

**REPUBLIC OF MACEDONIA
HEALTH SECTOR MANAGEMENT PROJECT (HSMP)
(IBRD Loan # 4733)**

**CONSULTANCY ON
HEALTH CARE PROVIDERS LEGISLATION
Contract DTF – MOH 01**

INCEPTION REPORT

By

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Submitted to

Ministry of Health of Macedonia

Skopje, 21 December 2007

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TERMS OF REFERENCE

The Contract between the Ministry of Finance and the Consultant stipulates the following scope of services to be provided:

“SCOPE OF SERVICES. The objective of the consultancy is to provide the Ministry of Health technical advice to draft a Health Provider Law. This law should create the legal framework defining decision rights such as clarifying the level of health provider autonomy over the control of inputs, labor, scope of activities, financial management, clinical management and non-clinical administration, strategic management, market strategy, sales and the production process, residual claims status (whether health providers will be allowed to retain profits). Moreover the law should prepare the health care providers to respond to various levels of market exposure and incentives to improve the work. The new health care providers are expected to compete for the market share of the insured patients by earning revenues under market conditions rather than passively depending on a budget allocation and financing according to the infrastructure and number of personnel.

The law should consider revision of accountability (rules for supervision of the organization, regulations, contracting or boards) and social functions (outlining the types of activities that health providers would have to fulfill to meet their social obligations.

Other areas relevant to country conditions will also be taken into account.”

The Consultant is scheduled to make two trips to Macedonia from his home base in Kettering, Ohio, USA. The first trip from 5 December 2007, arriving on 6 December until 22 December 2007; the second trip is expected to take place in/around 12 January 2008 until 31 January 2008.

This document contains the Inception Report.

I. STRATEGIC DECISIONS FOR THE CONSULTANCY

The government of Macedonia is interested in modernizing and making health care providers more efficient enabling them to operate with certain degree of autonomy responding to competition and market forces. The PDPL 3 World Bank Loan contains a policy action for a Health Providers Law.

Conversations with Deputy Minister Dr. Vladimir Lazarevic and consultations with the World Bank and within the Project Coordination Unit¹ lead to the conclusion that the most efficient way to approach the policy action for a Health Providers Law or Health Institutions Law was to focus of hospital autonomy. Primary health care has been largely privatized and there is no immediate intention to revise this status at the present time. Public hospitals and clinics should be the focus of the health care providers reform. Therefore, it has been agreed that this consultancy will center on the development of models for hospital autonomy.

Two main options can be considered (a) **delegated autonomy**, that is limited managerial autonomy granted to public hospitals under the control of the State (Ministry of Health) by amending the existing Macedonian legislation, and (b) **corporate autonomy** by exploring the possibility of State-owned Joint Stock Companies, Foundations and Holding Companies for public hospitals taking into account recent international experience (for example in Austria, Estonia and Slovakia).

Under corporate autonomy, a specific interest in the corporate models was expressed as these models could contribute to the “control of inputs, labor, scope of activities, financial management, clinical management and non-clinical administration, strategic management, market strategy, sales and the production process, and residual claims status” as indicated in the Terms of Reference.

A **Joint Stock Company (JSC)** is a company whose capital is divided into shares and the liability of shareholders is limited to the par value of the shares respectively held by them. In the case of a State-owned Joint Stock Company, the State has 100% of the shares and its liability is up to the value of those shares.

A **Holding Company** is a company that owns enough in another firm to control its management and operations by influencing or electing its Board of Directors. In the case of a State-owned Holding Company, the State has 100% (or a majority if municipalities, for instance, are also partners in the Holding Company) and by controlling the Board of Directors influences the appointment of the Directors of the companies under the Holding and their management and operation.

A **Foundation** is a non-profit organization that does not have membership, and whose principle aim of creation is to manage with the property (assets) it owns and it's used to accomplish its statutory goals.

By definition, corporate models for public hospitals are well suited for “market exposure and incentives”. These models could satisfy the government’s expectation for public hospitals to

¹ 10 and 11 December 2007

“compete for the market share of the insured patients by earning revenues under market conditions rather than passively depending on a budget allocation and financing according to the infrastructure and number of personnel”, as indicated in the Terms of Reference.

II. PROPOSAL FOR CORPORATE HOSPITAL AUTONOMY REFORM

2.1. Hospital Autonomy

In general, public hospital autonomy means legal, financial, administrative and technical decisional rights and capacity to exercise those rights over the production of health care services and their inputs (capital investments; technology; income; labor; and procurement) and outputs (quality and mix of services, efficiency, and patient satisfaction). Autonomy allows hospitals to respond to incentives, make their own decisions, and be subject to corporate accountability.

Hospital autonomy has many meanings. Some countries have experimented with decentralization and assigning controlled managerial decision making to hospitals. Other countries have devolved public hospitals to municipalities. More recently, the trend is to incorporate public hospitals as State-owned joint stock companies and to create State Hospital Holdings. This approach frees the public hospitals from ministerial management and from constraints in laws and regulations that consider public hospitals as a State managerial responsibility, and allows public hospitals to operate as corporations in a relative competitive environment and be accountable as corporations.

2.2. Basic Premises

Hospital reform is a complex political, financial, legal and technical process. Hospitals are difficult to reform and modernize and as part of the landscape difficult to close, and any discussion regarding closing or downsizing has political connotations.

All countries face constant pressures and challenges from different stakeholders to satisfy demands for affordable and better access to health care, for more sophisticated quality of care (new drugs and procedures), and for financial sustainability of public and private hospital financing. Public hospital reforms try to achieve responsiveness, access, equity and fairness in financial contributions, the defined goals of health care systems by the World Health Organization (WHO), but encounter serious political and vested interests opposition.

Transition countries have to deal with external and internal pressures for hospital reform. Externally, pressures from international donor and lending organizations, globalization, and by hospital reforms taken place in almost all countries. Internally, pressures from market driven governments that want to modernize public services with less government and more corporate management in public affairs, attract foreign investment and develop new industries including the health care industry. In coping with these pressures, countries find that the current legal, financial and organizational structures, and managerial instruments (still in many cases State budget, Civil Service and other constraints of public entities) are considered not suitable for reforming the public hospital sector. Although the need for change is almost self-evident taking action towards public hospital autonomy is difficult.

International experience shows that public hospital reforms are a critical component in health care systems modernization processes: (a) hospitals are usually the largest expenditure item in any health care system; (b) traditional long hospital use (length of stay) has changed over the last decade or so due to advances in medical technology, new surgical (non-invasive) procedures and more effective pharmaceuticals; and (c) new management and payment tools such as DRGs (Diagnostic Related Groups) have an impact in reducing average length of stay and in gaining in efficiency.

To be successful, public hospital reform should be formulated and be part of long-term health care policies translated in long-term explicit Strategies and Master Plans, approved at the highest level of government (the Executive Branch, Parliament and local governments). The goals of the reform should include new laws on public hospital autonomy (including reforms in other laws to achieve this main goal) to attain economic and clinical efficiency, better use of human resources, flexible financing, public/private mix in financing and delivery, and increased quality of care and patients satisfaction (patients rights).

A Hospital Reform Master Plan should precede the reform or be concomitant with the first stages of hospital legal reform. The Estonian experience (see below) shows that long-term Hospital Master Plan including human resource strategies (education, licensing etc), integrating hospital services at various levels, and open public debate and consultations involving as many stakeholders as possible and obtaining social acceptability for the reforms, are key elements for success. The Hospital Master Plan provides the framework for a long-term revision of the installed hospital capacity (numbers of hospitals, nature and distribution) and its quality (building assessment, water, heating, waste disposal, etc), to determine better resources allocation and outcomes.

Decision-making is transformed from state/ministerial to corporate with autonomy regarding staff, contracting, investments, out-sourcing, financial management, etc. Hospital autonomy with clear responsibility and accountability enable hospital managers with incentives and opportunities to introduce efficiency improvement measures in their hospitals, and this in turn should lead to hospital rationalization.

2.3. Recent International Experience

Recent experiences in Austria, Estonia and Slovakia (from which Macedonia can benefit), shows that rationalizing and modernizing the hospital sector is possible and desirable.

In Austria, the various States (Austria is a federal country) own, manage, and autonomously operate hospitals and clinics in a horizontal integration schemes is the model of State Hospital Holding Companies.

<p>AUSTRIA: A federal master plan (1997) to solve structural deficits and unsustainable expenditures in the hospital sector changed an input-based financing system (number of beds and length of stay) to an output-based prospective system. The result from the change in payments system was an oversupply of beds and facilities. The concept of <i>State Hospital Holding Companies</i> introduced in the late 1970's brought horizontal integration of the hospitals</p>
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under the Holding Companies and facilitated the contractual relationships between State government and hospital management. The first hospital holding as a pilot was established in 1979 in Vorarlberg State owned by government of Vorarlberg (96% and four towns (1% each). The holding company has a market share of 84% and is the largest employer. In a period of 10 years, debts were paid. Rationalization took place with the closing of 3 hospitals and a substantial reduction in beds. Most municipalities followed the example and opted for transferring ownership and hospital assets to a *State Hospital Holding Company* at the State level (Landers). The Holding companies are established under Austrian corporate law as non-profit entities, and performs just like any other corporation with a Board of Directors that represents the owner (the local States) and oversees management. The local governments as owners of the Holding companies bear the residual liabilities (debts). The Master Plan is updated and continues in effect, including compulsory plans on hospital and equipment (2003) that are strictly followed.

Results: Added managerial flexibility and autonomy improved the management of resources with efficiency gains from economies of scale; reduction of excess infrastructure, consolidation of medical departments and specialties; and continued cost containment.

In Estonia, public hospitals are State-owned joint stock companies/or foundations registered under private corporate law and managed and operated as corporations. There are also Holdings that integrate hospitals and polyclinics.

ESTONIA: During 1999-2000 a long-term national **hospital master plan** was developed with a vision of hospital capacity for 2015. It called for an **autonomous legal status for hospitals** with management rights and responsibilities to achieve cost-containment decision-making, and exposure of hospitals to appropriate financial incentives to reward efficiency. To avoid local conflicts of interest, the development of the plan was contracted with an international consulting firm. In 2001, **the Health care Services Organization Act required all public hospitals to be incorporated under private law as foundations (trusts) or Joint Stock Companies** by 2003. According to this law, hospitals remain in the public sector but are managed as companies according to private law with full management rights over assets, full residual claimant status (“surpluses”) and access to financial markets. Supervisory Boards oversee management and represent the owner (the State). The legal transition from State entities to State-owned foundations or Joint Stock Companies resulted in the merging of 41 hospitals and outpatient clinics in urban areas into 6 networks. Management teams and supervisory boards were established and given operational responsibilities within the merged hospitals. 4 of the networks restructured the services and 7 facilities were closed. The number of beds decreased in all merged hospitals and bed occupancy increased to 70-80%.

In Tallin the Children’s Hospital Trust merged four hospitals and ambulatory buildings in three places. After two years two buildings were closed along with a significant reduction in beds and administrative staff. The savings in fixed costs allow increasing staff salaries.

Results: The Estonian model of incorporating public hospitals into foundations or joint stock companies and merging individual facilities into larger legal entities was efficient in implementing the politically and challenging hospital reform. Transfer of decisions from public officials to corporate management was essential in restructuring hospitals and in efficiency gains. The Estonian experience also shows that more attention has to be paid to the roles and responsibilities of Supervisory Boards and to continuous, open and clear communication within the merged hospitals and with the public at all levels.

In Slovakia, a partial reform (interrupted by the present government) transformed some hospitals into State-joint Stock companies that are managed and operated autonomously. The Slovak reform is interesting as it followed the logic that transforming the public hospitals into JSC required settling the existing debts. The new public hospitals as JSC have to start with a clean balance sheet like any other corporation.

SLOVAKIA: In 2004 a new government committed to health care reform introduced major changes (Act. No. 578.2004 on Health Care Providers, Medical Workers, Professional Organizations and other. The Law covered many subjects, and among them the transformation of public hospitals into joint stock companies for the provision of health care under the authority of that law. The Joint Stock Companies are State-owned and the Ministry of Health represents the owner. Commercial Code regulates the establishment, incorporation and related subject matters. All assets including real estate are to be transferred to the new joint stock companies. The share capital of new joint-stock companies shall be formed by an in-kind contribution (current assets of providers) reduced by 5% value of the reserve fund.

The objective of this transformation (similar to the transformation of public health insurance companies into State-owned joint stock companies) was to liberate the new entities from State budget constraints and allows transparent accountancy (financial statement reviews by independent auditors). Autonomous management would allow insurance companies to pay the providers only eligible costs for actually provided services, and encourage medical facilities and medical professionals to maintain solvency on a standard level what requires strict revision of their own costs. Failing to do this the providers shall be exposed to penalties and permission and license removal and liquidation. On the contrary, profits would reward good management. The process was supposed to be finalized by 31st December 2006. Before the reform initiation the Government made efforts to settle debts of medical facilities (by a state owned joint stock company Veritel) in a maximum extent possible and the Government approved the appropriation of funds. The Cabinet had also proposed so that the Social Insurance Agency cancels a debt to the hospitals in the amount of SKK 6.5bn. The reforms, combined with the new threat of bankruptcy (until the reform, state-owned healthcare providers were protected by law from insolvency proceedings initiated by their lenders), helped to change the behavior of hospital management, as unlimited state funding was no longer available.

Results: Incomplete. After parliamentary elections in June 2006 a new government unfriendly to these reforms was elected. The hospital reform process has been stopped. The reform however was necessary. The main problems were (a) that it was not completed on time; and (b) direct out-of-pocket payments to share the costs of less serious diagnosis were not introduced and private coinsurance was not attained.

III. APPLICATION IN MACEDONIA

3.1. Is autonomous public hospital reform desirable?

The answer has to be yes. International experience shows that hospital reform granting degrees of autonomy to public hospitals brings efficiency, allows rationalization, better use of resources and quality of care. The government of Macedonia has as a policy objective to modernize the public hospital sector with autonomy and eventually achieve rationalization (reduction of facilities and beds and better distribution according to the need of the population as stated in the Health Strategy 2020), and this requires a public hospital reform.

International experience shows that any approach to hospital autonomy, restrictive or broad, has to be part of a long-term Master Plan and receive sustainable political and financial support (no interruption). The hospital autonomy models have to include the proper relationships with primary health care and structure the relationships with the private sectors in the public//private mix of delivery and financing.

3.2. Is autonomous public hospital reform feasible and what type of autonomy delegated or corporate?

It will depend on the depth and extent of the hospital autonomy reform. The legal team of the Ministry of Health² prefers a moderate reform by introducing amendments to the Health Care Law and the Law on Institutions towards a model of delegated autonomy. The other option briefly described in this report is for a more complex and far-reaching approach of corporate autonomy. Both models need to address, among others, the issues of management of human resources and their hiring and firing. The corporate model has more flexibility as all employees are hired under labor law or can perform under non-labor personal services contracts.

Both approaches are feasible, and both should be developed into draft laws to give the Ministry of Health options for final decision-making.

Either approach will require the drafting and enactment laws as instruments of policy implementation. One approach, the moderate approach will require a law amending existing laws; the other approach, more far-reaching will require a complete Hospital Autonomy law.

Regardless of the policy approach a Law will be necessary but not sufficient. The Law should be followed by changes in the way the hospital sector operates, in which health care financing is structured, and it will require the development of regulations by the Ministry of Health and the Health Insurance Fund. Outstanding debts need to be satisfied before any implementation of autonomic management. Autonomous hospitals under delegated or corporate autonomy will need to develop internal rules and regulations accordingly. Training in hospital management, business plans, and financial management will also be necessary. Other initiatives are interconnected, such as the introduction of DGRs need to be considered.

IV. CORPORATE MODEL FOR AUTONOMOUS HOSPITALS. BASIC CHARACTERISTICS

The model of corporate autonomy for Macedonia would be translated into a new Law establishing a special, comprehensive and systematic legal system for hospitals that opt for this model of autonomy (see Annex).

- The Law on Hospital Autonomy will introduce a new system for public hospital autonomy.
- The Law will be specialized and comprehensive law on hospitals, including public and private hospitals and specialty-consultative services.
- As a specialized Law it will prevail over the provisions of the Law on Institutions, the Law on Health Care/Health Protection and others for hospitals that will operate for the corporate autonomy model.
- The Law will be explicit in the changes in the current legislation.
- The Law will provide for a time frame for all public hospitals to transform into JSCs and for part of Holdings, as appropriate

² Working session with Angelina Bacanovic, Anka Georgievska, Valentina Cvetanovska, and Dejan Nikoloski, 19 December 2007

4.1. Public Hospitals as State-owned Joint Stock Companies:

- Public hospitals are transformed into joint stock companies (JSC)
- The State is the sole owner (100%) of the shares in the company
- There is no privatization, as the company will be a State-owned Joint Stock Company
- The JSC are registered as corporations
- The JSC are audited by independent external auditors as shall issue reports like any other corporation
- The JSC are non-profit.
- The JSC are subject to taxes.
- Any surpluses are re-invested, used as bonuses for the staff, and other applications as determined by the Board of the JSC. No surpluses shall revert to the State.
- The capital/assets are legally transferred to the new JSC and include, among others, (a) land, premises, equipment that will be valued as non-monetary assets, (b) monetary assets; (c) contracts, etc
- The JSC is subject to bankruptcy procedures
- The State has residual responsibility only for the value of the shares
- The residual debts can be satisfied only up to the value of the assets as determined by Court, and after assets are liquidated, the JSC is terminated
- A Board of Directors appointed by the State (Ministry of Health) manages the JSC
- The Board of Directors Board is accountable to the owner (Ministry of Health)
- The Board of Directors selects and appoints the General Director of the JSC
- The General Director is accountable to the Board of Directors
- (The final model could have both a Board of Directors and a Supervisory Board)
- There will be a Medical Director and a Financial Director under the General Director
- All staff is hired under Labor Law contracts
- The staff is accountable to the General Director
- The JSC has full contractual capacity with public and private entities
- The JSC has full administrative and financial managerial capacity and access to capital markets and banking.

4.2. State Holdings of Public Hospitals

- The Law on Hospitals will also develop the notion of Holding Companies that would put under one major corporate structure hospitals and clinics that have a legal status in order to have horizontal integration and rationalize the use of resources towards efficiency.
- The Holding could be a particularly useful model to integrate various hospitals that operate in a fragmented manner. (This could be an option to consider to operationally integrate the University Clinical Center into a Holding Hospital Company).
- The model can also be used to integrate hospitals outside of Skopje that are geographically distributed.
- The State Holding Companies will be structured and incorporated in accordance with the legislation on Holding Companies.

Development of the model will also explore the option of public hospitals as foundations.

4.3. Pre-Conditions

Drafting and approving of a Law amending existing legislation towards delegated moderate autonomy or towards corporate autonomy require complementary actions to be taken/developed at almost the same time. Sequencing these actions is most important for the success of the reform over time. Some of the actions that are needed are the following:

- Explicit political decision towards corporate Hospital Autonomy
- Decision of Public Hospital Autonomy (delegated autonomy, corporate autonomy or both) should be an integral part of the Health Strategy 2020

Regarding delegated autonomy, a new Law should propose all the changes in the existing legislation and set up procedures for this type of autonomy to operate, as expressed by the legal term of the Ministry of Health.

Regarding corporate autonomy, the following should take place:

- Drafting of a Hospital Law
- Negotiation and approval of the Hospital Law
- Development of a Hospital Master Plan (2008)
- Negotiating, paying and settling all public hospital debts
- Inventory and valuation of each hospital assets
- Databases
- Standardizing health information systems
- Incorporating selected hospitals as State-owned Joint Stock Companies
- Determining which hospitals could be part of one or more State Hospital Holding Company
- Training (business plans, hospital management, contracting, etc)
- Sustained effort with external technical cooperation

The number and types of complementary actions will take time, effort, the involvement of many stakeholders, and will have to be sustained, systematic and within a realistic time frame.

In addition, the Health Insurance Fund law will have to be adapted to the new hospital model. The following steps would have to be taken among others:

- The Health Insurance Law needs to be revised and harmonized
- New contracting processes need to be put in place
- Services and price negotiation mechanism need to be revised and put in place

V. BRIEF ANALYSIS OF MACEDONIAN LEGISLATION

Constitution. The Macedonian Constitution (1991) makes references to health in various articles. The language is in general very broad allowing for development of the concepts and their practicality by means of Laws. The Constitution declares the right to health (Article 39. Every citizen is guaranteed the right to health care. Citizens have the right and duty to protect and promote their own health and the health of others.) Provisions on the right to health care in Constitutions are declaratory. The right is not developed in the Constitution but in Laws that determine the scope and extent of this right as far as the Obligation of the State is concerned. This has been done in Macedonia with the Laws on Health Care and Health Insurance, for example. If the policy to the exercise the right to health care is better served with autonomous public hospitals, the Law can develop this notion into a system of autonomous public hospitals.

Therefore, in general, there seem to be no constitutional impediment for a hospital reform that would create State-owned corporations (joint stock companies or holding companies) registered as corporations and operating under corporate law.

Law on Health Care /Health Protection. The Law on Health Care /Health Protection (both names are used in the documents at hand) of 1991 as amended, defines hospitals as a type of health organization (article 101). And a health organization is the one that performs “health care activities” (article 6). The Chapter on Health Organizations (article 96-123) distinguishes between public, cooperative, mix or private institutions (article 96). The concept and structure of public hospitals as health organizations is based on the notion of State ownership *and* controlled management of these institutions. *In general, the philosophy of the law and its definitions and procedures represent a State ownership and management of public hospital that is rather strict and does not seem to allow the type of autonomy, flexibility and exposure to market forces as desired in the new public hospital policy.*

The legal team of the Ministry of Health is of the opinion that the existing norms in the Health Care Law can be modified and adapted in order to obtain the goals of hospital autonomy and that there is no need for a new Law on Hospital Autonomy based on the corporate model.

Regarding corporate autonomy, to establish and terminate a State-owned Joint Stock Company and State Holdings, corporate law is the one that should be applicable. Thus, in this model the articles on Establishing and terminate a health organization in the Law on Health Care would not be applicable (articles 96-100). The same argument is valid concerning rights and obligations of individual health care providers (articles 128-134) and management of health organizations (articles 139-143) that would not be applicable to the public hospitals as joint tock companies.

On issues such as types of health organizations (articles 101-123), qualifications of health care workers (articles 144-160) and monitoring of (quality/performance of) health organizations (articles 163-172), these issues will be addressed by the law on Hospital Autonomy and most likely changes with be made of the articles in the Law on Health care. Some of the concepts and procedures may be retained but the new Law will have a comprehensive system for autonomous corporate hospitals.

Law on Institutions. This law determines the terms and general performance of public services in the public interest. It deals primarily with Institutions that deliver these public services,

procedures for their establishment, permissions, administration, inspection, statutory changes and termination. It also covers resources necessary for work (financing), investment of funds, its property, organizational units and forms for cooperation and integration, ownership's transformation (Article 1).

The question is, are these norms suitable for the operation of public hospitals as joint stock companies? The answer is no.

Public Hospitals as joint stock companies have to be incorporated and operate under the rules and regulations of corporate/trade law. The new Law on Hospital Autonomy will detach public hospitals from the Law on Institutions.

The Law on Institutions considers transformation of ownership, and specifically to joint stock companies as a form of privatization (Chapter 9. Ownership Transformation, articles 92-112). In the hospital autonomy proposal, there is no privatization. The State retains the ownership of the public hospitals as the owner of 100% of the shares in the joint stock company or in a holding company. The concept and practice of hospitals as health care institutions in the Law on Institutions and the concept and practice of public hospitals as autonomous State-owned joint stock companies are different and incompatible.

The Law on Institutions defines public service as “delivery of services by the institutions in the area of education, science, culture, *healthcare*, social protection, child protection, protection of person that have intellectual and physical disabilities, and in other occupational activities that are determined by the law to be public services (article 2.7)”. The law on Hospital Autonomy would have to state that the Law on Institutions regulates the delivery of health care by public hospitals that are not autonomous and that the Law on Hospital Autonomy regulates corporate autonomous hospitals.

The Law on Institutions states that the “provisions of this law have subsidiary enforcement and they are enforced if it's not regulated differently by another law (article 1). And this will be precisely the case with the Hospital Autonomy law that will regulate differently the public hospitals as corporate autonomous entities.

Therefore, articles regulating hospitals as institutions in the Law on Institutions, such as foundation (articles 15-17), permits (articles 18-28), statutes (articles 32-34), permits withdrawn and termination (articles 35-39), the management (articles 40-54), professional quality (articles 64-65), funding (articles 66-74), assets (articles 75-78), capital investment (articles 79-81), staff and strikes (articles 83-86), supervision (articles 88-91), and privatization (articles 92-112), are all subject matters that will have to be regulated under corporate law and under special norms to be include in the new Law on Hospital Autonomy.

Like with the Law on Health Care, the Law on Institutions is in general, a law representing the philosophy of a State ownership and management of public institutions. As applied to public hospitals the definitions and procedures are rather strict and allow only limited delegated autonomy. The Law does not seem to allow for the type of autonomy, flexibility and

exposure to market forces as desired in the new public hospital policy that could be achieved with the corporate model of autonomy.

The legal team of the Ministry of Health is of the opinion that the existing norms in the Law on Institutions can be modified and adapted in order to obtain the goals of hospital autonomy.

The opportunity should be taken for the legal team of the Ministry for the Ministry to prepare a draft Law with amendments to the Law on Health Care, the Law on Institutions and other Laws is necessary to provide the Ministry with a systematic model of delegated autonomy within the existing health care legal system. This Consultant would prepare a draft Law on Hospital Autonomy based on the corporate model.

VII. CONCLUSIONS AND NEXT STEPS

Decisions will have to be made on approaches to hospital autonomy in due time. It is important for the Ministry to have options for decision-making. Therefore, it is suggested that both approaches (a) the delegated autonomy approach suggested by the legal team of the Ministry of Health (amendments to existing legislation) and (b) the corporate autonomy be prepared by January 2008.

This is important because in practice not all public hospital would be suited for full autonomy, and most likely there will be public hospitals operating under the corporate model and other operating under the model of delegated autonomy depending on decisions by the Ministry.

It would be better for the Ministry to keep both options by end-January 2008, rather than deciding now on either one of the autonomy models.

The legal team of the Ministry has stated that it is capable of making the proposals for amending the existing laws for the delegated autonomy model. This Consultant can be available in the next trip for consultations with and support to the legal team of the Ministry.

This Consultant will continue exploring and deepening into the corporate hospital autonomy, during the second trip to Macedonia scheduled for mid- to-end of January 2008. The Consultant's tasks would be:

- Drafting the Law on Hospitals with support of local Working Groups
- One workshop for communication
- First complete draft (31 January 2008)

Final Report (February 2008)

ANNEX 1. TENTATIVE OUTLINE FOR A HOSPITAL AUTONOMY LAW

A tentative outline for the new Law on Hospital Autonomy could be the following (to be refined and changed during the drafting process):

HOSPITAL AUTONOMY LAW. TENTATIVE OUTLINE
CHAPTER ONE. GENERAL PROVISIONS Purpose of the Law Scope of the Law Definitions
CHAPTER TWO. PUBLIC HOSPITALS Autonomy: scope and extent Types of public autonomous hospitals Accreditation and Licensing Hospital Master Plan Transition and non-autonomous hospitals
CHAPTER THREE. TRANSFORMATION OF PUBLIC HOSPITALS INTO JOINT STOCK COMPANIES Decision and Conditions to Incorporate Assets Charter/Articles of Incorporation Incorporation according to corporate/trade law Registration as corporation Governance (Boards, General Director, etc) Company representation Rights and obligations Staffing Accountability Reporting Merging Networking Termination
CHAPTER FOUR. FINANCING Health Insurance Fund Transfers from State Budget Co-payments Contracting Other sources of income
CHAPTER FIVE. REFERRALS Referral responsibilities Referral control
CHAPTER SIX. STATE HOSPITAL HOLDING COMPANIES Decision and Conditions to Incorporate Assets Charter/Articles of Incorporation Incorporation according to corporate/trade law Registration as corporation Governance (Boards, General Director, etc)

HOSPITAL AUTONOMY LAW. TENTATIVE OUTLINE

Company representation
Rights and obligations
Staffing
Accountability
Reporting
Control over companies under the Holding
Holding management
Termination

CHAPTER SEVEN. UNIVERSITY CLINICAL CENTER

CHAPTER EIGHT. MENTAL HOSPITALS

CHAPTER NINE. PRIVATE HOSPITALS

Private/public mix

CHAPTER TEN. SUPERVISION AND REGULATION

CHAPTER ELEVEN. PENALTIES

CHAPTER TWELVE. TRANSITORY PROVISIONS

ANNEX 2. AUTONOMOUS HOSPITALS BUSINESS PLANS: Basic Ideas

NOTE: There have been several training sessions in Macedonia on Hospital Business plans and some Hospitals have Business Plans. The following pages aim at showing the role and importance of Business Plans for Public Hospitals as Joint Stock Companies.

I. CONCEPT

A hospital business plan (BP) is a 3-5 year plan to identify, describe and analyze the business opportunities presented to the hospital. A BP examines the technical, economic and financial viability of these opportunities and develops strategies to translate them into concrete and reliable actions. The BP is regularly updated and revised at least once a year.

A BP projects the mission of the hospital into concrete, achievable objectives and strategies, following service activity and financial indicators. It evaluates the hospital organization, internal processes, financial situation and human resources and its environment in terms of client, patient needs and competition. The BP facilitates integration of the hospital board, hospital director and management teams, personnel, departments, information technology and financial resources in the achievement of common objectives.

II. BP PREPARATION

Preparing a business plan requires strategic thinking and definition of the basic principles, gathering data, building consensus, validation and writing, final discussions and editing the plan. It takes time and considerable effort.

BP guidelines are essential to standardize BP preparation and implementation and to facilitate training and BP preparation, evaluation and updating. The time frame required depends on the size of the hospital and availability of information and staff, but in general it takes around 2,000 person hours (depending on the size of the facility).

A completed BP gives the hospital as a joint stock company the advantage of addressing and responding to a more competitive health care environment. The preparation process is a critical training tool in decision-making for members of the Hospital Board of Directors, the General Director and staff.

2.1. Participants. BP preparation involves virtually all levels of management in the hospital. It is a *participatory* exercise opposite to the more typical plan preparation by top management only. One of the main advantages is “ownership” of the BP at all levels in the hospital. There are no surprises that originate from “not knowing” what high management is doing. Departments participate in decisions affecting their department and the hospital as a whole. Not all decisions made will necessarily be popular, but management will nonetheless have provided an opportunity for input.

Board of Directors: The Board of Directors is the ultimate responsible for BP design and

monitoring. The Board plays a critical role regarding the definition of the vision for the hospital in BP preparation. The Board is accountable to the State as owner of the hospital and will set the hospital's performance goals for the coming 3 to 5 year period. The Board initiate the BP process with a statement of the vision and in the end of the process approves the Business Plan prepared by the Management.

If the hospital institutional model has a **Supervisory Board**, this Board usually has the responsibility to monitor the results of implementation according to key performance indicators and according to the Hospital Law and trade laws, and participate in the process of BP preparation and approval.

Hospital Director: the Hospital Director is the leader of the process of BP preparation. He/she can delegate portions of the plan to selected individuals or committees such as the hospital Executive Committee or a high management planning committee; and to functional directors for preparation of initial drafts (Director of Human Resources, the Director of Finance/Chief Financial Officer, the Director of Engineering for preparation of the equipment/infrastructure sections, the Director of Purchasing). BP is a participatory process where all the personnel know their role. In the end, the Hospital Director has the responsibility for integrating and finalizing the BP

Hospital Executive Committee: The Hospital Executive Committee (usually the Hospital Director and key top functional directors (Clinical, Human Resources, Finance, Legal, etc.)), plays a major role in both oversight and direct plan contribution. The Committee is the key advisory body to the Hospital Director in reviewing and commenting on all information and draft documents prepared by others, and in the formulation of final recommendations.

Hospital Department Directors: Hospital Department Directors are the leaders at the departmental level. They play an essential role in BP preparation with gathering information, in analyzing the impact on the department of decisions made at the executive level, and in the providing recommendations.

Department Directors (1) evaluate epidemiologic and utilization data; (2) evaluate and prepare forecasts of new technologies, modalities and protocols to be utilized in care and treatment of patients; (3) discern potential new markets for both existing and proposed programs and services; (4) determine both scope and volume of services to be provided; (5) prepare forecasts of personnel and supplies needed to provide this volume; (6) prepare estimates of new equipment needs, equipment repairs, technology upgrades, and other issues germane to equipment—both mobile and fixed; (7) determine needs on infrastructure modifications; (8) recommend on rates and prices; and (9) provide input on departmental revenue generation, operating costs and budget forecasts.

The role of Department Directors is extremely significant, similar to the one of the departments or divisions of a large and complex businesses, operating as part of the complex and yet a unit.

Supervisory Levels: Staff supervisors in departments large enough to employ them can be a very helpful and provide useful ideas and inputs to Department Directors on all matters related to

the department, specially in-patient care units, where employees report directly to their respective shift supervisors. Supervisors can play a key role in design, validation and implementation at the impact level of the business plan, and can exercise considerable influence over employees.

2.2. Technical Support. BP preparation is an internal task of the hospital. It involves technical matters such as the collection of information and data and the preparation of tables or graphs, and, most importantly, many activities related to the evaluation of the appropriateness of potential services. The main idea behind BP development is the strategic thinking which takes into account the changes in the environment in order to adapt the hospitals to new demands and needs of the population and the health care market. External technical support could be necessary during the preparation of the first versions of business plans. External technical assistance may also provide a fresh view of problems and situations and help to promote change within the hospital.

2.3. Databases. An autonomous hospital reform has to be part of a Master Plan. Preparation of the Master Plan by the Ministry of Health will put together available information and produce new information that is very useful for each hospital in preparing their BPs. For instance, external data related to the hospital and to the Macedonian hospital system (public and private), including reports on financial performance relative to other hospitals; production and discharges data; information on management and clinical issues; infrastructure and equipment information; quality indicators; and human resources.

Of equal importance is reliable and complete data from the hospital itself. This will require gathering the data, cleaning the data (to make it realistic and reliable), and to evaluate the data from the hospital's own research and documents. For instance, previous planning documents, internal reports produced, past financial statements, budgets, financial audits, policies and procedures and related hospital-produced data and information, most of which with careful review is indispensable in BP preparation. Both sources are invaluable to the hospital BP preparation.

2.4. Expected Benefits. BP is a means to achieve excellence in hospital performance. It aims to implement a process to pursuit quality objectives that will benefit patients and users of the hospital and that will contribute to make the hospital successful as a corporation. Once completed, BPs makes managers more confident about their ability to set up and operate the hospital. It is about pulling together all the information in a sensible way to enable people to make better, more informed decisions today. This is conducive to clinical, administrative and economic efficiency

Hospitals operate in a dynamic environment where patients' expectations increase every day due to more information available, new technologies and treatments come into the market very often and put pressure on managers and the health system. The State also expects autonomous hospitals to perform efficiently. The business plan should ultimately provide clear guidelines on how to deal with these uncertainties. Therefore, BPs needs to out line the expected benefits for:

- a. *Patients and the population* they serve: decrease in waiting time for exams and appointments with specialists, available services closer to where they live, an experienced group of specialist who provide certain types of services.
- b. *Professionals and hospital personnel* in terms of job satisfaction and income.
- c. *Health system* with good clinical and epidemiological data.
- d. *Hospital as a corporation*, as a well managed, competent and financially sustainable entity.

Example of Table of Contents for Autonomous Hospital Business Plan

Cover page

Table of contents

Acronyms

Glossary

Executive summary

1. Introduction

2. Hospital Business Profile:

2.1. General information: legal status, location, installed capacity (physical), population environment, human resources (full and part time), equipment and technology, and suppliers

2.2. Services to patients

2.3. Services to other providers (networking)

2.4. Financing

2.5. Agreements

2.6. Accreditation, licensing, certifications

2.7. Current initiatives for hospital modernization

2.8. Team and corporate structure: building skills capacity

2.9. Quality of Care programs

2.10. Level of patient satisfaction

3. Mission of the hospital

4. Market Research and Market Opportunities

4.1. Market Research: actual and potential hospital services and customers

4.2. Competitive environment: description of competitors, public and private.

4.3. Opportunities for the provider network through cooperation

4.4. Patient strategies: how to attract clients, public relations, opportunity of care, performance of professionals and quality of care

5. Designing a Competitive Business Strategy

5.1. Definition of competitive services

5.2. Definition of key performance indicators

- 5.2. Definition of strategic investments
- 5.3. Performance risk analysis
- 6. Annual Operations Plan
 - 6.1. Prioritizing service activities
 - 6.2. Prioritizing performance indicators
 - 6.3. Definition of responsibilities to perform priority actions
 - 6.4. Financial estimates for the implementation of the plan
- 7. Prospective Strategies
 - 7.1. Services Forecasting
 - 7.2. Expected benefits for patients
 - 7.3. Expected benefits for the staff
 - 7.4. Expected benefits for the Hospital as corporation
 - 7.5. Benefits for internal clients
 - 7.6. Expenditures and investment forecast
 - 7.7. Analysis of financial statements
 - 7.8. Linkages with Health Strategy and Hospital Master Plan
- 8. Monitoring and evaluating the business plan
 - 8.1. Monitoring the key performance indicators
 - 8.2. Management indicators
 - 8.3. Mechanism for corrective measures
- 9. Annexes (Tables, Documents, others)

INTERVIEWS/METINGS

Ministry of Health

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