

MINISTRY OF HEALTH OF THE REPUBLIC OF MACEDONIA

HEALTH SECTOR MANAGEMENT PROJECT

CONSULTANCY ON BASIC BENEFITS PACKAGE REVISION

SECOND PROGRESS 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 progress report of 16 November 2006.

A second mission for the work on the BBP has taken place from 15 to 26 January 2007. It is planned to complete the BBP consultancy during a next mission to Macedonia in February-March 2007, in combination with the beginning of the work on the implementation plan for the national health strategy. The workshop and the final report on the BBP consultancy can be expected in the beginning of March, 2007.

This second progress report was not foreseen in the terms of reference, but it seems better to combine the results of this second BBP mission into a single document before organising the BBP workshop and writing the final BBP report during the next mission.

Chapters 3 and 4 have been written with the conclusions of the health summit in Mavrovo on 22-23 December 2006 in mind. Annexes B and C are suggestions for revision of the relevant chapters from the draft health strategy. Annex B is based on the pre-final draft of 8 March 2006, because it was more comprehensive. Annex C is based on the final draft of 10 April 2007 even though this final draft is also shorter than the pre-final draft.

2 MISSION ACTIVITIES

The consultant attended two meetings of the BBP Working Group, on 16 and 23 January. The second meeting was also attended by representatives of World Bank. A separate meeting with the health economist of the World Bank was organised on 22 January.

On 23 January, a meeting was held with representatives of the Ministry of Health (MoH) and the Republic Institute of Health Protection to discuss the future organisation and financing of the 13 national programmes, also known as 13 preventive programmes.

On the 17th of January, the Bitola Clinical Hospital and the HIF branch office in Bitola were visited, for an analysis of the organisation and financing of a regional hospital.

On Thursday 18 January, the consultant attended part of a meeting of hospital directors, organised by the Ministry of Health.

Progress of the consultancy was discussed three times with the deputy Minister of Health, on 18, 22 and 23 January.

The consultant met with representatives of the HIF management on 19 January to discuss the issues presented in chapter 3 before the meeting with the BBP Working Group. Another visit to the HIF took place on 24 January to discuss the results of the BBP consultancy and the meeting of the BBP Working Group with the financial manager of the HIF and the head of the HIF Control Department.

On 24 January, the psychiatric hospital in Negorci was visited. The purpose of the visit was to analyse the precarious situation in long-term psychiatric care, and especially to discuss possibilities of proper funding of such care in view of the reorganisation of the 13 national programmes and the responsibility of other ministries.

The pending developments and decisions in health care financing were discussed with the State Secretary of the Ministry of Finance on 25 January, with emphasis on the consequences of the joint collection of the social contribution (including compensation for the HIF), the size of the BBP (including the responsibility for paying cash benefits during maternity leave and sickness), the collection of co-payments by the providers (taxed by the Ministry of Finance), and the future of the 13 national programmes.

3 PROGRESS IN HEALTH FINANCING REFORM

3.1 Explanation

Chapter 3 presents the health financing reform measures that the Republic of Macedonia wants to implement. An earlier draft of chapter 3 was discussed by the BBP Working Group and other participants from the MoH and the HIF on 23 January 2007. In the present text of chapter 3, there are still some issues that require analysis or that have not yet been decided. They have been indicated as such. Some of them require agreement with other ministries, especially the Ministry of Labour & Social Protection and the Ministry of Finance.

3.2 Beneficiaries of social health insurance

All citizens of Macedonia will be entitled to one basic benefits package (BBP) financed via compulsory social health insurance organised by the Health Insurance Fund (HIF). That means that the presently non-insured citizens will be included in the social health insurance system, starting from 1 January 2008. Although precise numbers are missing, it is more or less known who these non-insured persons are:

- * Macedonians who have left the country with or without informing the civil registry in their place of residence;
- * Employees for whom the employer has not paid the contributions, either permanently or temporarily;
- * Self-employed or otherwise independent persons who have managed to escape the payment of their compulsory contribution;
- * Persons without proper documentation.

It will be necessary to analyse how and when these categories can be included into the pool of insured citizens.

The list of beneficiaries of social health insurance in articles 5-7 of the Health Insurance Law remains valid. However, one can question the entitlements of foreigners working in Macedonia (article 5).

As an option, one could add residence in Macedonia as a condition for membership of the HIF. Article 28 of the Health Insurance Law already describes the duty of a beneficiary to select a chosen doctor, but this could be reinforced as a strict condition for HIF membership.

All beneficiaries of the HIF will receive an individual fraud-proof electronic membership card but for technical and financial reasons this will probably have to wait until 2009. From 1 January 2008, all beneficiaries should have a temporary card that discourages misuse.

3.3 Contributions for social health insurance

Health care services can be financed from social health insurance contributions or from general taxation. Both methods have advantages and disadvantages.

Some advantages of a tax-based system are administrative simplicity, a reduced burden on hiring employees for (starting) entrepreneurs, and fewer problems of collecting contributions in a situation of high unemployment and poor registration of real personal income. Some disadvantages are that an institution for purchasing, administration and control is still needed (such as the National Health Service in the United Kingdom), that there may be more political interference with the revenues for the health care system, and that individual citizens feel more like passive consumers than like real members of their own health insurance fund. The advantages and disadvantages of a system based on individual contributions (from payrolls and otherwise) are the reverse. There is no international agreement on which system is best. Because Macedonia has a long experience in social health insurance, it appears better not to add yet another major reform measure. A simulation exercise will be performed at the request of the Ministry of Finance to analyse the consequences of changing to a tax-based system, but this has no direct influence on the revision of the BBP.

Continuation of the social health insurance system means collection of payroll-based contributions for employees, collection of contribution from the self-employed, and collection of contributions from social funds and other ministries on behalf of the unemployed, disabled, chronically ill, prisoners, pensioners, etc.

It is obvious that the payment of compulsory contributions must be improved and enforced. This is one of the aims of the proposed scheme of joint collection of all social contributions - including contributions for social health insurance - by the Public Revenue Office. The consequences of the joint collection by the Public Revenue Office are that the collection function within the HIF will disappear, and that there is an initial risk of lower revenues for the HIF because health insurance contributions are currently calculated by a more advantageous method than the method that will be used by the Public Revenue Office in the future. The HIF should try to obtain full compensation for

this initial loss from the Ministry of Finance. However, the overall goal of the joint collection is more revenues for each of the social funds. Without the collection function, the HIF will be better able to focus on its core business: strategic purchasing for its beneficiaries and control of the activities of the providers.

The revision of collection of contributions will require changes in articles 40-52 of the Health Insurance Law.

3.4 Content of the BBP

The basic characteristics of the BBP are:

- * it must be financially sustainable: expenditures cannot exceed revenues;
- * it should contain as many essential (priority) cost-effective services as financially possible.

In principle, all medical services available in Macedonia are included in the BBP, unless mentioned on the so-called *negative* list. However, for specific services in the BBP, co-payments must be paid by the patients, and some services and devices will only be provided up to a certain maximum cost. Only those pharmaceuticals are included in the BBP that are on a *positive* list, and again with certain limitations.

The BBP will also contain an explicit *positive* list of preventive services to be provided mostly by primary care staff: immunisations, antenatal care, health counselling, child growth monitoring, etc.

There will be a clear definition of the negative list, i.e. health services that will not be provided under social health insurance. For such services, the patients will have to pay user fees. However, all citizens will have the opportunity to purchase voluntary private insurance for these services and to cover the cost of co-payments.

At present, the negative list is described in articles 10 and 11 of the Health Insurance Law. The extent to which services must be added to this list can only be determined after the financial analysis of all health care services has been performed later in 2007.

However, all stakeholders should begin to think about possible additions to the negative list. The following suggestions can be made:

- * 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).

The shifting of responsibility for the cash benefits from the HIF to another party - possibly the Ministry of Labour & Social Policy - would require a major political decision by the Government.

The BBP can be adjusted regularly (for example annually) to improve the content and to maintain sustainability. The tools for this adjustment will be changes in the negative list (adding or deleting services), and changes in the co-payments (see section 3.5).

Part of the 13 national programmes will be added to the BBP on 1 January 2008 (see section 3.8) which will increase the total cost of the BBP.

At present, long-term care for patients in psychiatric hospitals is paid mainly by the HIF, with some contribution by the MoH through one of its 13 national programmes. This latter contribution should be transferred to the HIF from 2008. Total public funding for psychiatric inpatients is insufficient at approximately € 8 per patient per day and the situation in the psychiatric hospitals is barely acceptable. The cost for institutionalised mentally handicapped persons is largely borne by the Ministry of Labour & Social Affairs, with a small contribution from the HIF. It should be decided if long-term psychiatric care should remain the sole responsibility of the HIF in the future or that others should also contribute. This will also be relevant if in the future other institutions for long-term care are established, for example for patients with Alzheimer's disease. The Ministry of Justice should contribute to the cost of stay and treatment of psychiatric patients that are institutionalised by a court decision, but apparently does not.

Revision of the present BBP will require changes in the Health Insurance Law (articles 12-23, 24, and 30).

A suggestion for the description of the BBP is presented in Annex A.

3.5 Co-payments

Co-payments are used to discourage excessive use of health services and to generate revenues for the health care system. Co-payments are often frowned upon because they may limit access to needed health services, especially for the poorer segments of the population. Therefore they usually require exemptions for vulnerable groups which may be difficult to administer. However, the MoH and HIF are confident that they can manage a just exemption system in Macedonian social health insurance by targeting the right people and calculating the correct deductions and exemptions. Usually, the most socioeconomically deprived population is seen as the primary target group for exemptions, but sometimes other groups (for example the elderly) are also proposed. For an exemption policy to work, the total exempted population should not exceed a certain percentage of the beneficiaries. Apart from vulnerable persons, there is also a possibility of exempting the treatment of certain diseases, for example some communicable diseases.

When there is insufficient public funding for the BBP, co-payments cannot be avoided. The alternative would be to add services to the negative list for which user fees must be paid or private insurance must be purchased. Regular adjustment of co-payments and of the negative list (see section 3.4) will be used to maintain the sustainability of the BBP.

The present co-payment situation is regulated by articles 32-36 of the Health Insurance Law and a General Act of the HIF. For many services and drugs, approximately 10% co-payment is required, with a certain maximum per year and with certain exemptions. Co-payment revenues should be transferred by the provider to the HIF. The HIF could possibly expect roughly 1 billion denar per year from co-payments, but in reality only

half of this amount is received. It seems that some co-payments are either not collected or not transferred to the HIF. At present, co-payments account for only 3% of HIF revenues.

It is open for discussion for which services under the future BBP co-payments will be charged, and at what level. A suggestion could be: all drugs and the more sophisticated diagnostic tests in primary care, and all diagnostic and therapeutic services in secondary and tertiary care, including drugs, with certain exemptions and with a maximum per patient per year. The co-payments can be expressed as amounts in denar or as percentages of the costs of services. The financial analysis of BBP services to be carried out during May-September 2007 will provide more insight into the required level of co-payments and the size of the negative list.

There appears to be agreement that from 2008 onwards, the provider will collect and keep the co-payments, to be used for the facility and its staff. This will be an incentive for proper collection of co-payments. Such revenues for the facility will be subject to income tax. The HIF will reimburse the provider for the cost of the treated patient with deduction of the co-payment.

Changes in the co-payment system will require changes in the Health Insurance Law (articles 32-36).

3.6 Provider payment methods

The basic principle of the MoH and the HIF is to change the payment of health care providers from input-based financing to financing based on output and quality. Input is existing staff and physical infrastructure, output is the “production” of medical services.

For primary care, the chosen model is one of capitation payment plus some incentives, for example for the proper execution of prevention programmes.

For hospital services, the MoH and HIF have opted for a gradual move towards reimbursement per treated case, using the diagnosis related groups (DRG) approach. In 2007, the HIF will pay the hospitals according to historical budgets (60%), a limited number of DRGs (30%) and so-called “key performance indicators” (10%) that reflect certain aspects of quality of care. Over a number of years, historical budgets will be phased out completely and will be replaced by DRG reimbursement. In other countries using DRGs, the total number of DRGs varies from hundreds to thousands. All DRGs must reflect the real average cost of treating that group of patients, and must be updated regularly. Reimbursement based on DRGs and performance indicators requires national standardisation, good information systems (both in the hospital and in the HIF branch offices) and a proper control mechanism by the HIF with medical, epidemiological and financial expertise. As such information systems and control mechanisms are not in place at the moment, it is urgent to install them, but it will probably not be possible to accomplish this at short notice. Without proper control, a DRG system does not protect against cost increases. Cost increases coupled to budget caps will create waiting lists and implicit rationing of services.

The costs of investment, maintenance, consumables and depreciation of premises and equipment must be reflected in DRG prices, or they should be paid from separate government budgets. If all costs are included into the DRG prices (total cost accounting), the cost per DRG will become higher, which will put pressure on the size of the BBP and the level of co-payments.

In the short to medium term, one could consider an alternative to a DRG based reimbursement method: negotiated capped global budgets based on the type of services available in the hospital, a capitation element for the attached population, the expected case load, some performance indicators and comparison with similar hospitals. Whatever payment system is used, the list of points per procedure that has been established in 1992 should be considered as outdated because of continuous developments in relative costs, medical technologies and clinical protocols.

All rights and duties of the HIF and the providers must be specified in annual contracts, including the conditions for provider payment such as the need for transparent accountancy via audit reports. The HIF must be able to control that all requirements are met.

There is no agreement on how providers will be paid for services outside the BBP for individual patients. Should providers be allowed to determine their own price lists or should some regulation take place by the MoH? However, this decision is not directly relevant for the revision of the BBP.

For the method and level of reimbursement for services outside the BBP for privately insured patients, hospitals should negotiate themselves with private insurance companies.

3.7 Management issues for hospitals

There are several hospital management issues connected to the BBP and its financing.

An important issue is the debt problem. The size of the problem is not yet clear, but seems to be between € 60 and 120 million. This needs further analysis. It should be realised that most debts cannot be paid off by many health care institutions just by savings on running cost. The financial situation is already very tight without having to repay old liabilities. The MoH, the HIF and the Ministry of Finance should develop a solution whereby debts are restructured, written off or taken over by the government, of course with strict guarantees that no new debts are created. Hospitals should also not be allowed to make major investments - even if donated by donors - without MoH approval (“certificate of need”).

The financial situation would be easier for hospitals if they were able to determine their own needs in human resources, but as public organisations they do not have the freedom to lay off redundant staff at the moment. To some extent, staff salaries are still protected by the 60% of the budget based on historical data, but this percentage will decrease in the coming years. The future legal status of public hospitals has not yet been decided, but it appears that the government is willing to give greater autonomy to facilities in financial

and human resources issues. Greater autonomy will require hospital management training and the development of proper business plans. It also means investment in information systems and co-ordination with the information systems of the HIF and the Republic Institute of Health Protection.

It is not yet clear which public hospitals will continue to function in the future, what services they will provide, and what staff they will need. At present, there is a large variation in hospital statistics between the 15 regional secondary hospitals. The results of the “medical mapping” exercise that will be available later in 2007 are needed to develop a hospital rationalisation plan. At the moment, most hospitals have low occupancy rates although the number of beds per 1,000 inhabitants is not very high in international comparison. Some hospitals have extremely low occupancy rates although there is sufficient population living around them. An actual low occupancy rate is therefore not a reason for immediate closure or reduction of beds; such decisions should only be made in the hospital rationalisation plan.

The Government should decide to what extent the procurement of drugs, medical devices, equipment and consumables will become the responsibility of the individual public hospitals in the future, with (some) central procurement as an alternative.

It is obvious that the above-mentioned changes will require complex political decisions and legal changes.

3.8 Revised financing and oversight of 13 national programmes

The characteristics of the 13 so-called “national programmes” have been described in the progress report of 16 November 2006. The Government is willing to allocate the activities of the 13 programmes to either the future BBP or the regular public health programme. The reasons for this division are:

- * essential curative care belongs to the BBP under HIF control;
- * uninsured patients (a major group of beneficiaries of the 13 programmes) will not exist in the future;
- * it is not logical to introduce co-payments under the BBP and then to compensate for them from budget funds;
- * the MoH should not be burdened with the administration of health programmes;
- * essential public health services belong to the public health programme under control of the Republic Institute of Health Protection.

The proposal for the re-distribution of the 13 programmes in Annex D has been accepted by the BBP Working Group. The BBP part will be financed by the HIF, and the public health part by the budget of the MoH. The public health activities will be incorporated in the annual public health programme to be implemented by the Republic Institute of Health Protection and the network of regional public health institutes from 2008. The HIF and the public health programme should receive the appropriate share of the present funding for the 13 programmes.

Most of the activities under the 13 programmes are essential and should be paid from public - insurance or budget - funds, but a few activities are less cost-effective than others

and could be reduced in scope. For the time being, it has been accepted to limit the screening of students to primary and secondary schools. No decision has yet been taken about the introduction of nation-wide cancer screening.

3.9 References

See the progress report of 16 November 2006 for a list of references. For a discussion on the BBP and related issues, there are some interesting chapters in:

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)

- * Chapter 2: Evans RG. Financing health care: taxation and the alternatives.
- * Chapter 4: Preker AS, Jakab M, Schneider M. Health financing reforms in central and eastern Europe and the former Soviet Union.
- * Chapter 7: Robinson R. User charges for health care.

and 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), 2002 (accessible via www.euro.who.int)

- * Chapter 8: Langenbrunner JC, Wiley MM. Hospital payment mechanisms: theory and practice in transition countries.

5 NEXT STEPS

The BBP Working Group, the MoH and the HIF should work on the still open issues in health financing as described in chapter 3. Issues that are relevant in 2007 are:

- * further analysis of the presently un-insured population and methods to include them into the pool of beneficiaries;
- * preparation of the distribution of a fraud-resistant HIF membership card to all beneficiaries, possibly in the form of a temporary card for the year 2008;
- * organisational, administrative and financial consequences for the HIF of transferring the function of collecting contributions to the Public Revenue Office;
- * development of ideas for the negative list of services not covered by the BBP;
- * discussion within the Government on the responsibility for paying cash benefits during sickness and maternity;
- * discussion within the Government about a solution for the debt problem;
- * development of a control mechanism for the 30% of hospital revenues based on DRGs and the 10% based on key performance indicators;
- * development of a model for the managerial and financial autonomy of hospitals;
- * inventory of legal changes required for health financing reform.

Most of these issues will not be resolved before the final text of the national health strategy will be adopted on 20 February 2007, but some of the solutions could be incorporated in the health strategy implementation plan that will be prepared after adoption of the health strategy. The final text of the health financing chapter in the national health strategy will present the main principles of the health financing reform without going too much into detail (see Annex B). The work on the implementation plan for the national health strategy will start as soon as the strategy has been adopted, that is by the end of February 2007. The draft of the implementation plan should be completed by June 2007 after intensive discussions with all stakeholders.

A workshop is planned for 1 or 2 March 2007 to present the proposed BBP revision and related health financing issues to a wider audience of stakeholders. Participants should be invited 1 or 2 weeks before the workshop and receive the relevant parts of the health strategy (or even the whole strategy) as soon as the strategy has been adopted.

Some details can only be elaborated after the adoption of the national health strategy. An international consultant will assist the MoH and HIF on formulating a new co-payment policy in March and April 2007 (this is a policy action under the PDPL that should be completed by July 2007). A group of international consultants will assist the HIF in the financial analysis of the proposed BBP between April/May and September 2007, with preliminary results by July 2007.

In order to be ready for implementation of health financing reform actions from January 2008, draft budgets for the HIF (that means the BBP) and the national public health programme should be ready by July 2007, and final budgets in September 2007. This requires a decision on the exact division of the present 13 national programmes between the new BBP and the new public health programme, regarding both content and funding (this is another PDPL policy action).

Agreement should be reached by the Health Strategy Working Group and the MoH on the organisation and delivery of health services, especially in the field of primary care (see chapter 4 and Annex C).

ANNEX A - DESCRIPTION OF THE BASIC BENEFITS PACKAGE

The present BBP is described in articles 8 and 9 of the Health Insurance Law, and the present negative list in article 10. *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. There is no limitation on the duration of medically required hospitalisation (*note: this requires discussion*).

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).

In section 3.4 of this report, suggestions have been made for additions to the negative list.

Article e - co-payments

The consultant on co-payment issues will provide suggestions for this article.

ANNEX B - REVISED FINANCING AND OVERSIGHT OF THE 13 NATIONAL PROGRAMMES

<i>programme</i>	<i>to basic benefits package</i>	<i>to public health programme</i>
addiction care	medical treatment of addicts	health education; methadone programme
AIDS	treatment with antiretroviral drugs; testing of patients including pregnant women	health education campaigns; epidemiological surveillance including testing of risk groups
blood donation	-	the whole programme (implemented by the Red Cross)
brucellosis	treatment of patients	surveillance and investigations; health education
cancer screening	screening for breast cancer and cervical cancer	health education (awareness)
mother and child care	the whole programme, except health promotion and neonatal screening	health promotion; neonatal screening
psychiatry	treatment of inpatients and outpatients without time limit	-
public health	-	the whole programme
special categories	the whole programme	-
screening of students	-	screening of students < 18 years
tuberculosis	treatment of inpatients and outpatients	surveillance and investigations
uninsured patients	the whole programme	-
vaccine	-	purchase of vaccines