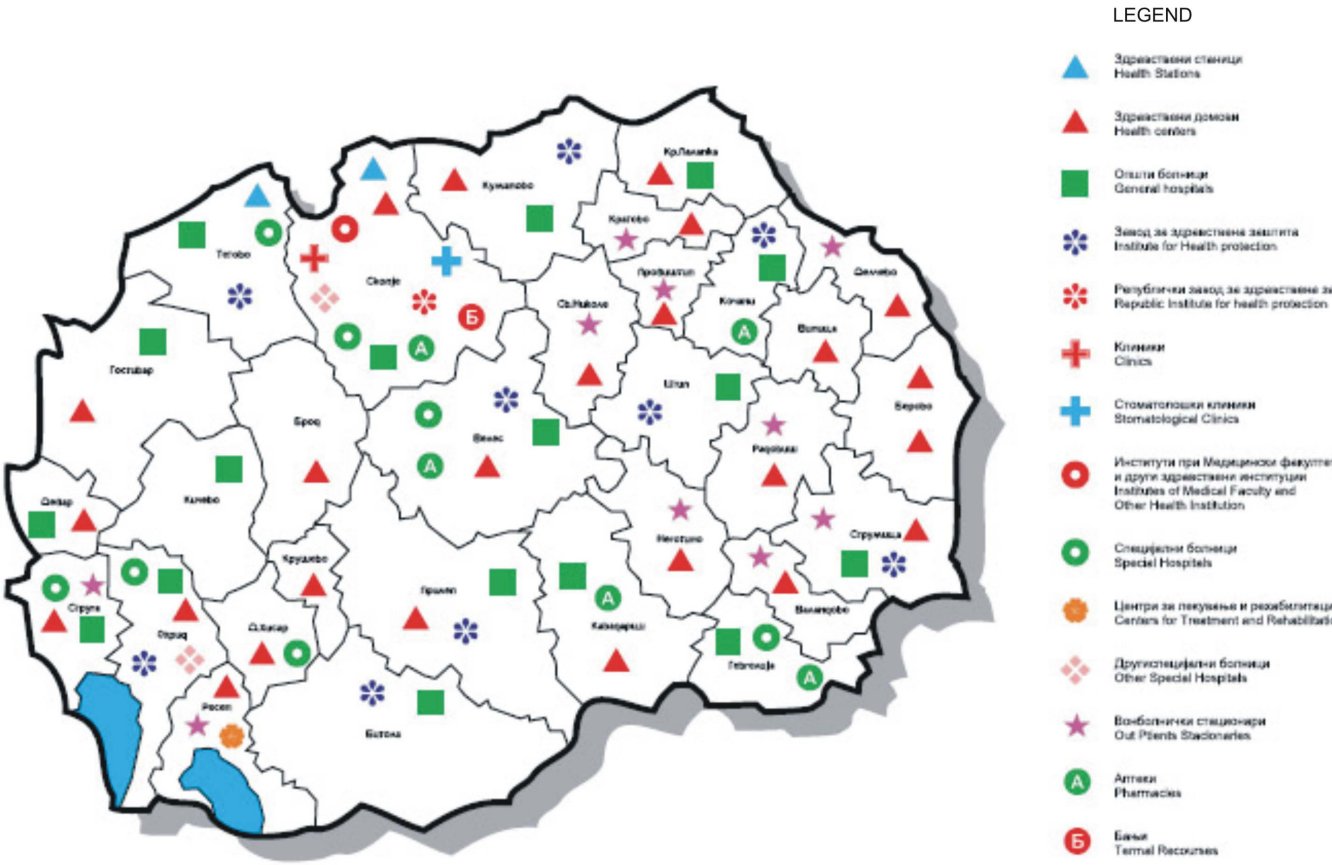
Source: Republic Institute for Health Protection

Graph 5.1 Health Care System in former Yugoslav Republic of Macedonia – Organizational structure



Source: Republic Institute for Health Protection

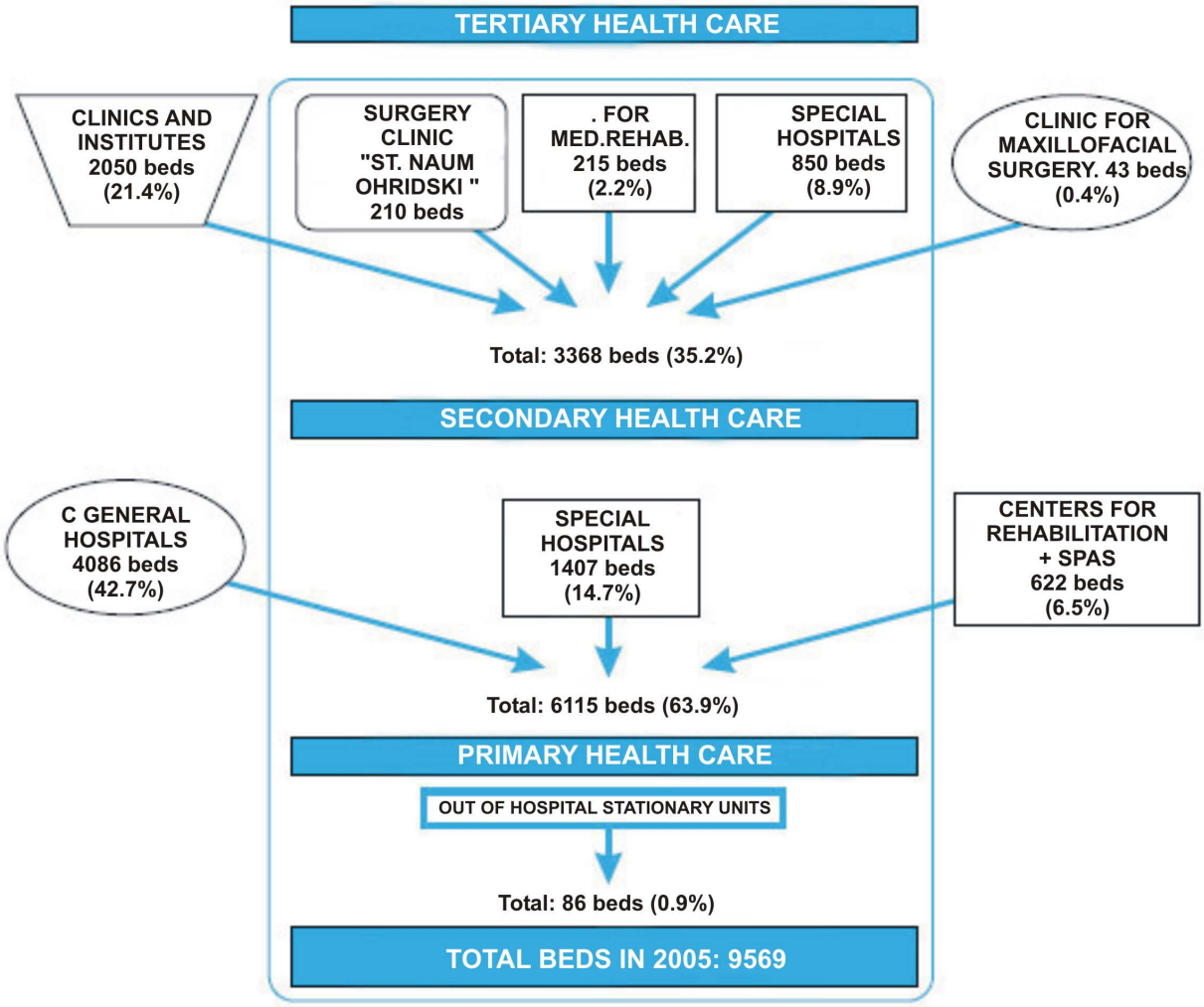
Map 5.2 Network of Public Health Organizations in former Yugoslav Republic of Macedonia



Source: Republic Institute for Health Protection

Source: Republic Institute for Health Protection

Graph 5.2 Network of inpatient health institutions and beds by level of health care in former Yugoslav Republic of Macedonia in 2005



Source: Republic Institute for Health Protection Annual Report 2006

Table 5.4 Total Hospital Capacity in former Yugoslav Republic of Macedonia by type 2004

Type of Hospital	Number of beds	Beds per 1000 population
General Hospitals in Medical Centres	4,117	2
Clinics & Institutes of the Clinical Centre of Macedonia, Skopje	2,058	1
Special Hospitals & Institutes (Including mental health)	2,263	1.3
Rehabilitation Centres	640	0.32
Spas	180	0.1
Beds in PHC sector	91	0.04
TOTAL	9,699	4.8

Source: Republic Institute for Health Protection Annual Report 2005

Table 5.5 Daily hospitals, personnel and beds, in former Yugoslav Republic of Macedonia in 2003, 2004 and 2005

DAILY HOSPITALS IN:	2003				2004				2005			
	Physicians, total	Specialists	Health personnel with higher and mid-level qualification	Beds	Physicians, total	Specialists	Health personnel with higher and mid-level qualification	Beds	Physicians, total	Specialists	Health personnel with higher and mid-level qualification	Beds
Psychiatric hospital Bardovci - Skopje for:												
psychoses	1	1	4	60	1	1	5	60	1	1	5	60
alcoholism	2	2	3	60	2	2	3	60	2	2	3	60
psychoses and other stress disorders	3	3	7	160	5	5	8	160	5	4	8	160
Daily hospital for addiction prevention "Centar"	-	-	-	60	3	3	7	60	2	2	7	60
Clinic for psychiatry - Skopje	2	2	2	2	1	1	2	2	1	1	2	2
Clinic for hematology - Skopje	2	1	2	6	1	1	2	6	1	1	2	6
Clinic for cardiology - Skopje	2	2	4	7	2	2	4	7	2	2	4	7
Clinic for endocrinology - Skopje	1	1	1	1	1	1	1	1	1	1	1	1
Institute for radiotherapy and oncology	-	-	-	-	-	-	-	-	-	-	-	27
Institute for speech, voice and hearing	1	1	-	-	-	-	-	-	-	-	-	0
Institute for mental health-Skopje	1	1	-	20	-	-	1	20	-	-	1	20
Medical Centre Bitola in:												
pediatric unit	-	-	-	9	-	-	-	9	-	-	-	9
neurology unit	1	1	2	-	1	1	2	-	1	1	1	-
infectology unit	-	-	-	15	-	-	-	15	-	-	-	15
pulmology and TB unit	-	-	-	4	-	-	-	5	-	-	-	5
Daily hospital for oncology and radiotherapy	1	1	1	3	1	1	1	3	1	1	2	5
Medical Centre Ohrid in:												
internal unit	-	-	8	8	-	-	8	8	-	-	5	8
Medical Centre Struga in:												
pediatric unit	-	-	-	7	-	-	-	7	-	-	-	7
general unit	-	-	-	4	-	-	-	4	-	-	-	4
internal unit	-	-	-	3	-	-	-	3	-	-	-	3
Health Centre Vevchani in:												
Lukovo	-	-	-	1	-	-	-	1	-	-	-	0

DAILY HOSPITALS IN:	2003				2004				2005			
	Physicians, total	Specialists	Health personnel with higher and mid-level qualification	Beds	Physicians, total	Specialists	Health personnel with higher and mid-level qualification	Beds	Physicians, total	Specialists	Health personnel with higher and mid-level qualification	Beds
TOTAL	17	16	34	435	18	18	44	436	17	16	41	459

Source: Republic Institute for Health Protection Annual Report 2006

Table 5.6 Health personnel and beds in special hospitals (long term care) on secondary level in former Yugoslav Republic of Macedonia in 2003, 2004 and 2005

HOSPITALS-CENTERS	Physicians						Health personnel with higher and mid-level qualification						Beds					
	Total			Specialists			Total			Per 1 physician			Total			Per 1 physician		
	2003	2004	2005	2003	2004	2005	2003	2004	2005	2003	2004	2005	2003	2004	2005	2003	2004	2005
Special hospitals for pulmon. diseases and TB	5	7	6	5	7	6	12	19	14	2.4	2.7	2.3	100	100	100	20	14.3	16.7
Special hospital for pulmon. diseases and TB - Lesok	0	2	1	0	2	1	0	7	5	0	0	5	0	0	0	0	0	0
Special hospital for pulmon. diseases and TB - Jasenovo	5	5	5	5	5	5	12	12	9	2.4	2.4	1.8	100	100	100	20	20	20
Special hospital for orthop. and traumatology Ohrid	33	33	37	25	27	27	122	121	126	3.7	3.7	3.4	350	350	270	10.6	10.6	7.3
Neuropsychiatry hospitals	29	28	28	22	21	21	193	178	178	6.7	6.4	6.4	750	750	750	25.9	26.8	26.8
Neuropsychiatry hospital Negorci-Gevgelija	10	10	10	7	7	8	52	50	50	5.2	5	5	270	270	242	27	27	24.2
Psychiatric hospital Demir Hisar	19	18	18	15	14	14	141	128	126	7.4	7.1	7	480	480	445	25.3	26.7	24.7

Source: Republic Institute for Health Protection Annual Report 2006

Table 5.7 Number of patients, average length of stay and bed occupancy in special hospitals (long term care) in former Yugoslav Republic of Macedonia in 2003, 2004 and 2005

HOSPITALS-CENTERS	Treated patients			Utilized bed-days			Average length of stay			Bed occupancy			Bed turnover		
	2003	2004	2005	2003	2004	2005	2003	2004	2005	2003	2004	2005	2003	2004	2005
Special hospitals for pulmonary diseases and TB	892	1,003	898	29,761	30,042	26,567	33.4	30	29.6	81.5	82.3	72.8	8.9	10	9
Special hospital for pulmonary diseases and TB - Lesok	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Special hospital for pulmonary diseases and TB - Jasenovo	892	1,003	898	29,761	30,042	26,567	33.4	30	29.6	81.5	82.3	72.8	8.9	10	9
Special hospital for orthpedics and traumatology - Ohrid	2,290	2,305	2,395	82,498	71,827	72,556	36	31.2	30.3	64.6	56.2	73.6	6.5	6.6	8.9
Neuropsychiatry hospitals	793	809	760	235,262	280,064	215,698	296.7	346.2	283.8	85.9	102.3	86	1	1	1.1
Neuropsychiatry hospital Negorci-Gevgelija	418	395	376	71,579	89,070	53,983	171.2	225.5	143.6	72.6	90.4	61.1	1.5	1.5	1.6
Psychiatric hospital Demir Hisar	375	414	384	163,683	190,994	161,715	436.5	461.3	421.1	93.4	109	99.6	0.8	0.9	0.9

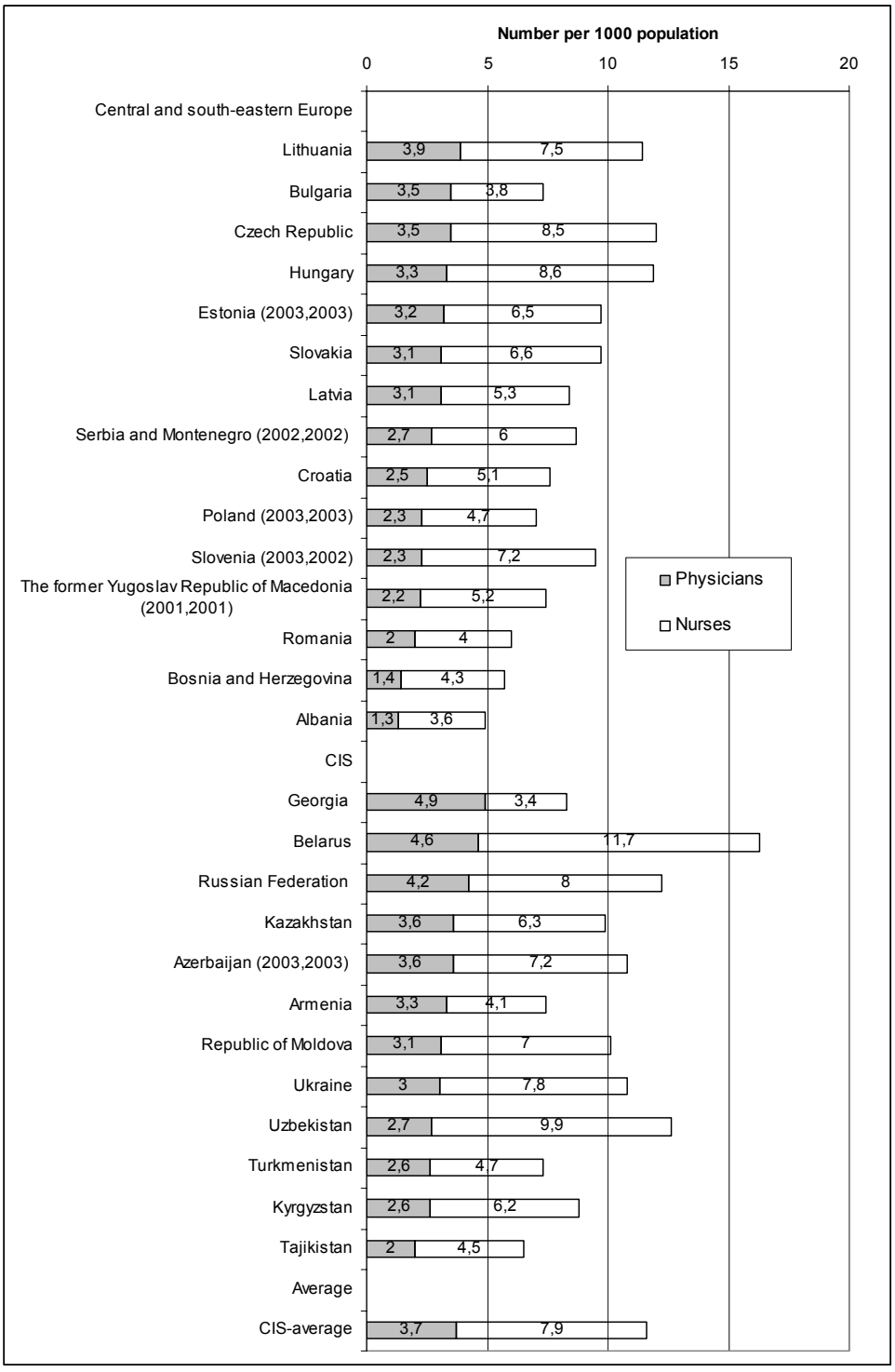
Source: Republic Institute for Health Protection Annual Report 2006

Table 5.8 Number of patients, average length of stays and bed occupancy in rehabilitation centers and environmental factor treatment hospital in former Yugoslav Republic of Macedonia in 2003, 2004 and 2005

HOSPITALS-CENTERS	Treated patients			Utilized bed-days			Average length of stay			Bed occupancy			Bed turnover		
	2003	2004	2005	2003	2004	2005	2003	2004	2005	2003	2004	2005	2003	2004	2005
Rehabilitation centers	3,341	3,348	3,774	103,459	100,633	82,713	31	30.1	21.9	54.6	66.7	51.3	6.6	7	8.5
Stationary pediatric health institution for treatment of rheumatic and other diseases - Ohrid	379	405	344	15,563	8,512	8,963	41.1	21	26.1	21.6	35.5	20.5	2.6	3.2	2.9
Institute for prevention and treatment of cardiovascular diseases - Ohrid	1,159	1,130	1,220	33,877	35,377	24,077	29.2	31.3	19.7	60.7	92.8	66	12.2	11.6	12.2
P.H.O. - Institute for dialysis, nephrology and rehabilitation - Struga	907	931	1,085	34,553	35,708	25,822	38.1	38.4	23.8	82.6	91.9	59	6.6	8.8	9
Institute for prevention, treatment and rehabilitation of chronic respiratory and specific diseases - Oteshevo	871	846	796	16,135	14,716	12,990	18.5	17.4	16.3	94.9	61.4	49.4	10.7	12.1	11.1
Centre for speech, voice and hearing	25	36	54	3,331	6,320	6,072	133	176	112	25.3	30.4	55.5	1	0.8	1.8
Other hospitals															
Environmental factor treatment hospital Katlanovo-Skopje	964	993	1021	20,069	21,351	21,343	20.8	21.5	20.9	24	30.5	32.5	4.4	5.4	5.7
Institute for gerontology	668	603	771	108,566	84,117	163,192	163	140	212	80.9	108	128	2.1	2.4	2.2

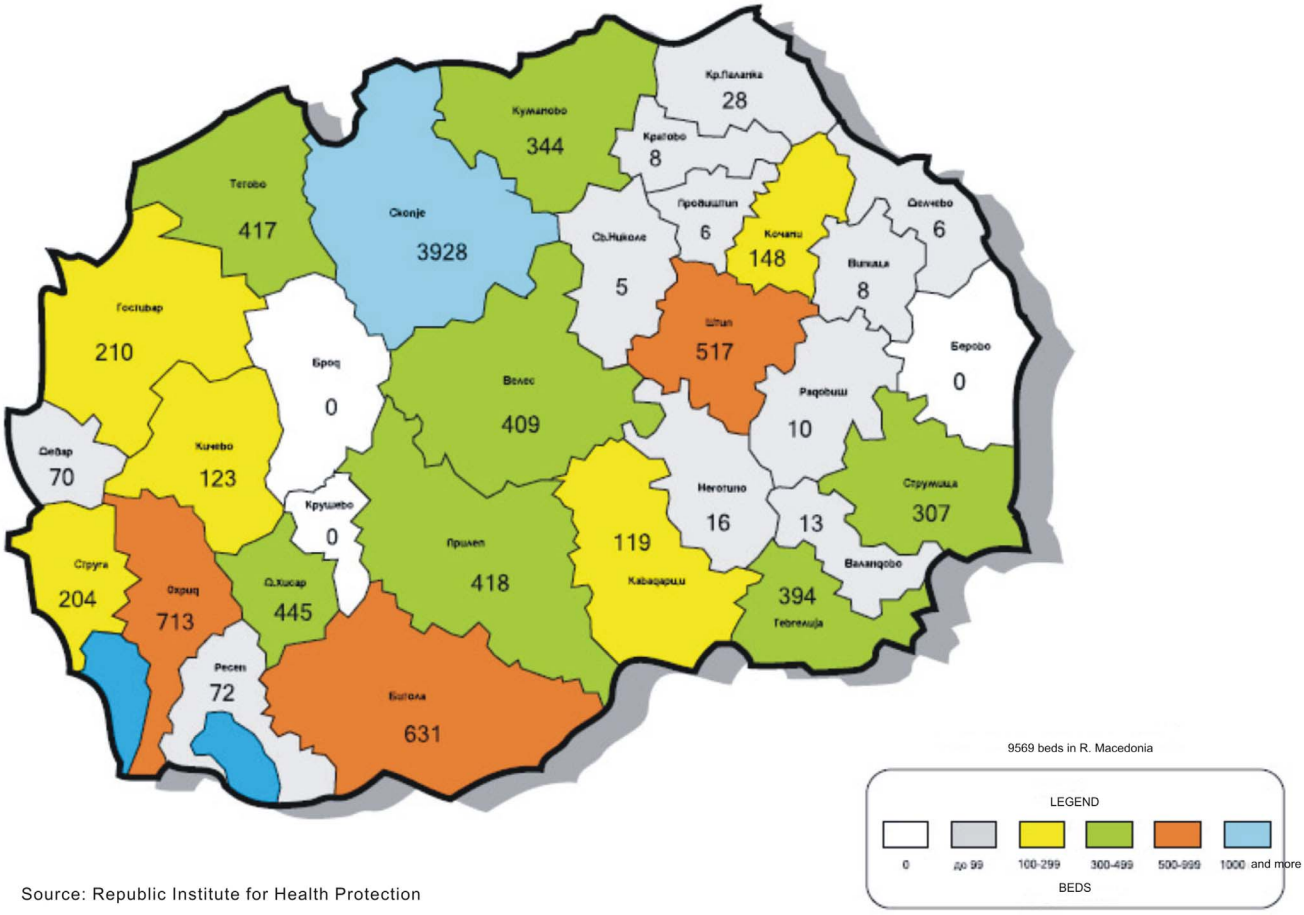
Source: Republic Institute for Health Protection Annual Report 2006

Graph 5.3 Number of physicians and nurses per 1000 population



Source: WHO Regional Office for Europe health for all databases, January 2006
Note: CIS: Commonwealth of independent states

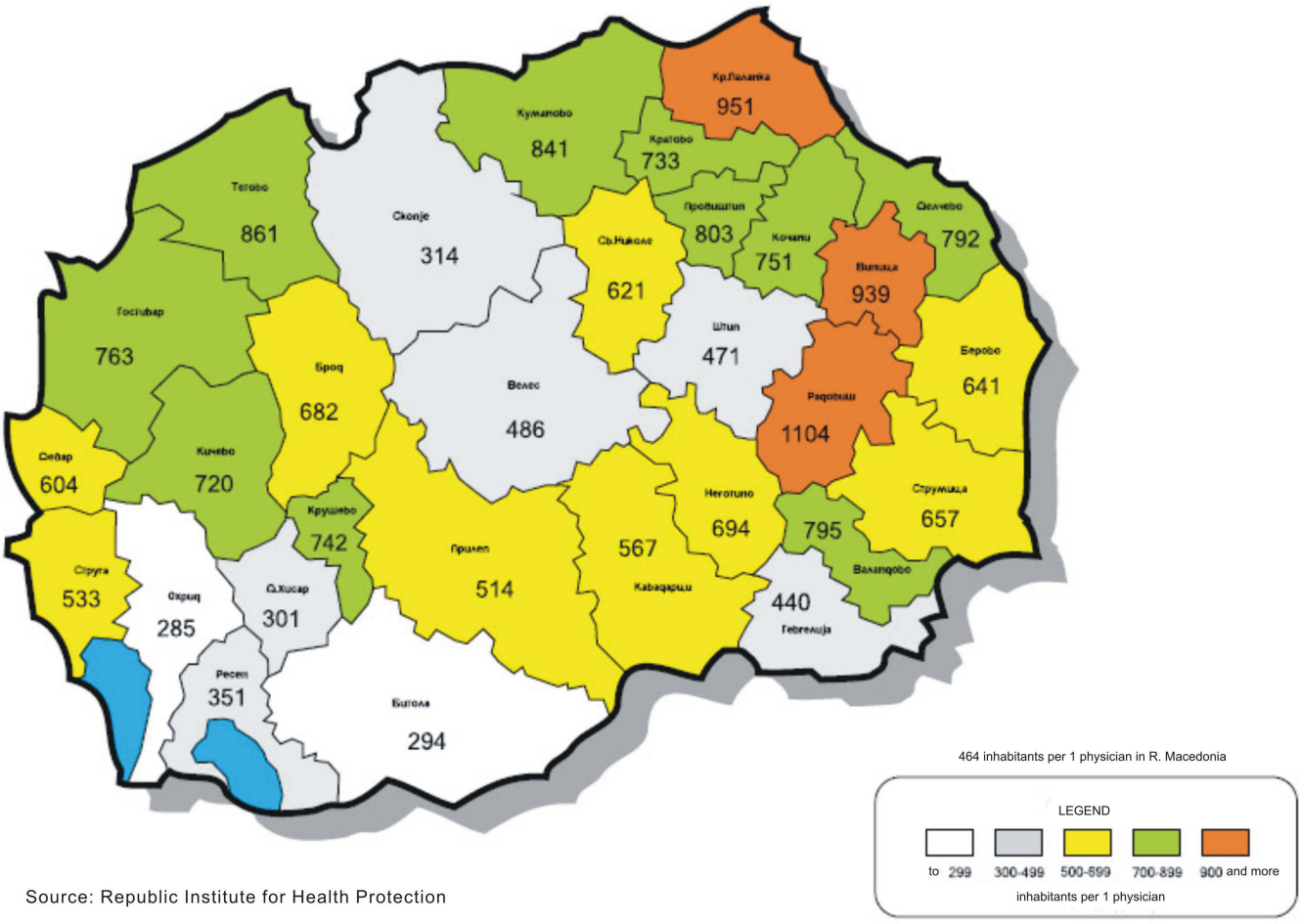
Map 5.3 Number of beds by health regions in former Yugoslav Republic of Macedonia in 2005



Source: Republic Institute for Health Protection

Source: Republic Institute for Health Protection

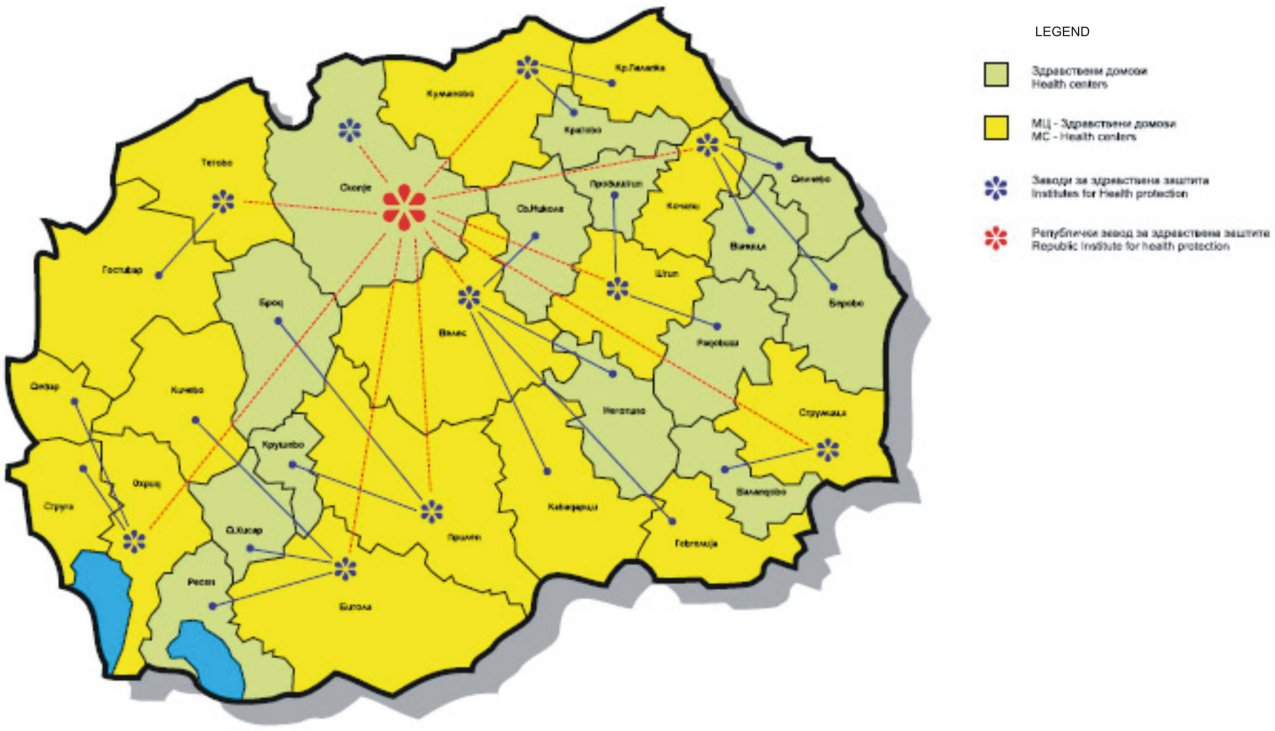
Map 5.4 Number of inhabitants per 1 physician by health regions in former Yugoslav Republic of Macedonia in 2005



Source: Republic Institute for Health Protection

Source: Republic Institute for Health Protection

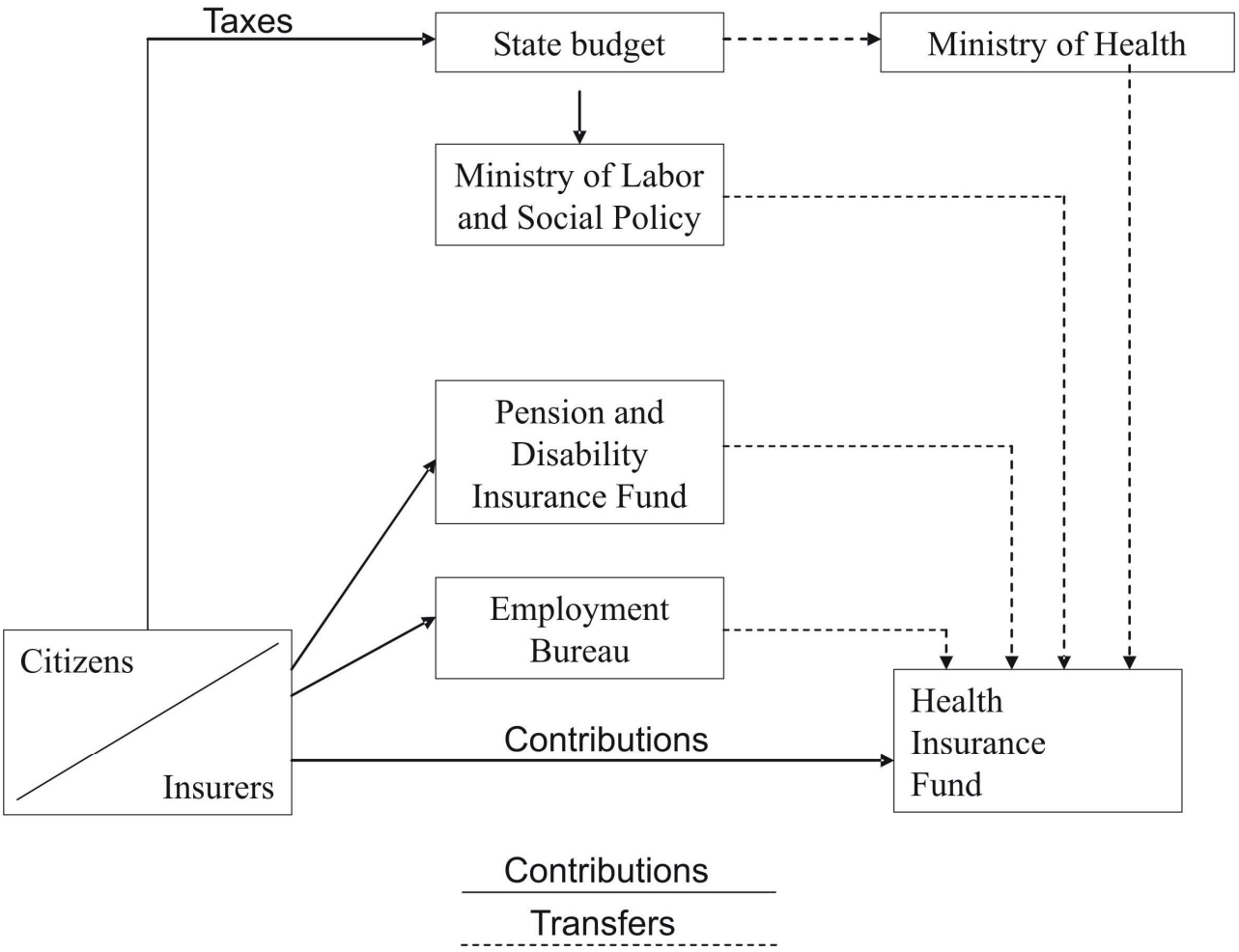
Map 5.5 Public health institutions network in former Yugoslav Republic of Macedonia in 2005



Source: Republic Institute for Health Protection

Source: Republic Institute for Health Protection

Graph 5.4 Sources of the Health Insurance Fund revenues



Source: WHO Health Systems in Transition – The former Yugoslav Republic of Macedonia 2006

Table 5.9 Structure of the revenues of the Health Insurance Fund (in percentage)

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
REVENUES											
Contributions	97.8	94.5	97.9	94.3	92.6	96.8	97.8	91,76	91,96	95,13	95,5
Contributions from salaries and allowances	70.0	64.8	66.4	63.7	61.0	60.6	63.6	56,97	57,27	58,91	59,5
Contributions from pension and disability insurance	25.0	21.7	22.8	20.8	20.0	20.7	21.2	21,87	21,66	22,50	22,6
Contributions from Bureau for employment for temporarily unemployed	2.3	7.5	8.4	9.4	11.2	15.2	12.6	12,54	12,58	13,42	13,2
Transfers from the Ministry of Labour and Social Policy	0.5	0.4	0.4	0.4	0.4	0.4	0.4	0,38	0,45	0,30	0,3
Other revenues	2.21	5.50	2.12	5.70	7.40	3.19	2.20	8.24	8.04	4.87	4.5

Source: Bulletin of the Health Insurance Fund 2006

Table 5.10 Structure of the revenues form salaries (%)

Revenues from salaries and allowances	2005	2006
Employees in public sector	49.23	48.23
Self employed	1.07	1.01
Workers in private companies	0.54	0.49
Agricultural workers	0.36	0.31
Others	0.82	0.75
Contributions for occupational disease or injuries	3.00	2.96
Contribution for previous years	3.87	3.49
Total revenues for salaries and allowances (%)	58.90	57.25

Source: Bulletin of the Health Insurance Fund 2006

Table 5.11 Number and structure of insured persons December 2006

Insured persons	Number		Index(%)	Structure (%)	
	2005	2006	06/05	2005	2006
Active employees	417,562	423,284	101.39	21.99	21.83
Active agricultural workers	18,623	18,038	96.86	0.98	0.93
Pensioners	297,324	313,396	105.41	15.66	16.16
Unemployed persons	268,213	273,999	102.16	14.13	14.13
Others	25,556	25,285	98.94	1.35	1.30
Total Insurees	1,027,178	1,054,002	102.61	54.11	54.36
Total family members	871,156	884,758	101.56	45.89	45.64
Total numbers of insured persons	1,898,334	1,938,760	102.13	100.00	100.00

Sources: Bulletin of the Health Insurance Fund 2006

Chapter 6: Conclusions and future challenges

6.1 Conclusions

In an effort to map the current system of social protection in the former Yugoslav Republic of Macedonia, with particular emphasis on problems of social exclusion, this study has analyzed main trends in social protection, monetary and non-monetary indicators of poverty and social exclusion, pensions as well as health and long term care. The study will conclude with outline of some of the most important messages from that analysis.

Although the system of social protection is characterized with well dispersed network of Social Work Centers (social services), it can be seen that there is a regional imbalance in skills and human resources. Lack of defined quality standards, licensing and accreditation for social services is additional concern, which needs to be legally stipulated and organized, especially for the purposes of the decentralization process. Currently, the system of social protection, both through its social welfare and social insurance monetary benefits, seems to provide only minimal amounts, which can not satisfy the basic needs of most of its recipients. In addition, some of the ceilings for these benefits (i.e. permanent social assistance, child benefits) implicitly discourage multi-numbered families, among which members of ethnic groups such as Roma and Albanian who have families with many children are particularly affected. The coverage of the social protection has been continuously a subject of ongoing restrictions, connecting eligibility with activation and workfare principles. The study reveals that at least 80% of the unemployed are not covered with the social assistance scheme, although this percentage is not adjusted according to the numbers of unemployed in one household that is in recipient of social financial assistance. Also, the coverage of the elderly by the social assistance schemes seems to be proportionally low with their overall numbers in the total population. This evidence is similar in regard to the pension system as well, where more than 70.000 (or 31.1%) people above the age of 65 are not covered with pension benefit.

Poverty assessment in former Yugoslav Republic of Macedonia is currently not based on European or any other international harmonized data source. However, the numbers of those experiencing poverty, measured according to the 70% of median expenditure in 2005 was 31%, which is exceptionally high. The administrative approach towards targeting socially excluded people employed by the Ministry of Labour and Social Policy has been rather arbitrary and focused only on four categories - 1) drug users and members of their families; 2) street children/children on the streets and their parents; (3) victims of family violence and 4) homeless people. The study suggests that there are number of other categories that lack access or are insufficiently covered by the social protection system. These include: rural poor, redundant workers, women from the ethnic community groups living in rural places, Roma as well children from large families (3 and more children) with unemployed parents and institutionalized children.

The study also recognizes the lack of systematic and efficient inter-ministerial, inter-sectoral and multi-stake holder participation in regard to the general process of policy creation and implementation in the field of poverty and social exclusion. Non coordination and non-cooperation between relevant institutions in the system (i.e. Centers of Social Work and the Employment Agency) complicates the administrative

procedures and reduces the efficiency of the system. Even in cases where such joint effort exists, it is based on a passive and short-term cooperation, hence reducing the possibilities for sustainability of the planned activities. But, in some This presents an important imperative for further inclusive social policy planning and implementation. Therefore, the crucial challenge for former Yugoslav Republic of Macedonia lies in the solution to define and implement social inclusion policy based on its economic possibilities, welfare demand and society capacities.

The work on this study has also signaled the scarcity of sound analysis and reliable statistical date-base in field of social protection and social inclusion. The majority of updated and available information's are realized by the international financial organizations (namely the World Bank), but their comparability is to some extent limited, due to the use of indicators, benchmarks and definitions other than those used by the EU. Even in cases where there is an existing national statistical measurement, it proves as highly unreliable or at least controversial. This especially concerns the Labour Force Survey, which seems to provide statistics that exaggerates the number of unemployed. Therefore, there is a need of general improvement and synchronization of national social statistics among the relevant public bodies (MLSP, Ministry of Finance, Employment Agency, Pension and Disability Insurance Fund, Health Insurance Fund, State Statistical Office) as well as its coordination with the EU statistical standards (i.e. ESPROSS).

Finally, the ongoing process of decentralization and the implementation of the Ohrid Framework Agreement on the local level are among the most important imperatives that need to be streamlined into the social inclusion policy. The process of decentralization (not only territorial, but financial as well) should be used for improving the human resources at the local level in terms of strengthening the capacities of professionals and staff that directly create local policies and/or work with socially excluded groups. Also the implementation if the OFA on the local level should contribute more towards improvement of participation of ethnic groups both in terms of policy creation/implementation but even more so in the context of increasing their participation in education, training and employment.

In general, challenges in the whole social protection system (inclusive of pension, and health) comprise of: more inclusive coverage, strengthening of human resources planning and training, rationalization of services in light of redistributing limited resources more effectively thus significantly improving the infrastructure of facilities as well as the quality of services, enabling adequate funding of services, as well as the decentralization and the local absorption capacity.

6.2 Challenges ahead

With aim to contribute to the planned JIM process in the former Yugoslav Republic of Macedonia, this study identifies series of specific challenges which have been encountered in the process of conducting this study:

6.2.1 Challenges concerning social protection and social welfare system:

- Targeting of social welfare benefits according to the social welfare demand. Efficiency of the social welfare benefits should be focused either (a) on eligibility

or (b) on duration and amount of benefits. Rigidities in both aspects can jeopardize adequacy, accessibility and social cohesion of its beneficiaries.

- Delivery of social welfare and social insurance benefits by institutions specifically created for those purposes. Currently, there seems to be overlapping of roles between institutions, for example in the case of the delivery of free health insurance, which can be obtained through the Employment Agency (institution not at all connected with the health sector). Such overlapping leads to increase/duplication of numbers of registered beneficiaries, as well introduction of unnecessary (rigid) eligibility rules, which potentially distance social welfare applicants at risk form the social protection system.

- Decentralization of Social Work Centers, both in terms of financing and delivery of social welfare. Evaluation of the local resources and needs should be undertaken in order to assess the capacities of the local municipalities. Decentralization of the Social Work Centers should lead towards improved access and efficiency of the social welfare system.

- Transparency and supervision of the social welfare system. Open and accessible social protection system can improve the trust among social welfare beneficiaries. Introducing more rigid legal stipulations regarding violations of the social welfare law, as well as giving more authorization to already existing supervision bodies within the MLSP can improve the current public image of the professionals involved in the social protections system.

- Increasing administrative capacity of the Ministry of Labor and Social Policy, as well as other institutions in charge for administration and delivery of social services, both on central and local level.

6.2.2 Challenges concerning eradication of poverty and social exclusion:

- Expending current governmental arbitrary and defined scope of socially excluded categories, to include: working poor, rural poor, redundant workers, women from ethnic communities living in rural places, Roma, children from large families (3 and more children) in particular with unemployed parents and children living in institutions.

- Development of new mobile, de-institutionalized services for more categories of socially excluded groups (than those existing), especially for the elderly people, as well as increasing the numbers of the daily care centers for homeless people as well as for street children/children on the streets.

- Differentiation of policy measures for different poverty groups. The National Strategy for Reduction of Poverty has identified three categories of poor in the former Yugoslav Republic of Macedonia, but as needs of these groups are different, so should be the measures directed towards them, i.e. (i) emphasis on training and counseling services for those defined as ‘new poor’; (ii) need for greater eligibility for financial transfers for those defined as ‘traditional’ and ‘chronic’ poor.

- Increased access to the resources, rights and services needed for the participation in society for those living in geographically remote locations. This can encompass mobile services, such as health check-ups, food supply, enabling of necessary pre-conditions for participation in trainings and other activities.

- Active social inclusion of young unemployed, which are not included in education, employment or training.

- Prevention of social exclusion from early years through: expending pre-school education to more universal provision, increasing access to primary education for vulnerable groups, i.e. Roma children, rural girls, children with disabilities and reduce drop-outs by strengthening the outreach component of the school, cooperation with local communities and inter-active methods that support each individual child learning and progress.

- Improved governance in the social protection system. Participation from different relevant governmental and non-governmental actors as well as people experiencing poverty in drafting and coordination of social inclusion policies. The NGO sector needs to be supported to de-concentrate and re-locate its services to places where there is need but no relevant capacity for provision of day-care services.

6.2.3 Challenges concerning adequate and sustainable pensions:

- Assessment of the elderly people not covered with the pension insurance. This report suggests that there might be around 70.000 people above 65 years of age not covered with pension insurance. Elderly people from this group that lack additional support from formal and informal social networks should be included in the social inclusion programs.

- Assessment of the coverage rate of the pension system among the elderly women. As women tend to live longer, it might be expected that those currently not included by the pension system are mainly women. They too should be incorporated as to be able to benefit from the social protection system.

- Assessment of other excluded groups from the pension system, i.e. redundant workers, rural farmer's spouses, members of certain ethnic groups (i.e. Albanians) as well as vulnerable ethnic groups (Roma) etc. with no adequate working record.

- Adequacy of the retirement income. Indirect solutions, like reduction or elimination of participation for medicines and health services for the elderly population, especially for those with age over 70, if they have sub-standard pension; increasing the positive list of medicines and provide sufficient quantities of medicines from the positive list in the pharmacies, as well as other direct subsidies should be considered that will make the retirement income sufficient and adequate for maintaining living standard of the elderly.

- Financial sustainability of the pension system. Improved contribution collection should be a priority issue since it has a severe impact on the financing and the viability of the pension system. The most efficient collecting networks should undertake the task and relevant legislation with clear functions must be enforced. Information networks, databases and coordination mechanisms should be put in place.

- Improve the transparency of the pensions system, through introduction of more frequent reports (than currently) from the private pension funds to the pension contributors. In this way any unpaid contribution of employers can be signaled more promptly, which can also be used by the Labour Inspectorate to control and sanction those violations.
- Costs of the new System – in particular charging structure and how benefits will be paid at retirement.

6.2.4 Challenges concerning accessible, high-quality and sustainable healthcare and long-term care:

The well-organized and effective health care system a prime responsibility of the Ministry of Health should have the following characteristics:

- Effectiveness: medical interventions must be based on evidence of health benefit (further improvement in the introduction of clinical guidelines, clinical performance indicators, continuous medical education, management trainings, capitation models incentives etc.)
- Efficiency: health care services should try to obtain the best results for the cost that society can afford which in former Yugoslav Republic of Macedonia is extremely limited (adequate revision of the BBP, improvement of the co-payment policy and National preventive programs. Possibilities with the CCT Project etc).
- Equity: all citizens should have equal access to the services they need, without regard for income or background (revision of BBP – one basic package for all, medical map outcomes, rational redistribution of the services, outcomes from the National Preventive Programs, Improvement of the Promotion programs. Possibilities with the CCT Project etc).
- Solidarity: in pooling the funds for health care services, the healthy should contribute for the sick, the rich for the poor, and the young for the old (Changes in the BBP and Co payment policy).
- Further strengthening of primary health care. More efforts should be made to strengthen the capacity of preventive health teams, update standards and protocols for the key health prevention and health promotion interventions (strengthen the outreach immunization work, antenatal care, and systematic check-ups of children, especially for the most marginalized children, families and vulnerable groups). As a possible form Youth Friendly Services could be mentioned as an effective strategy to carry out health promotion and health prevention among children and young people.
- In the context mentioned above, strengthening the capacity of the patronage nursing system could be an effective strategy for implementation of several health promotion and health prevention programmes. Also, the patronage

nursing system could function as a structure to lessen the burden of the secondary and tertiary health care, i.e. care and treatment for chronic and other diseases can be done at the community level thus shortening the hospital stay and reducing costs of higher levels of health care

- The Ministry of Health should insists on the existence of a network of the different types of primary and secondary health services in the whole country that combines good accessibility, lack of duplication, and an efficient and sustainable use of financial and human resources. The network should function as a system, which means that the various elements are complementary to each other and all contribute to the common goal of providing effective and efficient services to the public. In order the proper accessibility to be ensured, all health care facilities will need a license from the Ministry of Health, with regular re licensing, which is one of the aims of the ongoing heath mapping process.
- There is a need of further upgrading and harmonization of existing public health services and functions with the internationally recognized standards.
- Decentralization needs to be designed such that it doesn't interfere with, or weaken, the ability of the country to achieve its central health system goals. A major issue will be ensuring that decentralization does not increase inequities in access to necessary services and/or in the quality of services received between different localities or between different population groups. Increased autonomy of health care institutions will require adequate regulatory structures to be put in place.
- The current Basic Benefit Package is felt necessary to be reviewed by comparing it to international practices and taking into account demographic and epidemiological characteristics as well as fiscal sustainability issues. The most socio economically deprived population should be seen as the primary target group for exemptions of co-payments.
- In regard to the long term care services, it is expected that the process of transformation and de-institutionalization of the health care system in former Yugoslav Republic of Macedonia, will enable dispersion of the palliative and mental health care on community level and enhance home care throughout the country. Also, this process should support the conditions for establishment of daily hospitals and centers for palliative and mental health care.