

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

**PROGRESS REPORT (draft)**

by Kees Schaapveld, public health consultant

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## **1 INTRODUCTION**

It has been recognised for years that the present Macedonian Basic Benefits Package (BBP) available to the beneficiaries of the Health Insurance Fund (HIF) is not sustainable, meaning that there is a discrepancy between the cost of the services provided under the BBP and the revenues of the HIF. In view of international experience, the BBP is (too) large. At the same time, there are problems of collecting all contributions due to the HIF. This has led to the accumulation of debts, both at the HIF and for health care providers. The new Government of the Republic of Macedonia has stated that it wants to find a solution for these problems, with some measures to be implemented already before 31 December 2006 if possible. The World Bank has also asked the Government to indicate before the end of February 2007 which solutions are envisaged, as a policy action under the Programmatic Development Policy Loan (PDPL).

Therefore, the developments in the revision of the BBP can be divided into three phases:

- \* some urgent action on the BBP during November-December 2006 if feasible, at the request of the Government;
- \* the description of a more detailed approach during January-February 2007, at the request of the World Bank (PDPL);
- \* the financial analysis of the revised BBP during March-June 2007, needed for a firm foundation of the 2008 budget of the HIF.

International technical assistance for BBP revision can be made available under the World Bank supported Health Sector Management Project (HSMP). However, it takes time to procure such services. Therefore, the Ministry of Health (MOH) and the World Bank have agreed to expand the terms of reference of the already contracted international consultant for health strategy development - the author of this report - to assist the Ministry of Health and the HIF during the first two phases of the BBP revision. The objectives of this amendment to his contract are:

1. Analysis of the impediments to the sustainability of the present health insurance system.
2. Proposing alternatives for the design and implementation of a sustainable basic benefits package. This includes: a) options for adding services to the negative list, b) alternatives for the financing of the 13 so-called “preventive programmes” which presently are supposed to be financed from the budget of the Ministry of Health, and c) a proposal concerning the financing of non-medical benefits by the HIF.
3. Describing the further activities needed for the precise description of the content and cost of the basic benefits package, and the duties and rights of beneficiaries, HIF and providers. This includes the drafting of terms of reference for the technical assistance during the third phase of the BBP revision.

## **2 MISSION REPORT**

The first mission of the international consultant in the framework of the BBP revision took place from 29 October until 10 November 2006. During this visit to Macedonia, the following meetings were organised (in order of occurrence):

There were daily meetings with PCU staff, and especially with assistant co-ordinator Katerina Venovska who was also present during most other meetings.

The consultant met five times with deputy minister Vladimir Lazarevic; the first meeting was on 30 October and the last one on 10 November. All aspects of BBP revision were discussed, as well as a range of wider health financing and health strategy subjects, and the amendment to the contract of the consultant.

There was a short meeting with the Slovenian budgeting consultant of the MOH, Milan Cvikl, also on 30 October, during a session of the Health Management and Leadership Training Programme that was taking place in Skopje at that time.

On 31 October, there were three meetings with sectors of the MOH to discuss the 13 so-called preventive programmes and how their financing could be adapted: the sectors of prevention & PHC (Violeta Malinska-Petrushevska, Jovanka Kostovska, Donka Maneva), of hospital care (Anka Georgievska, Nikica Panova), and of health insurance (Borce Naumovski, Jordan Mishevski, Blagoj Doncev).

There was a meeting with the new HIF director Gorgi Trenkoski and three of his staff (new deputy director, assistant manager Brankica Katushevska, assistant manager Mihajlo Kostovski) on 1 November. A separate meeting with Mihajlo Kostovski took place on 2 November, to discuss the content of his recent presentations and documents on health insurance in general and the BBP in particular.

The Minister of Health Imer Seljmani received the consultant on 3 November.

On 7 November, the consultant met WHO pharmaceutical consultant Paul Spivey and national WHO staff member Marija Gulija to discuss the place of drugs in the revised BBP. On the same day, he met Sheila Beckett (United States Department of Treasury), resident advisor to the Ministry of Finance on budget policy and management, to discuss the planned changes in the collection of social contributions and the consequences for the HIF.

Wednesday 8 November was devoted to the workshop in the Kamnik restaurant, see chapter 5.

On 9 November, the consultant met with the new director of the Republic Institute of Health Protection Dragan Gjorgjev and his colleague Fimka Tozija. Topics of discussion were the upcoming first meeting of the new BBP Working Group, but especially the reform of public health in Macedonia, with emphasis on financing issues in the framework of annual public health programmes to be funded from the State budget.

A first meeting of the BBP Working Group and the international consultant took place on 9 November, although not all members were present. See chapter 6.

Although this was not the objective of this BBP mission, the international consultant attended two meetings of the Health Strategy Working Group, on 1 and 10 November. As the majority of its members are new, there was an intensive discussion to see to what extent a new approach and/or new subjects were needed and to what extent this was possible or impossible during the approximately 8 weeks available for producing the final draft. According to the chairman, approximately 20% of the last draft of the previous Working Group needed adaptation, especially based on the plans of the new Government.

### 3 ISSUES IN BBP DEVELOPMENT

The problems with the actual BBP are:

- \* the BBP is too large in view of the HIF revenues, therefore unsustainable, leading to the creation of debts;
- \* budgeting the BBP services is based on unrealistically low prices which also do not include the cost of investment and depreciation;
- \* some citizens (150,000-200,000?) are not entitled to the BBP for various reasons;
- \* the unsustainability of the present BBP is made worse by the imperfect collection of contributions from companies, individuals and even public funds;
- \* HIF revenues from official co-payments are very modest (3%);
- \* some essential services are presently outside the BBP (especially elements of the 13 “preventive programmes” but also - for example - long-term treatment of specific categories of patients);
- \* inclusion of non-medical benefits inside the BBP (7% of HIF expenditures).

**Table 1. Realised revenues and expenditures of the Health Insurance Fund in 2004 and 2005, in denar and %.** Source: HIF, 2006.

HIF	2004		2005	
<b>Revenues</b>	<b>14,698,642,548</b>	<b>100%</b>	<b>15,249,561,381</b>	<b>100%</b>
Contributions from salaries and other forms of personal income	8,417,953,548	57%	8,981,814,144	59%
Other non-tax revenues (co-payments)	564,211,024	4%	513,145,735	3%
Contributions from the Pension and Disability Insurance Fund	3,183,778,890	22%	3,417,132,194	22%
Contributions for unemployed individuals	1,848,850,820	13%	2,062,525,382	13%
Other transfers from social funds and Government budget	683,847,928	5%	<b>274,943,929</b>	2%
<b>HIF</b>	<b>2004</b>	<b>2005</b>		
<b>Expenditures</b>	<b>14,697,631,367</b>	<b>100%</b>	<b>15,205,637,521</b>	<b>100%</b>
HIF administrative costs	252,980,974	2%	<b>169,012,506</b>	1%
Primary health care	4,429,572,047	30%	4,588,553,590	30%
Specialist-consultative health care	3,312,694,593	23%	2,836,151,958	19%
Hospital care (including drugs)	4,940,635,822	34%	5,865,870,031	39%
Orthopaedic devices	173,035,849	1%	264,013,808	2%
Treatment abroad	220,346,975	2%	164,250,374	1%
Other health care services	200,578,417	1%	19,460,546	< 1%
Other contracting and operational expenses	36,452,428	< 1%	<b>35,682,821</b>	< 1%
Payments of compensations by the HIF (mainly for sick leave and maternity leave)	989,589,135	7%	<b>1,069,890,166</b>	7%
Expenses for interest and capital investment	141,745,127	1%	<b>114,312,740</b>	1%

Note: percentages do not add up to 100% due to rounding.

Revenues and expenditures of the HIF were approx. 15 billion denar or € 250 million in 2005, that is 835 denar or € 140 per capita (for approx. 1.8 million insured persons). For details, see Table 1.

Compulsory health insurance for employees is 9.2% of their gross salary. The employer is responsible for the payment of the contribution.

Employees pay 0.5% of their salary for insurance against occupational injuries and disease. This contribution is also transferred to the HIF.

In principle, the HIF expenditures should match its revenues. Since 2006, they appear to do so because all contracts with providers have a ceiling, but this has shifted the problem of accumulation of debts to the providers. However, providers also have themselves to blame, because some of them seem to consider a budget as a recommendation rather than something to respect by all means, and because they seem unable to run their institutions as a proper (not-for-profit) business.

It is not easy to predict future developments in HIF revenues and expenditures, even if a perfectly costed reduced BBP would exist. The following trends in revenue collection may or may not occur:

- \* a probable increase in revenues because of better collection (possibly 5-10%) (see Annex A);
- \* a probable decrease in revenues because of base harmonisation (see Annex A); this can be calculated assuming all other factors remaining equal, but that has not yet been done;
- \* a possible increase in revenues because of transfers from the MOH budget for part of the 13 prevention programmes (although probably not sufficient to cover the additional services)
- \* a possible increase if the Government agrees to a budget subsidy to the HIF;
- \* a probable increase in revenues because of growth of the economy/GDP.

There may also be an increase in MOH revenues if the Government agrees that the share of health care in the GDP and the share of the Ministry of Health in the Government budget are low in international comparison. Approximately 5% of GDP is spent on health care in Macedonia (including private payments). This figure is 6.5% in the European region of the WHO and 6.4% in the 10 newest member states of the EU. In Macedonia, approx. 85% of health care expenditures are public and 15% private.

The share of HIF contributions equals approximately 3.4% of GDP.

Possible future developments in HIF expenditures are:

- \* a probable increase in expenditures because of new and more expensive medical technology and drugs;
- \* a probable increase in expenditures because of ageing of the population;
- \* a probable increase in expenditures because of inclusion of part of the 13 preventive programmes;

- \* a possible increase in expenditures because the real cost of services may be higher than present tariffs (but expenditures can also decrease if bloated staff numbers are not being considered when paying providers);
- \* a possible increase in expenditures because of inclusion of formerly uninsured beneficiaries;
- \* a possible decrease in expenditures because of adding services to the negative list and/or increasing co-payments.
- \* a possible increase in expenditures because of adding services to the BBP, for example long-stay psychiatric care (it is not clear from the Health Insurance Law how such patients are insured).

Therefore, there will always be a need to regularly revise the BBP under social health insurance. Usually this is done annually.

In the framework of BBP revision, the Government of Macedonia has to take a number of decisions, each of which has consequences (see Table 2).

**Table 2. Decisions in BBP revision and their consequences.**

<i>decision to be taken</i>	<i>consequences</i>
1. add services to the negative list	a. selection methodology to be chosen b. calculate financial consequences c. amend Health Care Law and Health Insurance Law
2. include the presently uninsured as HIF beneficiaries	a. determine numbers and types of presently uninsured b. calculate financial consequences c. amend Health Care Law and Health Insurance Law
3. exclude non-medical benefits from the BBP	some other organisation must take over this responsibility: Ministry of Labour & Social Policy, or employers and/or employees, or another social fund
4. reform the collection of social contributions (see Annex A)	calculate consequences of base harmonisation for HIF contributions
5. revise and adapt rates of co-payment for different services, and determine exemptions	a. analyse present system of co-payments b. calculate financial consequences of changes
6. co-payments to be kept by providers (as an incentive)	co-payments should be automatically deducted from provider payments by HIF
7. cost of BBP services to be based on real costs and total cost accounting	a. cost calculations must include investment and depreciation cost b. cost calculations to be based on clinical standards where available c. cost calculations to be based on needed staff and beds, not on existing staff and beds

7. abolish present financing system for 13 preventive programmes	<ul style="list-style-type: none"> <li>a. HIF and MOH will divide the responsibilities</li> <li>b. HIF responsibilities to be incorporated into the BBP</li> <li>c. MOH responsibilities to be incorporated into annual public health programmes</li> <li>d. calculate financial consequences for HIF and MOH</li> </ul>
8. all HIF beneficiaries will have a personal membership card (smart card)	<ul style="list-style-type: none"> <li>a. administrative and financial consequences to be analysed</li> <li>b. blue coupons will disappear</li> </ul>
9. how should occupational injuries and disease be insured?	<ul style="list-style-type: none"> <li>a. cost of this category must be calculated</li> <li>b. should there be a separate social contribution for this purpose or not?</li> <li>c. should this specific insurance be implemented by HIF or by another insurer?</li> </ul>
10. other ministries and authorities should assume their responsibilities	<ul style="list-style-type: none"> <li>a. Ministry of Justice for medical care for detainees</li> <li>b. Ministry of Environment for part of environmental health protection</li> <li>c. Ministry of Agriculture for part of food safety</li> <li>d. local authorities for part of local public health activities</li> </ul>
11. introduction of deductibles in social health insurance?	analysis of feasibility and desirability of deductibles (poorest insurees will be hurt most, unless exempted)
12. how to solve the problem of debts of HIF and providers?	<ul style="list-style-type: none"> <li>a. analysis of existing debt problem needed</li> <li>b. Government agreement on how to solve this problem and how to share the pain</li> <li>c. IMF advice desirable</li> </ul>
13. decisions related to BBP revision	see slides 28-34 in Annex C
14. revised BBP ready for use in the 2008 budgets of MOH, HIF and providers	all outstanding issues must be solved by mid-2007, including the financial analysis of the new BBP

Some of these decisions can be taken before the end of 2006, but most consequences can only be overseen and solved in 2007. The various budgets for 2007 have already been agreed upon. It would be a very good result if the 2008 budgets of MOH, HIF and health care providers could be based on the revised BBP system.

#### **4 THE THIRTEEN PREVENTIVE PROGRAMMES**

Outside the present BBP financed by the HIF, there are 13 so-called “preventive programmes” that should be financed from the budget of the Ministry of Health. An

overview of these programmes is presented in Annex B. In fact, these programmes are a mix of individual prevention, collective prevention (public health) and medical (curative) care. Therefore, the name of “preventive programmes” is not appropriate.

The total cost of these programmes in 2006 was estimated to be 970.5 million denar, of which 428.9 million was expected from the extra tobacco tax and the remainder from the regular budget of the Ministry of Health. However, the Ministry of Health has received no revenues from the tobacco tax, and it has also not provided all required funds from the regular budget. It is not clear to what extent the 13 programmes have been implemented, but it appears that the immunisation rate of children has not suffered from the lack of funds. Apparently, some funding has been provided by other means, but it is obvious that the financial foundation of some of these “preventive programmes” is insecure.

The beneficiaries of the 13 programmes are:

- \* uninsured patients (to cover the cost of treatment of specific diseases)
- \* insured patients (to cover the co-payment for specific services)
- \* whole population (for public health activities)

In countries with a system of social health insurance, medical care should be paid by the health insurance fund (or privately for services fully or partially outside the basic benefits package) and public health activities should be paid from national or local public budgets. Individual preventive services - such as immunisation of children or cancer screening - could be financed from either source.

Some of the 13 “preventive programmes” are regular public health activities that should be funded from the State or regional budgets: Public health, Brucellosis, Blood donation, Screening of students, and Vaccines. Others are partly regular public health activities and partly regular medical care, such as AIDS, Cancer screening, Mother and child care, and Tuberculosis. Others again are purely medical programmes that should be included in the basic benefits package of social health insurance: Addiction care, Psychiatry, Special categories, and Uninsured patients. Therefore, the 13 “preventive programmes” should become either regular public health programmes or regular social health insurance benefits. None of these special programmes seems to qualify for voluntary insurance or private payments. Most of these so-called special programmes are essential, but one must realise that the cost-effectiveness of Cancer screening and Screening of students is low.

## **5 REPORT ON THE WORKSHOP OF 8 NOVEMBER 2006**

A full-day workshop was organised in the Kamnik restaurant near Skopje on 8 November 2006 to discuss issues that are relevant for the revision of the BBP. Participants were the major stakeholders in the field of health financing: Ministries of Health, Finance and Labour & Social Policy, MOH Health Commission, Consumers Organisation of Macedonia, Syndicate of Health Professionals, Health Insurance Fund, Republic Institute of Health Protection, Clinical Centre, PCU, and BSG Smart Card Systems.

Representatives of the professional associations and Chambers (doctors, nurses, etc.) were not yet invited at this stage. The agenda of the workshop was as follows:

- 1 Opening by the deputy Minister of Health, chairman of the workshop
- 2 Two presentations on the present situation in social health insurance, by HIF staff
- 3 Four presentations by the international consultant, followed by discussion, on the following topics (see Annex C):
  - \* Outline of options for the future health financing system
  - \* Content of the BBP
  - \* The future financing of the 13 preventive programmes
  - \* Subjects related to the definition of the BBP
- 4 Summing up and conclusions, by the director of the HIF.

The presentations by the HIF focused on the lack of sustainability in the present health insurance system. Since the beginning of 2006, the HIF has capped all contracts with providers so that the HIF does not further increase its debt problem and in fact has paid some of its old debts. Moreover, the contract prices were lower than requested by the providers, although still based on historical data. However, the providers did not adapt to the new situation and increased their debts. Total cost also rose because of increase in demand and new treatment methods. Actual total debts are estimated at 1 billion denar for the HIF and 2.7 billion denar for the health care facilities. In fact, the total debt problem in the Macedonian health sector has increased, but to some extent this is masked by the sale of assets such as pharmacies. A solution must be found for the debt problem, and a new sustainable financing system must be adopted.

As the questions after the presentations, the discussion after each subject, and the conclusions of the workshop were very much inter-related, no attempt will be made here to separate them. Instead, the following paragraphs present an overview of the important elements of the workshop.

Several participants stressed the need for more control of providers by the HIF to check the volume and quality of actually performed services for the official beneficiaries, and the revenues and expenditures of the providers. This would require more technical staff at the HIF, which should not be a problem because HIF administrative costs are low in international comparison.

Most - but not all - participants seemed to realise that the present BBP must be reduced, but there was no agreement on which services could be added to the negative list. As there is no information about the real cost of services (the presently used price list is outdated and does not include drugs, materials, investment and depreciation costs), it is difficult to propose what should be inside and what should be outside the BBP. Most participants agreed that contracts between HIF and providers should not be based on input (existing staff, equipment, number of beds, etc.) but on output, i.e. on “services” or “production”. For depreciation, it is necessary to know who are the owners of health care facilities (this information should be available by mid-2007).

Most participants agreed with the principle of private voluntary additional insurance for services outside the BBP or for an upgrade in BBP services (single hospital rooms etc.). The HIF should not offer such additional insurance because that would be unfair competition for private insurance companies, and because private actuarial insurance is very different from social health insurance, but not all participants agreed with this.

The majority of participants agreed on adding the presently uninsured citizens to the HIF beneficiaries, but there were questions about who these citizens were, why they were not insured, how many of them existed, and about the additional cost for the HIF.

Regarding additional revenues for the HIF, some suggested a general Government subsidy. Some participants also proposed that the Ministry of Health would receive a higher share of the Government budget.

Revision of provider payment systems has been discussed, without arriving at specific proposals for primary care and secondary care. Capitation for primary care seemed generally accepted, and the risks of fee-for-service payment recognised. A form of capitation payment could even be used for regional hospital services and for regional public health programmes.

It was generally agreed that co-payments were needed in the BBP, but essential prevention programmes and vulnerable groups should be exempted. There was doubt among some participants if private primary care physicians would be willing and able to assume the responsibility for individual preventive activities for their clients (such as mother & child care) if these services were to be included into the BBP.

Most participants agreed that the 13 so-called “preventive” programmes were partly preventive, partly curative and partly public health, and that their financing should be re-organised as such (although no precise distribution was agreed during the workshop). This financing should be transparent and not virtual, as is the case at the moment. Specific attention was asked for the plight of chronic psychiatric patients. Such programmes should also be evaluated to see what outcomes have been achieved for the funding provided. The RIHP should propose annual public health programmes with well-founded budgets, to be financed from public funds (and not by the HIF). Public health needs a new public health law plus a public health strategy and implementation plan. The participants did not pronounce themselves on the method of financing medical care for occupational injuries and diseases (and also not on the method of financing preventive occupational safety & health programmes).

## **6 BBP WORKING GROUP**

The BBP Working Group was established on 8 November 2006 and a first meeting took place the next day. Not all members were present during this first meeting. Because written terms of reference were not available, the Working Group members discussed what would be expected from them. They also advised to modify the membership of the

Working Group. It was agreed that the international consultant would draft terms of reference for the BBP Working Group, based on the communication from the World Bank health economist and on his own terms of reference. This proposal is presented below. The PCU assistant co-ordinator explained the place of the BBP revision within the Health Sector Management Project, the PDPL, and the health strategy development.

The membership of the Working Group was modified soon after, to include another economist and with a new chairman. Expertise among the members is now distributed as 3 lawyers (1 from HIF and 2 from MOH), 2 economists (1 from MOH and 1 from HIF), 1 public health expert (RIHP) and 1 clinician (Clinical Centre).

The subjects on which this Working Group should advise are basically the same as for the international consultant (see chapter 1) but their mandate is of course different. The BBP Working Group will continue its activities after the first international consultant will complete his task in February 2007. The Working Group will continue to work with the team of consultants that will be responsible for the financial analysis of the revised BBP between March and June 2007.

For the terms of reference for the new BBP Working Group, the following is proposed:

1. Analysis of the impediments to the sustainability of the present health insurance system.
2. Proposing alternatives for the design and implementation of a sustainable basic benefits package. This includes: a) options for adding services to the negative list, b) alternatives for the financing of the 13 so-called “preventive programmes” which presently are supposed to be financed from the budget of the Ministry of Health, and c) a proposal concerning the financing of non-medical benefits by the HIF.
3. Describing the further activities needed for the precise description of the content and cost of the basic benefits package (including co-payments), and the duties and rights of beneficiaries, HIF and providers.

For the tasks under 1. and 2., the BBP Working Group will be assisted by the present international consultant (author of this report) until February 2007. For the task under 3., the Working Group will be assisted by a team of consultants to be contracted by the Ministry of Health. This team can hopefully be in place from 1 March 2007.

The duration of the activities of the BBP Working Group has not yet been established, but preferably the Working Group should be active at least until June 2007.

The Working Group is free to produce its own reports to the Minister of Health and the HIF, but as an alternative (or additionally), they should comment on the reports to be produced by the consultants. The first international consultant will produce two reports: the present draft Progress Report by mid-November 2006, and a final report in February 2007. For the reports by the next team of consultants, see chapter 7.

## 7 TERMS OF REFERENCE FOR THE FINANCIAL ANALYSIS OF THE FUTURE BBP

### Background

At independence in 1991, the Republic of Macedonia inherited a system of social health insurance from the former Yugoslavia. Wage-related contributions are collected from formally employed citizens and from self-employed persons. Social funds pay the contributions for unemployed, disabled and pensioned citizens. In this way, approximately 90% of the population are insured against the risk of ill-health. This social health insurance system is being implemented by the national Health Insurance Fund (HIF) that contracts most existing health care providers for this purpose. However, the collection of official contributions is not optimal. Approximately 10% of the population are not insured for various reasons, such as not being registered or because employers did not pay the contributions. The beneficiaries of the HIF are entitled to a basic benefits package (BBP) that is described in the Health Insurance Law and that is very generous in international comparison. Some co-payments are required for some services, but they are limited. The main problem is that the revenues of the HIF do not match the cost of providing the official BBP to the insured population. This has led to large debts for the HIF. In 2006, budget ceilings have been introduced in all contracts between the HIF and the health care providers. The effect is that the HIF does not accumulate further debts, but the problem of debts has been shifted to the providers, also because budget discipline is weak and because official prices of services are below their real cost. In the period of November 2006 - February 2007, the Ministry of Health and the Health Insurance Fund will re-design the system of social health insurance and the BBP. The new BBP should fulfil the following criteria:

- \* The HIF revenues should be sufficient to provide the beneficiaries with the services to which they are entitled: the new BBP must be sustainable.
- \* The services in the BBP have been selected on the basis of proven cost-effectiveness, in other words: the new BBP should contain as many priority services as revenues allow.
- \* The co-payments within the new BBP will not cause major problems of access to essential services for the poorer part of the beneficiaries. If necessary, some groups can be exempted from paying co-payments or pay lower co-payments.
- \* The contracted providers are able to provide the BBP services for the price agreed between them and the HIF.

It is expected that in February 2007, the Government of Macedonia will have agreed on the principles of the design of the new BBP. There will also be proposals to exclude specific services from the BBP (negative list) and proposals to maintain or introduce co-payments for specific services within the BBP. However, these proposals will have been based on rough estimates of the cost of these services. Therefore it will not yet be possible to see if the proposed BBP will fit into the financial envelope available to the HIF (largely based on compulsory contributions by the beneficiaries).

## **Consultancy services**

The Government of the Republic of Macedonia wants to contract a consultancy firm to conduct a financial analysis of a new sustainable basic benefits package to which the entire population (2 million citizens) will be entitled.

The consultants should calculate realistic cost figures for the services within the BBP, and calculate the effect of introducing co-payments of various levels, possibly also for different target groups among the beneficiaries. The cost calculations should be based on clinical guidelines where they exist; they should *not* be based on the salaries of existing staff, because there is a surplus of staff in many facilities. Therefore, the calculations should not be based on existing health care infrastructure (input) but on output (production) by the providers. The methodology to be developed by the consultants must be such that it can be used by HIF staff for the proper budgeting of future BBPs after 2007. Therefore, the consultants have to work closely with the HIF staff designated by the HIF management.

If the cost of the services in the draft BBP is above or below the expected revenues of the HIF, the consultants will have to suggest deleting or adding services from/to the BBP, and/or make changes in the proposed co-payments.

Not only are volume and price of BBP services important, but their quality must also be assured. However, the system of quality assurance and quality control is not part of the tasks of the consultancy team. Other experts have worked and are still working on this issue.

The new provider payment methods to reimburse the providers for services provided under the new BBP will probably not yet have been decided in February 2007. This is important because the methodology for calculating the cost of services by the consultants depends on how the services will be described in the contracts between the HIF and the providers: service units should equal provider payment units. The consultants will have to propose a feasible system of service/payment units. Although there is much interest in a DRG approach to contracting and provider payment, it does not seem realistic to expect this to be available in the short term. Therefore, a simpler cost calculation system must be designed, although it may be possible to calculate the cost of a small number of case-based service units as examples.

For the calculation of costs in the Macedonian health care sector, the consultants will have to co-operate with a sample of primary and secondary care facilities, plus the Clinical Centre (university hospital). Some facilities are already piloting new management information systems.

The consultants will not be involved in the calculation of the cost of public health programmes to be financed from the State budget. This will be done by the Republic Institute of Health Protection. Neither will they need to look at services that will

definitely not belong to the BBP, and must be paid by the patients themselves, either out-of-pocket or via voluntary additional private health insurance.

In November 2006, the Minister of Health has established a new BBP Working Group with members from the Ministry of Health, the HIF, the Republic Institute of Health Protection, and the Clinical Centre. The consultants will have to work closely with this Working Group. The consultancy takes place in the framework of the World Bank supported Health Sector Management Project. The activities of the consultants will be co-ordinated by the Project Co-ordination Unit that will also make relevant documents available to the consultants, such as legal texts, HIF reports and consultancy reports (most of which have been translated into English).

From November 2006 until February 2007, an international consultant is assisting the Ministry of Health and the BBP Working Group in the re-design of the BBP. His progress report will be made available to the consultancy firms that are invited to bid for this assignment. His second report will be available to the selected consultancy firm in February 2007.

The Government of Macedonia is preparing a national health strategy for the period 2007-2020, including a chapter on health financing and health insurance. The final draft of this document should be available in January 2007.

The deliverables under this assignment are the following:

**a Reports**

- 1 An inception report two weeks after the beginning of the assignment. This inception report should contain a first analysis of the situation and a detailed action plan for the remainder of the assignment.
- 2 A progress report halfway during the assignment. This report will describe the methodologies developed by the consultants and the first results.
- 3 A draft final report two weeks before the end of the assignment. This report will contain the results of all the tasks undertaken by the consultants according to the terms of reference. This includes a full description of the proposed 2008 BBP: services, costs, and provider payment methods.
- 4 The final report should be submitted before the 15th of July 2007.

All reports should describe the activities that took place during the assignment and the various missions undertaken by the members of the consultancy team. All reports will be in English and translated into Macedonian.

**b Workshops**

The consultants will organise three workshops for 20-30 key stakeholders in this field, to discuss the inception report, progress report and draft final report with them.

In its bid, the consultancy firm will propose a preliminary action plan for the required tasks and the CVs of the proposed team members. The team proposed by the firm should have the necessary expertise in health financing, priority setting and financial administration, and experience in transition countries. The total amount available for this assignment is [.....].

The duration of this assignment will be from 1 March until 15 July 2007.

## **8 PRELIMINARY RECOMMENDATIONS**

It is nearly impossible to quantify the extent to which the BBP should be reduced to become sustainable, when a proper financial analysis is not available and many trends are not clear yet. Based on international experience it is certain that the reduction must be more than marginal. Such a large reduction is difficult to achieve with priority setting methods. In other words: it would be very difficult to exclude as many health care services from the present BBP as needed to make it sustainable. Adding major health services to the negative list will cause an outcry and will pose serious equity questions. Therefore an important contribution should also come from increased co-payments (possibly for different services than at present), with some exemptions for vulnerable groups.

The political and financial effect of a larger negative list and increased co-payments should to some extent be counterbalanced by an effort to increase the collection of contributions (including the control of fraud and the discontinuation of protection of weak companies), by the decision to include formerly uninsured patients, and by an increased MOH share of the State budget. An increased MOH budget could be used both for public health programmes and for a subsidy to the HIF.

The Government has asked which BBP actions could be undertaken before 31 December 2006. It may be clear from Table 2 in chapter 3 that the Government could take several decisions before the end of 2006, but that implementation would have to wait until 2007. The Government should take a coherent (comprehensive) approach to health financing reform, and should not initiate isolated actions without agreement on the overall picture. It is also not realistic to expect that the 2007 budgets of ministries and HIF can be changed at such short notice and that laws can be amended. However, some actions could be taken at relatively short notice if certain requirements are fulfilled:

\* Technically speaking, changes could be made in the co-payment situation (decisions 5 and 6 in Table 2), but that would require that the co-payment analysis (see chapter 9) is available and that the financial consequences of changes in the co-payment system can be calculated quickly.

\* Another action that could be taken at short notice would be to eliminate most dental treatment for adults from the BBP, as has been done in many countries. However, the right to dental care is assured by the Health Insurance Law, and the consequences for the public dental services would be considerable. Dental care (children + adults) accounts for approximately 4% of HIF expenditures.

\* And finally, the 13 “preventive” programmes could be separated into MOH responsibilities (public health and possibly some preventive activities for individual

citizens) and HIF responsibilities (curative services and the remainder of the preventive activities for individual citizens). However, this would require that uninsured citizens would be accepted by the HIF (decision nr. 2) and that appropriate financial flows would be redirected from the Government and the MOH towards the HIF.

In principle, all decisions to be taken according to Table 2 in chapter 3 are phrased as recommendations by the international consultant, except those with a question mark (nr. 9, 11 and 12). It remains to be seen how many of them will be feasible in reality and which will be accepted by the Government.

## **9 NEXT STEPS**

The MOH should discuss this BBP progress report with major stakeholders - including the World Bank midterm review mission in November 2006 - in order to get feedback on the proposed approach.

The consultant assumes that there will be agreement on the health financing chapter (including the BBP paragraph) in the draft health strategy to be presented during the Mavrovo conference in December 2006.

The next mission of the international consultant is planned for 14-26 January 2007.

In January 2007, the consultant would like to visit a regional hospital with good financial data (revenues, expenditures, debts), data on ownership and value of property and equipment, and good utilisation data. It would then be attempted to obtain a rough estimate of the cost of various services, using a simple system of service units, for example cost per capita of the attached population or cost per bed-day in different departments (surgical, internal, etc.). One or more HIF experts should join in this visit.

It would be very helpful if the HIF would prepare an overview of the co-payment situation in social health insurance. Such a document would present which types of co-payment are being used at the moment, at which rates, and for which services, and which groups of beneficiaries are exempted. Maybe such a document already exists and only needs to be translated into English. However, some additional information is also needed: which revenues have been generated from different types of co-payment, and what happens with such revenues? Why did the HIF receive only 513 million denar from co-payments in 2005, that means on average only € 4-5 per beneficiary?

It would also be useful if the HIF (possibly with other organisations) can calculate and present the debt problem in the Macedonian health care sector, and indicate solutions. Who owes what to whom, for example on 31 December 2006. This would not only apply to the HIF, but also to the MOH, health care providers, suppliers, etcetera. Note that the IMF report (see Annex C) states that in 2004, the HIF collected contributions of approximately 8.8 billion denar, whereas expenditures were 14.9 billion denar. This

statement is in sharp contrast with the debt data presented by the HIF and by the State Audit Office in its report of 15 September 2006.

It would also be useful if the HIF, together with the Pension & Disability Fund, the Ministry of Finance and the IMF consultants, could calculate what the consequences are for the HIF if the HIF contributions will be collected on the basis of a different system (“base harmonisation”, see Annex A), assuming all other factors remaining the same.

## **ANNEX A - CHANGES IN THE COLLECTION OF SOCIAL CONTRIBUTIONS**

The IMF has proposed a plan for the improvement of the collection of taxes and social contributions to the Government of Macedonia. The original proposal is presented in the IMF report:

John Brondolo, Koenraad van der Heeden, Mary Aiston. Former Yugoslav Republic of Macedonia: improving the collection of taxes and social contributions. IMF, Fiscal Affairs Department, February 2005.

A follow-up report has been submitted to the Government in October 2006:

John Brondolo, Koenraad van der Heeden, Harish Mendish. Former Yugoslav Republic of Macedonia: Launching the next phase of revenue administration reforms. IMF, Fiscal Affairs Department, 30 October 2006

The main objective of the proposed revenue administrative reforms is the improvement of the operations of the Public Revenue Office (PRO). One important aspect of this is the joint collection of wage taxes and social contributions. The Government should agree with the IMF proposal that the collection of taxes and collection of social security contributions will be gradually integrated during the next 3 years, as an efficiency measure. The three social funds could then better concentrate on their core function: managing the benefit entitlements of their insurees. As an intermediate step, the collection of social security contributions will first be integrated into the Pension & Disability Fund (PDF), because it is supposed to be the best functioning social fund. Later, the collection of all social contributions will be integrated into the PRO.

The HIF should harmonise its way of calculating the required contributions with the method used by the PDF and the Employment Fund (EF). The report states that this will unfortunately reduce total HIF revenues. This so-called “base harmonisation” requires that the social insurance funds and the employers adjust their accounting systems. The IMF hopes that base harmonisation will take place by 1 April 2007. After that date, large contributors - i.e. major companies - will pay their HIF and EF contributions to a Large Contributor Office (LCO) within the PDF. Later in 2007, *all* contributions - also those from small and medium contributors - should be collected by the PDF. By the end of 2008, the LCO will have merged into the Large Taxpayers Office (LTO) of the PRO. In 2008-2009, the PRO will take over all responsibility for the collection of social contributions and in 2009, *all* social contributions will be collected by the PRO.

At present, social contributions are deductible for the personal income tax, but that may not be the case in the future. This would make no difference for future HIF revenues, but puts a heavier burden on taxpayers and enterprises.

A problem appears to be that data processing at the HIF is organised at the branch level without linkages to HIF headquarters. This requires that data are distributed by USB stick. By 2008, this should have been replaced by an electronic communication system.

The whole revenue administration reform will be managed by a Task Force and overseen by an Inter-Ministerial Steering Committee that includes the Minister of Health and the director of the HIF.

The message for the Ministry of Health and the HIF is: this appears to be a sensible reform, but make sure that a) the various social contributions are collected into separate accounts, b) all social health insurance contributions will reach the HIF, and c) any shortfall in social health insurance contributions because of the base harmonisation is compensated by budget transfers or otherwise. There will, of course, be a lot of work for HIF staff to change its administrative system.

## **ANNEX B - SUMMARY OF THIRTEEN PREVENTIVE PROGRAMMES**

Note: For easier reading, the names of these 13 programmes have been abbreviated. The programmes are presented in alphabetical order, and not according to importance or size.

### **Addiction care**

Hospitalisation and day care for addicted persons. The HIF pays for such treatment, but only for insured persons and only for maximum 30 days. The programme would cost 63.5 million denar, of which 18.5 million denar from the State budget and 45 million expected from the tobacco tax. It is intended for uninsured addicts, court cases and patients that still need treatment after 30 days. No mention of prevention programmes.

### **AIDS**

This is largely a public health programme for surveillance, testing, and health education, with a smaller part for treatment of uninsured patients with antiretroviral drugs. Total value: 7.4 million denar, of which 3.4 million for tests, 2 million for drugs and 2 million for health education.

### **Blood donation**

This programme asks for 37 million denar, of which 28 million for paying donors who have donated blood more than 10 times (?). The remainder is for promoting and organising blood donation. The State budget will provide 8.7 million, and the HIF 1 million for co-payments. The difference (27.3 million) should come from the tobacco tax.

### **Brucellosis**

This is a typical public health programme executed by the network of Institutes of Public Health. The total cost 7.1 million should largely be included in the budgets of the IPH network, except for the co-payment for uninsured hospitalised patients.

### **Cancer screening**

This programme aims at regular screening of 20% of the women between 19 and 65 for cervical cancer. It includes educational activities to increase the awareness of cervical and breast cancer prevention. Total cost is 11.5 million denar, of which 8.5 million to be paid from the State budget and 3 million from the tobacco tax.

### **Mother and child care**

This is a key preventive programme with the usual activities for women and children: health education, antenatal care, obstetric care, postpartum care, family planning, and child screening and monitoring. Immunisation is covered under a separate special programme. These forms of health care are normally covered by social health insurance,

but the preventive programme asks for 86.5 million denar for uninsured mothers and children, and 43.2 million for the co-payments that insured mothers and children have to pay for deliveries and hospitalisation of infants. Total is 129.7 million denar. Apparently, only 25.3 million denar will be provided by the 2006 State budget, so that the difference (104.4 million) should be provided from the tobacco tax.

### **Psychiatry**

This programme takes care of the psychiatric cases for whom the HIF is not paying: uninsured patients, chronic patients (?), and court cases. The Ministry of Justice should be paying for the patients that are hospitalised by court order, but apparently does not. The cost of the programme would be 70.6 million denar, of which only 34.5 million is reserved in the 2006 State budget. The remainder (36.1 million) should come from the tobacco tax.

### **Public health**

This preventive programme consists of the normal activities of the IPH network, divided into the 4 traditional domains of social medicine, laboratory/microbiology, sanitary and hygiene, and epidemiology, plus 2 other groups: extraordinary situations and radiation protection. The cost of laboratory/microbiology activities is not mentioned and apparently included into the regular HIF budget. The cost of the other 3 domains plus 2 other groups is 95.6 million denar. Then there is 151.1 million denar for investment (?) for the preparation against an influenza pandemic. The total is 246.8 million denar.

### **Special categories**

This is not a preventive programme but a special programme for various categories of patients: dialysis treatment (46 million denar), drugs for patients with kidney transplants (62.6 million), cancer treatment (18.2 million), insulin treatment (76.3 million), treatment with growth hormone (3.2 million), and haemophilia patients (12.8 million). Basically, the special programme is for uninsured patients and for covering the co-payments of insured patients. The text gives a total of 159 million denar required from public sources, but the calculations are not clear. It is proposed that the State budget provide 75 million and that the remainder (84 million) should come from the tobacco tax.

### **Screening of students**

School children and students receive a medical examination 6 times: 3 in primary school, 2 in secondary school, and 1 in the first year of university. The cost-effectiveness of such programmes is questionable. The cost of the programme is 16 million denar, mostly for the screening of uninsured students, and partly (3 million denar) to cover the co-payments for insured students. This amount is covered by the State budget.

## **Tuberculosis**

This is a standard tuberculosis control programme, with X-ray examinations, laboratory tests, BCG vaccination, health education, contact tracing and treatment. The total cost is 12 million denar, of which 4.2 million to cover the co-payments for treatment of insured patients. The text does not mention the cost of treating uninsured patients.

## **Uninsured patients**

This programme seems to overlap with others. It covers services for the uninsured population, sub-divided into pregnant women, children under 1, children 1-18, persons over 65, and persons of any age. Different services are covered for each category. The list of services for the category of any age contains treatment of patients with approximately 40 specific diseases. For these 40 diseases, not only the cost for uninsured patients will be borne (7.4 million), but also the co-payments for insured patients (59 million). The second biggest item in this programme is deliveries for uninsured women: 56.2 million denar. The total cost of the programme is 158.9 million denar. It is mentioned that 21.2 million denar will be provided from the State budget, and 129.1 million denar from the tobacco tax. (Note: this does not add up to 158.9 million).

## **Vaccines**

This is not so much a preventive programme as a budget to purchase the vaccines needed for the national immunisation programme and for immunisation of epidemiological cases (such as tetanus for wounds, and suspected rabies). Total cost is 51 million denar, to be borne by the State budget.

## ANNEX C - PRESENTATION GIVEN AT THE BBP WORKSHOP

<b>Design of the basic benefits package</b> by Kees Schaapveld, consultant of the Ministry of Health of the Republic of Macedonia Kamnik, 8 November 2006	1
A Outline of the future health financing system B Content of the basic benefits package C What to do with the 13 special programmes? D Subjects related to the definition of the basic benefits package	2
A Outline of the future health financing system * revenues * benefits * expenditures * responsibilities	3
definitions: * social health insurance * private (actuarial) health insurance * additional (supplemental) health insurance * mandatory (compulsory) health insurance * voluntary health insurance * financing from public budgets * out-of-pocket payments * basic benefits package (BBP)	4
probable Macedonian model: * largely compulsory social health insurance for the basic benefits package for all citizens * some voluntary health insurance for additional medical services for some citizens * some out-of-pocket payment for medical services for all citizens (BBP and non-BBP) * public budget funding for public health activities for all citizens (continued on next slide)	5

6
<p>probable Macedonian model (cont'd):</p> <ul style="list-style-type: none"> <li>* the BBP can only be insured by the Health Insurance Fund (HIF) (and not by private companies)</li> <li>* all citizens will have a HIF electronic card</li> <li>* the category “uninsured” will disappear</li> <li>* additional health insurance can only be provided by private companies (and not by the HIF)</li> <li>* HIF expenditures cannot exceed its revenues (BBP = revenues – administrative cost – reserve/debts)</li> </ul>

7
<p>Contributions to the Health Insurance Fund:</p> <ul style="list-style-type: none"> <li>* from employers/employees for employed persons and their families</li> <li>* from the social funds for the unemployed, disabled and pensioners and their families</li> <li>* from the self-employed</li> <li>* from the State budget for all other citizens</li> <li>* option of State subsidies to the HIF</li> </ul>

8
<p>proposals:</p> <ul style="list-style-type: none"> <li>* the BBP contains only individual health care benefits, and no cash benefits</li> <li>* treatment of work-related injuries and diseases could be either in the BBP or covered by a separate compulsory insurance</li> <li>* the Republic Institute of Health Protection proposes annual public health programmes and budgets to the Ministry of Health and other ministries</li> </ul>

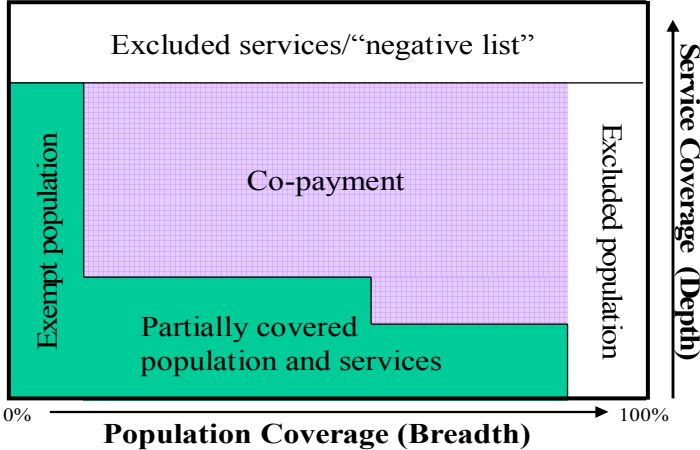
9
<p>Discussion</p> <ul style="list-style-type: none"> <li>* one BBP for all citizens</li> <li>* individual health services in the BBP paid by HIF</li> <li>* public health programmes paid from State budget (various ministries)</li> <li>* no more “uninsured”</li> </ul>

10
<p>Discussion (cont'd)</p> <ul style="list-style-type: none"> <li>* law enforcement against non-payment of contributions by individuals, companies, and public authorities</li> <li>* HIF debts not allowed</li> <li>* no cash benefits in the BBP</li> <li>* what about occupational injuries/diseases?</li> </ul>

B	content of the basic benefits package	11
*	what is a BBP?	
*	priority setting	
*	positive lists and negative lists	
*	co-payments	
*	incentives	

12

### Benefit package with co-payments and different levels of coverage



Priorities		13
*	Priorities between sectors and within the health care sector.	
*	Priority setting means ranking and rationing, needed because of mismatch between demands and resources.	
*	Who wants priority setting? (consumers, providers, HIF, politicians, experts/scientists?)	

Methods for priority setting:		14
*	economic analysis by independent researchers	
	- all costs and all benefits (incl. negative ones)	
	- cost-effectiveness analysis (health benefit)	
	- cost-utility analysis (QALY)	
*	public opinion	
*	consensus among professionals	
*	affordability for the public, equity issues	
*	technology assessment for excluding non-effective care	

Results of cost-benefit analysis for some medical procedures (BMJ, 6 September 1997, p. 597)

PROCEDURE	COST PER QALY (£)
cholesterol testing and diet therapy	220
advice to stop smoking from patient's own doctor	270
hip replacement for arthritis	1,180
kidney transplant	4,710
breast cancer screening	5,780
cholesterol testing and drug therapy if indicated (ages 25-39)	14,150
neurosurgery for malignant brain tumours	107,780

explicit rationing:

limiting access to low-priority services:

- excluding services from benefits packages
- user fees
- excluding certain groups from priority services (e.g. elderly from transplantation)

implicit rationing:

- creates waiting lists
- less financing for low-priority services (dilution of services)
- lays burden mostly on doctors

International experiments in priority setting

- \* Oregon (from 1989)
- \* Netherlands (from 1992)
- \* New Zealand (from 1993)
- \* Sweden (from 1995)
- \* Georgia (from 1996)
- \* common features: cost-effectiveness ratios, consultation process, political decisions
- \* fewer experiments in recent years

After the priority exercise in the Netherlands, the following services were transferred to the negative list:

- \* cosmetic surgery and IVF (not essential)
- \* physiotherapy and alternative medicine (not effective)
- \* experimental transplantation (not efficient)
- \* dentistry (including dentures), oral contraceptives, over-the-counter drugs, and a few smaller items (affordable)

Present “negative list” in Macedonia	19
* drugs and devices not on the positive list	
* cosmetic surgery	
* abortion for non-medical reasons	
* above standard services	
* treatment of acute alcohol intoxication	
* several types of check-up and certificates	
* certain vaccinations	
* spa treatment?	

Other limitations in the present BBP:	20
* co-payments for certain services	
* no treatment abroad without preliminary approval	
* “essential” drugs not on the positive list only with special approval	
Conclusion: the present BBP is very comprehensive / generous	

For individual preventive services, we need a positive list:	21
* mother and child care: antenatal and obstetric care, growth monitoring, immunisation, home visits, etc.	
* family planning	
* some forms of screening	
* individual health education	
* others?	

Which services could be excluded from the BBP on the basis of one of the following criteria:	22
* not essential for health	
* low or no effectiveness	
* low cost-effectiveness	
* exclusion does not cause major problems of access or equity	
* other criteria?	

What about:	23
* differentiation in rate of co-payment according to age or income level?	
* first 1000 denar not reimbursed by social health insurance (except vulnerable groups and except chosen doctor)?	
* no reimbursement for secondary care without referral from the chosen doctor?	
* inclusion or exclusion of occupational injuries and diseases?	

C	The future financing of the 13 special programmes (short description of these programmes: see handout)	24
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	Characteristics of the 13 programmes: <ul style="list-style-type: none"><li>* mix of individual health services and public health activities</li><li>* beneficiaries:<ul style="list-style-type: none"><li>- uninsured patients (for treatment)</li><li>- insured patients (for co-payment)</li><li>- whole population (for public health)</li></ul></li><li>* most (but not all) programmes are essential</li><li>* programmes receive inadequate financing</li></ul>	25
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	Proposed principles: <ul style="list-style-type: none"><li>* main group of beneficiaries (uninsured) will disappear</li><li>* paying co-payments from public funds is counter-productive</li><li>* public health financed from State budget</li><li>* individual health services paid from insurance or out-of-pocket</li><li>* individual preventive services can go either way (e.g. immunisation, screening)</li></ul>	26
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	Consequences: <ul style="list-style-type: none"><li>* included in BBP: addiction care, AIDS treatment, mother and child care, psychiatry, special categories, tuberculosis, uninsured patients</li><li>* included in annual public health programme: health promotion activities, blood donation, brucellosis, public health, vaccines</li><li>* for discussion: cancer screening, screening of students</li></ul>	27
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D	Subjects related to the definition of the basic benefits package <ul style="list-style-type: none"><li>* rationalisation of the health sector</li><li>* purchasing and contracting issues</li><li>* provider payment methods</li><li>* incentives for HIF, providers and consumers</li><li>* control of corruption and fraud</li></ul>	28
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	Rationalisation of the health sector <ul style="list-style-type: none"><li>* planning of human resources</li><li>* “medical map”</li><li>* “a bed built is a bed filled”</li><li>* market or planning?</li></ul>	29
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Purchasing and contracting issues	30
* active (strategic) purchasing by the HIF	
* selective contracting	
* autonomy of facilities	
* contracting services, not infrastructure (salaries, beds)	
* unit of service related to provider payment method	

Provider payment methods	31
* unit of service = unit of payment	
* DRG popular but difficult	
* cost control essential	
* fee-for-service most risky	
* capitation for primary care	
* relation between provider payment method and quality of services	
* administrative simplicity	

Incentives for the Health Insurance Fund	32
* expenditures must fit revenues	
* strategic purchasing	
* selective contracting	
* control of eligibility of patients	
* careful audits of contracted providers	
* control of referral rates (gate keeping)	
* accountability of Board and management	

Incentives for the providers	33
* managerial autonomy (training needed)	
* management information system	
* human resources according to need	
* control of eligibility of patients	
* careful with referral to higher level	
* risk of not being contracted by HIF	

#### Incentives for the consumers

- \* selection of a chosen doctor
- \* no free secondary care without referral
- \* no HIF coverage if contribution is not paid
- \* no HIF coverage without being registered
- \* first x denar per year to be paid out-of-pocket, or refund at the end of the year if consumption is less than x denar?

## **ABBREVIATIONS**

BBP	= basic benefits package
BCG	= bacille Calmette Guérin (tuberculosis vaccine)
BMJ	= British Medical Journal
DRG	= diagnosis related group
EF	= Employment Fund
EU	= European Union
HIF	= Health Insurance Fund
HSMP	= Health Sector Management Project
IMF	= International Monetary Fund
IPH	= Institute of Public Health (= Institute of Health Protection)
IVF	= in vitro fertilisation
LCO	= Large Contributor Office
LTO	= Large Taxpayers Office
MOH	= Ministry of Health
PCU	= Project Co-ordination Unit
PDF	= Pension & Disability Fund
PDPL	= Programmatic Development Policy Loan
PHC	= primary health care
PRO	= Public Revenue Office
QALY	= quality adjusted life year
RIHP	= Republic Institute of Health Protection
WHO	= World Health Organisation

## **SOME RELEVANT DOCUMENTS ON HEALTH FINANCING REFORM**

selected by Kees Schaapveld for the workshop on 8 November 2006

1 Carrin G, James C. Reaching universal coverage via social health insurance: key design features in the transition period. Document nr. EIP/FER/DP.04.2. Geneva, World Health Organisation, 2004 (accessible via [www.who.int](http://www.who.int))

2 Hauck K, Smith PC, Goddard M. The economics of priority setting for health care - a literature review. Washington DC: World Bank / Health, Nutrition, and Population division, November 2003 (accessible via [www.worldbank.org](http://www.worldbank.org))

3 Kutzin J. A descriptive framework for country-level analysis of health care financing arrangements. *Health Policy* 2001;56:171-204

*Good overview of the subject of health care financing with emphasis on health insurance. Hard copy available in the PCU.*

4 Langenbrunner JC, Wiley MM. Chapter 8: Hospital payment mechanisms: theory and practice in transition countries. In: McKee M, Healy J (eds). *Hospitals in a changing Europe*. Copenhagen: European Bureau of the World Health Organisation (European Observatory on Health Care Systems series) (accessible via [www.euro.who.int](http://www.euro.who.int))

5 Mossialos E, Dixon A, Figueras J, Kutzin J (eds). *Funding health care: options for Europe*. Buckingham/Philadelphia: Open University Press, 2002 (accessible via [www.euro.who.int/document/e74485.pdf](http://www.euro.who.int/document/e74485.pdf))

6 Normand C, Weber A. *Social health insurance, a guidebook for planning*. Copenhagen: World Health Organization, 1994

*Although relatively old, this book is - in my opinion - a classic and compulsory reading for all those involved in the development of social health insurance. Hard copy available in the PCU.*

7 Waters HR, Hussey P. Pricing health services for purchasers - a review of methods and experiences. *Health Policy* 2004;70:175-184

*Good text on provider payment systems. Hard copy available in the PCU.*

8 World Health Organisation - Regional Office for Europe. *Approaching health financing policy in the European Region*. Document nr. EUR/RC56/BD/1. Copenhagen: WHO, 26 June 2006 (accessible via [www.who.int](http://www.who.int))