

MINISTRY OF HEALTH OF THE REPUBLIC OF MACEDONIA
HEALTH SECTOR MANAGEMENT PROJECT
CONSULTANCY ON BASIC BENEFITS PACKAGE REVISION

FINAL REPORT (draft)

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1 INTRODUCTION

In the framework of the consultancy on the development of a health strategy for the Republic of Macedonia, some additional consultancy services have been agreed for the revision of the basic benefits package (BBP) under social health insurance. The background and objectives of this additional consultancy have been described in the first BBP progress report of 16 November 2006. A second progress report was submitted on 26 January 2007. According to contract, the present consultancy will be concluded by a workshop and a final BBP report. This final BBP report does not repeat the information provided in the two progress reports. Therefore the reader is referred to the first and second progress reports for aspects of the health financing reform that are not discussed in this final report.

The first progress report analysed the difficulties facing the present BBP and the special position of the 13 so-called national (or preventive) programmes. It also presented the results of the first BBP workshop on 8 November 2006.

The second progress report developed the major BBP issues in more detail, with emphasis on the beneficiaries of social health insurance, the contributions to social health insurance, the content of the BBP, the co-payment situation, provider payment methods, and the future of the 13 national programmes. It also contained a non-related chapter on the future of primary care in Macedonia.

Progress has been made in reaching consensus among the major stakeholders on how to overcome various obstacles in health financing, and now is the time to elaborate this consensus into a strategy by taking important decisions. If the health financing system in general and the BBP situation in particular are to be improved as from January 2008, the foundation for implementing practical measures must be ready by mid-2007. This foundation consists of Government decisions, legal changes, cost calculations and administrative adaptations. Important issues have been discussed with key stakeholders separately (see chapter 2) and during the second BBP workshop on 7 March 2007 (see chapter 3). The remaining work to be done is described in chapter 4.

Conclusions and recommendations based on the entire BBP consultancy between October 2006 and March 2007 are given in chapter 5.

Continuing assistance will be given by other consultants in the coming months: they will work on co-payment issues and on the financial analysis of the new BBP. The time schedule is tight, but it is essential not to miss the deadline of introducing the new health financing measures by 1 January 2008.

2 MISSION ACTIVITIES

The consultant met with representatives of the Institute of Mother and Child Health Care on 1 March 2007. The purpose of the meeting was to explain the tasks and organisational set-up of the Institute, and to discuss the future role of the Institute in the activities for mother and child care once the 13 national programmes would have been redistributed.

The BBP Working Group met with the consultant on 2, 6 and 9 March. All topics mentioned in this final report were discussed. The meeting on 6 March was specifically devoted to the preparation of the workshop, and the meeting on 9 March to analyse the results of the workshop and consider the next steps in health financing reform.

The deputy Minister of Health met with the consultant on 2 and 5 March, to discuss the present situation in BBP development and the planned workshop.

The Minister of Health received the consultant on 5 March. He mentioned the equity risks of co-payments, while the poor are also faced with unofficial payments. Financial transparency was required in the whole health care sector. The future BBP should preferably be described as a detailed positive list, without undue emphasis on the negative list.

The consultant met with director and staff of the Health Insurance Fund on 5 March. They accept that the scientific and financial foundation of the 2008 BBP cannot yet be optimal, but that a step forward must be made. The team of consultants for the financial analysis of the new BBP will work with the counterparts from the Fund to make the estimates as realistic as possible. The Fund is able to calculate the cost of the part of the 13 national programmes that will probably be shifted to its responsibility in 2008. The introduction of an electronic membership card for Fund beneficiaries is seen as important but not as an urgent matter.

An incomplete Health Strategy Working Group met with the consultant on 8 March. The key question was when the strategy will finally be ready and adopted by the Government. There are apparently still issues that are not completely resolved, e.g. in the field of primary care. The consultant needs the official strategy document, translated into English, to start his work on the implementation plan for which only approximately 2 x 2 weeks are available. The proposal is to have the next mission to Macedonia between 22 April and 11 May, on the condition that the strategy is ready in time. The working group discussed a model for the implementation plan that the consultant has developed.

The consultant met with Marija Kisman-Hristovska, head of World Health Organisation country office on 8 March, to discuss progress in the development of the national health strategy, and the role of the World Health Organisation in this development.

The coordinator for component 1 of the Health Sector Management Project participated in all visits and meetings.

3 REPORT ON THE SECOND BBP WORKSHOP ON 7 MARCH 2007

A second workshop on BBP development took place in the Holiday Inn in Skopje on 7 March 2007. Most of the 47 invited persons attended at least part of the workshop. Unfortunately, the invited representatives of the Ministry of Labour & Social Policy did not attend, although this ministry plays a key role in health financing reform.

The first introduction was given by deputy minister Vladimir Lazarevic who presented a brief overview of the issues at stake: the unsustainability of the BBP, the debts problem in the health care sector, the dissatisfaction of the patients with the provided services, the existing fraudulent practices, the health care costs for prisoners (for which the Ministry of Justice should pay), and the fact that the Health Insurance Fund has to pay cash benefits for maternity leave and sick leave. He announced that there will be one single BBP for all citizens in 2008 (including presently uninsured persons), that co-payments should be collected and kept by the providers as from 2008, and that the 13 national programmes would be divided into insurance programmes and public health programmes.

The second introduction was presented by the director of the Health Insurance Fund Gorgi Trenkoski, who emphasised the key role that the BBP plays in health financing reform. He described how the Health Insurance Fund was trying to solve the dire financial situation and to combat financial irregularities. He questioned if the Fund should be responsible for long-term institutional care, and asked for more attention for modern equipment and for prevention. The lack of mammography equipment in Macedonia was given as an example, making a breast cancer screening programme impossible.

For the presentation by the international consultant, see Annexes A and B. The questions asked to the audience (see last three slides) were deemed too simplistic by the president of the Doctors Chamber. All participants agreed that the 2008 BBP should be different from the present one, but reactions to the proposals for the negative list were mixed. Approximately half of the participants agreed that most dentistry could become the private citizen's responsibility, a majority thought that treatment abroad and travel expenses could be eliminated from the BBP, but a majority wanted to keep cash benefits for maternity and sick leave and outpatient drugs within the BBP. Most participants were of the opinion that approximately 20% would be a fair percentage of total health expenditure that could be paid out-of-pocket (or insured privately).

The Doctors Chamber wanted a detailed positive list for the BBP, based on clinical guidelines, including a revision of the existing description of primary care activities in the Health Insurance Law and the Rulebook of the Health Insurance Fund. The Chamber had specific advice on home visits, emergency care, over-use of injections, medical certificates and maternity leave. The Chamber was ready to work with the Ministry of Health and the Health Insurance Fund on the design of the 2008 BBP, but a deadline of June 2007 was impossible to meet. Participants from the Mother & Child Health Care Institute, the Republic Institute of Health Protection and the Institute of Occupational Health also asked for a more detailed description of the future BBP, especially in the field of prevention: activities, costs, health benefits. There was some discussion and disagreement between the Health Care System Union, the Ministry of Health and the Mother & Child Health Care Institute about the present and future responsibility for prevention by chosen doctors and prevention teams. The Doctors Chamber and the Macedonian Medical Association also had some more general comments on health care reform.

The next presentation by Branislava Katushevska of the Health Insurance Fund described the present situation with co-payments. It is a rather complex system, that generates relatively few revenues for the Fund. Over 2006, co-payment revenue was calculated at 785 million denar, but only 286 million were transferred by the providers to the Fund. For example, the Clinical Centre paid only 10% of the amount due to the Fund. To a large extent, the Fund compensated for the difference by reducing its reimbursement of the providers. Co-payments are often not collected from relatives and friends of the medical personnel. The Fund recommends to make the co-payment system simpler, to let the providers keep the co-payments, to eliminate the cheaper drugs from the BBP, and to make sure that the Fund is compensated by the Ministry of Finance (via the Ministry of Health) for the additional costs caused by absorbing part of the 13 national programmes into the BBP.

In the general discussion, several participants asked to stop talking about reform and to start implementing. The Ministry of Finance was critical about financial administration and lack of rationalisation in the health care sector, and was very clear about the fact that no additional funds for the sector could be expected. Providers could keep the co-payments, but only under

strict control. The 13 national programmes could be organised and financed in a different manner, but only via the Ministry of Health.

The director of the Bitola Clinical Hospital gave an overview of the successful efficiency measures he has taken, and pleaded for a large increase in co-payment levels.

The workshop was concluded by the deputy minister with a summary of the tasks ahead.

4 DEVELOPMENT OF THE BASIC BENEFITS PACKAGE

4.1 Content of the BBP

Apart from the meetings with the BBP Working Group and staff members of the Ministry of Health and the Health Insurance Fund, the consultant has discussed his views on the description of the BBP with the major stakeholders during the workshop on 7 March 2007 (see Annex A and Annex B).

There appears to be a strong desire by some in Macedonia to have a BBP with a detailed, scientifically sound, positive list of services of which the costs have been carefully calculated. The idea is to divide everything that Macedonian health care has to offer into - for example - 1,000 medical interventions, of which - for example - 800 are covered by social health insurance and 200 must be paid out-of-pocket or insured privately. The idea is further that the real cost of all these medical interventions will be calculated, so that the description of the BBP automatically leads to a budget projection and a provider invoicing and payment system. The provider payment system would be based on the categorisation of medical activities into DRGs, especially for hospital services. The twin objectives of having a long detailed positive list and of basing hospital reimbursement on DRGs are related, although it is not necessary to have a detailed BBP for the implementation of a provider payment system based on DRGs. However, such a classification system for the BBP and for provider payment is definitely not realistic in the short term. It would require a major investment in information systems and scientific capacity (large pool of epidemiologists, statisticians, economists, clinical experts), years of preparation, and continuous adaptation after its introduction. It can therefore only be a medium-term objective, not yet applicable in 2008. If Macedonia wants to describe its 2008 BBP as a positive list, it is better to keep the existing article 9 of the Health Insurance Law which is rather general but appears to cause no problems.

One of the best-known experiments in a social insurance package based on a long list of detailed medical services ranked according to priority took place in the state of Oregon. The reader is referred to: *New England Journal of Medicine* 1997;337:651-5 and 720-3.

The Ministry of Health will recruit a team of consultants who will help with the development of a methodology for the financial analysis of medical interventions in Macedonia and who will provide estimates of the real cost of the proposed 2008 BBP. The terms of reference for this consultancy describe its goal as: "To determine and insure financial sustainability of the future BBP, by performing detailed fiscal analysis of its content and raising capacity of Ministry of Health and Health Insurance Fund staff for performing regular BBP sustainability updates." The staff of the Ministry of Health and the Health Insurance Fund and the team of consultants will hopefully gather sufficient data by mid-2007 to make a reliable estimate of the cost of the proposed 2008 BBP. When this cost will be compared to the projected revenues of the Health Insurance Fund, decisions can be taken about the necessary adjustment of the negative list and/or the co-payment system.

4.2 Co-payments

There seems to be agreement that from 2008 onwards, the providers can keep the co-payments they collect from the patients. This is, of course, an incentive for proper collection of co-payments and an additional source of revenue for the provider. It will require changing article 36 of the Health Insurance Law. According to existing tax legislation, the provider will have to pay income tax over the amount of collected co-payments. As this change will cause a decrease in the revenues of the Health Insurance Fund (3-4% according to 2005-2006 data), it must have consequences for the Health Insurance Fund expenditures. If providers are paid by global budgets, the Health Insurance Fund could reduce payments to providers across the board. If the Health Insurance Fund pays the providers according to DRGs or fee-for-service, the amount of reimbursement per DRG/service must be reduced, because Health Insurance Fund reimbursement + co-payment + tax must equal the real cost of the DRG/service in a non-profit public system (with adjustment for exempted patients who do not pay co-payments). The proposal to let the providers keep the co-payments was briefly mentioned in the second BBP progress report of 26 January. It is explained in more detail here to avoid confusion about this issue.

An international consultant will assist the Ministry of Health and the Health Insurance Fund in April-June 2007 to develop a more detailed co-payment plan. The official goal of that consultancy is “to revise the existing co-payment policy in order to contribute to the financial sustainability of the BBP, without undue risk for the accessibility to the BBP by the vulnerable population groups.” Without wanting to interfere with that consultancy, the present consultant can suggest the following:

Co-payment principles

- A co-payment system should be simple, easy to understand for patients and providers, and easy to administer.
- Preventive services should not require co-payments.
- For debate: primary care should have no co-payments, except for drugs (and diagnostic tests?).
- Treatment of communicable diseases with external effects (such as tuberculosis, sexually transmitted diseases, and meningitis) should have no co-payment.
- Co-payments should target especially those services for which over-consumption exists (do such services exist in Macedonia?).
- There should be a just exemption system for poor patients. Providers must be obliged to treat all patients in their region, also if they are exempted from paying co-payments.
- Co-payment revenues should remain with the provider, who has to pay income tax on them.

Co-payment methodology

- Co-payments can be expressed as a percentage of the cost of a treatment or as a fixed amount in denar; amounts in denar may be easier to understand for patients.
- Co-payments should have an annual ceiling for each patient. This requires registration at the Health Insurance Fund.

- Co-payments could also be defined as any amount over a certain ceiling, especially for devices. For example: the Health Insurance Fund pays a maximum of x denar for eye-glasses, and extra costs should be paid by the patient.

One can simulate the revenues of a simple co-payment model. In 2005, there were 210,775 hospital admissions and 2,831,315 specialist outpatient consultations in Macedonia. If we assume that:

- 10% of the patients will be exempted from paying co-payments;
- co-payment will be 300 denar per specialist outpatient consultation;
- co-payment will be 3000 denar per hospitalisation (this is approximately 10% of the average cost of a hospitalisation);

then co-payment revenues for the providers would be: $0.9 \times 210,775 \times 3,000 + 0.9 \times 2,831,315 \times 300 = 1,333,547,550$ denar (in reality somewhat less, because some patients with multiple admissions may reach the ceiling for co-payments, certain diseases may be exempted, etc.). Such extra revenues could solve the present financial problems of the hospitals, including their debts and their need for investment and repairs.

Other co-payments may be added to this amount if applicable, e.g. for drugs and diagnostic tests.

4.3 Uninsured population

It has proved to be problematic to find out who are presently uninsured for social health insurance in Macedonia.

According to the “Statistical Yearbook of the Republic of Macedonia 2006”, 1,898,334 persons were insured by social insurance in 2005, or approximately 94% of the total population (2002 census). However, the Yearbook makes no distinction between the various forms of social insurance (health insurance, disability insurance, etc.).

According to the Health Insurance Fund website, there were 1,841,973 persons insured by social health insurance on 31 December 2006.

The Employment Agency has provided data on health insurance for unemployed persons. In January 2007, there were 250,409 persons registered as unemployed, who as such are being covered by health insurance. Out of these 250,409 persons, 220,798 are insured for health insurance only, i.e. they do not receive unemployment benefits or any other social benefits. Out of these 220,798 persons, 75,244 persons officially declared that they have registered as unemployed only for the purpose of receiving health insurance. Some of the characteristics of this group of 75,244 are:

- * 93% of them are unemployed for more than 1 year;
- * they belong more or less evenly to all age categories;
- * 63% belong to ethnic minority groups;
- * 29% are female.

There are no data on the number of (self-)employed Macedonians who are not covered by health insurance because they themselves or their employers did not (timely) pay the required contribution.

In a letter of 23 February 2007, the Ministry of Justice declared that it is responsible for health care for 2,002 prisoners. Such health care is to be paid from the Government budget; the letter does not state specifically that this means the budget of the Ministry of Justice. The cost of

health services provided outside the prison facilities must be invoiced by the provider; the letter does not state specifically to whom this invoice should be addressed.

The Ministry of Foreign Affairs has approximately 400 staff and family members living abroad. They are insured by the Health Insurance Fund. The Ministry of Foreign Affairs would prefer if they would be exempted from paying Fund contributions and instead insure themselves with an insurance company in the country where they are stationed. In that manner, they would avoid paying the 20% regular co-payment for treatment abroad and a lot of paper work. However, the Ministry of Foreign Affairs does not seem to realise the high cost of private health insurance in western countries.

Data on Macedonians who have left the country have not yet been provided by the Ministry of Interior.

The conclusion is that it is still not possible to quantify the problem of the uninsured Macedonian citizens. This is not an urgent problem as long as these persons do not fraudulently use the public health care system, for example with a “borrowed” identity.

4.4 Next steps

If the reform of the Macedonian health financing system in general and the BBP in particular is to lead to a new and improved situation as from 1 January 2008, the following actions must be taken:

- * acceptance of the National Health Strategy 2007-2020;
- * official agreement on the negative list for the 2008 BBP;
- * official agreement on the co-payment methodology for the 2008 BBP;
- * official agreement on the new method of financing of the 13 national programmes;
- * official agreement on the inclusion of presently un-insured citizens;
- * Government agreement on the transfer of responsibility for monetary benefits during sick leave and maternity from the Health Insurance Fund to another entity;
- * calculation (estimation) of the cost of the 2008 BBP;
- * agreement on the source of financing for capital investments and depreciation, especially in hospitals;
- * preparation and calculation (estimation) of the 2008 public health programme;
- * revision of the Health Care Law;
- * revision of the Health Insurance Law and by-laws;
- * revision of the budget methodology in the Ministry of Finance (especially for the 13 national programmes, but also for the consequences of the new method of collection of contributions);
- * solution for the debt problem, especially for hospitals;
- * establishment of provider autonomy, especially for hospitals (this is linked to the development of a hospital rationalisation plan);
- * becoming serious about collecting all legally required health insurance contributions from companies, individuals and even government agencies.

Many of the above-mentioned actions will be presented as recommendations in the next chapter. In autumn 2006, the idea was to introduce some health financing reforms by mid-2007 or even from the beginning of 2007. It is clear now that it will require hard work to be ready for the beginning of 2008. The time schedule is tight but not impossible.

5 CONCLUSIONS AND RECOMMENDATIONS

The issues at stake for health financing reform - including BBP reform - have become very clear to all stakeholders during the past months. Some reform issues appear to be accepted by most, whereas others remain controversial. In both cases, it is now time for decision-making at Government level.

Consensus appears to have been reached on:

- * a single BBP for all beneficiaries (including presently uninsured);
- * central collection of contributions by the Public Revenue Office;
- * re-arrangement of financing and oversight of the 13 national programmes.

Consensus has not yet been reached on:

- * the negative list of medical services excluded from the BBP;
- * exclusion of monetary benefits from the BBP;
- * the co-payment system;
- * establishment of hospital autonomy.

Suggestions and recommendations for BBP reform can be found throughout both progress reports and this final report. Other consultants will continue to advise the Macedonian authorities on BBP issues - in particular co-payment issues and cost calculations - during the coming months. At this stage in the BBP development, the present consultant wants to present the following summary of recommendations based on his work in the past 5 months.

1. Adopt a revised BBP for 2008 by the end of June 2007.
2. In the 2008 BBP, a few items should have been added to the existing negative list.
3. The co-payment system should be simplified, co-payments should be retained by the providers, and they should amount to 1-1.5 billion denar in 2008.
4. User fees (= negative list) and co-payments together should amount to approximately 25% of total health expenditures.
5. The 13 national programmes should be re-arranged as agreed. The intensity with which these programmes will be implemented should depend on the funds made available by the Ministry of Finance via the Ministry of Health.
6. Provider payment should include the cost of investment, depreciation and maintenance.
7. Irregularities, fraud and unofficial payments should be reduced as much as possible.
8. The control function of the Health Insurance Fund should be strengthened.
9. The willingness among private insurance companies to introduce voluntary additional health insurance packages should be explored. If such willingness does not exist, the Health Insurance Fund could establish a separate branch for such voluntary insurance.
10. Legal changes should be prepared and adopted as soon as possible, but definitely before the end of 2007.
11. It is important to include the presently uninsured population into the system of compulsory social health insurance, but this is not urgent if they do not make use of the BBP services.
12. Adopt the national health strategy 2007-2020 as soon as possible.

It would be advisable to integrate the activities of the various consultants on related subjects in the Health Sector Management Project. There are consultants for health strategy development, BBP principles, financial analysis of the BBP, co-payment methodology, management of the Health Insurance Fund, budget training, hospital management,

development of business plans, public relations, and establishment of the Policy Analysis Unit. These are all important subjects by themselves, but the activities under these consultancies are not sufficiently inter-connected at the moment.

ANNEX A - WORKSHOP PRESENTATION

Description of the Basic Benefits Package

By Kees Schaapveld
BBP workshop
Skopje, 7 March 2007

Problems with the existing BBP

- * unsustainable
- * unrealistic prices for services
- * 10% (?) of the population not insured
- * poor collection of contributions
- * modest revenue from co-payments (3%)
- * separate financing of 13 national programmes
- * inclusion of cash benefits (7%)

Description of the existing BBP

Health Insurance Law

- * positive list of services in article 9
(15 types of services)
- * negative list of services in article 10
(23 types of services)

HIF Rulebook (2003)

- * Detailed positive list of services in articles 23-79 (+ administrative rules)

Articles 9 + 10 of the Health Insurance Law should together cover all existing health care services.

In other words: article 9 = “everything” minus article 10.

Or can you name one curative service that does not fit into either article?

Suggested description of the BBP

- * BBP includes all medically required evidence-based services available in all contracted health care facilities, *except* a precisely described negative list of curative services.
- * BBP includes precisely described positive lists of preventive services, drugs, devices and non-medical services (transportation, accommodation).
- * Gate-keeping and co-payment rules apply.

- * Advantages of not detailing the entitlements of the beneficiaries of health insurance:
 - * simplicity for patients and providers
 - * no litigation
- * However, there is no urgency to change article 9 if it has not created problems so far.
- * A very detailed DRG-based description of the BBP is un-manageable.
- * Much more important: clear negative list.

No problems with the present negative list in article 10 of the Health Insurance Law, except:

- * no rehabilitation for degenerative diseases over 18 years
- * no rehabilitation for addiction after 30 days
- * the negative list is almost certainly too limited

Criteria for the negative list:

- * health problem is not life threatening
- * exclusion does not create higher costs later on
- * relatively low cost of the service (patient can pay)
- * extremely high cost of the service (HIF cannot pay)
- * low cost-effectiveness of the service

Suggestions for the negative list:

- * keep article 10 of the H.I. Law, possibly with a few modifications
- * all dentistry except preventive dentistry for children 0-14 years?
- * all treatment abroad?
- * travel expenses (article 24 of H.I. Law)?
- * cash benefits (maternity, sick leave)?
- * all drugs in outpatient care?

Description of positive list of preventive services:

- * too general in article 9 of the Health Insurance Law
- * inappropriate in articles 24-25 of the HIF Rulebook

Proposed positive list of preventive services under the BBP (according to official programmes)

- * antenatal, obstetric and postnatal care
- * immunisations
- * child monitoring 0-14 years
- * individual health counselling
- * screening programmes (which?)
- * family planning?

Other aspects of the Basic Benefits Package

- * Relation with contracting and provider payment
- * Should the cost of capital investment and depreciation be included in the BBP?
- * Should there be a time limit on BBP benefits?
- * Which % of total health expenditures should be paid out-of-pocket?

Next steps in BBP development

- * detailed proposal for co-payments (see next presentation)
- * financial analysis of the cost of BBP services
- * agreement on the 2008 BBP by June 2007
- * communication with public and providers
- * opportunities for private voluntary insurance

Risks in BBP development

- * delay in design, not ready for 2008
- * no agreement on negative list
- * real cost of new BBP under-estimated
- * resource allocation system not linked to available BBP resources
- * legal changes not ready in time
- * no solution for debt problem

The 2008 BBP should be different from the present BBP.

green = I agree
red = I disagree

The following services should be added to the negative list:

- * all dentistry except preventive dentistry for children 0-14 years
- * all treatment abroad
- * travel expenses (article 24 of H.I. Law)
- * cash benefits (maternity, sick leave)
- * all drugs in outpatient care

green = I agree
red = I disagree

What is fair (or necessary or realistic)? Which percentage of total health expenditures should be paid out-of-pocket or via private health insurance?

0% - 10% - 20% - 30% - >30%

green = I agree
red = I disagree

ANNEX B - WORKSHOP HANDOUT: ALTERNATIVE DESCRIPTION OF THE BASIC BENEFITS PACKAGE

The present BBP is described in articles 8 and 9 of the Health Insurance Law (and in the HIF Rulebook of 2003), and the present negative list in article 10 of the Health Insurance Law. *Treatment* for occupational injuries and diseases is *included* in article 8, but *preventive* services belonging to the domain of occupational safety & health are *excluded* in article 11.

An alternative description of the BBP would be the following:

Article a - general entitlements

The beneficiaries of social health insurance are entitled to all forms of diagnostic services, medical treatment and revalidation that are provided by medical institutions or departments of medical institutions that have concluded a contract with the Health Insurance Fund, with the limitations mentioned in article b. The contracted medical institutions are obliged to provide services according to the principle of evidence-based medical practice and according to official clinical guidelines wherever they exist. There is no limitation on the duration of medically required treatment including hospitalisation.

The beneficiaries are also entitled to the following non-medical services:

1. ambulance transportation in emergency situations.
2. accommodation and food during hospitalisation, including accommodation and food for a companion of a hospitalised child under 3 years.

Article b - limitations to general entitlements

The following limitations exist to the entitlements described in article a:

1. the services mentioned in article d are excluded (negative list).
2. the beneficiary has no right to services in secondary and tertiary care without a referral from his or her chosen doctor, except in emergency situations.
3. only those pharmaceuticals and medical devices can be prescribed that are on the positive list established by the Health Insurance Fund.
4. co-payments are required for services described in article e.

Article c - preventive services

The beneficiaries of social health insurance are entitled to the following preventive services according to official protocols:

1. antenatal, obstetric and post-natal care.
2. immunisations according to a list of indications established by the Health Insurance Fund.
3. monitoring of growth and development of children 0-14 years.
4. health counselling by the chosen doctor.
5. screening for risk factors or early stages of serious disease (genetic and congenital disease, cardiovascular disease, cancer,)?
6. family planning?

Article d - negative list

To a large extent, the list in article 10 of the Health Insurance Law should remain valid. However, two exclusions are questionable and one could argue their inclusion into the BBP:

- * medical rehabilitation for degenerative diseases after 18 years of age (think of rehabilitation after hip fracture because of osteoporosis, myocardial infarction, visual and acoustical impairment, etc.; in fact, most adult diseases are degenerative diseases.).
- * treatment or rehabilitation for addiction after 30 days (such treatment usually takes more than 30 days).

Suggestions for additions to the negative list are.

- * all dentistry except preventive dentistry for children up to 14 years;
- * treatment abroad (both when treatment is not available in Macedonia, and when the insured person is travelling or working abroad);
- * cash benefits for sickness leave and maternity leave;
- * travel expenses (article 24 of the Health Insurance Law);
- * all drugs in outpatient care.

Article e - co-payments

(Co-payments are discussed separately, see next presentation.)