Health Sector Reform in the Republic of Macedonia

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Aim. To evaluate the results of current reforms in Macedonian health sector.

Methods. Description and situation analysis, covering the period 1991-1997, are focused on demographic and vital indicators, morbidity and mortality data, elements of health care system, legislation, health insurance, health care financing, and elements of health care reforms.

Results. The Republic of Macedonia experienced changes in the social and economic situation, similar to those in other countries in transition. The growing number of dependents (young and old persons) impact high health expenditures. High priority health problems were infant and premature adult mortality. As an inheritance of the former political system, the development of different parts of health care services was unbalanced and insurance and local network of health facilities were highly decentralized. The reforms addressed health financing and reimbursement, organization and management of health services, and pharmaceutical policies and supply. The legislation was revised, but new revision is needed.

Conclusions. Health care reforms were needed in Republic of Macedonia in order to overcome the problems associated with early phase of transition. The disadvantages of the current reforms are: lack of proper political will for the implementation of activities according to the planned schedule, initial over-utilization of hospital care, and no significant changes in financing of the public sector facilities. The advantages are that the health system did not disintegrate, universal access to health services was maintained, free choice of physician was promoted, and public/private mix of services was established and financed by the Health Insurance Fund.

Key words: financing, organized; health care reform; health expenditures; health manpower; health services; health status; insurance, health; insurance carriers; legislation; Macedonia (FYR)

During the last decade, the Republic of Macedonia experienced changes in the political system, which affected the social and economic situation and thus transformed the entire fabric of social life. Although the reforms undertaken during the transition were eagerly accepted, soon they resulted “in drastic social changes, experienced by many people as a heavy burden: a decline in welfare and deterioration in the quality of their lives” (1). Similar or even worse situation was observed in the other countries in transition (2). Despite these changes, there has not been a sharp deterioration in the health status of the population (3). However, there have been some direct and indirect impacts upon the health care system, and consequently upon each individual's health. Thus, it was necessary to update the existing health strategy (4) and undertake a reform of the health sector.

The idea of health being a prerequisite for human and social development was the basis of the health care reform (1). The guiding constitutional principle defined the Republic of Macedonia as a welfare state (5). Thus, health care, social security and insurance, including health insurance, special care of maternity, children and minors, and healthy environment are constitutional issues in articles 34, 39, 42, and 43 of the Constitution of the Republic of Macedonia (5).

This report presents the changes in health status of the population and health care system, including health legislation, health insurance system and advantages and disadvantages of the current reforms.

Health Status of the Population

Demographic and Vital Indicators

Over the past decades, the population in the Republic of Macedonia has been gradually increasing and aging (6). Changes in the gender structure of the population were observed, with the number of men progressively decreasing and the number of women in their fertility age slightly growing. The age structure (proportions) of the population in the 1975-1990 period had a tendency of a mild decrease of young people under 20 years of age, moderate increase of persons aged 20 to 59, and increase of people over 65 (3). Recently, these processes have changed. Between 1991 and 1997, the number of persons aged 0 to 19 has moderately increased and the working age population aged 20-59 years has slightly decreased (Table 1). The ongoing process of aging of the population, together with the growing percentage of old persons,
will significantly impact the high health expenditures and impose a need for restructuring of the health services. Life expectancy was 69.6 years for men and 74.0 years for women in 1993/95 (1). During the past two decades, the natural growth of the population in the 1991-1997 period has been slow with slight oscillations (Table 2). The total number of live born infants has been slowly decreasing (7). The crude mortality rate has been slowly increasing from 7.2 in 1991 to 8.3 deaths per thousand in 1997 (7). As a consequence of a decreasing birth rate and increasing mortality rate, the rate of natural increase has been gradually falling, from 9.0 in 1991 to 6.5 per 1,000 population in 1997 (7). Compared to the countries with similar economic status, the Republic of Macedonia has more favorable demographic and vital indicators, as well as increased life expectancy and lower maternal mortality rates than the Eastern European countries with higher per capita income (Table 3). However, compared to the developed countries, these indicators are unfavorable (8). Table 1. Demographic indicators (%) in the Republic of Macedonia, 1991-1997 (6) Table 2. Vital indicators in the Republic of Macedonia, 1991-1997 (7) Table 3. Comparative demographic and health indicators for the Republic of Macedonia and other countries in 1991 (8)

Mortality and Causes of Death
An overview on the mortality rates in 1991-1997 (9) indicates a constant increase of general mortality rate and slow changes in the share of certain causes of death (Table 4). The leading causes of death were cardiovascular system diseases and malignant neoplasms, amounting to 72.5% of the deaths in 1997. The increased prevalence of deaths due to malignant neoplasm poses a serious problem. Also, there is a significant share of symptoms and insufficiently defined conditions noted as causes of death, indicating poor performance of health care services (10). The most frequent causes of death were directly influenced by demographic aging of the population and the impact of numerous risk factors, including unhealthy lifestyles, high incidence of stress situations, deteriorating socioeconomic conditions, obesity, inadequate nutrition, lack of exercise, smoking, alcohol, and environmental pollution. The maternal mortality rate has been low for a long time. In 1994, the rate was 0.8 per 100,000 fertile women or 12 per 100,000 live births, and in 1996 there were no cases of maternal death (10). This is a good indicator of an efficient health care for pregnant women and mothers in their early maternity. Infant Mortality Over the past decades, infant mortality rate has been very high as a result of unfavorable socioeconomic factors inherited from the past (Table 2). High mortality infant rate (105.8 per 1,000 live births in 1965) led to several action programs aimed to decrease high infant mortality. As a result, infant mortality has gradually decreased by ten to twenty per thousand in five-year periods and reached the level of 15.7 per thousand live births in 1997 (7). Initially, the programs were focused mainly on decreasing post-neonatal mortality and, since 1985, on decreasing perinatal and neonatal mortality. Additional programs for the improvement of prenatal and perinatal health care are being planned.

Morbidity
The presentation of overall morbidity data for the entire 1991-1997 period is rather difficult because statistical health service computes the prevalence and incidence of diseases separately for primary health care (outpatient and hospital care).

The morbidity reported by primary health care centers shows a decline in eighties and early nineties, an increase in 1994/95 and a decrease in the next years (11) (Table 5). Leading diseases in the primary health care were the respiratory diseases, comprising one quarter to one third of the cases in general medicine and occupational medicine units, and two thirds to three quarters of the cases in units for preschool and school children and teenagers health care (11). In general medicine and occupational medicine units, respiratory and cardiovascular diseases comprised half of the total morbidity cases (11). In the primary care units for preschool children and school children and teenagers, infectious diseases comprised less than 5% of all cases, lower than in the past two decades. Morbidity rates registered in hospitals (1995 was the last year with records) show that respiratory diseases were the most frequent (16%), followed by cardiovascular diseases (13%), digestive diseases (12%), and injuries and poisoning (7%) (11). Infectious diseases are subject to obligatory registration and special preventive programs, so it is not surprising that they had a declining trend. However, the level of most European countries has not still been reached. A fall in the prevalence of tuberculosis in 1993 (from 163.2 per 100,000 population in
1980 to 79.4 in 1993) was followed by a slight increase to 83.3 in 1997. The incidence of tuberculosis in 1996 was 31.7 per 100,000 population (11). AIDS was registered for the first time in 1987, and since then a total of 37 HIV positive patients and carriers of the virus have been registered.

Immunization
Over the past decades, the immunization programs covered 92-98% of the children. In 1992, the level of coverage declined due to transport problems which lead to a shortage of vaccines (8). Immunization is performed continuously for diphtheria, tetanus, whooping cough, polio, measles, mumps, and rubella, as well as for type B hepatitis and flu in cases with epidemiological indications.

Health Care System
In the following section, we shall describe the elements of the health care system, i.e., facilities, manpower, services, legislation, insurance, and financing.

Health Care Institutions: Facilities, Manpower, Services
Network. Health care is provided by both public and private sector institutions, through a network of organizational units and specialized personnel. Out of total 145 public health care institutions, distributed on three levels, 59 are on primary health care level (8 medical stations, 34 health care centers, 10 out-hospital dispensaries, and 7 pharmacies); 39 institutions are on the secondary health care level (16 general hospitals, 6 specialized hospitals, 7 treatment and rehabilitation centers, and 10 regional health protection institutes); and 47 on the tertiary level (25 university clinics: 18 medical and 7 dental, 15 university institutes at the Medical School, 4 specialized hospitals, National Medical Rehabilitation Institute, and National Health Protection Institute). Recently, efforts have been made for restructuring the health care system, i.e., to decrease the number of pharmacies and medical centers into health centers and general hospitals to distinguish primary from secondary level of health care. Also, university clinics have been reorganized as the University Clinical Center and University Dental Center, both in Skopje, established to cover tertiary level of health care services. The private sector has been continuously increasing since 1991 and at present comprises 1,065 health care units: 401 medical and 347 dental offices, 316 pharmacies, and 24 other institutions.

The network of public health care institutions is relatively well distributed across the country. It includes over 1,500 different health care units providing relatively equitable access for the whole population. In the rural areas, there are 298 public and 116 private health care units; some of them have, however, only visiting doctors, which is particularly true for the poorly inhabited mountain villages (12).

Manpower. Health care system employs 23,612 persons. Of these, 4,464 are physicians, 1,078 dentists, 342 pharmacists, 10,646 qualified nurses and other health personnel, and 6,192 non-medical staff. In the private sector there are 565 physicians, 347 dentists, and 317 pharmacists (13). Compared to the total number of citizens the ratio is 410 citizens per one physician, 1,398 per one dentist, and 3,032 per one pharmacist, which is a good prerequisite for a quality health care.

Functioning. The back-bone of the health care system is the primary health care, which offers services in 34 health care centers, providing integrated preventive, diagnostic, therapeutic, and rehabilitation services. At the primary level, each of the following is separately organized: general medicine services, health care of preschool and school children, teenagers, women and workers, dental care, home visits and emergency services, hygiene and epidemiological services, health-statistics, and supply of pharmaceuticals. Primary health care services are also available in rural areas. Trained personnel at the primary level is satisfactory. Primary health care is provided according to the principles of integrated preventive, diagnostic, therapeutic, and rehabilitation services.

The secondary level consists of specialist counseling services as well as general and specialized hospitals providing diagnostic, therapeutic, and rehabilitation services for persons recommended by the primary level services.

Table 4. Major causes of death in the Republic of Macedonia, 1991-1997 period (9)
Table 5. Morbidity rates registered by primary health care services and general practice in the Republic of Macedonia, 1991-1997 (11)
Table 6. Structure of health services (% of total services given) at all levels of health care in the Republic of Macedonia, 1993-1997 (12)
Table 7. Indicators of health care services in the Republic of Macedonia, 1991-1997 (13)
Table 8. Revenues and expenditures of the Health Insurance Fund (US$1,000), 1991-1997 (15)
Table 9. Expenditures (%) in health care institutions in the Republic of Macedonia, 1995-1997a (5)
The tertiary level consists of the university clinics and institutes, and other health care institutions providing highly differentiated health care (12). Since health care is provided at three levels, physicians’ recommendations are used to refer patients to a higher level.

The health care institutions have satisfactory space capacities, comparatively large for the existing economic resources. However, due to financial constraints, their maintenance is sometimes neglected, leading to deterioration of part of the facilities. Maintenance of the existing medical equipment and the supply of new equipment is also limited. Part of the equipment is out-of-date or malfunctioning, which poses a difficult problem in diagnostics and treatment. Over the past few years, there have been some improvements due to international aid and loans, and purchases by the Health Insurance Fund.

In the period 1991-1995, there has been a noticeable decrease of health care services in the public sector, followed by a moderate increase in 1996/97 (12,13). The reason was the change in the use of health care due to economic and legal factors, i.e., non-mandatory referral by primary level physicians to higher levels of health care services and lack of funds due to irregular payments of health contributions (8). The analysis of the structure of health care services (Table 6) clearly indicated that, up to 1995, services on the secondary and tertiary levels were used to a greater extent than recommended by the World Health Organization, thus imposing a heavy financial burden on the Health Insurance Fund (12). With the amendments on the Health Care Law (14), compulsory referrals were reintroduced and there was a consequent reduction in the service abuse at secondary and tertiary levels. The hospitals had a long hospitalization periods of treatment time and a low occupancy rate (Table 7), especially in general hospitals, where the occupancy rate was below 60% (13). The reforms undertaken in the health sector were focused on alleviating those unfavorable conditions.

Health Care Legislation
The Health Care Law was adopted in 1991 and defined the organization and functioning of health care system, rights and access to health care, health insurance, responsibilities of individuals, employers, and the state, type of services, partnership negotiations, financing of health care, professional associations, etc. (14). The novelties of the law were a new role of the key subjects of the system, reintroduction of private practice, introduction of voluntary insurance, reintroduction of compulsory and additional compulsory insurance, establishment of the Health Insurance Fund, introduction of medical, dental, and pharmaceutical chambers, and reintroduction of health professionals associations. In 1993/95, amendments to the Health Care Law were adopted, which defined in detail the rights of citizens under this law. The eligibility requirements for exercising this right were more rigidly defined, following the principle of previous payment of health insurance over the period of 6 months and continuous payment of the contributions. The amendments also related to the citizens’ right to choose their physician in the primary health care, and an obligatory use of referral for higher level health services.

The Government recently called for the adoption of two additional laws: (a) on the health care system, establishing the rights and obligations of citizens who enter the health care system, and possibly some alternative types or functioning of health care institutions; and (b) on the health insurance system, requirements for insurance of citizens and their rights, as well as restructuring of the health insurance services.

Health Insurance System
Coverage. The health insurance system, set and developed over the past decades, has been gradually covering citizens and reached full coverage at the beginning of the nineties. There was a sharp decline in the coverage in 1994 and 1995, (67.6% of the population in 1995), followed by a gradual increase in the next two years, 80.5% in 1996 and 83% in 1997 (15).

Access. Access to health insurance has been established through the participation by enterprises and other organizations, through a private practice, and through regular monthly payment of the health care insurance contributions. The contributions for the unemployed are paid by the Employment Office, for the social welfare recipients by the Ministry of Labor and Social Policy, and for the retired by the Pension and Disability Insurance Fund (14). The insured persons exercise their rights through the Health Insurance Fund.

Types of insurance. According to the Health Care Law (14), there are three types of health insurance: (a) compulsory or mandatory, (b) additional compulsory or mandatory-supplementary, and (c) voluntary. The voluntary insurance has not been implemented in practice. The Law lists the groups for which insurance is mandatory. The solidarity principle is a key element for exercising the basic health care rights. The State Budget finances some basic health care rights for uninsured persons who belong to a high-risk group with regard to age, sex, or disease.
Health Insurance Fund provides an extensive list of health care services, drugs, sanitary materials, orthopedic devices, sick leave reimbursements, and cost coverage for health care abroad for certain cases.

It must be stressed that in the time of excessive political, economic, and social changes, a health policy providing wide coverage and health care services for the unemployed, the needy and uninsured included in the risk groups, largely contributed to preserving the feeling of security of the citizens. The constitutional right to health care was granted by the state. Health care services were provided even for insured persons who did not pay their contributions in full or in time, so late or insufficient payment was tolerated and the continuity of insurance was not interrupted. Although economically weak, the Republic of Macedonia still kept the status of a social state.

Health Care Financing and Financial Situation of Health Care Institutions

The health care system is financed by the Health Insurance Fund established in the Ministry of Health (14). During the 1991-1995 period, the revenues from contributions decreased by approximately 40% in real terms as a result of the reduction in employee incomes, breakdown of socially-owned enterprises, payment evasion by many enterprises, and increased unemployment (15). In this situation, the only option was to decrease the funds allocated to the health care institutions, since it was not regarded feasible to reduce the network and employed personnel in the health care institutions. Since then, the situation changed only slightly. The revenues of the Health Insurance Fund in 1995 were 8.41 billion denars, in 1996 9.56 billion denars, and 10.6 billion denars in 1997 (Table 8) (15). The structure of expenditures of the Health Insurance Fund was very unfavorable (Table 9). Additional efforts were made to collect revenues by accepting decreased payments to settle outstanding debts. Also, a new program for drugs supply by public tenders was introduced, resulting in sustainable price reduction. All these measures partly alleviated the finance deficit in the health care system.

In the 1991-1996 period, the reduced revenues of the Health Insurance Fund resulted in decreased funding of the health care institutions. The employee salary funds decreased by 45% in real terms and salaries were paid with a two-month delay; the funds for medications were down by approximately 40%, as well as those for medical expendable material and maintenance of the equipment, and investments were almost frozen (Table 9). Many of the health care institutions were not able to regularly pay their liabilities toward the suppliers of food, drugs, electric power, heating, etc. Thus, at the end of 1995, the debts amounted to 790.5 million denars (US$19.3 million) and the Fund reprogrammed a part of those obligations for the succeeding year. In 1996 and 1997, the losses of the health care institutions amounted to 801.4 and 1,602 million denars, respectively.

In the efforts to find alternative options for supplementary funding, co-payment for health care services was introduced as the participation of the insured persons. However, the effects were not as great as expected because of the wide range of exemptions (determined by age, sex and disease). Pursuant to global trends in the economic policy, the co-payment of the insured persons was doubled, but still with minor financial effects (4.5-5% of the revenues in the health care institutions).

Health Care Reform

Immediately after political changes in 1991, the Government initiated a program for health care reforms by revising the existing health legislation and addressing certain structural problems in the health system (14). A single, centralized Health Insurance Fund was established in order to maximize risk-sharing and alleviate regional inequities in the quality of care. Socially-owned facilities were transformed into a network of public sector facilities, and private sector services were authorized, with the possibility of reimbursement for private services. Free choice of the physician was granted, but only the amendments in 1993 instituted an appropriate referral system. Financial participation or co-payment by patients in the costs of services was also introduced in 1993 (14).

Bearing in mind the stagnation of the health system associated with the early phase of transition, along with the financial constraints of the health sector following the real reduction in national income (16), a strategy for the health sector reform was developed (17). The main points of this strategy were: (a) maintaining the universal access to basic preventive and curative health services and essential drugs; (b) promoting diversity and patients’ choice in provision of health services; (c) redefining the role of the public sector in health policy and service delivery, as well as establishing a more appropriate public/private mix of health services; (d) improving fiscal sustainability of public spending for health; and (e) increasing the efficiency of resource allocation and use. For the next three years (1996-1999), the plan was to implement the core policy agenda focusing on: (a) health financing and reimbursement; (b) organization and management of health services; and (c) pharmaceutical policies and supply (17). Starting from the middle of 1996, with the aid from domestic and foreign experts and in cooperation with the World Bank, functioning of the health care system in those three areas has been analyzed.
The primary objective of the project was to find the most appropriate solutions to rationalize the health care network, and improve the financing and quality of the services in order to meet the demands of the citizens.

The main idea introduced in the financing of the health care institutions was payment on the principle of capitation in the primary health care, and fee-for-service payment on the secondary and tertiary level, however, limited in quantity and type of services. In order to support this kind of financing, a package of guaranteed basic health services is being considered, which would structure the obligatory insurance by clearly differentiating the primary health care services, the outpatient services in specialized institutions, as well as the short-term and long-term hospital stays. The expensive services included in the package would be subject to previous approval or covered by the voluntary insurance. However, strict implementation of legislative program of the contracting is a prerequisite for this type of financing.

In order to alleviate negative effects caused by the deficit, the Ministry of Health and Health Insurance Fund introduced several measures including the centralized public purchase of drugs, sanitary materials, and equipment (previously such purchase were made independently by each health care institution, leading to excessive spending).

The major objective of the planned reforms is further strengthening of the primary health care, mainly by the introduction of the right to choose a physician, continuous training of the physicians in the primary health care, and modernizing of the medical equipment, as well as focusing on closing the gap between urban and rural areas.

During 1996 and 1997, necessary arrangements for the support of the reforms were made, including the choice of a physician, improvement of the equipment on the primary health care level, designing the packages of health services, and adjusting the information system. Also, possibilities are being considered to introduce modern market-based managing of the health care institutions through training of their managers and other employees.

The key elements of the reforms have been considered, including review of the mechanisms for regular revenue income in the Health Insurance Fund, relocation of funds according to the burden of diseases, introduction of new methods of co-payments or additional payments by the citizens for health services, used as a corrective method to reduce misuse of the higher-level services and provision of additional income for the health care institutions, use of different types of insurance, and active participation of the citizens in sustaining and improvement of their health. Some of the amendments to support these programs in the health legislation have already been drafted (18).

To successfully assess the effects, the Ministry plans to implement reform elements in two pilot municipalities. Activities are also undertaken to inform the citizens and the interest groups about these activities, because without their support and participation the reform of the health care system could not be successfully implemented (18).

Advantages of Current Reforms

The advantage of the health care reform was that the system did not disintegrate. To build up a new health care system would require time, efforts, and resources (human resources, facilities and equipment). Following the experiences of other countries, it was agreed that the reform measures should be gradually implemented so as to prevent the dissolution of the system. There were also efforts to restructure the health insurance system. Outdated Self-managing Communities of Interest for Health Care on national and municipal level, 31 in total, were replaced with a single Health Insurance Fund with branch-offices on the local level. Institution of a single Insurance Fund provided for a rational utilization of reduced financial resources, prevented a financial collapse of the health care institutions, and allowed further functioning of the health care system.

The second advantage of the reform was the promotion of the private health care sector. Before 1991, there were no legal provisions that would allow private health care institutions except for dental care. Competition between the private and public sector is one of the elements of boosting the quality of health care (19) Also, the citizens have the possibility to choose better quality of health care services.

Further promotion of the primary health care and re-introduction of referral system were also among the advantages of the reform, due to their positive impact on the financial sustainability of the health sector.

Disadvantages of Current Reforms

The initial amendments in the health legislation adopted after the independence of the Republic of Macedonia did not stem from previous cost-benefit or cost-effectiveness studies. Also, the citizens were not consulted or invited to give comments and suggestions, so those amendments were widely criticized and caused negative functional effects.

Another significant negative effect was the shift of the service use from primary to higher health care
levels. There are efforts to stop that trend and to reduce inadequate use of hospital health care, i.e.,
long average hospital stay, low bed occupancy rate in general hospitals, and increased use of the
highly specialized hospitals or tertiary level of services (13). The positive attempts to preserve the
public sector by reducing funds for wages and material costs resulted in decreased motivation of the
employees in the health care institutions and, consequently, a fall in the quality of health services
(19).
There are still no significant changes in the financing of health care institutions. The proposed
regulations stipulated financing on a contractual basis and invoicing of services in accordance with
the Health Services Price List (20). However, these rules were implemented only in the private sector,
while the public sector was awarded funds by the Health Insurance Fund to cover the wage costs,
material costs and maintenance, even without signing any contracts for the type and quality of the
services rendered. This delayed the necessary organizational and management restructuring in the
public sector and lead to increased scope and decrease in the quality of health services, as well as
inefficient use of resources.

Conclusions
Health care reforms were needed in Republic of Macedonia to overcome the problems associated
with the early phase of transition. It mainly addressed priority health problems contributing to infant
and premature adult mortality. Appropriate strategy, aims, and objectives for health sector reforms
were adopted. For proper implementation of the reforms, further revision of the legal documents is
needed in order to allow using the basic benefits for compulsory insurance coverage, revised co-
payment, and captivation payment mechanism in primary health care. Improving the quality of health
services is greatly needed, as well as integration of medical and financial information system of the
public sector. Few other prerequisites are needed for successful implementation of the reforms,
including implementation of the activities according to the planned schedule, timely processing of
health indicators, and much more improved information to the public on the activities undertaken.

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References
1 United Nations Development Programme and Ministry of Development of the Republic of
2 The World Bank. The challenge of transition. World development report 1996. Published for the
3 Ministry of Health of the Republic of Macedonia. Highlights on health in Macedonia. Skopje: The
Ministry; 1994.
4 World Health Organization. The Future of health in European region. In: Health for all targets. The
health policy for Europe. Copenhagen: WHO Regional Publications. European HFA Series No. 4;
5 Constitution of the Republic of Macedonia [in Macedonian]. Official Gazette of the Republic of
6 Statistical Office of the Republic of Macedonia. Population according to censuses and population
grouped according to age and sex, by censuses [in Macedonian]. In: Statistical Yearbook of the
7 Statistical Office of the Republic of Macedonia. Rates of births, deaths, and marriages, and survey
of natural change of the population [in Macedonian]. In: Statistical Yearbook of the Republic of
3-11.
10 National Health Protection Institute of the Republic of Macedonia. Implementation report on
preventive health care program in the Republic of Macedonia [in Macedonian]. Skopje: The Institute;
11 National Health Protection Institute of the Republic of Macedonia. Morbidity data [in Macedonian].
12 National Health Protection Institute of the Republic of Macedonia. Health care services [in

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