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The Impact of Social Assistance Programs on Reducing Inequities in Health Care Among Vulnerable Groups in the Republic of Macedonia (A Small Scale Descriptive Study)

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Abstract

Aim. The aim of this research was to look at the impact of social assistance programs on reducing social inequities in health care among the vulnerable groups in Macedonia.

Materials and methods. A small scale descriptive study was conducted using open ended questionnaire among the homeless, socially excluded Roma and people dependent on state provided financial allowances. These vulnerable groups were considered to be at highest risk of poverty and social exclusion.

Results. Our research findings indicate that there are differences and inconsistencies in the implementation and effectiveness of the social assistance programs for the beneficiary populations in Macedonia. We found that these people were exposed to high financial expenses needed to access the health care services. This situation contributes to the deepening of their poverty.

Conclusions. There is need to raise the awareness and to improve the communication strategies of the Government. Special programs should be designed and implemented at local level to target these vulnerable groups in order to increase the availability and access to health care services.

Introduction

In Macedonia there are no monitoring and evaluation systems of the social assistance programs and their impact on reducing the inequities in health care (1) among vulnerable populations. At the same time, health inequities are not evaluated as well. The official Macedonian institutions are producing annual reports on the general health related issues, but little efforts are done to measure the health inequities among beneficiaries of social assistance programs.

The Republic Institute of Health Protection is producing annual reports on the general health status of the population by regions and towns. Regional Institutes of Health Protections collect, analyze and disseminate morbidity data, while the mortality data are collected by the State Statistical Office. These data show significant differences in the health status by ethnicity, region and employment status among Macedonian population (2).

Apart from the official statistics, a study conducted in 1996 measured the inequities in the delivery of health services and found significant variations in the quality of clinical care as well as in self-reported health status of the population in four surveyed municipalities (3).

Social inequities in health care delivery are directly influenced by the widespread poverty in the country and the financing of the health care system. According to the data of the State Statistical Office for 2007, it was estimated that 29.4% of Macedonian population live in poverty (4). In addition, the Poverty Assessment Report for 2003 found that approximately 113,000 (6% of the population) had consumption expenditures below the amount needed to purchase the minimum food basket (Minimum food basket is estimated by the State Statistical Office). The poverty rate among the unemployed is 39.1%, and majority of the poor people (64.3%) live in households where the head has no, or only primary education (5,6). Recent studies found that the burden of payments for health services is yet increasing the poverty, particularly among socially vulnerable groups in the world (7), and the situation may be similar or even worst in Macedonia.

On the other hand, the financing mechanisms of the health care system have also an impact on the social inequities in health care, particularly among the vulnerable groups. In Macedonia the health system is financed by compulsory social contributions (8,9). The health contributions from public and private sector employees represented 8.6% of their gross salary before June 2001 when the contribution rate was formally increased to 9.2% (10). However, the existing health financing system faces serious challenges due to the high official unemployment rate (33.8%) in the country, resulting in a permanent lack of resources. This directly impacts the access of patients to the health care. In order to reduce the burden of contributions in the formal economy and to reduce the unemployment rate, the government has proposed an ambitious plan to decrease all social contributions, including those for health, from 9.2%, to 6% by 2011 (11). However, there are big concerns that the plan will have a negative financial impact on the health system. This may generate an increase of the already high out of pocket expenditures for the patients (See Table 1), widening the social inequities in the access to health care services (6,13).

Table 1: Household expenditure survey 2008.

Type of personal expenditure on health	Average expenditure on health per person in MKD	%
Total consumption on health care	2949	100
Drugs and medical devices	2020	68.5
Outpatient services	829	28.1
Hospital services	93	3.4

Source: Statistical yearbook 2008

Some vulnerable groups such as homeless and people beneficiaries of the social assistance programs are mostly exposed to be affected by the lack of resources of the health care system and the widespread poverty in the country. The government of the Republic of Macedonia has ongoing strategies and programs that target these population groups, but there is little available research to assess the impact and effectiveness of these programs.

The purpose of this study was to identify the limitations of the existing programs, their impact on reducing the inequities in access to health care for the beneficiaries and to make some recommendations for improvement.

The aim of this research study was to explore the socioeconomic conditions of these people, to assess their self reported health status, as well as their access to the health care.

Material and methods

We have conducted a small scale descriptive study among homeless and people dependent on the social transfers of the state. In addition, we have reviewed current strategies, programs and action plans targeting these people.

In Macedonia there are only two homeless shelters located in Katlanovo and Chichino Selo. There are three additional day care centres established by the Macedonian Orthodox Church and the Ministry of Labour and Social Policy. These facilities were suggested by the Ministry of Labour and Social Policy as locations where homeless people can be captured and interviewed. The residents of these centres are homeless people, socially excluded Roma and people dependent on the social transfers of the state.

An open-ended questionnaire was developed, covering aspects like demography, socioeconomic conditions and health status of the interviewed persons. A team of interviewers were initially trained in methodological issues and in conducting interviews. The managers of each centre were explained at first that the participation in the survey is voluntarily and anonymous. The interviews were conducted following an announcement on the purpose of the study. The residents were requested to volunteer for the interviews. Each of the residents who accepted to be interviewed was included. It was decided to interview around 30% of the total number of people accommodated in the homeless shelters. This percentage of respondents was considered to be a representative

sample for the population under study. The same methodology was applied in interviewing the people in the day care centres.

Results

The population under study consists of 33 individuals divided into three categories: Homeless people, poor and socially excluded Roma, and poor elderly people dependent on the services provided by the church.

Majority of the respondents were females 21, and additional 12 were males. Eleven of the respondents were in the group below 50 years of age, 17 were between 50-69 years and five persons were 70 years or older (see Table 2). Most of the females had children under the age of 18; eight of them had 1 or 2 children and six had 5 or more children. These 33 persons have in total 50 children or on average 1.5 children per person.

Table 2: Distribution of the interviewed population by age and gender.

Gender	Age groups						Total
	30-39 years	40-49 years	50-59 years	60-69 years	70-79 years	+80 years	
Female	5	3	4	5	3	1	21
Male	1	2	4	4	1	0	12
Total	6	5	8	9	4	1	33

Majority of the respondents, particularly people in the age group 30 to 59 years, became residents of the centres as a result of new urban planning in some of the Skopje municipalities (Butel, Kisela voda, Aerodrom). It is rather common for the municipality to decide to use the land of the old social houses to build new apartments or shopping centres. Under such circumstances, the residents of these social houses were forced to move elsewhere and they became eligible for social assistance programs financed by the State.

For these people accommodation is provided by the Ministry of Labour and Social Policy (MLSP) in one of the two homeless shelters in the surroundings of Skopje (Chichino Selo and Katlanovo). The social assistance care provided is not consistent to all homeless, depending on the locations where the homeless people were accommodated. Thus, our research revealed that the people who are accommodated in Katlanovo benefit of hotel-like accommodation and regular meals, but they do not receive any financial assistance (the so-called "social allowance") from the MLSP. On the other hand, the people who were accommodated in Chichino Selo, receive a social allowance in the amount of 1400 denars (app. 23 EUR) and accommodation, but they do not receive hot meals. The people in the latter group cannot afford regular meals since the social allowance is too small. Frequently, these people suffer of malnutrition which was obvious even by physical observation.

Opposite to the people who are accommodated in the homeless shelters, the people who use church services are in better financial position. Most of them receive social allowance and have their own accommodations where they live.

In general, the income level of these groups of people is very low and in most cases does not reach more than 6000 denars per month (an equivalent of 98 EUR) (see Table 3).

Table 3: Distribution of the income by gender of the respondents.

Gender	Persons by the level of income			Total
	No income	Up to 3000 MKD	3000-6000 MKD	
Female	8	8	5	21
Male	4	6	2	12
Total	12	14	7	33

The income of the respondents depends strongly on their age. Thus, the majority of the respondents in the age groups of 60-69 and 70-79 years have an income ranging between 3000-6000 denars per month. Among elderly, the pensions which are around 4000 denars represent an important factor to mitigate poverty. Most of the elderly people in the shelters live in poor health and they spent more than half of their pensions on pharmaceuticals and health care (see Table 1). The largest share of these expenditures goes for pharmaceuticals since there is no exemption for the co-payment. A smaller percentage is devoted for the access to hospital care. The high cost of pharmaceuticals influences the ability of these people to purchase an appropriate amount of food. They have frequently to choose between accessing health care services and pharmaceuticals or purchasing food for themselves and their immediate family.

Finally, a general characteristic of the group under study is their low education level. Almost all of the respondents had any formal education or had just finished primary education (32 of 33 respondents).

Twenty-five of the 33 surveyed persons reported that they suffer of some disease or distortion of their health status. Most of the females reported some health problems. The top four self reported health

Table 4: Distribution of respondents by the level of education.

	Persons by the level of education			Total
Gender	No education	Primary	Secondary	
Female	11	9	1	21
Male	3	9	0	12
Total	14	18	1	33

conditions of this group (for both sexes) were: psychiatric disorders; high blood pressure; heart problems; or depression.

Table 5: Distribution of self-reported health status by gender.

	Persons by self reported diseases			Total
Gender	Yes	No	Not available	
Female	18	1	2	21
Male	7	2	2	12
Total	25	4	4	33

In terms of economic and geographical access to health care most of the respondents reported different problems. The main problems were related to the lack of health insurance and long distance to the nearest health care facilities. Half of the respondents who self-reported health problems have health insurance. The absence of the health insurance has hindered the access to health care for the other half (see Table 6).

Table 6: Distribution of health insurance coverage by gender of the interviewees.

	Persons by health insurance coverage			Total
Gender	Yes	No	Not available	
Female	12	9	0	21
Male	3	5	0	8
Not available	1	2	1	4
Total	16	16	1	33

Our findings show that the access to health facilities and pharmaceuticals depends on the location of the shelter where these people are accommodated. For instance, most of the residents in Katlanovo have health insurance and accordingly regular access to primary health care services. In addition, GPs visits twice per week are organized to perform regular check ups to their patients. Attending doctors provide drugs and treatment whenever needed. There is not any additional cost for these services.

For the specialist health care services, the homeless from Katlanovo visit the clinics in Skopje, which is 35 kilometres away from the shelter. The residents need to use public transportation to access the secondary and tertiary health services because there is no organized transport. This is an additional financial burden to the limited budgets available to these people. There is also a financial obstacle in the access to pharmaceuticals that are not provided by the homeless centre. The residents need to purchase the necessary drugs with a co-payment from the pharmacies in Katlanovo. If the drugs included in the positive list [Positive list refers to the drugs covered by the Health Insurance Fund, available in Macedonian (12)] are not available, the individual have to pay the full price of the drug instead of small co-payment.

The people accommodated in Chichino Selo (village) have health insurance and receive primary health services. Primary health care is provided in the nearest health facility or in some of the nearby clinics of primary medicine. The distance to these facilities varies depending on the location of the current accommodation. Thus, for the inhabitants of Chichino Selo the distance to the first clinic is around 5 kilometres (to the municipality of Gjorche Petrov policlinic). The other alternatives, like Idadija policlinic in the center of Skopje are located 12 km away from their place of residence. The longest distance is up to 15 kilometres to access the Bit Pazar health center. These facilities can be accessed by public transportation that absorbs part of their very limited financial resources.

The residents in Chichino Selo usually purchase their medications in cash and were not informed that the pharmaceuticals can be obtained with prescription from the doctor and small co-payment. Unfortunately, the prescription is not always a guarantee that the drugs will be available at the pharmacies, since there is chronic lack in supplies of all drugs in the positive list. Thus, these people spend half of their income on medications and access to health care. This observation confirms the findings from the recent Household Survey from 2008, the average expenditure for pharmaceuticals representing the largest expenditure for health (Table 1).

The people who use the services offered by the churches are in a better financial position since most of them receive social allowance or have minimal pension. In addition, they have their own accommodation such as house or an apartment. However, they are still very poor as their available financial resources do

not cover the basic living expenses. Similarly to other respondents in our survey, these people reported significant financial barriers in the use of health services and drugs.

Discussion

The findings of our research indicate that there are differences in the effectiveness of the social assistance programs in Macedonia. Most of the beneficiaries of these programs went into poverty and became eligible for social assistance largely as a result of poor economic situation of the country, and few opportunities to find a job. A key factor that prevents them finding a job is their low education level.

More than half of the respondents benefited from at least one of the social assistance programs. These programs were designed to provide accommodation to the homeless, or to financially support them.

Our study has revealed that the beneficiaries are not always aware of the content of the social assistance packages and of their rights. This refers mainly to the availability of the health insurance, as well as to the existence of safety nets for the co-payments of pharmaceuticals and use of hospital services (14-16). Most of the respondents reported that they were not aware on the criteria required by the Health Insurance Law how to access the health insurance. This finding may indicate that communication toward the beneficiaries represents a weakness of the social assistance programs. In addition, huge administrative obstacles and documents requested by the authorities jeopardises the access to the social assistance programs. Also there is no organized system for assisting these people to find jobs and usually they are forced to look for short term, underpaid jobs on the informal market in order to support their living standard.

According to the existing legislation, the health insurance is provided to all people officially registered as unemployed at the Agency for employment. Unemployed who are not registered are eligible to access the health care services within the frame of one of the thirteen special preventive programs financed by the State budget. This program is designed to cover the health expenses of the uninsured, being administered by the Ministry of Health.

Finally, our findings show that the access to health facilities and use of pharmaceuticals depends on the location of the shelters where the beneficiary populations are accommodated. Thus, while in one of the centres there are regular visits of GPs and free disbursement of pharmaceuticals, the residents of the other shelter did not benefit of such privilege and were forced for additional financial burdens to access the health care facilities. The problem of economic access to the health care services represents a particular matter of concern in tackling social inequities in health in developing countries. Frequently, the vulnerable groups are forced to pay for health services and pharmaceuticals and consequently, pushed into deeper poverty, a phenomenon known as medical poverty trap (17,18). Thus even for the pensioners in our group who have regular but small monthly income, the mitigating effect of the pensions is influenced by their deteriorating health status and the health care related expenditures particularly for pharmaceuticals.

Limitations of the study. The findings presented here are based on a research of small group of respondents that may not be representative for the general situation in the country. Due to the fact that only volunteers have been interviewed, the findings could have been biased. We believe that this study provides initial insights and further research and analyses are required to determine the impact of social assistance programs to the level of inequities in health care among these groups of people.

Conclusions. This study shows some gaps in the existing contents and implementation of the social assistance programs and it points on the need for their improvement. The global financial crisis that threatens the world may affect the country with even deeper unemployment and poverty. This may result in more people becoming depended on the state provided social assistance. Therefore, these programs need to be consistent in their approaches and in the benefits they offer to their recipients, particularly in the terms of access to health care services. There is also a need to support and strengthen the research on the effectiveness of social programs. The existing programs must be supported by specific communication strategies targeting the residents of the homeless shelters, the poor and other disadvantaged groups on their right to health insurance and health care. Otherwise, poor education and low access to information among these people may further widen the social inequities in health status of our population. The country needs to revise the design and implementation of the existing social assistance programs and to set up regular system of monitoring their impact.

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