ВЛИЈАНИТО НА СОЦИЈАЛНИТЕ ДЕТЕРМИНАНТИ ВРЗ ЗДРАВЈЕТО НА РОМИТЕ И НИВНИОТ ПРИСТАП ДО ЗДРАВСТВЕНАТА ЗАШТИТА ВО РЕПУБЛИКА МАКЕДОНИЈА

SOCIAL DETERMINANTS’ EFFECT ON ROMA HEALTH AND THEIR ACCESS TO HEALTH CARE IN THE REPUBLIC OF MACEDONIA
SOCIAL DETERMINANTS’ EFFECT ON ROMA HEALTH AND THEIR ACCESS TO HEALTH CARE IN THE REPUBLIC OF MACEDONIA
ВЛИЈАНИТО на социјалите детерминанти врз здравјето на Ромите и нивниот пристап до здравствената заштита во Република Македонија / [автори на истражувањето Борјан Павловски ... и др.]. - Скопје : Фондација Отворено општество - Македонија, 2015. - 32 стр. : илуст. ; 21x25 см

Насл. стр. на припечатениот текст:
Social determinants effect on Roma health and their access to health care in the Republic of Macedonia.

- Автори: Борјан Павловски, Дарко Антиќ, Јасминка Фришчиќ, Марија Галевска, Стојан Мишев


1. Павловски, Борјан [автор]
a) Роми во Македонија - Здравствена заштита - Истражувања

CIP - Каталогизација во публикација
Национална и универзитетска библиотека "Св. Климент Охридски", Скопје

364.69:614.2([214.58:497.7][047.31])

Насл. стр. на припечатениот текст:
Social determinants effect on Roma health and their access to health care in the Republic of Macedonia.

- Автори: Борјан Павловски, Дарко Антиќ, Јасминка Фришчиќ, Марија Галевска, Стојан Мишев


1. Павловски, Борјан [автор]
a) Роми во Македонија - Здравствена заштита - Истражувања
INTRODUCTION

This document is an addition to the baseline study on the health status, health rights and access to health care of Roma people in the Republic of Macedonia titled “We Are All Human: Health Care for All People Regardless of Their Ethnicity”.

The baseline study identified differences in terms of health status, access to health care and exercise of health rights between Roma and the general population in the Republic of Macedonia. In that, it was established that these parameters are more unfavourable among Roma respondents compared to members of other ethnic groups.

Subject of analysis in this document is the effect of different social determinants on Roma health, access to health care and exercise of health rights in the Republic of Macedonia. Namely, population’s health status is conditioned by numerous external factors called social determinants of health. Known is the fact that even in the most developed countries, people living in poverty or people living in unfavourable conditions have shorter life expectancy and more frequently suffer from diseases compared to the general population. Social differences lead to health inequalities and create a vicious circle that furthers the marginalization of particular population groups.

Researching the effect of these determinants on Roma health is of essential importance, primarily because of this group’s marginalization in the society. In addition to being a marginalized group, different subgroups within the Roma population enjoy different health and health rights due to the fact that some of them live in much more unfavourable conditions. These subgroups are more liable to health risks and face difficulties in accessing health care and exercising their health rights.

Analysis of the effect of social determinants on Roma health was performed with a view to determine how they influence Roma health and thereby contribute in the policy-making process aimed at overcoming inequalities in health care and promoting health of the most marginalized groups, including their access to health care.

This document includes detailed analysis of three social determinants, those being: monthly income per household, labour status and education level.
WHAT IS ALREADY KNOWN ABOUT THESE DETERMINANTS?

People from lower social gradients have shorter life expectancy and more frequently suffer from diseases. Poor social and economic circumstances affect the health of people throughout their life. People further down the social ladder are more liable to serious illness and premature death compared to those near the top of the social ladder. However, the effect of social determinants is not exclusive only to the poor people, as the social gradient in health is different within the same social gradient, resulting in middle class white collar workers and lower ranking staff suffering from more diseases compared to higher ranking staff (1). Therefore, differences can be expected between Roma people of different social and economic status. More specifically, although as an ethnic group they are marginalized and excluded, differences within this group can have significant influence on their health status.

Poverty has a major effect on health and premature death, and certain population groups, such as Roma, are more likely to live in poverty. Absolute poverty is lack of basic material necessities of life and continues to exist, even in the richest countries of Europe. Unemployed, ethnic minorities, homeless people, migrants, refugees are at particular risk for living in poverty (1), and large percentage of Roma falls under one or more of these categories. Relative poverty means being much poorer than most people in the society and is defined as living on less than 60% of the national median income (1). Baseline research findings include the fact that the average monthly income of Roma households is by 77% lower compared to the total funds available per household on national level. Relative poverty prevents access to adequate housing, education, transport and other means necessary for full participation in societal life. Social exclusion means that people are not treated equally and leads to poorer health and premature death (1).

The greater the length of time that people live in disadvantaged circumstances, the more likely they are to suffer from a range of health problems, particularly cardiovascular diseases. Poverty and social exclusion increase the risks of divorce and separation, disability, illness, addiction and social isolation, thereby forming a vicious circle that deepens the predicament people face.

Unemployment causes more illness and premature death, whereas job security increases health, wellbeing and job satisfaction. Evidence from a number of countries shows that, even after allowing for other factors, unemployed people and their families suffer a substantially increased risk of premature death. Health effects of unemployment are directly linked to its psychological consequences and financial problems it brings, especially debt (1).

Job insecurity has negative effect on people’s health, notably because it has been proved that its effect on the health appear as early as people learn that their jobs are threatened, even before they actually become unemployed. It has been proved that insecure job has negative effect on the mental health, self-reported health status and cardiovascular diseases. Equally to unemployment, job dissatisfaction and job insecurity can also be harmful for people’s health. Employment does not guarantee protection of individual’s physical and mental health. Job quality and job security are equally important for the health of people (1).

Baseline study showed that significantly higher share of Roma are unemployed compared to the members of other ethnic groups. Moreover, household income among Roma families heavily depend on social allowance and irregular or insecure jobs.

Education level is a key factor that has direct effect on employment and income level of people. Namely, persons without education and persons from lower education categories face more difficulties in finding employment, and usually perform poorly paid jobs of lower quality.
I. INCOME

1. HEALTH STATUS

Monthly income per household has a major effect on the manner in which Roma people perceive their health. Namely, higher income per household results in higher share of respondents who assessed their health as “good” (Chart no. I.1). It should be noted that the share of respondents who assessed their health as “good” is lower among Roma people whose monthly income per household is higher than 30,000.00 MKD, as 18.3% of all Roma respondents from this income category assessed their health as “very good”.

Roma respondents’ income level does not affect the frequency of colds, flues and respiratory infections. Namely, Roma respondents from all income categories reported same rate of suffering from acute respiratory diseases (77.2%) in the last 12 months.

Chronic health problems that necessitate regular health care services are most common among respondents from the lowest income category (45.1%) and they are gradually decreasing with the increase of their income category reaching 31.8% among respondents whose income level is above 30,000.00 MKD (Chart no. I.2).

Share of Roma respondents suffering from gastrointestinal infections in the last 12 months is equal among all income categories, which means that the income level does not affect the occurrence of this type of diseases.
2. PRIMARY HEALTH CARE

Higher monthly income per household results in lower share of Roma respondents who have not selected their registered general practitioner (Chart no. I.3). All respondents from the income categories above 15,001.00 MKD have selected their registered general practitioner.

Answers of Roma respondents provide the conclusion that their income category does not affect the exercise of emergency medical services. Namely, in the last 24 months, Roma respondents from different income categories equally enjoyed emergency medical services, with the exception of Roma respondents from the lowest income category (Chart no. I.4).

Respondents' income category is directly related to the regular immunization of their minor children. Namely, higher income categories are marked by increasing share of respondents who regularly take their minor children to be immunized. (Chart no. I.5).

3. OUT-PATIENT SERVICES IN SECONDARY AND TERTIARY HEALTH CARE

Respondents' income category does not affect their need to visit specialist MDs in the last 24 months, which means that Roma respondents from different income categories had identical needs to visit specialist MDs. This equally concerns visits to specialist MDs at health care facilities at primary level, general hospitals, special hospitals and university clinics in Skopje.

Satisfaction with the behaviour of specialist MDs is conditioned by Roma’s income category. More specifically, respondents whose income amounts from 3,001.00 to 7,500.00 MKD reported the lowest level of satisfaction, while those whose income amounts from 7,501.00 to 15,000.00 MKD indicated the highest level of satisfaction with the behaviour of specialist MDs.

Nevertheless, respondents’ income category does affect their dissatisfaction with the health services received. Therefore, dissatisfaction with the health services received is higher among Roma from lower income categories (Chart no. I.6).
4. IN-PATIENT SERVICES IN SECONDARY AND TERTIARY HEALTH CARE

Respondents’ income category does not affect in-patient care for Roma patients at public hospitals. Therefore, same shares of Roma from different income categories were treated at different types of hospitals, i.e. at general hospitals, special hospitals and university clinics in Skopje (Chart no. I.7).

Dissatisfaction with the behaviour of MDs and nurses during their hospital stay is most prominent among Roma patients from lower income categories, but also among respondents from the highest income category (Chart no. I.8).

Dissatisfaction with the health services received is higher among Roma respondents from higher income categories (Chart no. I.9).
5. PATIENTS’ RIGHTS

Respondents’ income category is not correlated with the fact whether Roma patients were administered local anaesthesia or not when undergoing small surgical interventions during their visits to specialist MDs and during their hospital stay.

There are no significant connections between respondents’ income category and their right to receive visits during their hospital stay, as well as the coverage of Roma patients with health care and dentistry services.

Income category of respondents has certain effect on the exercise of the right to second medical opinion. Namely, the highest share of Roma patients from the lowest income category reported that they have been prevented to exercise their right to second medical opinion (Chart no. I.10).

Contrary to the situation observed in terms of the right to second medical opinion, the highest share of answers indicating lack of information, i.e. ignorance about their right to second medical opinion was observed among Roma respondents from the highest income category (Chart no. I.11).

As was the case with majority of patients’ rights, respondents’ income category does not affect the exercise of their right to privacy when visiting specialist MDs. This also applies to the exercise of the right to information and the right to provide written consent for performance of medical interventions.

Roma respondents’ income category does not play a role in their exercise of the right to information, i.e. insight in their medical records or transcript thereof during their hospital stay or after they have been discharged. Non-exercise of this right is almost equally present among patients from different income categories (Chart no. I.12).

Chart no. I.10 – Roma respondents who requested but were denied the right to second medical opinion, according to their monthly income per household

Chart no. I.11 – Roma respondents who are unaware of their right to second medical opinion, according to their monthly income per household

Chart no. I.12 – Roma respondents who did not exercise their right to insight in medical files or transcript thereof, according to their monthly income per household
6. ACCESS TO MEDICINES

Roma patients’ income category affects their access to medicines. Namely, respondents from lower income categories are more likely to be unable to purchase the prescribed medicines at the cost of the Health Insurance Fund (HIF) (Chart no. I.13).

Income level per household is correlated with the answers provided by Roma patients about the discriminatory behaviour demonstrated by specialist MDs. Such behaviour was reported by all Roma respondents, irrespective of their income category, but it was most prominent among respondents from lower income categories (Chart no. I.15).

7. DISCRIMINATION

Reports on unkind behaviour demonstrated by specialist MDs are more frequent among Roma from lower income categories, while partially unkind behaviour was equally reported by all Roma respondents, irrespective of their income category (Chart no. I.14).

Direct relation was observed in terms of Roma respondents’ income category and the kindness of health professionals during their hospital stay. Namely, higher income category of patients results in lower share of answers indicating unkind behaviour, which means that the highest share of respondents who reported unkind behaviour of health professionals was noted among those from the lowest income category (Chart no. I.16).

Income category cannot be correlated with the occurrence of poor treatment on the part of health professionals towards Roma patients during their hospital stay. Namely, high and relatively equal shares of Roma respondents from different income categories reported poor treatment on the part of health professionals.
8. ACCESS TO WOMEN HEALTH SERVICES

Respondents’ income category does not play a role in the selection of their registered gynaecologist as a precondition for Roma women’s exercise of gynaecological services. Notably, equal shares of Roma women from different income level reported that they have selected their registered gynaecologists.

Practices whereby free-of-charge gynaecological services have been charged are most frequently reported by Roma women from the lowest income category (up to 3,000.00 MKD), but they were equally reported by patients from different income categories. Frequent occurrence of these practices when visiting their gynaecologists was reported by female patients from the income category from 7,501-15,000 MKD, followed by female patients from the income category of up to 15.001-30.000 MKD (Chart no. I.17).

Unkind behaviour on the part of their registered gynaecologist was most frequently reported by Roma women from the lowest and the highest income category (Chart no. I.18).

Roma women from the lowest and the highest income category reported the worst treatment on the part of their registered gynaecologist (Chart no. I.19).

No connection was observed between Roma women’s income category and failure to regularly visit their registered gynaecologist. This also applies to the connection between their income category and regular visits to the doctor for examinations of their breasts. Moreover, Roma women’s income category does not affect the rate of diagnosed STDs in the last 12 months.

Unlike the situation presented above, it seems that patients’ income category does affect their knowledge about the need for regular pre-
ventive gynaecological examinations with PAP test. More specifically, this awareness is the lowest among Roma women from the lowest income category. The higher their income category, higher is the patients’ awareness about this need (Chart no. I.20).

Income category also affects Roma women’s knowledge about their right to free-of-charge PAP test and mammography. Namely, greatest ignorance of this right was noted among Roma women from the lowest income category. The higher the income category, lower is Roma women’s ignorance of this right (Chart no. I.21).

![Chart no. I.21](image)

**CONCLUSIONS**

**Health status.** Monthly income per household does not affect the self-reported health status of Roma respondents. Roma people from lower income categories assessed their health as worse compared to those from higher income categories. The fact that health status of people from lower income categories is worse was confirmed with the more frequent occurrence of chronic health problems among Roma respondents. Chronic diseases are most common among Roma respondents from the lowest income category.

**Primary health care.** Monthly income per household affects the respondents’ coverage with registered general practitioners, which is a precondition for exercise of services in primary health care. More specifically, the share of Roma respondents who have not selected their registered general practitioner is the highest among those from the lowest income category. In addition to the selection of their registered general practitioner, respondents’ income category affects the regular immunization of their minor children. Actually, the higher their income category, higher is the regular immunization of their children. This social determinant does not influence respondents’ exercise of the right to emergency medical services, which was provided to equal shares of Roma people from different income categories.

**Out-patient services in secondary and tertiary health care.** Monthly income per household does not affect the need for specialist and consultation health care of Roma respondents or their satisfaction with the behaviour demonstrated by specialist MDs. Nevertheless, income category does affect the respondents’ dissatisfaction with the health services received, which is higher among those from lower income categories.

**In-patient services in secondary and tertiary health care.** Need for in-patient care and treatment does not depend on the respondents’ income category, however their dissatisfaction with the behaviour demonstrated by MDs and nurses and their dissatisfaction with the health services received is directly correlated with the income category. Greatest dissatisfaction was reported by Roma from the lowest income category.

**Patients’ rights.** Income level per Roma household does not influence the exercise of patients’ rights, with the exception of the right to second medical opinion. The highest share of Roma from the lowest income category reported their inability to exercise this right.

**Access to medicines.** Income level affects Roma respondents’ access to medicines, i.e. the lower their income category, higher is the inability to purchase the prescribed medicines at the cost of the Health Insurance Fund.

**Discrimination.** Unkind and poor behaviour on the part of specialist MDs towards Roma patients is more common among the respondents from the lower income categories. This also applies to the kindness and care enjoyed by Roma patients during their hospital stay.

**Access to women health services.** Income category is directly related to practices on charging health services, which means that Roma women from the lowest income category most frequently reported that their registered gynaecologists charged them for their services. Income category of Roma women affects their awareness on the need for regular preventive gynaecological examinations and their knowledge about the right to free-of-charge PAP test and mammography. Awareness about these rights is on the lowest level among women from lower income categories.
II. LABOUR STATUS

1. HEALTH STATUS

Labour status is a very important social determinant of health. Several authors and studies show that unemployment or unregulated labour status have serious consequences on the health and access to health care.

Due to these reasons, the present study analyses the effect of labour status on Roma health and their access to health care.

As regards the self-reported health status, significantly higher share of employed respondents assessed their health as “very good” compared to answers provided by unemployed and people with unregulated labour status. The situation is the least favourable among people who are beneficiaries of social allowance, where the lowest share of respondents assessed their health as “very good” (Chart no. II.1).

In addition to the favourable situation observed in terms of respondents’ self-reported health status, significantly lower share of employed people reported that they have suffered from acute diseases compared to unemployed and people without regulated labour status. The situation among social allowance beneficiaries is the most disadvantaged (Chart no. II.2).
Moreover, occurrence of STDs is the lowest among regularly employed persons and is marked by a trend of increase among people with unregulated labour status, unemployed people, with the highest share noted among social allowance beneficiaries (Chart no. II.3).

On the other hand, there is no significant difference between respondents from different labour categories in terms of acute gastrointestinal diseases and infections in the last 12 months.

Chronic diseases are equally affecting employed, unemployed and people with unregistered labour status. Nevertheless, chronic diseases are almost twice as more frequent among social allowance beneficiaries compared to respondents from other labour categories (Chart no. II.4).

Chart no. II.2 – Roma respondents who suffered from acute respiratory infections in the last 12 months, according to their labour status

Chart no. II.3 – Roma respondents who were diagnosed with STDs in the last 12 months, according to their labour status

Chart no. II.4 – Roma respondents who are suffering from chronic diseases, according to their labour status
2. PRIMARY HEALTH CARE

Coverage with registered general practitioners in primary health care is high with all labour categories of Roma people and accounts for more than 90%.

Differences were observed in terms of children’s regular immunization, where people with regular employment reported 100% of regular immunization, while this share is lower among respondents from other labour categories. The lowest rate of regular immunization for minor children was noted among social allowance beneficiaries (Chart no. II.5).

3. OUT-PATIENT SERVICES IN SECONDARY AND TERTIARY HEALTH CARE

Equal shares of Roma from all labour categories indicated that they visited specialist MDs at public health facilities in the last 12 months. Nevertheless, differences among them were observed in terms of the facilities where they received these services. Namely, compared to respondents from other labour categories, employed respondents more frequently indicated that they visited the university clinics for specialist health care services (Chart no. II.6).

Respondents’ satisfaction with the behaviour demonstrated by specialist MDs is almost identical among different labour categories, except for respondents who are social allowance beneficiaries, which indicated significantly lower satisfaction (Chart no. II.7).
4. IN-PATIENT SERVICES IN SECONDARY AND TERTIARY HEALTH CARE

In the last 24 months, equal shares of Roma from different labour categories benefited from services in in-patient health care. However, significantly higher share of unemployed respondents, respondents with unregulated labour status and social allowance beneficiaries expressed their dissatisfaction with the behaviour of health professionals during their hospital stay compared to respondents with regular employment (Chart no. II.9).

Similarly to the previously observed situation, dissatisfaction with health services received in out-patient health care is most prominent among people who are social allowance beneficiaries, and the least prominent among people with regular employment (Chart no. II.8).
5. PATIENTS’ RIGHTS

As regards the respect for patients’ rights, in most cases there are no significant differences in answers provided by Roma respondents from different labour categories.

For example, only half of Roma from all labour categories exercised their right to avoid unnecessary suffering and pain. There are no differences in terms of patients’ right to receive visits during their hospital stay, as two thirds of respondents from all labour categories indicated that they have exercised this right.

Be that as it may, respect for certain patients’ rights is marked by differences, which are a result of respondents’ labour status. Actually, although a relatively small share of Roma were denied health care when they needed it in the last 24 months, this phenomenon is more common among social allowance beneficiaries compared to respondents from other labour categories (Chart no. II.10).

Significantly higher share of employed respondents exercised their right to second medical opinion compared to respondents from other labour categories (Chart no. II.11).

As regards the respect for the right to privacy in out-patient health care, research results show that unlike respondents from other labour categories, higher share of respondents who are social allowance beneficiaries reported that their right to privacy has been violated (Chart no. II.12).
6. ACCESS TO MEDICINES

Labour status of respondents affects their access to medicines prescribed by their MDs and included on the positive list of medicines of the Health Insurance Fund (HIF). Namely, social allowance beneficiaries, unemployed and people with unregulated labour status are often unable to find the prescribed medicines in the pharmacies at HIF’s cost and have to pay for them out of their pockets (Chart no. II.13).

![Chart no. II.13](image)

**Chart no. II.13** – Roma respondents who are often unable to find the prescribed medicines at HIF’s cost, according to their labour status

7. DISCRIMINATION

Discriminatory practices and poor treatment at public health facilities are more often directed at Roma patients compared to members of other ethnic groups. Nevertheless, the frequency of these practices is different among different groups of Roma and is conditioned by Roma patients’ labour status.

More specifically, Roma respondents who are social allowance beneficiaries more frequently indicated that they have been treated with less kindness in out-patient health care, while this phenomenon was the least common among Roma patients who have regular employment (Chart no. II.14). Similarly, poor behaviour on the part of health professionals in out-patient health care was reported by around 5% of Roma who are unemployed or social allowance beneficiaries. None of Roma respondents who are employed provided this answer.

![Chart no. II.14](image)

**Chart no. II.14** – Roma respondents who indicated that health professionals in out-patient health care treated them with less kindness compared to other patients in the last 12 months, according to their labour status

Similar situation was observed in terms of services provided in in-patient health care. Namely, Roma respondents who are unemployed or social allowance beneficiaries reported the highest number of cases in which health professionals treated them with less kindness, while Roma respondents who are employed did not report such cases (Chart no. II.15).

![Chart no. II.15](image)

**Chart no. II.15** – Roma respondents who indicated that the health professionals in in-patient health care treated them with less kindness compared to other patients in the last 24 months, according to their labour status
8. ACCESS TO WOMEN HEALTH SERVICES

Regardless of their labour status, Roma women are equally covered with services provided by registered gynaecologists, as high share of them indicated that they have selected their registered gynaecologist.

Although there are no differences in terms of coverage with registered gynaecologists, Roma women from different labour categories reported different treatment and service provision on the part of their registered gynaecologist. For example, unemployed women and women who are social allowance beneficiaries more frequently reported that they have been charged by their registered gynaecologist for free-of-charge services compared to employed women (Chart no. II.16).

As regards the behaviour demonstrated by registered gynaecologists and directed at Roma patients, it should be noted that it is the least adequate in the cases of women with unregulated labour status and women who are social allowance beneficiaries (Chart no. II.17). In addition, the highest share of women who are social allowance beneficiaries and women with unregulated labour status reported that in the last 12 months they have faced poor and inadequate behaviour on the part of their registered gynaecologist (Chart no. II.18).
Differences exist also in terms of regular preventive gynaecological examinations, where a significantly lower share of social allowance beneficiaries make regular preventive examinations compared to Roma women from other labour categories. Women with unregulated labour status also indicated less frequent visits to their registered gynaecologist for preventive examinations (Chart no. II.19.).

Roma women’s knowledge about sexual and reproductive health is directly related to their labour status. Namely, smaller shares of women who are social allowance beneficiaries and women with unregulated labour status are aware that regular preventive gynaecological examinations can result in timely detection and treatment of cervical cancer (Chart no. II.20.).
CONCLUSIONS

Health status. Health status of Roma who are social allowance beneficiaries is significantly more unfavourable compared to the health of respondents from other labour categories. Moreover, unfavourable health status was observed among respondents with unregulated labour status and unemployed respondents compared to those who have regular employment. This conclusion is based on the self-reported health of respondents, as well as research findings related to the occurrence of acute respiratory diseases, STDs and chronic diseases. More specifically, according to the self-reported health status, the health of social allowance beneficiaries is assessed as the worst, while better assessments were noted among unemployed and respondents with unregulated labour status, and the best assessments were noted among employed respondents. In addition, acute and chronic diseases are most common among social allowance beneficiaries and their frequency is gradually decreasing with other labour categories, with the lowest occurrence among employed respondents.

Primary health care. Irrespective of their labour status, the coverage of Roma people with registered general practitioners is on high level. However, the immunization rate is lower among social allowance beneficiaries and people with unregulated labour status compared to the immunization rate among regularly employed persons, which is very high.

Out-patient services in secondary and tertiary health care. Irrespective of their labour status, Roma respondents reported equal level of utilization of services in out-patient health care. Nevertheless, differences were observed in terms of health facilities at which these services were provided, whereby regularly employed respondents more frequently benefited from these services at the university clinics in Skopje. Satisfaction of Roma patients with the behaviour of health professionals is significantly lower among social allowance beneficiaries, while no differences were observed in the answers provided by respondents from other labour categories. On the contrary, major differences were noted in terms of their satisfaction with the health services received, where the highest satisfaction was reported by employed Roma, and lower levels of satisfaction were indicated by Roma respondents from other labour categories, with the lowest satisfaction observed among social allowance beneficiaries.

In-patient services in secondary and tertiary health care. Services related to in-patient health care were equally accessible to all Roma respondents, regardless of their labour status. In that, employed Roma respondents did not express dissatisfaction with the behaviour of health professionals, while respondents from other labour categories indicated different levels of dissatisfaction with the behaviour of health professionals during their hospital stay.

Patients’ rights. Respect for certain patients’ rights is not directly related to Roma people’s labour status, and primarily concerns the right to avoid unnecessary suffering and pain and the right to receive visits during their hospital stay. On the other hand, exercise of other patients’ rights, such as the right to health care services, was disrespected due to the respondents’ labour status. In that, cases of violation of this right were most frequently reported by social allowance beneficiaries and variable frequency of such cases were reported by respondents from other labour categories. Same situation was observed in terms of the right to privacy in out-patient health care, which was the least respected in cases of patients who are social allowance beneficiaries. On the other hand, the right to second medical opinion was marked by the highest respect among Roma who have regular employment, and it is declining with respondents from other labour categories.

Access to medicines. Access to medicines is particularly difficult for Roma who are social allowance beneficiaries, as well as for Roma with unregulated labour status and Roma who are unemployed, especially because higher shares of these respondents were unable to find the prescribed medicines in pharmacies at HIF’s cost.

Discrimination. Roma who are social allowance beneficiaries and Roma who are unemployed are more liable to discriminatory behaviour on the part of health professionals in out-patient and in-patient health care compared to Roma who have regular employment.

Access to women health services. Regardless of their labour status, Roma women reported equal coverage with registered gynaecologists in primary health care. Nevertheless, women who are social allowance beneficiaries more frequently face barriers in accessing these services compared to women from other labour categories. Namely, registered gynaecologists of these women more frequently imposed charges for free-of-charge services, which results in lower level of satisfaction among Roma women with the behaviour of their registered gynaecologist. On the other hand, almost all women undergo regular preventive gynaecological examinations, with the exception of Roma women who are social allowance beneficiaries, as lower share of them indicated that they regularly make these examinations.
III. EDUCATION

In compliance with the principle of mutuality and interdependence of human rights, exercise of the right to health among Roma is conditioned and depends on the exercise of other human rights and freedoms, including the right to education. This section of the analysis addresses access to health care for Roma people in terms of their right to education, with a focus on access to, availability and quality of health care services for Roma people with different education level.

1. HEALTH STATUS

Research findings show that to a greater extent Roma from lower education categories, in particular those without completed education or with completed primary education, assess their health as “poor” compared to Roma with completed secondary education or higher education (Chart no. III.1).

Self-perception of their health as “poor” among Roma from lower education categories is confirmed with research findings on the frequency of health problems they are facing. Namely, there is a tendency of decreasing reports about chronic health problems among Roma from higher education categories. In comparison, more than half of Roma without education are suffering from chronic health problems, which is not the case among Roma with completed college or higher education, as three times as less respondents from this category reported such health problems (Chart no. III.2).
On the other hand, there are no significant differences among Roma from different education categories in terms of other health problems, such as respiratory and gastrointestinal infections. As regards STDs, no significant differences were observed in the answers provided by Roma respondents from different education categories, with the exception of Roma respondents with completed college or higher education, as they have not been diagnosed with STDs.

2. PRIMARY HEALTH CARE

In general, coverage with registered general practitioners in primary health care is on high level among Roma respondents from different education categories. However, the lowest coverage with registered general practitioners was observed among Roma without education (85.4%), whereas no significant deviations were noted among Roma respondents from other education categories, and their respective coverage rates range from 95% to 97% (Chart no. III.3).

In the context of Roma respondents’ education background, it is important to note that the immunization rate of minor children is lower among Roma respondents from lower education categories compared to those from higher education categories. There is direct connection between the education background of Roma people and the regular immunization of their minor children.
immunization of their children, which means that the immunization rate is higher with every higher education level completed by Roma respondents. For illustration purposes, only 73.8% of Roma without education regularly take their children to be immunized, while the share of Roma respondents with completed college or higher education is 100% (Chart no. III.4).

3. OUT-PATIENT SERVICES IN SECONDARY AND TERTIARY HEALTH CARE

In the last 24 months, equal shares of Roma respondents from different education categories visited specialist MDs at public health facilities. In the context of their education background, it has been established that Roma with completed college or higher education more frequently visited the university clinics in Skopje compared to Roma respondents from lower education categories (Chart no. III.5).

Chart no. III.5 – Roma respondents who visited different types of public health facilities for out-patient health care in the last 12 months, according to their education level

Roma respondents’ education level and their satisfaction with specialist services received at public health facilities are directly correlated. Namely, dissatisfaction with the behaviour of specialist MDs is most prominent among Roma respondents without education, as only one third of them are completely satisfied with the health services received, compared to Roma respondents with completed higher education, two thirds of which reported complete satisfaction with the services received from specialist MDs (Chart no. III.6).

Chart no. III.6 – Roma respondents who are completely satisfied with the behaviour of specialist MDs, according to their education level

Behaviour of specialist MDs towards Roma patients is closely interrelated with the quality of services provided. Reports on dissatisfaction with the behaviour of specialist MDs by Roma respondents from lower education categories are also reflected in their dissatisfaction with the health services received. Only 28.6% of Roma respondents without education are completely satisfied with the health services received, 50% of them are partially satisfied and 21.4% of them are completely dissatisfied (Chart no. III.7).

Chart no. III.7 – Roma respondents who are completely dissatisfied with the behaviour of specialist MDs, according to their education level
4. IN-PATIENT SERVICES IN SECONDARY AND TERTIARY HEALTH CARE

Differences were observed in the answers provided by Roma respondents from different education categories about utilization of in-patient health care services, whereby higher shares of Roma without education and Roma with uncompleted primary education received in-patient health care in the last 24 months (Chart no. III.8).

On the other hand, differences were observed among Roma respondents from different education categories in terms of their satisfaction with the behaviour of MDs and nurses during their hospital stay. Large number of Roma respondents reported complete dissatisfaction with the behaviour of health professionals in in-patient health care, where the highest number of such answers was provided by respondents without education and respondents with completed primary education. Consequently, the lowest shares of respondents from this two education categories reported complete satisfaction with the services received in in-patient health care (Chart no. III.9).

Chart no. III.7 – Roma respondents who are completely satisfied with the health services provided by specialist MDs, according to their education level

Chart no. III.8 – Roma respondents who were hospitalized at different types of public hospitals, according to their education level

Chart no. III.9 – Roma respondents who are completely dissatisfied with the behaviour of MDs and nurses during their hospital stay, according to their education level
5. PATIENTS’ RIGHTS

As regards exercise of patients’ rights by Roma respondents, a direct connection was observed between respondent’s education level and the extent to which he/she exercised specific rights in health care, whereby Roma from lower education categories are in much more unfavourable position. It should be noted that often inability to exercise their patients’ rights is primarily due to the fact that Roma people lack information about the rights they enjoy as patients and the mechanisms for their exercise.

Education level of Roma respondents affects their access to health care and dentistry services, where 100% of Roma with completed higher education did not report cases in which they were denied health care and dentistry services when they needed them. On the contrary, Roma from lower education categories, in particular those without education, reported cases in which they were denied these services. This situation is additionally complicated with Roma’s lack of information about their rights in health care, which can significantly contribute to expectations and perceptions of Roma people in relation to whether they have been denied a certain right or not. More information about the protection mechanisms is necessary for Roma people to get involved in exercise of their rights in health care. To a higher extent, Roma who are illiterate or Roma without education were unable to answer whether they have been denied health care and dentistry services.

Right to privacy was less respected by specialist MDs when they provided services for Roma without education and Roma from lower education categories. Every third Roma respondent without education and with uncompleted primary education reported a situation in which he/she was undergoing examination or medical intervention in the presence of people who should not have been present or without his/her consent, while every fourth Roma respondent with completed primary education reported such violation of the right to privacy in outpatient health care. Smaller shares of Roma respondents with completed secondary, college or higher education reported such violations of their right to privacy (Chart no. III.10).

Right to consent when undergoing surgery or complicated medical procedure was to a great extent disrespected in cases of Roma without education and Roma from lower education categories. As high as 29.6% of Roma without education were subjected to surgery or other complicated medical procedure without their previous written consent. Their share is lower with the increase of Roma respondents’ education level. Consequently, such practices were reported by 22.2% of Roma with uncompleted primary education, 17.4% of Roma with completed primary education and 13.6% of Roma with completed secondary education (Chart no. III.11).
Right to second medical opinion was more frequently exercised by Roma from higher education categories (Chart no. III.12).

![Chart no. III.12](chart1.png)

Respect for their right to avoid unnecessary suffering and pain was reported by two thirds of Roma from different education categories, including those without education. Only exception therefrom are Roma with uncompleted primary education, as smaller share of them indicated that they have been administered anaesthesia when undergoing small surgery or other medical procedure that can cause pain (Chart no. III.13).

![Chart no. III.13](chart2.png)

There are no significant differences or conditional relations between the right to insight in medical files and the right to receive visits during their hospital stay and the education level of Roma respondents.

### 6. ACCESS TO MEDICINES

Roma respondents from lower education categories are in more unfavourable situation in terms of purchasing prescribed medicines from the positive list approved by the Health Insurance Fund (HIF). Roma respondents from lower education categories were more frequently unable to find the medicines in pharmacies at HIF’s cost. In comparison, 59.5% of Roma without education were unable to secure their prescribed medicines at HIF’s cost compared to 17.6% of Roma with completed higher education (Chart no. III.14). Having in mind that Roma without education and Roma with uncompleted primary education are in more disadvantaged financial situation, their health status is additionally worsened by their inability to pay out of their pockets for the medicines they need.

![Chart no. III.14](chart3.png)

**Chart no. III.12** – Roma respondents who requested and were granted second medical opinion, according to their education level

**Chart no. III.13** – Roma respondents who were administered anaesthesia when undergoing small surgery or other medical procedure that can cause pain, according to their education level

**Chart no. III.14** – Roma respondents who often cannot find the prescribed medicines at HIF’s cost, according to their education level
7. DISCRIMINATION

Discrimination of Roma in the health care system is under significant influence of their education level, which means that Roma from lower education categories are more liable to discriminatory practices on the part of health professionals.

There is direct connection between Roma people’s education level and the less kindly behaviour of specialist MDs at public health facilities, i.e. higher share of Roma who have faced this situation are from lower education categories. Specialist MDs treated Roma without education and Roma with uncompleted primary education with less kindness compared to other patients. Same conclusion is applicable in cases where specialist MDs poorly treated Roma patients in terms of provision of health services, and the “poor” treatment was most frequently reported by Roma without education and Roma with uncompleted primary education (Chart no. III.15).

Same conclusion is inferred in the case of Roma who were hospitalized, where Roma from lower education categories more frequently reported poor treatment or unkind behaviour on the part of health professionals during their hospital stay.

Although there are no significant differences in answers provided by respondents from different education categories, the share of Roma women who did not face unkind treatment on the part of their registered gynaecologist is the lowest among Roma women without education (62%). In average, more than 70% of Roma women with uncompleted primary or secondary education indicated that they have never faced poor treatment on the part of their registered gynaecologist, while this statement is true for all Roma women with completed higher education. Poor treatment on the part of their registered gynaecologist was more often reported by Roma women without education and Roma women from lower education categories (Chart no. III.16).

Moreover, Roma women from lower education categories reported multiple cases in which they were faced with such treatment on the part of health professionals, as 16% of Roma women without education, 16.2% of Roma women with uncompleted primary education, 13.1% of Roma women with completed primary education and 10.5% of Roma women with completed secondary education indicated that they were targeted with unkind behaviour more than once.
8. ACCESS TO WOMEN HEALTH SERVICES

Coverage of Roma women from different education categories with registered gynaecologists ranges from 61.7% to 88.4%. In addition, research data do not show differences among Roma women without education (67.1%) and Roma women with completed higher education (63.6%) in terms of having selected their registered gynaecologist.

Although there are no differences in the coverage of Roma women from different education categories with registered gynaecologist, different practices were observed in terms of charges imposed by registered gynaecologists to Roma women for services covered by the health insurance. High shares of Roma women reported that they were always or often charged for these services, which means that such practices pursued by registered gynaecologists are primarily affecting Roma women without education and Roma women with uncompleted primary education (Chart no. III.17).

Low level of information among Roma women from lower education categories results in rare visits to have their breasts examined. Higher education categories correspond with lower shares of Roma women who have never visited their MDs for this type of examinations (Chart no. III.18).

Chart no. III.17 – Roma women who were charged by their registered gynaecologist, according to their education level

Chart no. III.18 – Roma women who never visited MDs for examination of the breasts, according to their education level

Chart no. III.19 – Roma women who reported regular preventive gynaecological examinations every 2 years or more frequently, according to their education level
Information of Roma women about their sexual and reproductive health and the need for regular preventive gynaecological examinations is lower among women from lower education categories. Roma women without education are the least informed about risks related to cervical cancer and the benefits of preventive gynaecological examinations with PAP test. Awareness on the need for regular gynaecological examinations is higher among Roma women from higher education categories (Chart no. III.19).

Roma women from lower education categories are the least informed about the importance of regular preventive gynaecological examinations for their sexual and reproductive health (Chart no. III.20).

**Primary health care.** Roma people’s education level conditions their coverage with primary health care. Although the general conclusion implies high coverage of Roma with primary health care services, the coverage of Roma without education is the lowest and the lowest number of them reported that they have selected their registered general practitioner. Moreover, Roma respondents’ education level is directly related to the regular immunization of their minor children, whereby the immunization rate is gradually increasing with the next education category.

**Out-patient services in secondary and tertiary health care.** Education level of Roma does not affect their needs for services in out-patient health care. Nevertheless, direct correlation was observed between Roma respondents’ education level and their satisfaction with the services provided in out-patient health care. Namely, higher shares of Roma from lower education categories indicated dissatisfaction with the behaviour of specialist MDs and the quality of health services received.

**In-patient services in secondary and tertiary health care.** Education level of Roma respondents affects their needs for in-patient health care, as higher shares of Roma without education and Roma with uncompleted primary education were hospitalized in the last 2 years. On the other hand, high share of Roma from these two education categories indicated complete dissatisfaction with the behaviour of health professionals and services received during their hospital stay.

**Patients’ rights.** Exercise of patients’ rights among Roma is directly connected to their education level, whereby Roma from lower education categories are in more unfavourable position. More Roma respondents from lower education categories reported cases in which they were denied health care and dentistry services in the last 24 months compared to Roma from higher education categories. Moreover, Roma from lower education categories indicated lower exercise of their patients’ rights, such as right to privacy, right to consent when undergoing surgery or complicated medical procedure, right to second medical opinion, right to avoid unnecessary suffering and pain. Only exception therefrom was observed in relation to the right to insight into or transcript of medical records, as well as the right to receive visits during their hospital stay, where respondents from different education categories indicated variable exercise of these rights.

**Access to medicines.** Roma respondents’ education level affects their access to medicines, where the most unfavourable situation was observed among Roma from lower education categories as they were more often unable to find the prescribed medicines from the positive list at the cost of the Health Insurance Fund.

---

**Chart no. III.20 – Roma women who are aware that regular preventive gynaecological examinations can result in timely detection and treatment of cervical cancer, according to their education level**

**CONCLUSIONS**

**Health status.** Direct correlation was observed between the respondents’ education level and their self-reported health status. Roma from lower education categories assessed their health as worse compared to Roma from higher education categories. This conclusion is further supported with the more frequent occurrence of chronic health problems among Roma without education, with a decreasing tendency of reported health problems with the increased education level of Roma respondents.
Discrimination. Education level has significant influence on discrimination against Roma in the health care system, where Roma from lower education categories are more liable to discriminatory practices on the part of health professionals. Unkind behaviour and poor treatment are among negative practices identified in primary, outpatient and in-patient health care.

Access to women health services. Direct connection was observed between respondents’ education level and charges imposed from registered gynaecologists, which means that higher shares of Roma women from lower education categories reported that their registered gynaecologist imposed such charges. Moreover, the low level of information among Roma women from lower education categories results in rare visits to MDs for examination of the breasts. Awareness about the need for regular preventive gynaecological examinations is lower among Roma women from lower education categories.

BIBLIOGRAPHY