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March 1999 (Volume 40, Number 2)

Health Insurance System in the Republic of Macedonia

Donèo M. Donev
Institute of Social Medicine, Joint Institutes of the Medical Faculty in Skopje, Skopje, Republic of Macedonia

The current health insurance system of the Republic of Macedonia was introduced by the Health Protection Law, which was adopted in 1991 and modified and supplemented by the amendments in 1993 and 1995. According to this Law, health insurance was established as an obligatory, supplementary obligatory, and voluntary insurance for certain kinds of health care. This report gives an insight into the specificities and practice of all three types of insurance in the Republic of Macedonia. A person can become an insured to the Health Insurance Fund on the basis of 23 modalities. More than 80% of the citizens are eligible to the obligatory health insurance, which provides a broad scope of basic health care rights. Payroll contributions are equal to 8.6% of gross earned wages and more than 70% of health sector revenues are derived from them. Besides some other basic resources and contributions for health financing, co-payments for health care expenses by users were introduced in 1993. Health financing and reform of the health insurance system are of high importance within the ongoing health care reform in the Republic of Macedonia. It is expected that the new Law on health insurance will strengthen the mechanisms for collecting revenues and introduce new methods of co-payment and risk-adjusted reallocation of the funds related to age structure and health status of the population.

Key words: health care; health expenditures; health insurance; health plan implementation; hospital costs; insurance, health; planning, health and welfare; Macedonia (FYR); resource allocation reform

Health insurance, as one of the most significant civilization gains of the contemporary world, presents a legal normative and regulatory organized mechanism for acquiring funds on different bases, in order to provide prompt quality and efficient prevention and protection of people's health.
The current health insurance system in the Republic of Macedonia was introduced in 1991 by the Health Protection Law (1), which was modified and supplemented by the amendments in 1993 (2) and 1995 (3). There are three types of health insurance according to this Law: obligatory, supplementary obligatory insurance, and voluntary insurance for some kinds of health care.
Obligatory health insurance is based on the principles of obligation, mutuality, and solidarity. If necessary, each insured person can use the health care and the rights from health insurance in an unlimited amount for basic health care rights, covered by the obligatory health insurance. On the other side, there is an obligation to all employees or other bearers of insurance for continuous payment of contributions for health insurance. The contribution rate is the same for all, regardless of the level of salary or income, or the frequency or amount of the health services use on the account of the health insurance funds. The principles of mutuality and solidarity are compulsory (1-5).
Supplementary obligatory insurance exists for separate risks or separate groups. It provides preventive and screening measures and use of health care in case of injury at work and occupational diseases. It also applies to the insured who have additional agrarian, manufacturing, or other activity. Supplementary obligatory health insurance is also established for the insured who insure, beside themselves, more than 4 family members (the average family in the Republic of Macedonia consists of 5 members). If the insured's family consists of more than 5 members, for each next family member there is an additional contribution payment for health insurance (1,4).
Voluntary health insurance was introduced for the health services that were not covered by the obligatory health insurance. It covers the use of some specific health care services, as well as services at a higher level of standard or comfort than those offered by the obligatory health insurance, i.e., standards regulated by the Ministry of Health. Voluntary health insurance includes aesthetic surgery, sanatorium treatment, use of health services with higher standard or comfort, use of medicines not included in the list of medicines determined by the Ministry of Health, use of orthopedic facilities, and instruments not included in the list prepared by the Ministry of Health, etc. (1,4).
However, due to the lack of interest shown by the citizens for realization of the voluntary health insurance rights, as well as due to the wide range of obligatory health insurance rights, voluntary

health insurance has not yet been implemented in practice.

Modalities of Becoming an Insured through Obligatory Health Insurance

1991 Health Protection Law promotes various modalities for a person to become the member of the obligatory health insurance offered by the Health Insurance Fund. Almost all citizens (more than 80% of the total population) of the Republic of Macedonia are insured by the obligatory health insurance system in various modalities: (a) on the basis of their employment – employed individuals (workers), individuals working in the private sector, and individuals performing agrarian activity (farmers); (b) on the basis of their retirement rights – retirement, disability and family pensions, as well as pensions and disability rents from foreign insurance bearers; and (c) on other grounds – unemployed persons registered by the Employment Office, users of basic social care rights, war-disabled soldiers, disabled civilians from the war, family members of the insured who serve in the Army of the Republic of Macedonia, prisoners, etc. (1,4).

Citizens who are not included in any of the above-mentioned groups because of various reasons, can obtain obligatory health insurance by paying health insurance contribution for themselves.

The obligatory health insurance, apart from covering the active insuree (bearer of insurance), also covers his/her family members: spouse and children up to the age of 18, or to the age of 26 if they are students involved in regular education. In addition to the citizens of the Republic of Macedonia, obligatory health insurance is also valid for foreign citizens and individuals without any citizenship, if they are employed on the territory of the Republic of Macedonia, in domestic or foreign firms, in international organizations or diplomatic residencies, or if they are involved in an expert training or education in the Republic of Macedonia. Foreign citizens from countries having international agreements with the Republic of Macedonia for social insurance, use health care rights according to those agreements (1,3-5).

The expenses of the health care services for the citizens of the Republic of Macedonia who are not Fund insurees, are covered by the State budget in the following cases: (a) health care of children and adolescents up to the age of 18, pupils and students up to the age of 26, and individuals older than 65; (b) health care of women related to pregnancy, delivery, motherhood, and contraception; and (c) treatment of infectious diseases, mental diseases, rheumatic fever with complications, malignant diseases, diabetes, chronic dialysis, progressive nervous and muscle diseases, cerebral paralysis, multiple sclerosis, cystic fibrosis, hemophilia, thalassemia and similar diseases, epilepsy, alcoholism, and drug addiction (1,4).

Rights from the Obligatory Health Insurance

Health Insurance Fund provides the right to the health care, as well as the right to a sick-leave and other financial reimbursements to the insured (1,4,6).

The obligatory health insurance, on the principle of solidarity as a key element for providing the health care rights, provides the insured with the following basic health care rights/benefits: (a) medical examinations and other kinds of medical assistance in order to determine the diagnosis, follow-up, or check the health status; (b) undertaking expert medical measures, other measures and procedures for promoting the health condition, i.e., prevention and early detection of diseases and other health disorders; (c) providing emergency medical assistance; (d) outpatient treatment or home care treatment at the user's home; (e) health protection related to pregnancy and delivery; (f) implementation of preventive, therapeutic and rehabilitation measures; (g) prevention and treatment of oral and dental diseases; (h) medicines, supporting materials for application of medicines and sanitary materials needed for treatment; (i) health education of the population; (j) specialist-consultative health care, which includes examination of the health status of the insured and establishing diagnosis and giving recommendation for further treatment; (k) performing specialized diagnostic, therapeutic, and rehabilitation procedures; (l) prosthetic, orthopedic, and other facilities, supporting and sanitary instruments, and dental technical devices according to the General Act issued by Ministry of Health; and (m) examination of the health status, providing treatment, rehabilitation and care, accommodation, and meals during hospitalization (1,4).

In addition to the basic health care rights, the obligatory health insurance also provides the rights to the active insuree to the reimbursement of salary due to illness or injury, medical examination, voluntary donation of blood or biological tissues, during sickness leave or due to a pregnancy and maternity leave for 9 months, as well as for the care of a sick child up to age of 3 years (no limit) or other family member (up to 30 days). All insured have the right to the reimbursement of the travel and other expenses for usage of health services (1,3-5).

Realization of the Rights to Health Care

The obligatory health insurance rights are used by the insured and their family members through Health Insurance Fund, on the basis of the issued health card, and a confirmation of paid contributions (1,3,6).

Basic health care rights may be realized on all levels of the health care system as follows: 1) primary health care, including general practice, occupational medicine, pediatrics, school medicine, gynecology, and general dental practice; primary health care also cover emergency medical assistance and home treatment; 2) consultative-specialist health care provided in health centers and medical centers; 3) sub-specialist health care provided at the clinics and institutes of the Medical Faculty in Skopje and some other health institutions at the national level; 4) hospital health care; and 5) medical rehabilitation at outpatient services, medical centers, and hospitals during the hospital treatment, as well, as specialized medical rehabilitation in specific rehabilitation centers as a continuation of the hospital treatment (6).

An insuree has a right to the treatment in a foreign medical institution (1,4,6) if the disease cannot be treated in the Republic of Macedonia and if there is a possibility for a successful treatment in some foreign country. The conditions and procedures for this aspect of health care are regulated precisely by the General Act of the Ministry of Health. Physician recommendation and the approval by the Health Insurance Fund Committee is required before granting the insurance coverage. Coverage for services obtained abroad that are available in Macedonia is not covered, in order to protect against erosion in utilization of Macedonian medical care.

Resources for Health Financing

Health care system services and certain broader public health activities are financed by the monthly payroll (profit) contributions of the employed persons in public and private sector and contributions from the income of the enterprises and other organizations, general budgetary revenues, external assistance, and limited imposition of users fees (1-4,8,9). Most of the revenues (over 95%) are raised from the health insurance contributions in accordance with determined rates.

About 60% of domestic health sector revenues, in 1995-1997, were derived directly or indirectly from payroll contributions to the Health Insurance Fund. Direct contributions from public and private sector wage-earners (all persons engaged in different forms of socially organized or personal labor) were equal to 8.6% of gross earned wages, and they were withheld from the employer. The contributions from the income of enterprises and other organizations are almost symbolic, less than 0.5% from the total income of the firm.

Certain percentage of money from payroll contributions to the Pension and Disability Fund and the Employment Fund is transferred to the Health Insurance Fund for health coverage of the retired, disabled, and eligible unemployed persons. For pension beneficiaries, the contribution rate (14.7%) is applied to the net pension reimbursement, while for the unemployed and for recipients of social assistance, the contribution rate of 12.5% is applied to 70% of the lowest net salary in the country (2,3,9). These funds are transferred to the Health Insurance Fund by the Ministry of Labor and Social Policy. About 25% of domestic health revenues in 1996 and 1997 were transferred from the Pension and Disability Fund, and about 8% from the Employment Fund.

Farmers have to contribute 15% of the cadastre income, i.e., a rate of 2.8% of the lowest labor price per family member, but, in total, not more than 8.6% of the gross lowest labor price, for all family members. For the citizens with a private enterprise and their employees, the rate is 14.7%, applied to 65% of the average net worker's salary (9).

The general budget was also a negligible source of revenue for the health sector until 1992, when financing of the most prevention programs was shifted from the Health Insurance Fund to the budgetary financing (2). The general budget in 1996 accounted for about 3.5% of domestic health revenues (8,9).

Revenues generated through user fees for health services and applied devices amounted to 1-2% of domestic health revenues.

User Participation in Health Care Expenses

The insured and their family members have to pay (2-5) from their personal funds a certain percentage of the health services price, as follows: (a) 20% of the price of health services and medicines, up to the amount limited by the Ministry of Health, and 30% of the price above that limit; (b) 10% of the costs for hospital treatment, including all costs for services and medicines except for injection therapy; (c) 20% of the total expenses for approved treatment abroad; (d) 20% of the price of hearing or dental prosthetic devices, and (e) 50% of the price of any other prosthetic device.

Fees were set by the Ministry of Health in 1993 (2). An attempt of the Ministry of Health, through Health Protection Law in the 1991, to introduce co-payments on all goods and services covered by the health insurance, was ruled down by the Constitutional Court as infringing on the fundamental right to health care. In order to erase financial constraints in the health sector, Ministry of Health once again, by the 1993 Amendment, proposed co- payments on all insured goods and services (20% for outpatient care, drugs, hearing aids and dental devices; 10% for hospital care; and 50% for prosthetic and orthopedic devices). The Amendment was adopted (2).

There is no co-payment for health care in the following cases: (a) for children up to the age of 14; (b) for women if the care is related to pregnancy, delivery, maternity leave, and family planning, except for artificial abortion up to the third child; (c) for workers and disability pension users in relation to treatment and rehabilitation of injuries at work and occupational diseases; (d) for users of the basic rights according to the Law of Social Protection; (e) users of health services in relation to the treatment of certain debilitating, costly, and often life-threatening diseases; (f) for blood donors who have voluntarily donated blood more than 10 times; (g) for persons older than 65, except for the medicines covered by Health Insurance Fund, and where they pay 5% of the medicine's price; (h) after the age of 14 up to the age 18, there is a reduced payment fee from personal funds, amounting to 5% of the price of health services or of the medicine's price (2,3).
There is no co-payment for health care related to orthopedic and prosthetic devices in the following cases: (a) for children up to the age of 18; (b) for the insured who use prostheses, orthopedic, and other facilities and devices as a consequence of an injury at work or occupational disease; (c) for blood donors who have voluntarily donated blood more than 10 times; and (d) for persons who are released from co-payment according to special regulations (war disabled persons or family of soldiers who were killed in action) (2,3).

Health Insurance System in the Health Care Reform in Macedonia

After its newly gained independence in 1991, the Republic of Macedonia inheritance from the social system of the former Yugoslavia was a social model of obligatory health insurance and highly decentralized and locally funded health care system. The main weak points of the system were tendency toward further fragmentation and duplication of unsustainable services, excessive staffing that exacerbated the duplication of care, interregional differences, and inequities in the amount and quality of care. That system became unsustainable, particularly in actual economic circumstances and economic transition. Up to 1991, there were 35 independent self-management communities of interest for health care on the municipal level and one on national level. All of them were replaced by a single centralized Health Insurance Fund within the newly created Ministry of Health, with branch offices of the Health Insurance Fund on the local level. Centralization was an attempt aimed first of all, for stronger control of resource utilization and more equitable distribution during the transition period and economic crisis.
In the period after 1991, both the health insurance system and health care system were faced with numerous problems, as a result of: (a) the war conditions in former Yugoslavia; (b) the economic and transportation blockades; (c) drained inflow of funds from health services given to patients coming from other places out of Macedonia, (d) decreased funds from the insurance for more than 40% in real terms, due to the great number of unemployed persons, breakdown of socially-owned enterprises, and reduction of employee income; and (e) different types of tax evasions and other manipulations with obligatory health care payments.
Total national health expenditure, expressed as a percentage of GDP, decreased from 6.2% in 1990 to 4.8% in 1992, compared with 7.6% in 1995. Per capita health spending decreased from US$66.8 in 1990 to 39.2 in 1992, compared with US$97 in 1995 (7,8). Salaries were a fixed expense and this caused a serious shortage of supplies and equipment for primary health care. In the period from 1990 to 1993, health consumption decreased for about 60%.
Thus, at the very beginning of the independence, there emerged an inevitable necessity to undertake urgent measures to prevent further erosion of the health system, provide sustainable volume and quality of the health services, and introduce urgent long-term reforms of the health care system and health insurance system.
The Health Protection Law, adopted in 1991, also authorized private health services and pharmacies but did little to streamline the public health system, create incentives for increasing efficiency, or define legal and regulatory environment for the private providers (1,4,10).
Shortages of medications were mitigated only modestly by humanitarian assistance, which covered the essential needs for medicines and medical materials. Negotiations with the World Health Organization and the World Bank were also initiated to acquire loans and technical support for the implementation of the health sector reforms.
In 1993, Ministry of Health undertook activities for a reform process (7,10,11) aimed mainly at: (a) allocating the resources on areas with an immediate impact on the health status of the population and maintaining the basic health services operational through provision of adequate drugs and other consumables; (b) undertaking structural reform and reorganizing of the health care system; and (c) facilitating privatization and development of private health services in order to stimulate competition and improve quality of care and health services.
Ministry of Health asked the World Bank for assistance for further implementation of the reform, and Macedonia became a member of the World Bank in December 1993. The Health Sector Transition

Project was the first funded project of the International Development Association of the World Bank in the social sector in the Republic of Macedonia, and the first donor intervention for reform and restructuring of the health sector.

One of the components of the health care reform strategy was financing (3,7,10,13). It included defining the reforms in pricing policy, benefit packages, and reimbursement mechanisms for ambulatory and hospital services. The objective was to develop new policies and mechanisms which would: (a) maintain broad access to care; (b) create financial incentives for efficiency and cost containment; and (c) remunerate public and private providers equally on the basis of the performed services.

Co-payments for health care services were introduced in 1993 as an alternative option for supplementary funds, as well as to prevent excess utilization of services, but because of the wide range of exemptions (determined by age, sex, and disease) the financial effects were very poor (only about 4-5% of the revenues of the health institutions). The long list of exemptions proved that users fees were not only unlikely to be an effective policy mechanism to collect revenues but, more importantly, they encouraged greater use of health care services for exempted groups, with associated higher costs for the Health Insurance Fund, especially in cases certain health conditions involving extensive and costly care. Those provisions had substantially weakened the initial impact of the participation policy.

During 1991-1995, the revenues collected from contributions decreased by approximately 40% in real terms as a result of lower salaries, bankruptcy of socially-owned enterprises, evasion of payments by many enterprises, and, of course, increased unemployment. Consequently, the revenues of the Health Insurance Fund significantly decreased, resulting in decreased funding of the health care institutions.

Regardless of all the efforts, the expected results did not come, and, in the end of 1994 and the beginning of 1995, Health Insurance Fund entered a very difficult phase, with obvious symptoms of breaking down the health system, which was built over for a very long period of time. In early 1995, with the assistance of local and foreign experts and in cooperation with the World Bank, an urgent analysis of the conditions in the health system was made, and a strategy for undertaking sanitation measures was established, simultaneously determining the short-term measures and activities for long-term reform of the health sector. The health care system was analyzed in three segments: (a) financing and management; (b) primary health care and health promotion; and (c) supply of drugs and medical materials. The primary objective was to find the most appropriate solutions for redesigning the health care network and functions of the system in order to meet the demands of the citizens for high quality health services (13).

An extreme rationing of medication and medical necessities and other material expenses of all health organizations was undertaken by organizing tenders and bidding for central purchase of drugs, sanitary materials and equipment, which resulted in price reduction. In order to achieve equal distribution a central pharmacy store was formed, which, according to the Health insurance financial reports for 1995 and 1996, saved millions of dollars, or about 20% of the funds spent on the same material during the period up to 1994. The competition principle and competitive conveniences for more efficient and rational provision of health services were introduced. This was made possible by the newly imposed legal opportunity to sign an agreement with private organizations and with health professionals for providing health services by personal labor at the account of Health Insurance Fund and in accordance with the norms and standards. This created possibilities for more economic performance of health services. Many other organizational measures were also undertaken, which slightly improved the global financial situation of Health Insurance Fund. At the end of 1995, the expenditures were almost balanced with the revenues (except for a part of the transferred loses from the previous years, which remained uncovered). The situation in 1996 changed slightly and the revenues of the Health Insurance Fund increased by 13.7% compared to 1995 (8,9). The trend of diminishing the level, efficiency, and quality of health care services and insider's rights was stalled.

The main principle of the reallocation mechanism of the funds from Health Insurance Fund to health institutions was financing on a contractual basis and invoicing of services according to the official list. This principle was implemented only for financing the private health sector. The public health institutions expenditures were covered by the Health Insurance Fund in order to cover the wage costs, material costs and maintenance, even without signing any contract for the scope and quality of the services. Because of this, measures to restructure organization and management in the public health sector were delayed, and the quality of health services and motivation of the health workers decreased, resulting in an inefficient use of the resources.

The previous system of referral practice, i.e., a necessity of a written referral to the specialist from primary health care physicians, was abandoned soon after Macedonia gained independence, as part

of the changes in the socio-economic and political context and general movement to increase personal freedom and freedom of choice. This aggravated the budget problems to the Health Insurance Fund because of the increase in specialist costs and hospitalizations. By 1995, amendments to the Health protection law re-established the referral practice by providing direct specialist-consultative and hospital health care only in emergency cases. The same revision of the Law requires that each insured person selects a primary physician from the same municipal area, who will be responsible for the follow-up of the health status of the insured, provision of medical assistance, prescription of medicines, issuing the certificate for sick leave, and referral to higher level services. The physician has been chosen from one of the following fields/disciplines: general medicine, occupational medicine, pediatrics, school-age children medicine, or gynecology. However, a widespread opinion is that many primary physicians are still more ”traffic policemen”, directing patients toward specialists, than ”gate keepers”, motivated and empowered to treat and cure broader scope of illnesses and conditions. According to the results of a survey done by the Physician's Chamber of Macedonia in 1998, low payments and bad working conditions caused frustration and low self-esteem of the physicians, as well as low motivation and satisfaction with their work (the average salary of the general practitioners is about US$200).

In 1996, a comprehensive health care reform was undertaken when the World Bank awarded the Ministry of Health of the Republic of Macedonia a loan of US$19.4 million. The basic goals of the reform were to achieve universal access to high quality health care and establish cost effective finance and delivery systems. The initial reform efforts were supported by a grant from the World Bank. Technical assistance was provided by the RAND corporation from the USA. They joined a team with policy-makers at the Ministry of Health, Health Insurance Fund, and other health professionals in the Republic of Macedonia in order to initiate reform analysis and create new strategies. The proposed new health care policies were directed to the following specific objectives: (a) identification of the health care priorities in the Republic of Macedonia through assessing the burden of diseases and effectiveness of available treatment; (b) reduction of the overall health expenditures and put them in balance with revenues; (c) shifting health care utilization patterns away from expensive forms of care; (d) producing a benefits package that is more cost-effective and co-payment structure that improves sectoral efficiency in order to reduce the existing gap between financial resources and given health benefits to the citizens; (e) developing a capitation plan for primary health care providers and concept of family medicine in primary health care, or reorganize the concept of general practitioner's; (f) establishing an integrated and automated health information system as a support for better management in health care system; and (g) proposing an advocacy information strategies that facilitates the reform process.

In the last two years, activities have been taken for the implementation of the principle of capitation within the primary health care level, for strengthening the citizen's right of a physician's choice choosing the doctor and for creating a basic package of health care services, as well as fee for service payment on the secondary and tertiary level. To support these activities, adjustment of the health information system and management of the health institutions through training of the managers and other employees was initiated.

However, the activities for acquiring humanitarian aid and other kinds of support did not stop. Macedonia also entered several programs of the European Union (PHARE) for solving few substantial problems through non-refundable financing.

It must be emphasized that all undertaken measures and activities resulted in partial and temporary alleviation of the problems during the painful transition period in the Republic of Macedonia.

The most recent activities are directed to the adoption of a new Law on Health Insurance which has already been prepared in its first version and proposed to the Parliament. The new Law on Health Insurance is expected to strengthen the mechanisms of collecting regular revenues for the Health Insurance Fund, and to introduce new methods of co-payments or additional payments by the citizens for health services, development of different types of insurance, as well as risk-adjusted reallocation of the funds according to the age structure and health status of the population.

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Recieved: March 1, 1999
Accepted: March 29, 1999

Correspondence to:
Donèo M. Donev
Institute of Social Medicine
Joint Institutes of the Medical Faculty in Skopje
50 Divizia Street, No. 6
91000 Skopje, Rep. of Macedonia
pharma@lotus.mpt.com.mk

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