Health inequity and COVID-19 in North Macedonia

Investing in health and well-being for a fairer and more equitable future for all

UNEQUAL RISKS OF INFECTION AND SEVERE ILLNESS

UNEQUAL EFFECTS OF CONTAINMENT MEASURES

UNEQUAL CONSEQUENCES OF SOCIOECONOMIC IMPACT
ABSTRACT

This paper summarizes the impacts of COVID-19 and containment measures on health, the health system and essential health goods, services and resources, such as housing, fuel, food, income and employment, in North Macedonia. In considering actions taken so far to contain COVID-19 and mitigate its negative effects, the paper also highlights areas in need of greater attention to ensure that no one is left behind in North Macedonia, and signposts policy opportunities to enable transition to a better, fairer and more equitable future for all.

Keywords

HEALTH AND SUSTAINABLE DEVELOPMENT
LEAVING NO ONE BEHIND
SOCIAL DETERMINANTS OF HEALTH
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Strengthening of the health system has been the main focus of the national priorities for North Macedonia in recent years. A series of system-wide interventions and reforms have been initiated for better health and social protection, and quality of care and services. At the primary care level, with the support of WHO, we designed primary health care reform in line with the Astana Declaration of 2019. The COVID–19 pandemic has additionally heightened the need to intensify our efforts and to continue restructuring of the health system in a way to ensure high-quality care for all people in the country irrelevant of their situation. We would like to see no gaps in access to both prevention and health care between rich and poor, urban and rural, older and younger, men and women, and to provide all means for improved universal health coverage for all.

Primary health care has been on the front line in responding to the COVID–19–related health impact on the people and contributed to our public health actions, such as contact–tracing, close monitoring of COVID–19 patients in their homes and deployment of the COVID–19 vaccine. In addition, primary health care endeavoured to maintain essential care services for patients with chronic conditions, pregnant women and newborns, and routine vaccinations.

In fulfilling our national goal to leave no one behind, we continuously increased the budget for people with rare diseases to be completely covered with suitable and modern treatment options and issued the national strategy for rare diseases for 2020–2030.

The digitalization of services and the building of strong electronic systems should continue, as COVID–19 has provided an opportunity for rapid implementation of digital tools to reach people in need.

Monitoring socioeconomic impact is also one of most relevant ways to address the well known fact that not all people are affected equally by the health, social and economic impact of the COVID–19 pandemic. Building on this understanding, we are able to identify the most vulnerable with particular health needs and design interventions for better support.
In North Macedonia, we have observed that older people are particularly affected by COVID-19: they are more vulnerable to COVID-19 complications and risk of death. At the same time, younger people are bearing the burden of prolonged lockdowns and curfews in terms of access to health-related goods and services such as education and work-related opportunities.

The *Health inequity and COVID-19 in North Macedonia: investing in health and well-being for a fairer and more equitable future for all* report comes at the right time as the country is working on facing acute needs for rapid response to the pandemic crisis and transitioning to a more sustainable and resilient health system. It demonstrates that investment in health, health systems and addressing health determinants needs to be at the heart of socioeconomic COVID-19 recovery. The report guides us towards potential timely and proportionate all-of-government and all-of-society interventions in the health sector and beyond to ensure that negative impacts of COVID-19 and its containment measures on people do not become long-term structural problems. We look forward to being able to use this methodology for wider monitoring of health determinants across the health system. This is based on our conviction that addressing vulnerabilities will prevent deterioration in human capital and in economic development both in the short and long terms with better responses and a comprehensive national recovery strategy.

**Dr Venko Filipche**
Minister of Health, North Macedonia
FOREWORD BY THE WHO REGIONAL DIRECTOR FOR EUROPE

There is an unprecedented understanding among the public, governments and the international community that health is critical to the stability, resilience and sustainability of our societies and economies. This has been demonstrated during the height of the COVID-19 pandemic, and it is vital now as we focus on transition and efforts to build a better future.

The pandemic has touched all of us and all aspects of our lives. But the effects have been more devastating for those who were already living in poor health, in poor quality homes, in underdeveloped, fractured communities and at risk of poverty and discrimination. New vulnerabilities have also emerged. Those with chronic health conditions, children excluded from learning, young people not in employment, education or training, and women, who comprise as much as 80% of the health and social care workforce, have been particularly hard-hit.

We will not be able to move forward when so many in our societies are falling behind. Closing gaps in health and well-being within and across countries of the WHO European Region is therefore not only the right thing to do; it is also the smart thing to do for any country that is committed to building a better future.

A major priority of the WHO European Programme of Work 2020–2025, “United Action for Better Health in Europe”, is to make sure that we level up health for all and invest in the right kind of policies and systems that leave no one behind. Within the health sector, big achievements can be made through strengthening universal health coverage, removing impoverishing co-payments and scaling up gender-responsive primary care based on multidisciplinary models of delivery implemented in partnership with community-based organizations.

We know that we are not alone in taking action to build a fairer and healthier future. Across governments, other ministries want vibrant economies, nonviolent societies, well educated and informed citizens, and resilient, sustainable environments, as described by the Sustainable Development Goals. There is a way to realize all these goals together, and health equity is core to that way.
We from public health need to join forces with other public sectors to leverage the common space around prioritizing public goods for health equity, such as decent and affordable housing, universal social protection, secure employment and healthy working conditions, universal digital connectivity and the green economy. These bring co-benefits for health, human capital, fiscal stability, inclusive growth and social cohesion.

Strong health leadership is essential to address these interconnections and the work of North Macedonia presented in this report shows how countries are taking the initiative to invest in health and well-being for a fairer and more equitable future for all.

The work is an inspiration to other countries, and I am convinced that we can succeed and have more impact by establishing political and technical alliances, working across the whole of society, to build commitment and consensus to achieve a culture of health equity and well-being for all. This is a powerful signal of a successful and sustainable society.

Dr Hans Henri P. Kluge
WHO Regional Director for Europe
WHY INVESTING IN EQUITABLE HEALTH AND WELL-BEING FOR ALL AND IN HEALTH SYSTEMS IS CENTRAL TO BUILDING A BETTER FUTURE FROM COVID-19

Although COVID-19 infects those exposed indiscriminately, the risk of exposure and the severity of its health, social and economic impacts are not equal. Those with poor health and insecure lives and livelihoods before the pandemic are experiencing these negative impacts most, and this in turn places increased pressure on health systems that already are under stress from COVID-19. Even before the pandemic, evidence from 25 European countries suggested that avoidable inequities in health are estimated to cost 9.4% of gross domestic product (GDP), or €980 billion, with approximately 15% of these costs passed on to social security systems and 20% to the health-care system (1). In addition to increases in morbidity and mortality, the exacerbation of inequities that existed before COVID-19, as well as the emergence of new vulnerabilities during the pandemic, may result in the deterioration of human capital and uneven developmental outcomes in both the short and long terms unless timely and proportionate responses and a comprehensive recovery strategy are put in place.

Investing in health systems protects health and supports sustainable and equitable recovery for all across sectors. Evidence suggests that one year of additional average life expectancy corresponds to 4% GDP growth, and in high-income countries, a 10% decrease in cardiovascular disease mortality corresponds to 1% GDP growth (2). One key mechanism underlying the bi-directional relationship between health and the economy is employment. The health sector is a sizeable employer in every economy as well as a significant source of decent work, providing health and social protection for its workers and their families. An analysis of the health sector in North Macedonia in 2019 revealed that almost 70% of employees in the health sector are publicly employed, with nearly all of them (97.7%) having decent contracts that include social benefits in the form of pensions and health and unemployment insurance (3). In 2017, employment in health and social work increased in northern, southern and western Europe to account for over 12% of all jobs, and this figure is expected to increase (4). When compared to 62 other sectors across the WHO European Region, the health sector had one of the greatest impacts on household income, thereby contributing to fiscal stability (3). A recent analysis of the
health sector’s impact on the national economy in North Macedonia showed that in both 2010 and 2015, a €1 increase in spending in the health sector led to an estimated increase of €1.31 in household incomes (3).

Evidence from previous crises suggests that underinvestment in health systems during the COVID-19 response and recovery will raise levels of ill health and increase financial hardship, which undermines progress toward universal health coverage (5). Together, this will lead to increases in noncommunicable diseases and poor mental health that will limit participation in daily life and decrease social and economic resilience. This in turn will increase the risk of poverty and social exclusion and present long-term societal challenges to fiscal sustainability through many mechanisms. Poor mental health, for example, is likely to result in decreased productivity and an increase in early drop-out from the labour market, resulting in higher social welfare costs and lost tax revenues. Even before the pandemic, mental illness alone cost European Union (EU) countries, on average, more than 4% of GDP, with the direct and indirect effects from lost productivity and higher health- and social-care costs totalling €600 billion (6).

Health inequities resulting from, and exacerbated by, COVID-19 will also take effect systematically over the life-course and between generations. This occurs through: the accumulation of lifetime experiences of positive and negative health–influencing factors; variation in the substantiation of rights; inconsistencies in the provision of health and health–related goods; and lack of services and the resources needed to live a healthy life. Children of mothers who had poor access to and/or received poor-quality maternal and reproductive services, for example, are more likely to have worse child development and health in the first 1000 days of life (7). This in turn can lead to reduced ability to benefit from schooling, which may restrict employment opportunities, lead to greater poverty and create ill health both in adults and their children. Poor health in adults further reduces contributions to the economy and people’s earning potential. COVID–19 has constrained the ability to intervene positively and prevent the accumulation of negative life experiences that result in health inequities. As a result, COVID–19 may lead to more fundamental changes and transformations in the unequal distribution of health and socioeconomic risks, impacts and outcomes, with long–term implications for health and sustainable development.
In 2019, prior to COVID-19, there were substantial differences in health and in access to health-related goods and services and the resources needed to live a healthy life in North Macedonia.

- Almost 40% of the population (829 000 people, 39.9%) were at risk of poverty or severe material deprivation or were living in households with very low work intensity. This is almost double the EU average of 21.4% (8). Furthermore, 126 000 people (6.1% of the population) faced all three of these risks, which is over five times higher than the EU average of 1.2% (8) (Fig. 1). In 2018, just under 7% of households in North Macedonia were further impoverished, impoverished or at risk of impoverishment after out-of-pocket payments for health care, down from around 10% in 2006 (9). Poverty, particularly debt, is linked to higher rates of stress and mental ill health.

Fig. 1. At risk of poverty or social exclusion by type of risks, North Macedonia, 2019 (thousands)

Source: authors, based on data from Eurostat (8).
• The proportion of children at risk of poverty or social exclusion was 43.8%, which is again almost double the EU average of 23.1% (8). There is a strong association between material deprivation and under-5 mortality rates. Children living in poverty have poorer health and perform less well at school.

• The labour-force unemployment rate in North Macedonia was 17.3%, which is 2.75 times as high as the 6.3% rate in the EU (10). Decreased funding from payroll taxes, combined with relatively low contribution rates and low transfers from the state budget, limits the health sector’s resilience to economic shocks and leads to fiscal pressure and hospital deficits (9). Additionally, 18.1% of young people aged 15–24 were not in employment, education or training, compared to 10.1% in the EU (11). This has a negative impact on mental health, rates of suicide and substance abuse and skills development to participate in the labour market, with potential long-term consequences.

• The proportion of the population reporting their health to be poor or very poor was 9.1%, only slightly higher than the EU average of 8.4% (12). This figure rose with age to account for approximately 28.9% of those aged 65 and over, compared with an estimated 17.8% in the EU (12).

• Self-perceived long-standing limitations in usual activities due to a health problem was reported by 14.7% of people in North Macedonia, compared to 24.6% in the EU (12). Inequities in self-perceived long-standing limitations in usual activities due to a health problem according to years in education nevertheless are greater according to gender in North Macedonia than in the EU, with 2.5 times as many men and nearly five times as many women with the fewest (as opposed to the most) years in education having self-perceived long-standing limitations in usual activities due to a health problem (12) (Fig. 2). In the EU, two times as many men and nearly 2.5 times as many women with the fewest (as opposed to the most) years in education had such self-perceived long-standing limitations (12).
Compared to an estimated 3.5% in the EU, 4.9% of people in North Macedonia declared some form of unmet need for medical examination (12). Inequities in unmet need for medical examination according to years in education are much greater between North Macedonia and the EU than between genders. In North Macedonia, 4.5 times as many men and 4.72 times as many women with the fewest (as opposed to the most) years of education declared some form of unmet need for medical examination (12) (Fig. 3). In the EU, 1.46 times as many men and 1.25 times as many women with the fewest (as opposed to the most) years in education made this declaration (12) (Fig. 3).
In 2003, total spending on health in North Macedonia was on a par with the EU at approximately 9% of GDP; by 2007, total spending on health in North Macedonia declined to approximately 6.5% of GDP, where it has remained ever since, while it rose in the EU to almost 10% of GDP (Fig. 4) (13). Public spending on health has decreased as a percentage of total spending on health in recent years from a height of 66% in 2013 to 57% in 2018 (13). Nearly all private spending on health in North Macedonia is in the form of out-of-pocket payments. From 2003 to 2018, out-of-pocket payments declined from a height of 44% of total spending on health in 2003 to a low of 32% in 2008, only to rise again to 42% by 2018 (13). While the share of households with out-of-pocket payments declined from 62% in 2006 to 46% in 2018, inequities persist, as richer households consistently are more likely to have out-of-pocket payments than poorer households (9). In 2018, only 17% of households in the poorest quintile had out-of-pocket payments, compared to 70% in the richest quintile (9).

**Fig. 4. Total spending on health (% of GDP), North Macedonia and the EU**

Source: authors, based on data from WHO Global Health Expenditure Database (13).
COVID-19 and its containment measures have exacerbated pre-existing health and socioeconomic inequities. The negative impacts resulting from the pandemic tend to be greatest among those in the most vulnerable situations. In addition, COVID-19 has created new vulnerabilities. During the pandemic, negative socioeconomic impacts and their inequities have been experienced through three pathways: the direct effects of COVID-19 through differential rates of infection and outcomes; the direct effects of containment measures on the conditions of daily life and treatment for non-COVID-19 health conditions; and the subsequent interplay of adverse social and economic conditions, including those related to the environment, and health (Fig. 5) (14).

Fig. 5. Three pathways for COVID-19 socioeconomic impacts and their inequities

Source: WHO Regional Office for Europe (14).
How have the first two waves of COVID-19 changed the health equity landscape in North Macedonia?

The severity of the health impact from contracting COVID-19 in North Macedonia, including the burden of disease and mortality, varies according to socioeconomic factors, pre-existing health conditions, geography, age and gender. As of the end of January 2021 (15):

- 90,753 cases of COVID-19 had been registered, resulting in a cumulative incidence rate of 4482.6 cases per 100,000 people (15):
  - Shitp, a centre of the textile industry, and Skopje registered the highest incidence rates of 6654.3 and 6549.2 per 100,000, respectively (15);
  - 4.8% of COVID-19 infections were among healthcare workers (15);
  - 7.7% of individuals diagnosed with COVID-19 were not covered by state insurance;

- there were 2866 deaths among registered cases of COVID-19, resulting in a case-fatality ratio of 3.1%, compared to 2.2% across the WHO European Region (15,16):
  - Krusevo, a small town (population under 10,000) in the Pelagonia region, registered the highest case-fatality rate of 8.7%, despite a below-average incidence rate of 2182.2 per 100,000 (15); and

- the health impact of COVID-19 varied according to:
  - **comorbidity**: 31% of all registered cases had at least one chronic health condition and these cases accounted for 72.8% of deaths (15);
  - **age**: while people aged 50–59 have the highest incidence rate (6110.3 per 100,000 people), mortality rates were highest in people over 60, accounting for 78.8% of deaths (15);
  - **gender**: men and women account for similar proportions of cases, but men accounted for 62.8% of deaths (15);

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1 These data were extracted from electronic health records of the e-health directorate.
○ **regions and municipalities**: two regions (Polog and Northeastern) are particularly affected by relatively low incidence rates and relatively high case-fatality rates compared to national averages; both of these regions also have relatively low Human Development Index (HDI) scores of 0.741 and 0.735, respectively, compared to a national average of 0.76 (15); municipalities in other regions, including Delchevo, Strumica and Radovish, have relatively low incidence rates, relatively high case-fatality rates and relatively low HDI scores, suggesting that these areas should be prioritized in the response to COVID-19 to prevent further deaths (Fig. 6).

Fig. 6. Subnational trends in relatively low incidence rates, relatively high case-fatality rates and low HDI scores, North Macedonia

According to a preliminary global analysis of the health impact of COVID-19 within and across countries, the subnational variation and trends identified above are in line with recent findings from Spain, Sweden and the United Kingdom and in the WHO European Region (17).
How have COVID-19 and containment measures impacted essential health goods and services and increased inequities in North Macedonia?

The Government of North Macedonia implemented a number of measures to contain COVID-19, including physical distancing, staying inside and being locked down, closure of workplaces and education establishments (such as early years facilities, schools, colleges and universities) and/or interruption and disruption of service provision. These measures have had an abrupt effect on both the demand and supply sides of economic activity. While the immediate fiscal stimulus and economic packages from the Government have helped to mitigate negative economic impacts, these measures are not sustainable. Production has stalled and suffered in many sectors, mobility has been restricted and supply chains have been disrupted. Lower consumer confidence and spending amid higher uncertainty about the future has also affected demand and production. Additional short-term economic measures need to be well targeted and closely monitored, with due consideration given to equity, accountability and transparency.

The socioeconomic impact of the containment measures and their effects on health and the health system include the following.

- **Social isolation**, which may disproportionately affect older people, particularly those living alone, and single-carer adults, young people, and children and adolescents, can lead to loneliness and mental health problems and to increased stress, anxiety and harmful use of alcohol and substances. Children lacking contact with peer groups may fall behind and miss critical social and emotional developmental milestones, with long-term implications for their health and well-being.

- **Closure of workspaces and/or reduced provision of services** contribute to a loss of employment and jobs, which may trigger mental health problems and additional stress, including in individuals who fear losing their jobs. Since entitlement to publicly financed care is linked to the payment of contributions, some people are likely to find it increasingly hard to pay for, and therefore to access, health care and other benefits and protections (9). In North Macedonia, 84.8% of the employees who lost their jobs had secondary education or less, with women and those in manufacturing, wholesale, retail and hospitality (such as accommodation and food service) particularly affected (18).
• **A decline in household income** since COVID-19 began has been reported by 53% of the population, resulting in increased poverty rates and reduction in the ability of families to afford the essentials for a healthy life (such as quality shelter, food, fuel and medicines), particularly for those in the lowest income quintile, people living in cities and those in households with dependent children (19). Food insecurity is approximately 2.3 times higher in households in the lowest income quintile compared to those in the highest in North Macedonia (20). In addition to financially securing access to the essentials for a healthy life, increased income security can help to reduce psychosocial stress and prevent longer-term physical and mental health problems resulting from a loss of control over the conditions of daily living, particularly for children and those living with dependants.

• **Closure of early years facilities and schools** have disproportionately affected disadvantaged children (such as those living in poverty, in adverse housing conditions and with inadequate access to the Internet and computers) and women, with potential long-term impacts on their health and well-being. Even before COVID-19, nearly twice as many children in North Macedonia were at risk of poverty or social exclusion compared to those in the EU (8). Fewer years in education is associated with poorer health and increased mortality later in life due to a lack of the skills and/or qualifications needed to obtain and retain employment and earn a sufficient income to live healthily and be able to make healthy choices. Closure of early years facilities and schools also has a disproportionate impact on women, who continue to be the main carers for children at home. This contributes to women’s withdrawal from the labour market, which may decrease household income and lead to reduced long-term security for women and families from health and pension entitlements. Prolonged, intermittent and unpredictable school closures may also hinder women’s return to the labour market, which is likely to have more catastrophic effects on women who cannot work from home and who do not have access to alternative caring arrangements, and result in poorer physical and mental health outcomes.
How have the consequences of COVID-19 created a negative cycle that reinforces health and socioeconomic inequities?

The non-COVID-19 health effects of containment measures will not be felt equally, and many will have socioeconomic impacts. In turn, negative socioeconomic impacts affect health determinants and the risk of contracting COVID-19, as illustrated in Fig. 1 and described below.

• **Disruption and prolonged interruption of health service provision** is likely to increase unmet need and risks worsening health, disproportionately affecting those with chronic health conditions and people with fewer years in education and income, unemployed people, those in middle age and above, and people living in rural areas. Preliminary research from a survey reported in May 2020 found that 25% of respondents had postponed medical examinations due to COVID-19 \((21)\). If this is not addressed, it may deepen health and health-related inequities and increase the risk of economic and social exclusion of those already struggling to stay healthy and participate in employment and civic life.

• **Poor mental health** is more prevalent among workers in non-secure and temporary employment. Even before COVID-19, 2.2 times as many men and 1.6 times as many women in the lowest income quintile experienced poor mental health compared to those in the highest income quintile in North Macedonia \((20)\). Across Europe, 46% of inequities in adult mental health are due to income insecurity, and depression and anxiety are among the top five causes of overall disease burden in the WHO European Region \((22)\).

• **Inability to travel** to obtain health and health-related goods and services and the resources needed to live a healthy life (such as food, fuel and health care) due to mobility restrictions and disruption to public transportation are likely to result in increased unmet need and poorer health outcomes. Equally, the reduction of emissions triggered by the lockdown has led to air quality improvements in many places, showing what can be achieved if economies operate more sustainably \((23)\).

• **Confinement in homes that are overcrowded and without basic sanitation and thermal comfort** increases stress and anxiety disorders. Overcrowding and lack of sanitation can also increase the risk of COVID-19 infection among household members. Even before COVID-19, the annual health costs in the EU of treating people with illnesses directly linked to poor
housing were estimated at €194 billion (24). In North Macedonia, approximately 57% of those in the bottom income quintile are living in overcrowded houses, compared to approximately 26% in the EU, with people in cities, children and households with dependent children more likely to experience overcrowded living conditions (8). Approximately 35% of poor households in rural areas in North Macedonia are not using basic or safely managed sanitation services (25). Overcrowded homes and homes without thermal comfort can further compound socioeconomic inequities by, for example, negatively impacting children and adults learning and working from home. Fifty per cent of single-parent households with children in North Macedonia reported problems keeping their home warm in winter, which increases the use of potentially harmful fuels for heating and health risks due to low indoor temperatures (25,26).

• **Young people not in employment, education or training** were recognized as a particularly vulnerable group following the 2008 financial crisis. Young people who have experienced acute insecurity and have struggled, fallen behind or been unable to continue employment, education or training, among other forms of deprivation during COVID–19, are at increased risk of poorer health and socioeconomic outcomes over the life–course. In addition to high unemployment rates and high rates of young people aged 15–24 not in employment, education or training, the situation appears worse for young people between the ages of 20 and 34, many of whom also experienced financial hardship during the 2008 financial crisis. The rate of young people aged 20–34 in North Macedonia who were not in employment, education or training fell from a persistent high of 33.9% from 2012 to 2015 after the financial crisis to 26.7% in 2019, a figure that is nearly double the EU average of 13.6% (10). While all age groups across Europe have experienced a significant decrease in mental well–being since the onset of COVID–19, women between the ages of 18 and 44 have registered the lowest levels of mental well–being, men between 18 and 24 have experienced the largest drop in mental well–being, and almost two thirds of young people aged 18–34 are at risk of depression (27). Children who have already fallen behind or who are at risk of falling behind in educational attainment are also at higher risk of experiencing poorer health and socioeconomic outcomes as young people without the right combination of investment, support and intervention.
As of March 2021, the Government of North Macedonia had introduced five fiscal packages to mitigate the impact of COVID-19 and its containment measures. The fifth fiscal package, introduced on 16 February 2021, provided 9.7 billion denars (€160 million) to support economic measures under the following four pillars: direct support to businesses; additional support to the private sector; creation of a more favourable business environment; and support for citizens affected by the pandemic. Together, these five fiscal packages comprise various combinations of interventions, including interest-free loans to private companies and micro-, small- and medium-sized enterprises, wage subsidies, suspension of payments and interest accumulation on outstanding debt, support for workers who are laid off, and stimulus payments to unemployed, poor and young people. The manufacturing sector in North Macedonia has been particularly hard-hit, as its global value chains have the highest exposure of all countries in the western Balkans. Women account for 80% of the workforce in manufacturing of clothes and textiles, placing them at particularly high risk of unemployment and poverty (28). Amid increased economic insecurity, there is evidence of forced labour, including child labour, adding further urgency to the need to eliminate modern slavery in North Macedonia (29).

In the health sector, the Government increased health system capacity and mobilized medical staff from all public and private hospitals to respond to COVID-19 at the beginning of the pandemic in March 2020. Most of the increased pressure on essential and frontline workers is beingshouldered by women, who occupy 74% of jobs in the health-care sector in North Macedonia (3). The Government also adopted a decree allowing the Health Insurance Fund to cover out-of-network private health institutions to perform intensive care and therapy activities. The Health Insurance Fund also took measures to simplify administrative procedures at primary care level and introduced e-prescriptions to minimize unnecessary contact between general practitioners and patients.

Early in the pandemic, the Government took a number of actions to ensure access to health and health-related goods and services and the resources needed to live a healthy life, including freezing...
the price of basic food products, medicines and disinfectants. The Ministry of Labour and Social Protection simplified and relaxed criteria for accessing the guaranteed minimum assistance scheme; by the end of August 2020, this resulted in approximately 2000 new applications for guaranteed minimum income assistance. The Government also increased the availability of services for people experiencing domestic violence, established a free phoneline for positive parenting, provided services to support people with disabilities and older people, and covered part of energy consumption costs from April to September 2020. One parent of children under the age of 10 (with the exception of some essential workers) was allowed to stay at home when schools were closed. To support third sector organizations such as nongovernmental and community-based organizations, the Government introduced funds to promote the development of projects that address the needs of those in vulnerable situations.
The formulation of COVID-19 recovery and transition plans presents an unprecedented opportunity to build healthier and more resilient people, societies and economies and promote an environmentally sustainable future. Even small investments in the right combination of policies across sectors for health and well-being can help to maintain physical and financial security and protect the lives and livelihoods of the most vulnerable. A 0.1% GDP investment in each of the following policies – active labour market programmes, social and health protection, and community services and amenities (such as secure affordable housing, food, fuel and safe neighbourhoods) – can improve the lives of 15 000 people falling behind in a country of 4 million (20). Investing an additional 1% of GDP in primary health care is the most cost–effective way to make progress towards universal health coverage, if accompanied by efforts to strengthen coverage policies and improve financial protection (5).

In addition to the mitigation measures already introduced by the Government of North Macedonia, investing in health and well-being can help to address the negative and inequitable health, social and economic impacts of COVID-19 and its containment measures. Health equity is central to building a more equitable, fair and sustainable future through COVID-19 recovery and transition, and the following actions should be taken to ensure that no one is left behind.

**Health equity as an investment in human capital**

Addressing the burden of disease and improving physical, mental and social well-being for all directly contributes to learning and productivity in the form of economic and social participation, including employment, informal care work and civic engagement. To address health, social, environmental and economic inequities and invest in human capital formation in North Macedonia, actions should be taken to:

- systematically support people most affected by stress and mental health problems, including health, care and informal workers (30,31), those in insecure work and at risk of poverty and social
exclusion, those most exposed to inadequate environmental conditions in their homes and daily surroundings (25), and those who are socially isolated (32,33); this may include long-term planning, social housing campaigns, emission reduction, and enhancing digital and community mental health services for those who need them (34);

- support the safe and equitable reopening of early years facilities (35), including educational and mother and baby clinics, to support childhood development and educational attainment, in addition to enabling women to (re-)enter the workforce, including in the health sector (36);

- improve youth employment and skills training in areas that will need a larger skilled workforce post-COVID-19, including in the health sector, with a focus on shortages in areas such as digital skills (37); and

- sustain gains made towards achieving universal health and social protection coverage by prioritizing the retention of coverage that has been extended during COVID-19, particularly for people in the most vulnerable situations and for those made newly vulnerable during COVID-19; this may include the development and implementation of a long-term strategy to achieve universal health and social protection coverage, with a focus on those who were already left behind before the pandemic and on those whose health and livelihoods have been most affected (such as older people, women, informal workers, those with reduced working hours or who lost their jobs and employment, and children and young people) (9,38,39).

**Health equity as an engine for fiscal stability and sustainable labour market recovery**

Health supports and promotes fiscal stability and labour market recovery by enabling productive employment and human capital formation as well as stabilizing and increasing household income that levels up individuals and families. To address health, social, environmental and economic inequities and ensure fiscal stability and a sustainable labour market recovery in North Macedonia, actions should be taken to:

- increase fiscal space and stimulus for public spending in the health sector to protect and promote human capital formation,
prevent value destruction, ensure resilience, enable needed adaptation in the health sector, preserve and improve equity of access to health care, build stronger financial protection and reduce unmet need (5,9,40);

• preserve economic value by continuing to protect and subsidize employment and jobs and prevent the loss of skilled workers abroad, particularly in the health sector, which contributes to stabilizing household income and increasing gender equity and social protection, including access to health insurance and pensions (3,28,41,42); and

• support a sustainable labour market recovery driven by job creation in the green and health economies, with new employment opportunities that are gender-sensitive and made available both to people in vulnerable and isolated situations and those with lower labour market participation rates, including young people, those at risk of violence and abuse, and people at risk from the mental health effects of COVID–19 (43,44).

Health equity as a driver of decent work and smart, inclusive and sustainable growth

The health sector is one of the largest providers of decent work, which is defined by the International Labour Organization as (45):

work that is productive and delivers a fair income, security in the workplace and social protection for families, better prospects for personal development and social integration, freedom for people to express their concerns, organize and participate in the decisions that affect their lives and equal opportunity and treatment for all women and men.

By providing decent work, the health sector drives smart, inclusive and sustainable growth through sustainable employment and by ensuring equitable access to quality health–care services without financial barriers. To address health, social and economic inequities and ensure decent work and smart, inclusive and sustainable growth in North Macedonia, actions should be taken to:

• ensure decent work throughout the health sector, particularly for women and informal workers (31,41), and that all frontline service sector workers, including health and care workers, are protected physically and financially from the risks and consequences of COVID–19 infection and disease (46,47);
• establish a health–protection and health–promotion workplace initiative to prevent sickness absence, work injury and rights violations at work and increase reporting and accountability for work accidents, injuries and rights violations when they occur (48,49);

• improve digital physical infrastructure and scale up affordable Internet coverage to reduce inequities in learning and working from home (44); this will contribute to ensuring equitable access to digital health interventions and prevent health inequities over the life–course (50,51); and

• provide incentives to create additional jobs and transition existing work into the formal economy, particularly for groups with low labour market participation rates and worse health outcomes, such as Roma and disabled people (52,53); together, this would secure financial contributions to the health system and increase financial protection and universal health coverage for those experiencing vulnerability, with consequent improvements in health outcomes (9,54).

Health equity as a foundation for social cohesion and community resilience

Health inequities in life expectancy, morbidity and mortality rates, and COVID–19 infection and disease severity can exacerbate income and gender inequities and perpetuate uneven subnational developmental outcomes. To address health, social, environmental and economic inequities and strengthen social cohesion and community resilience in North Macedonia, actions should be taken to:

• scale up digital health interventions within and beyond primary care settings to support people to stay connected and manage their health and health conditions, including pre–existing mental and physical health conditions, particularly for those in the most vulnerable situations and for people in rural areas (55,56); this should be done in partnership with other sectors and should complement efforts to scale up physical digital infrastructure, ensure access to affordable Internet coverage and close the digital divide (44);

• ensure adequate environmental and living conditions for all households to enable active and healthy lifestyles and reduce the unequal distribution of environmental risk that contributes to overall levels of health inequities (25,57);
• include all population groups in health and other needs assessments and in local, regional and national strategic preparedness and response plans, and address their needs through effective multisectoral and multi-stakeholder coordination (58–62);

• ensure that social assistance is green and inclusive, and partner with local authorities to make sure that available services and income support are non-stigmatizing and reach those in vulnerable situations to prevent acute insecurity and its negative health consequences (38,54);

• build capacity in municipalities and communities, including strengthening third sector and community-based organizations, statutory care services and local health groups, to allocate resources based on needs and complexities of vulnerabilities to prevent acute insecurity and its negative health consequences; this should be done in partnership with other sectors to ensure that available services and support are accessible to all and reach those in vulnerable situations (60,63,64); and

• strengthen routine monitoring of health and vulnerability policies by developing a data dashboard that integrates socioeconomic indicators (such as housing status, access to food and fuel, educational attainment and employment status) with advances in digital and primary health care infrastructure and services, in partnership with other sectors (65,66).

Health equity as a necessity for safety and security

The negative impacts of COVID-19 on those experiencing vulnerability before the pandemic have demonstrated the importance of health equity for crisis preparedness. Equally, inclusive participation in crisis response, management and governance promotes safety and security amid instability and uncertainty, and more equitable and sustainable approaches to recovery. To address health, social, environmental and economic inequities and ensure safety and security for all in North Macedonia, actions should be taken to:

• facilitate safe active travel and reduce the risk of unsustainable shifts towards private motorization that are reflected in the drastic decrease in the number of publicly transported passengers; this is critical both to ensuring equitable access to health services and preventing ill health due to poor air quality (66,67);
• join up public health advice, community engagement and strategic communications to prevent a shadow pandemic of fake and misleading news that may lead to unintentional self-harm from inappropriate prophylactic or treatment measures and foster a lack of trust in scientific information and public health authorities (60,68); and

• promote health and social security through the preservation of gains in universal social protection and health coverage and regular updating and implementation of domestic plans in compliance with the International Health Regulations (38,54,58).

**Health equity as a cornerstone of sustainable development**

Health equity is central to leaving no one behind and to attaining the Sustainable Development Goals (SDGs). Evidence from health, social, environmental and economic impact assessments can be used to frame discussions on positioning health as a central theme in SDG localization processes and on joint actions, as well as multi- and intersectoral policies shown to be effective in addressing health determinants. While neither SDG 3 (Good health and well-being) nor SDG 10 (Reduced inequalities) were identified as priority goals in North Macedonia’s first SDG voluntary national review, published in July 2020 (69), COVID-19 has highlighted the inextricable link between health equity and sustainable development. This is also recognized in the Republic of North Macedonia and United Nations Sustainable Development Cooperation Framework (UNSDCF), which was signed on 26 October 2020 (51).

To address health, social, environmental and economic inequities and build upon health equity as a cornerstone of sustainable development in North Macedonia, actions should be taken to:

- ensure equitable and sustainable access, with financial protection, to green, safe and quality health services for all (5,9,65);

- foster sustainable lifestyles and establish low-emission economies and societal systems to reduce environmental damage and its unequal distribution and impacts (70,71);

- ensure a positive, mutually reinforcing relationship between the health sector and the three strategic priorities of North Macedonia’s new UNSDCF (sustained and inclusive economic...
and social development; climate action, natural resources and disaster risk management; and transparent and accountable democratic governance) throughout the response, transition and recovery from COVID-19 (51); 

• meet and, where possible, exceed EU progress towards the health-related SDGs;

• develop a dashboard based on a minimum set of indicators of health, health equity and equity in the conditions and policies that determine these health and equity indicators to monitor transition and recovery and build resilience across all sectors (14); and

• reaffirm the commitment of partners and multilateral collaborators to uncovering and acting upon new and pre-existing health inequities and their determinants early and throughout the COVID-19 response and recovery to ensure that no one is left behind (14).
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