



Public Policy
Paper

Recommendations for Integrating Gender Equality and Social Inclusion (GESI) in the Law on Health Insurance

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What Is the Purpose of This Public Policy Document?

The purpose of this document is to present the findings and opportunities for integrating gender equality and social inclusion (GESI) in relation to the Law on Health Insurance (hereinafter referred to as “the Law”) and to assess the justification for making GESI-related amendments to the legislation in the field of health insurance. This includes covering the vulnerable and marginalised categories on any basis, covering the services for socially excluded groups, and equality in access to those services.

What Does the Law on Health Insurance Regulate?

The Law regulates the access to health services for all citizens on the principle of equality and inclusion and establishes the requirements and procedures for the use of health insurance, with an emphasis on the protection of public health and the efficient use of financial resources.

Under the Law, health insurance is established as compulsory and voluntary. Compulsory health insurance is administered by the Health Insurance Fund and applies to all citizens for the provision of health services and monetary benefits based on the principles of inclusion, solidarity, equality and effective use of funds. Voluntary health insurance is administered by insurance companies under this Law and the Law on Voluntary Health Insurance.



In accordance with Article 9 Paragraph 1 of the Law on Health Insurance, insured persons are provided with the right to basic health services, including:

- a) in the primary healthcare system**
- b) in specialised consultative health care**
- c) in hospital (short-term and long-term) health care**

What Is the Concept of Health Insurance?

Health insurance is one of the mechanisms for providing universal health coverage, with the aim of ensuring equality in access to health services (including promotional, preventive, curative, rehabilitative, and palliative health services), meaning that everyone who needs a health service should be able to receive it, not just those who can pay for it. Moreover, this approach should ensure that people are protected from financial risk, i.e. to ensure that the cost of using health services does not put them at risk of serious financial hardship.

To answer the question of whether and how much of the population is covered by effective health care, three basic questions need to be answered: For whom?, What? and How much?

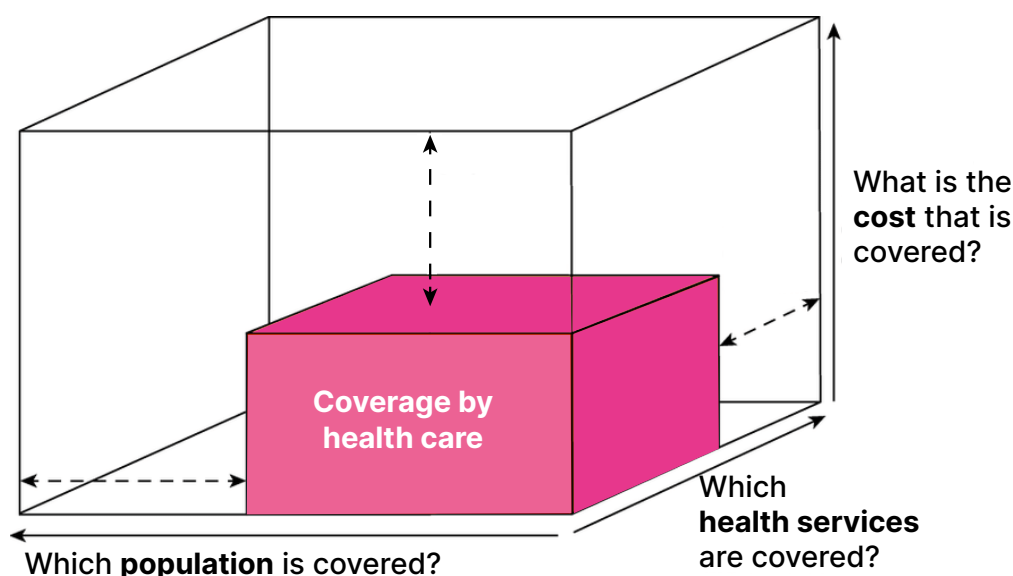


Figure 1: Three dimensions of the efforts to provide universal health coverage

These principles of coverage with health services and the share of their costs are similar in all countries across Europe. However, depending:

- on the financial power of the states
- on the allocations for health care
- on the effectiveness of the healthcare systems, the state's share in covering the costs of health care varies.

In our country, compulsory health insurance is the backbone of providing universal health care. However, there are segments of health care that, for various reasons, are not covered by health insurance, and because of their public health importance, additional government programmes have been designed, from which residents receive additional health care entitlements (immunisation programme, for rare diseases, for HIV prevention, for addictions, screening programmes, for exemption from co-payment, etc.). These programmes are implemented through the Ministry of Health.

By ensuring the greatest possible level of gender equality and social inclusion (GESI) in health insurance, the necessary steps are provided in observing the principles of universal health coverage. In this context, this document will address the weaknesses and shortcomings, presenting them across the three dimensions specified above: For whom? What? and **How much?**

Identified Health Insurance Weaknesses Associated with GESI

For whom? – Which population is covered and which is left behind?

The Law provides the basis for all citizens in our country to be included in health insurance. The Law is inclusive and there are almost no persons left behind when it comes to the right to obtain health insurance. Employed people, unemployed people, pensioners, individual farmers, religious officials, persons under social protection, detached workers, foreigners working or studying in Macedonia, prisoners, fighters, etc. may all become health insurance holders.

However, obtaining a health insurance does not necessarily mean having access to health services. After regulating the grounds of health insurance (by way of registration with the Fund on a ZO-1 application form), the basic requirement is that the health insurance contribution be paid to the Fund by the contributor. Employers are the contributors paying the health insurance contribution for their employers; for the unemployed people it is the Ministry of Health or the insured persons themselves; for the persons under social protection it is the Ministry of Social Policy, Demography and Youth, etc.



Moreover, it is important to point out that health insurance in our country is provided on a family basis, meaning that every person holding a health insurance has the right to cover his family members with the same contribution – spouses and children born in wedlock or out of wedlock, adoptive parents, adopted children and dependent children. Children of health insurance holders are covered by health care until they reach the age of 18, or until they reach the age of 26 in the case of university students.

One of the indicators of the comprehensiveness of our health insurance is the number of people insured. Namely, according to the latest data available from the State Statistical Office (SSO), the most recent population estimate (as of 31.12.2022), and the latest 2021 census of population, there are 1,829,954 residents in the Republic of North Macedonia. In December 2022, 1,854,400 insured persons were registered with the Fund, which is more than the estimated number of residents in the country.

1.828.954

Number of residents
according to the
2021 census

1.854.400

Registered insured
persons - December 2022

However, is it really true that “no one is left behind”?

Like any other system, our health insurance system, too, has its risks, even when looking at the first steps that are necessary to access health care, i.e. registration with the Health Insurance Fund and paying the contribution. We have listed below the cases that have been identified as possible areas of improvement in this segment.

Do All Minors Have Equal Access to Health Services?

The Law does not allow a minor to be an independent holder of health insurance, hence the following weaknesses:

1. Whether or not a minor insured through a parent or guardian will benefit from health care depends on whether or not the health insurance contribution has been paid for the health insurance holder (the parent).
2. By way of this provision, the Law puts a particular group of minors in a disadvantaged position, in that they cannot benefit from health care if the contribution has not been paid for the parent, as the insurance holder. One should keep in mind that the health insurance contribution for family members is not paid separately.
3. Children without parents who are placed in foster care facilities immediately after their birth become registered in the Fund's system as independent health insurance holders, even though there is no such provision in the Law.



Proposed Amendments:

In order to overcome the discrimination with regard to the exercise of the right to health care for all minor children, and bearing in mind that there are no financial implications, we propose that an addition be made to Article 5 of the Law, which defines the grounds of insurance, and add a new ground of insurance reading "Children under 18 years of age, unless otherwise insured".

By introducing the new ground of insurance, minor children will continue to be able to be insured as members of the family, however, in circumstances when there is an obstacle to the exercise of the right to health insurance, they will be able to become insured on this new ground. This constitutes a form of additional care for young people that sends a reassuring message about how important the youth are for our country. We would also like to point out that such a legal solution is already working in Serbia.¹

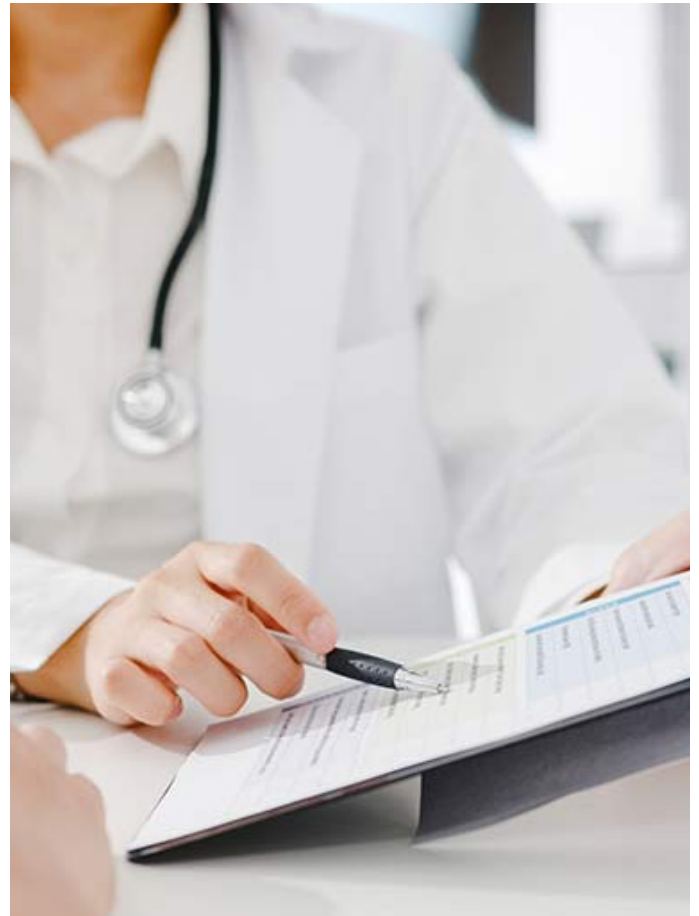
¹ Article 16 Paragraph 1 Point 1 of the Law on Health Insurance of the Republic of Serbia provides that "A person who does not meet the requirements to obtain health insurance on any of the grounds provided for in the Law, nor to be insured as a family member, may become self-insured: –children until reaching the age of 18, and for school children and university students until the end of their regular schooling, and not later than reaching the age of 26".

What Barriers Are Faced by Vulnerable Groups of Citizens Who Have Lost Their Jobs?

Persons are registered in the compulsory health insurance system as health insurance holders on one of the grounds specified in Article 5 of the Law on Health Insurance. On the other hand, in its Article 10, the Law on Compulsory Social Insurance Contributions regulates the contributors who should pay the compulsory health insurance contribution in relation to all health insurance grounds.

The Fund is the competent institution to implement this provision and grant the status of a health insurance holder to an unemployed person who has no other grounds for insurance, in accordance with Article 5 Paragraph 1 Point 15 of the Law on Health Insurance and Article 10-a of the Law on Compulsory Social Insurance Contributions, to which end the Fund uses the data from the Public Revenue Office.

The Fund grants the status of a health insurance holder to the above-mentioned category of persons by way of a resolution adopted ex officio, based on the request submitted by the person and the data retrieved from the Public Revenue Office.



According to Paragraph 1 of Article 10-a of the Law on Compulsory Social Insurance Contributions, a citizen may exercise their health insurance rights if they **have earned an income in the previous calendar year not exceeding the annual net amount of the minimum wage for the previous year** according to the law. Paragraph 2 of this Article regulates that a citizen may exercise their health insurance rights **even if they have earned an income in the previous calendar year exceeding the annual net amount of the minimum wage for the previous year**, but not exceeding the annual amount of the minimum basis for calculating and paying the contributions, **only in the case when in the previous two months they have earned an income that is less than the amount of the minimum wage for the previous year** according to the law on a monthly basis.

In accordance with the provisions of the Law on Compulsory Social Insurance Contributions, at the beginning of February each year, new limits are published as to the income earned on family level for the previous year, according to which persons are registered with the health insurance system. This derives two groups of people:

- people with lower incomes, whose contributions are paid by the Ministry of Health,
- people with higher incomes, who pay for their own contributions.

In 2024, the Ministry of Health was paying the health insurance contributions for persons whose family net income in 2023 was lower than 242,100.00 denars. The Ministry also pays for those people whose family income was between this level and 345,564.00 denars, in the case when their family income made in the previous two months was less than 40,350.00 denars. Everyone else pays their own contribution, and in 2024 it stood at 1,852.00 denars on a monthly basis.

² Преземено од веб-страницата на Фондот: <<https://fzo.org.mk/proekt-za-nevraboteni-lica>>

According to the legal provisions specified above, the group of “people with lower incomes” should also include persons who lost their jobs in the course of the year and have earned an income in the last two months less than the amount of the minimum wage in the previous year. However, this provision does not apply.

To paint a clearer picture, we would like to point out the case when in granting the status of a health insurance holder to a person who has lost their job, their income made in the previous year when they were receiving their salary will not be taken into account, if they provide evidence from the PRO that in the previous two months they have earned an income that is less than the amount of the minimum wage for the previous year. In this case, the health insurance contribution for this person is paid by the state, i.e. by the Ministry of Health. The problem arises when this person cannot provide evidence from the PRO of the income made in the last two months, and thus cannot exercise their legally safeguarded right to have the state pay for their contribution.



In such a case, the Fund can only take into account the income made in the previous year as already processed by the competent institution and make a charge for payment of the health insurance contribution.

Taking the applicable legal provisions into account, we would like to point out that the income made in the previous year does not provide true data on the current financial situation of the insured person and their family. Also, a person who has lost their job in the course of the year does not have the opportunity to submit evidence before the institutions that they have made an income in the previous two months less than the amount of the minimum wage for the previous year.

A real picture of a person’s financial situation can only be obtained if the Fund conducts an ex officio check with the PRO of the income for the last two months prior to the application for voluntary health insurance for all persons wishing to access the voluntary health insurance.



Proposed Amendments:

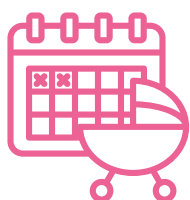
In order to ensure the proper and equitable determination of the insurance ground for persons who have lost their job, it is necessary for the Minister of Health to move forward with amendments to Article 10-a of the Law on Compulsory Social Insurance Contributions, which will allow for real-time inter-institutional verification of income for all persons when determining their insurance ground, with only the income of the last two months (or only for the previous month) being checked before joining the health insurance system, rather than the income of the entire last year.



Article 9 of the Law on Health Insurance and the Rulebook on the Content and the Manner of Exercising the Rights and Obligations of Compulsory Health Insurance regulate the rights enjoyed by persons who are insured with health insurance. However, weaknesses and unfair access to rights have been identified. Some of the **barriers to accessing specific rights from health insurance** are listed below.

Why Are Some Pregnant Women Excluded from the Right to (Full) Maternity Leave?

The right to a leave pay during a temporary incapacity to work is one of the statutory rights deriving from the compulsory health insurance laid down in the Law on Health Insurance (Articles 13 to 23). Leave pay is reimbursed if the insured woman is in an employment relationship but is prevented from going to work on account of illness, injury or pregnancy, childbirth and maternity. The requirement for accessing this right is that the insured woman has been employed for at least 6 months prior to childbirth, that her health insurance contribution has been paid regularly, and that the chosen primary gynaecological care provider has issued an assessment of temporary incapacity to work.



During pregnancy, childbirth and parenthood, a woman has the right to:

9

months of uninterrupted paid leave

12

months of uninterrupted paid leave if she has given birth to multiple children at once

The leave pay is reimbursed for the period of time determined by the labour relations regulations. This means that during pregnancy, childbirth and parental leave, the woman is entitled to a paid leave from work for an uninterrupted duration of 9 months, or 12 months if she has given birth to multiple children at once (twins, triplets and more). The funds for the exercise of this right are provided from the Budget of the Republic of North Macedonia through a competent authority.

However, the amendments to the provision of Article 170 Paragraph 2 of the Law on Labour Relations made in 2015 have made it possible to ensure equality of women workers in terms of their entitlement to leave pay during pregnancy, childbirth and parenting. This is not only about them taking time off from work, but is also about providing for them financially during one of the periods of life when mother and child are most vulnerable. In such cases, the timing of the commencement of pregnancy leave is important as a prerequisite for exercising this right. A woman worker with a fixed-term employment contract, despite the termination of her employment relationship, is equal in terms of using the leave pay to a worker with a permanent employment contract.

Article 170 (Paragraph 2) of the Law on Labour Relations

“THE WORKER USING A LEAVE ON ACCOUNT OF PREGNANCY, CHILDBIRTH AND PARENTING, CHILD CARE AND CHILD PROTECTION SHALL BE ENTITLED TO A LEAVE PAY UNDER THIS AND OTHER LAWS AND THE COLLECTIVE AGREEMENT. AN EMPLOYEE WHOSE FIXED-TERM EMPLOYMENT CONTRACT HAS BEEN TERMINATED THROUGH EXPIRATION OF THE CONTRACT AND IS RECEIVING A LEAVE PAY DURING A LEAVE ON ACCOUNT OF PREGNANCY, CHILDBIRTH AND PARENTING, SHALL CONTINUE TO EXERCISE THEIR RIGHT UNTIL THE EXPIRY OF THE LEAVE AT THE EXPENSE OF THE AUTHORITY RESPONSIBLE FOR IMPLEMENTING THE COMPULSORY HEALTH INSURANCE.”

Contrary to the intent for which it was introduced, this measure creates inequality because, in practice, this right can only be exercised by women workers who are registered on a fixed-term employment contract, and not by women workers registered on a permanent employment contract, and whose employment relationship has terminated in the course of their maternity leave on any ground (bankruptcy, liquidation, redundancy, etc.).

Another problem is that the right provided for in the Law on Labour Relations to women workers who are registered on a fixed-term employment contract is not at the same time regulated by the Law on Health Insurance, given that the compulsory health insurance enforcement authorities are competent for the application of this provision. Such a legal gap in the Law on Health Insurance leaves room for different interpretations as to which insured persons this right applies to.



Proposed Amendments:

In order to overcome such discrimination, we propose that Article 170 Paragraph 2 be amended to give the right to continued reimbursement of leave pay on an equal footing as with all women workers whose employment relationship has been terminated on any ground during the period of using the maternity leave, irrespective of the form of their employment (fixed-term or permanent), or Until amendments are made to Article 170 Paragraph 2 of the Law on Health Insurance, it is necessary to add a new paragraph to Article 52-a of the Law in the form of derogation that the reimbursement of leave pay on account of pregnancy, childbirth and maternity shall continue even after the termination of employment of the insured person registered on a fixed-term employment contract.

Another category that needs to be covered is individual women farmers, who, due to their specific employment status, are not covered as health insurance holders entitled to leave pay for childbirth and maternity. It is therefore necessary to recognise a special right to maternity leave pay in the Law on Health Insurance for individual women farmers.

It is recommended that the right of individual women farmers be named differently, in a separate article of the Law on Health Insurance so that there are no unnecessary remarks that this does not concern a right deriving from employment relationship. It is also necessary to add a separate article to regulate that individual women farmers will be entitled to a leave pay on account of pregnancy, childbirth and maternity. This article will define the right, determine its duration, and specify that the funds will be provided from the state budget. Furthermore, it is important to add a separate article (following Article 14) which will set the amount of leave pay in the amount of a percentage of the average salary or in the amount of the minimum wage stipulated by law. This article should also regulate the payment method.³

³ You can read more about the proposals to address the issue of non-provision of paid leave on account of pregnancy and maternity to individual women farmers at the following link: <https://mzd.mk/wp-content/uploads/2023/10/Mreza-zazashtita.pdf>

What Reproductive Health Services Should the Package Expand With?

Article 10 of the Law lists 21 groups of health services which are not covered by compulsory health insurance, including: *medicines that are not specified on the List of Medicines (this also includes oral contraception, since currently no pharmaceutical product of this group is on the List), *termination of pregnancy, if not medically indicated, *artificial insemination after a third failed insemination attempt.

To overcome the challenges created by the restrictions in exercising reproductive health rights, which are experienced by health insurance holders, and especially socially vulnerable groups of citizens, we propose expanding the package of services as follows:



1. Provision of Contraceptives:

Sexual and reproductive health services fall within the defined scope of primary health care. The Rulebook on the Content and the Manner of Exercising the Rights and Obligations of Compulsory Health Insurance in the Primary Health Care Provided by the Chosen Primary Care Provider, which they are obliged to provide to the insured person, includes, among other things, preventive measures for “the protection of women in connection with pregnancy, childbirth, postpartum care and contraception” (Article 28). However, the Rulebook sets no restrictions that these services should only be provided by the chosen primary care provider in the field of gynaecology.

In our country, no modern contraceptive method is specified on the Positive List, and is therefore not paid for by the Fund. Women are particularly disadvantaged because they do not have the financial means and must cover the cost of contraception out-of-pocket in order to be able to properly plan for family and maternity.



Proposed Amendments:

Certain modern contraceptives should be covered by health insurance for specific target groups at the primary level of health care. This will allow for the real and full exercise of the women's right to health care in relation to contraception through chosen primary care providers. If this concerns contraceptives that include a hormonal component, they should be included in the Positive List of Medicines; and if this concerns other methods, the possibility should be considered of including them in the List of Orthopaedic and Other Aids.



2. Termination of Unintended Pregnancy:

Under the Law on Health Insurance, termination of unintended pregnancy, unless medically indicated, is not paid for by the Fund.

Vulnerable groups of women do not have the opportunity to terminate unintended pregnancies and are often forced to keep the child in families with multiple children (or single-parent families) without adequate care and developmental conditions. Given this, it is very important that the Fund covers the costs of unintended pregnancy termination for these insured persons.



Proposed Amendments:

In order to leave room for free choice and individual decision-making regarding family and maternity planning for all, both for those who wish to have offspring and for those who do not wish so or cannot afford

- Deleting the Point 9 of Article 10 – “Termination of pregnancy, if not medically indicated”. This way this health service will become included in the basic package of services for all insured persons, or
- Amending the Paragraph 9 of Article 10 – “Termination of pregnancy, if not medically indicated, except for vulnerable groups under social protection regulations”.



3. Reproductive Care and Support for Biomedically Assisted Fertilisation (“In-Vitro”):

Health insurance, according to the provisions of the Law, includes services ranging from reproductive assistance to a third unsuccessful fertilisation attempt.

One should consider how much money is required for a young family to undergo these lengthy and uncertain procedures, which may all, within the three attempts paid for by the Fund, result in failures, meaning that all further attempts should be paid out-of-pocket. Therefore, at the public hearing held in the RNM Assembly on 31.05.2022 on the topic of:

“With Legislative Amendments to Greater Support for Patients Facing Infertility”, organised by the Association for Human Reproduction and Biomedically Assisted Fertilisation, the main emphasis was placed on increasing the number of approved procedures for in-vitro fertilisation to a total of six, regardless of whether it is for the first, second, third or fourth child.



Proposed Amendments:

To provide more opportunities for couples experiencing infertility and seeking help to start a family, it is necessary to increase the number of in-vitro procedures paid for by the Fund by amending **Point 10-a of Article 10** as follows:

10-a) artificial insemination following a sixth failed fertilisation attempt, regardless of whether for the first, second, third, or fourth child.

In the countries of the region (Serbia and Croatia), this right is given much more broadly than the current regulations in the RNM. ⁴

Sa? – A varfëron kostoja disa të siguruar?

Data from the national health accounts show that the healthcare system relies heavily on out-of-pocket payments. In 2018, the share of out-of-pocket payments in current healthcare expenditure was **42%**, far above the **EU average of 22%**. Out-of-pocket expenses for health care in Macedonia are mainly made for **medicines dispensed by pharmacies**, followed by outpatient treatment. While in 2006 medicines accounted for 67% of all out-of-pocket payments made by families for health care, this share has increased to **80% in 2018**.



42%



22%

EU average

The share of out-of-pocket payments in current healthcare expenditure



According to the Law, the Fund covers the costs incurred by health facilities for health services provided according to predefined (reference) prices. Moreover, it has been envisaged that health insurance holders should contribute with out-of-pocket payments up to 20% in the cost of health services and up to 50% in the cost of orthopaedic and other aids. When the Law was passed in 2000, this provision served as a protective social measure, the purpose of which was to limit the healthcare-related financial burden on citizens, at least for services covered by the package, at a level of up to 20%. This level corresponds to the average out-of-pocket payments by EU citizens. However, 18 years later, out-of-pocket payments in the country have doubled from this level, which has been found to be acceptable, and according to the WHO analysis, the biggest driver of this is the cost of medicines dispensed in pharmacies. As established by WHO, the reasons for this are complex, but one of them is the exemption from co-payment policy.

⁴ Serbia – Article 5 of the Rulebook on the Content and the Scope of the Health Care Rights and Compulsory Health Insurance and Co-payment regulates that the following expenses are covered by the Fund: – for the first child, for an unlimited number of attempts and an unlimited number of frozen embryo transfers up to the age of 45 of the woman; – for a second child, for two attempts and three frozen embryo transfers up to the age of 45 of the woman; – three stimulation procedures and three frozen embryo transfers with donated sperm in women who do not have a child and do not have a partner. Croatia – Article 10 Paragraph 5 of the Law on Biomedically Assisted Fertilisation provides that the treatment of infertility in an insured person by way of a medically assisted fertilisation procedure covered by the Croatian Health Insurance Fund includes: – four attempts at intrauterine insemination (IUI); – six attempts at extracorporeal fertilisation (IVF); with two attempts mandatorily being in a natural cycle.

Should Certain GESI Target Groups Be Further Exempted from Co-Payment?

Article 34 of the Law, as well as certain government programmes, provides for co-payment exemption of health insurance holders as a protective measure for persons at health or socio-economic risk (cases of illness or a health condition, low income, age, etc.). However, for prescription medicines paid for by the Fund this exemption only applies to people with special needs and to people with organ transplants (but only for two medicines).

Unlike with prescription medicines, when it comes to health services, the target group of beneficiaries and the coverage of diseases that are exempted from co-payment are much larger (pregnant women, newborns, people with cancer, HIV, tuberculosis, measles, hepatitis and other infectious diseases, progressive, nervous and muscular diseases, cerebral palsy, cystic fibrosis, epilepsy and other diseases; then. people with lower family incomes, people who have exceeded a particular annual level of payment, blood donors, guaranteed minimum assistance beneficiaries i.e. persons unable to work and beneficiaries of alternative care, etc.).



Proposed Amendments:

To implement the amendments to the Law so as to extend the scope of the exemption to also include co-payment for prescription medicines.

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