

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

FINAL REPORT

FOR

**Budget Training for Staff of the Health Insurance Fund, Ministry of
Health, Health Care Providers and Ministry of Finance**

Under Terms of Reference

**Budget Training for Staff of the Health Insurance Fund,
Health Care Providers and the Ministry of Health**

WITH PROPOSAL

**ON FUTURE DIRECTIONS ON DEVELOPMENT OF
MACEDONIAN HEALTH CARE BUDGETING, CONTRACTING
AND PURCHASING ACTIVITIES**

PREPARED

BY

**Milan Martin Cvikl
Čebelarska 13, Ljubljana,
Slovenia**

Ljubljana, October 31, 2006

FINAL REPORT

Budget Training for Staff of the Health Insurance Fund, Health Care Providers and the Ministry of Health

WITH PROPOSAL ON FUTURE DIRECTIONS ON DEVELOPMENT OF MACEDONIAN HEALTH CARE BUDGETING, CONTRACTING AND PURCHASING ACTIVITIES

Introduction and Summary of the Work Undertaken

This is final report under TORs for Budget Training for Staff of the Health Insurance Fund, Health Care Providers and the Ministry of Health prepared within Health Sector Management Project. It first provide Final report on Budget Training for Staff of the Health Insurance Fund, Health Care Providers and the Ministry of Health with details of undertaken missions of building a Trainers Team and second in the view of proposal for future work it provide Directions on Future Development of Macedonian Health Care Budgeting, Contracting and Purchasing Activities

As it is known the Republic of Macedonia has received a Specific Investment Loan from the International Bank for Reconstruction and Development. The objectives of the overall Health Sector Management Project are: (i) to upgrade Ministry of Health (MOH) and Health Insurance Fund (HIF) capacity to formulate and effectively implement health policies, health insurance, financial management and contracting of providers; and (ii) to develop and implement an efficient scheme of restructuring of hospital services with emphasis on developing day-care services and shifting to primary care. The project comprises four components:

- **Component 1: Policy Formulation and Implementation:** to assist the MOH in implementing critical functions such as policy and strategy formulation, monitoring and evaluation of health reforms and public information and communication. The component includes three sub-components: (i) support to overall health policy and strategy development, (ii) public relations and communications, and (iii) improving MOH management and business processes;
- **Component 2: Strengthening HIF Governance and Management:** to improve governance and management of the HIF as the organization responsible for purchasing health care services for its beneficiaries under the compulsory health insurance scheme. The component includes three sub-components: (i) Eligibility criteria and revenue collection, (ii) HIF management, and (iii) Purchasing functions;
- **Component 3: Improving Service Delivery:** to improve the quality and efficiency of health care providers by supporting development of staff skills, introduction of new management methods and instruments and essential upgrades of units selected to implement well defined sub-projects. These improvements will enhance the

management and operational capacity of health care providers, putting them in a better position to respond to the challenges and incentives of new contracting arrangements with HIF. The component includes two sub-components: (i) Hospital Management and Primary Care, and a (ii) Grant Facility for Improving Service Quality and Efficiency;

- **Component 4: Project Management, Monitoring and Evaluation:** to ensure effective administration and implementation of the project a Project Coordination Unit (PCU) is established within the MOH, which is responsible for all day-to-day project implementation activities on behalf of the MOH and HIF.

The exact work under TORs for Budget Training for Staff of the Health Insurance Fund, Health Care Providers and the Ministry of Health have been undertaken as part of efforts to improve MOH and HIF management and business processes as defined within component 1 and component 2.

The objectives of the assignment on Budget Training for Staff of the Health Insurance Fund, Health Care Providers and Ministry of Health were as follows:

- a) to train around 20 trainers in budget formulation of Health Care Institutions, and
- b) to guide and monitor the training by trainers of around 230 health care personnel in budget formulation.

The training of trainers consisted mainly of staff from the Health Insurance Fund, Ministry of Health and Ministry of Finance and focused on current status on budget formulation and implementation in Republic of Macedonia, imposed in 2006 with new budgets for HCIs as prepared by HIF under IFIs instructions. The trainers became familiar with key issues and were in turn to train around 230 persons from Health Care Institutions. The purpose of the training was to provide (i) HIF personnel the knowledge of the processes of creating their budget, controlling their expenditures and reporting to the Board on the implementation of their budget, and (ii) Health Care Institution personnel with the knowledge of the budget operations, enhanced in financial planning and resource allocations skills, under fixed budget ceilings, a new concept for the various entities in the health care system.

In summary it could be concluded, that objectives of the assignment were completely fulfilled. Within HIF, MoH and MoF and including some staff of HCIs in the Republic of Macedonia the group of some 20 trainers (see the list of lectures in the detailed reports) **is established, trained and it became fully operational.** Specialized in different areas of budget formulation, budget preparation, budget execution, accounting, budget reporting and budget internal and external audition the group is able to undertake full training of the health care personnel in budget formulation.

But it shall be mentioned that actual establishment of such a group is only a necessary condition for health sector reform process in area of budget training. The group is able to undertake budget training as requested. But for the group to act as full-fledged budget team of HIF and of MoH only first, further guidance and assistance is needed. Sufficient

condition for success of health care reforms are linked with overall policy change in Macedonian Health Sector and with further improvement of HIF management capacity. In this context Republic of Macedonia health care budget process need to involve full budget formulation, linked with improvements in contracting process that is closely connected with improved purchasing of health care services. In order to **strengthen HIF Governance and Management in line with both:**

- a) Prime Minister's position in his Government's 100 STEPS PROGRAMME that **HIF shall obtain the function of strategic purchaser,**
- b) **and with HSMP component ensuring** that governance and management of the HIF as the organization responsible for purchasing health care services for its beneficiaries under the compulsory health insurance scheme need to be improved;

follow-up work needs to continue on both to improve HIF management and to improve HIF's Purchasing functions.

Such a process as part of the overall set of health care reform initiatives need to include development of a detailed budget formulation process linking health care budget with policy decision and initiatives and implement an appropriate contracting and budgeting process.

Some elements of those reforms are provided in the rest of this Final Report. The document first provide in a descriptive notes a proposal for **Future Directions on Development of Macedonian Health Care Budgeting, Contracting and Purchasing Activities.** Then the document provides short summary of detailed reports of individual missions building the Budget Training Capacity. Detailed reports of individual missions and details of Budget Training performed are included into individual missions reports.

The most important question is now for the authorities to decide **how they want to proceed with Health Care Budget Formulation.** Namely, old incremental budgeting approach or budgets based on historical revenues proceeds cannot provide necessary change to Health Care Reforms and cannot proved HIF role of a Strategic Purchaser. Only full fledged Budgeting and Contracting Process in the context of purchasing of services from HCIs at different levels could provide improvements to the quality of health services in Macedonia, a mandate given by voters at summer 2006 elections to new team of policy makers.

Follow-up Activities in the area of Health Care in Macedonia linking Budgeting, Contracting and Purchasing

In order to implement a change on Health Care Sector authorities need to undertake major next steps in the following three important areas for health care in Republic of Macedonia:

- a) Health Care Financing**
- b) Health Care Services Provision**
- c) Health Care Services Purchasing and Payments**

To facilitate such a process in this part of a Final Report we provide in each section first a short description of Issues and then present some proposals for Republic of Macedonia. These are preliminary proposals and shall be refined in a further dialogue with authorities. But they are based on observations from Budget Training and from discussions with Trainers and Participants.

In the area of health care financing, services provision and purchasing analysis and proposals provides an input into implementation of Macedonian National Health Strategy taking into account the strategic decision that HIF is to become (i.e. to remain) Strategic Purchaser of Health Care Services in the name of Macedonian citizens insured under obligatory, centralized Health Care Insurance Scheme administrated by HIF.

Ad a) Health Care Financing Issues and Some Proposals for Republic of Macedonia

In the system of Health Care Financing the obligatory, centralized, public health care financing shall remain the basis of health care financing. Current legislation provides on paper many rights and benefits, but citizens-as insured people, as patients are not provided with expected services mainly due to inappropriate allocation of health care programs and due to overall lack of fund.

Thus a vicious circle continues - lack of trust of insurers in the system and their avoidance of contributing into pool of resources, while attempting via informal ways and means to continue with utilization of services.

That is linked with the fact that "public funds" are not appropriately administrated by Health Insurance Fund, which is dominantly managed by the Government and in this context too politicized. Health Care issues became central political issues in Macedonia and during previous elections campaign (and most likely in future campaigns) appropriate allocation of HIF funds and qualitative provision of services were (and will remain) key political question. There are pros and cons of a situation whether HIF shall be kept institutionally independent from single Central Government Budget. In that case decision on life and death shall not be discussed at the benches of Macedonian Sobranje, but they would be rather first discussed at Management Board of HIF and in Assembly of

HIS, i.e. among insurers and providers of services at closed sessions of its formal bodies of governance. It is understandable that for resolution of financial problems of HIF it is easier to keep it part of Central Government Budget but even in this case special earmarked contribution shall be kept a separate vehicle defining level of HIF revenues. In either case Government need to ensure fund for National Health Care Preventive Programs and for Capital Investments in Health Care System.

Clearly the health policy is to be defined by the Government and Ministry of Health is responsible for development of the overall structure of Health Care System including Health Care Financing. This include definition of the level of contribution rate, development of future voluntary insurance schemes to finance co-payments or better services in line with obligatory centralized health care insurance scheme and definition of the overall package of benefits. Only in such circumstances HIF can become Strategic Purchaser.

Health Care System need to prevent opting-out, though there will be attempts by affluent and richer groups of population in Macedonia requesting opting-out that need to be carefully managed..

Currently the package of health services and cash payments in Macedonia is on paper and thus in principle rich, despite some 20% co-payments. But health care services delivered are of poor quality. Citizens need to provide out of pocket payments for medical material or drugs. HCIs perform their services at given low prices of services only with major increase of unpaid obligations toward providers of drugs, medical material etc., or with the quality level that need to be reviewed. Infrastructure variable costs are not being paid or paid with delays. Level of arrears at HCIs is very high. HIF cash payments are paid with delays.

Thus a major decision will need to be sooner or later resolved and i.e.:

- to preserve level of benefits and increase quality of services with **additional resources** in order to respect procedures for actual utilization of benefits, higher utilization of HCIs capacities, improved budgeting process and respecting budgetary rules, implementing transparent waiting lists with additional funds for reduction of waiting lists and better control, procedure and negotiations process on how limited funds are to be allocated among different levels and types of program and providers etc.
- or, new, and **limited** benefits package need to imposed, should there be no change on the level of resources provided for obligatory Health Insurance Fund. For example, just in the areas of drugs provision, a positive list of drugs with current 20% co-payments may need to be reduced or share of co-payments be increased. In such a case a negative list, need to be expanded. What could be considered is the introduction of intermediary list of drugs with higher level of co-payments, and implementation of new voluntary insurance scheme that would provide for insurance of high level of co-payments.

On the level of services it is important, that patient choose their selected doctors at the primary level. Doctors without a pre-defined level of patients should not have contracts with HIF. Primary level doctors shall act as gate-keepers for higher level of care and portion of its pay shall be weighted according to the standard deviation (adjusted for age structure of patients) of the national level of referral to higher level of care.

Ultimately, what is the most important that an appropriate health care financing policy solution shall be implemented that transform a classical budget process into result, output oriented budgets. That demands in area of health care budgeting process in Macedonia utilization of **public expenditure management techniques of contracting and negotiations** shall enable development of strategic purchasing capacity at level of Macedonian Health Insurance Fund.

Health care Budget should be within the budget process appropriately apportioned to enable purchasing of services, rather than just paying for costs of wages, medical material and drugs, infrastructure costs etc.. This apportionment of budget into services (types and volumes of medical services promoting and enabling health care) is within limited resources extremely difficult process.

Such a process could be developed through a **contracting process**. See for details Box 1 on **Purchasing of Services and Contracting Process as a Core of Strengthening the Purchasing Function of the Health Insurance Fund of the Republic of Macedonia**. This process need to be organized in such a manner that contracting and negotiations process would lead toward a consensus among suppliers, with the Government as ultimate arbitrage.

BOX 1: PURCHASING OF SERVICES AND CONTRACTING PROCESS AS A CORE OF STRENGTHENING THE PURCHASING FUNCTION OF THE HEALTH INSURANCE FUND OF THE REPUBLIC OF MACEDONIA

If there is a single message that needs to be emphasized by the new policy team it is the one of the need to increase transparency of health care management. That can only be achieved by **strengthening the purchasing function** of HIF, as envisaged by Prime Minister in his 100 STEPS PROGRAM. Theory and practice of this varies, but in essence **key issues are linked with introduction of transparent and effective purchasing and CONTRACTING PROCESS** (see for more details in **CHAPTER 8 PURCHASING OF HEALTH CARE SERVICES**, Hernan L. Fuenzalida-Puelma, Sheila O'Dougherty, Tamas, Gintaras Kacevecius and Mark McEuen in the new Observatory Book on Health Care in Central and Eastern Europe which is attached in **Annex 3** and is for the sake of preparation for the workshop summarized below).

Pls. note that in the logic of inter-dependent health care financing functions (collection, pooling, purchasing and provision), **purchasing is the function that allocates financial resources (pooled from various collecting sources) to obtain the delivery (provision) of certain health care goods, services and hopefully, better quality of care (consumer satisfaction)**¹. These features are particularly evident in **the financing of health care goods and services**. The execution of the purchasing function requires an entity as Purchaser engaged in a compound of horizontal and vertical institutional relationships. The Purchaser establishes interactions with the sources of funding, with health care providers, and with consumers. The financing could be for services that take place in **public establishments** and are provided by health care professionals and technicians as public employees, or it could be health care services obtained through contracting arrangements from **public and private providers**.

The main legal and financial instrument for the performance of an independent purchasing function is **contracts**. Contracts set forth the

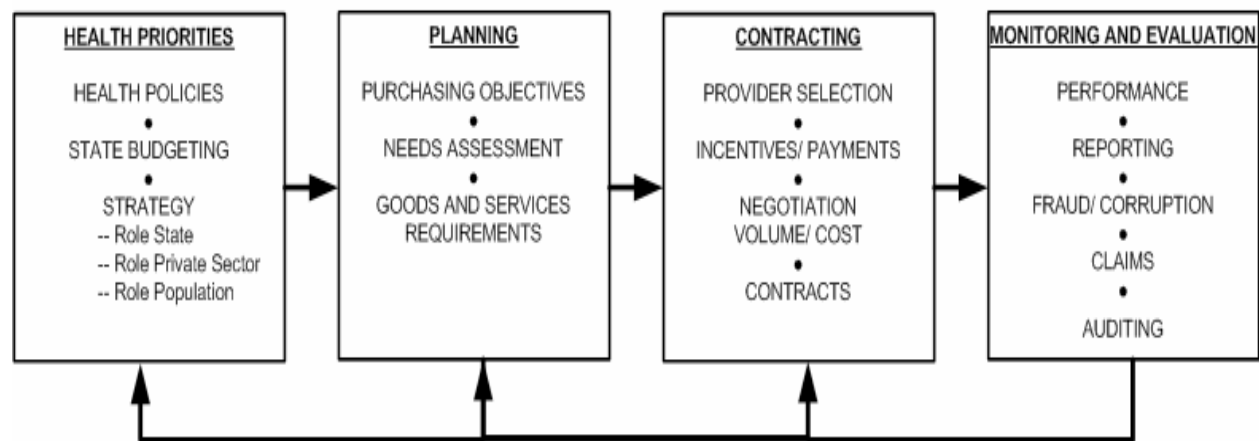
¹ Based on Kutzin 2000.

reciprocal obligations of the parties involved, such as terms on the type of goods and services to be delivered, prices, information and reporting, requirements and conflict resolution. **In summary**, the purchasing function is exercised (both in the public and private sectors) through an intricate system of contracting². In the private sector, contracting is the main tool to conduct business. For the public sector the interest in contracting lies in the desire for more effective and efficient use of scarce public resources, to incorporate flexibility into the usually rigid public sector contracting mechanisms (public procurement), in attracting the participation of the private sector in the implementation of public policies more effectively (in the provision of services and in supplementary voluntary financing), and in making purchasing between public agencies more effective.

Contracting requires a legal framework³ and effective mechanisms of enforcement. Political interference in decisions needs to be minimized. Health care professionals and health care sector managers need to acquire new skills and understanding of the legal and financial aspects of health care contracting. The public private mix in the delivery of health care goods and services is made possible and effective with a clear, transparent, accountable and enforceable contracting system (norms and procedures). **In most counties, contracting is becoming a central part in the management of the purchasing function. This shall also be the case in Macedonia.**

Contracting health care goods and services has aspects that can be found in any contracting process regardless of where this process takes place institutionally (State Purchasing Agency, Health Fund, or even in a relatively autonomous Department within a Ministry of Health). Ideally, an autonomous health fund would pool the financial resources, allocate them via contracting, and regulate the quality of the services and the providers through contractual enforcement. We call this **CONTRACTING PROCESS**, depicted below:

CONTRACTING PROCESS



© Hernán L. Fuenzalida-Puelma

1. HEALTH PRIORITIES. Health Priorities reflect health policies, a process usually vested in Ministries of Health. To be effective, the process has to be open, dynamic and ongoing with adequate information, proper and systematic consultations with stakeholders, and

² Contracting is becoming an increasingly important feature in the purchaser–provider relations in both Western Europe (for example, Denmark, Spain and the United Kingdom) and Eastern Europe (for example, Czech Republic, Estonia, Georgia, Kyrgyzstan, Latvia, Romania and the Russian Federation) (See Gottret and Schieber 200X).

³ Building the proper framework requires (a) a thorough revision of the existing purchasing/procurement legal framework in the public sector to introduce amendments to the existing public sector legislation. For example, if the Purchaser is a State agency that has to abide by the public sector procurement norms without the flexibility of contracting under private civil and commercial codes, the contracting process has serious inherent limitations; and (b) an assessment of how the current contracting is taking place: how autonomous contracting is from political interference, how transparent, how accountable, and how effective it is in terms of value-for-money and in the quality of the services contracted and delivered.

⁴ Dikson, et al

⁵ Common fraud and abuse practices include billing for services not furnished; misrepresenting the diagnosis to justify payment; soliciting, offering, or receiving a kickback; blowing up charges; and falsifying certificates of medical necessity, plans of treatment, and medical records to justify payment.

⁶ In the United States, the Government Accounting Office (GAO) has indicated that fraud concerning Medicaid (health care coverage for eligible low income individuals jointly financed by the federal government and the states) even a rate as low as 3% would mean a loss of almost \$4.6 billion in federal funds in fiscal year 2003, <http://www.gao.gov/new.items/d05855t.pdf>

supported with political commitments to assign health care prominence among national priorities.

2. PLANNING. When resources are limited resources (public and private and usually there are also limited resources regardless of the wealth of the nation) and the institutional capabilities are weak, health care financing planning requires thorough and realistic understanding of the actual and future capabilities of both the public and the private financing and delivery. The Purchaser and the Ministry of Health play define the contracting plan of health care goods and services. This joint responsibility consolidates the mandates, competences and responsibilities of the Ministry and the Purchaser. The role of the Ministry is one of policy, regulation and supervision; the role of the Purchaser is to co-define what and from whom to purchase. Planning as a basis for contracting process includes .

- ◆ **Health Needs Assessment.** Determining health needs demands close and realistic assessment of the health wants of the populations conducted by the Ministry *with* the Purchaser and involving providers and other stakeholders under sound technical foundations. The assessment determines what and why the State needs to purchase certain health care goods and services that guide prioritization. Ministerial decisions taken *in conclave* are unrealistic and rarely attest to be of any value.
- ◆ **Purchasing Objectives.** The Health Needs Assessment translates into strategies to sufficiently provide a basic package of health goods and services to the population that the population would consider meaningful. It entails dealing objectively with the vested interests of individual and institutional health care providers. It implies a realistic and fair involvement of the private sector in the delivery, and eventually the financing of health care goods and services that are accessible and affordable.
- ◆ **Packages of Services.** The basic package of health care goods and services to the financed should derive from the needs assessment and serve the purchasing objectives set forth by the Ministry of Health and the Purchaser. The existential problem with basic packages is that it is not possible to have all-inclusive, and determining what has to be excluded is always, one way or another, discriminatory. Moreover, since basic packages cannot be absolute, the problems what to do when a person is admitted under one situation covered by the basic package and evolves into a more complex situation not covered by the package. Who sustains the additional financial cost? The Purchaser or the provider? If it is the provider, then there is risk sharing. Fine in theory, but in practice it could also mean discrimination, malpractice, and abandonment of the patient.

3. CONTRACTING. Contracts are legally and economically more effective when there is a clear separation between the Purchaser and health care providers (individual and institutional) *and* when contracts are enforceable.

- ◆ **Provider Selection.** The Purchaser needs competence and the capacity to select the providers with which it will contract. The contracting cycle proper starts with identifying and selecting providers. The Purchaser calls providers to submit information to build a *Registry of Selected Providers*. Those that meet the requirements make it into the Registry. Selection depends on the availability of providers, the market structure for providers to operate, and the legal framework. Where there is only one provider the purchasing agency have no options. In this case the purchaser builds up a *Registry of Sole Source Providers*. Selective contracting requires (a) a mandate for the purchaser to select providers, to build a Registry of Selected Providers and to contract only with those selected. This mandate is rarely found in these terms. Without it, however, selective contracting can be illusory. The goal of selective contracting is to encourage competition between competent providers. Sometimes there is reluctance in the use of selective contracting with public institutional providers due mainly to political reasons because many public hospitals would not meet the basic selection criteria and would be left out the Registry and not be eligible to receive contracts. The political and social consequences are evident in the short term. The vested interests of those affected, institutionally and personally, play a role in not fully implementing selective contracting. Contracting selectively with private providers is either based on influence and connections (usually former public providers now in the private section with connections with the Purchaser), or simply does not take place. In the Russian Federation, for example, it is reported that in spite of enacted legislation in 1993 insurance purchasers have never contracted with non-governmental providers. In Poland, low payment rates have discouraged providers from seeking contracts, preventing competition among providers precluding the use of possible market mechanisms to increase efficiency⁴.
- ◆ **Incentives/Payments.** The rules on contracting need to be known in advance. The Purchaser has to issue guidelines/instructions on the types of contracts (performance and services contracts), and on the types of incentives built into each type of contracts. Incentives should focus on improving quality. The inclusion of quality measures contributes towards the development of a culture of quality in service provision. For example, formulas for calculating payment for every service; level of resources available to the provider by type of service; financial incentives based on results; definition of financial year (particularly important when tenders take place all year round); submission of financial statements; reporting requirements (clinical, financial managerial); invoicing scheduling; when payments are due; charges and interests; procedure and periodicity for reimbursement and payments; and appeal procedures. Capital investment financing (clinical and non-clinical equipment; buildings, major repairs) should not be part of health care financing.
- ◆ **Negotiations: volume/costs.** Contracting focuses on costs and volumes of goods and services. Once specified in the contracts, delivery obligations correspond to defined ranges of purchased services, with coverage and terms of access, and standards for safety and quality. Negotiations take place with providers from the Registry of Selected Providers and from the Registry of Sole Source Providers. The Purchaser calls for biddings or tendering (if needed according to the legislation) for multiple providers to

submit technical and financial proposals. The Purchaser negotiates each individual case for Sole Sourcing directly.

- ◆ **Contracts.** The Purchaser develops standard contract formats and annexes (with clinical, financial, administrative and reporting requirements), which make contracting simpler and less costly. Contract language usually becomes more precise over time. The duration of contracts increases over time as Purchaser and providers gain in experience and mutual trust. Contracts establish legitimate expectations that need to be honored. If contracts are not honored because the State resources are not made available from the State budget, the contracting system does not work.
- 4. MONITORING AND EVALUATION.** Monitoring contractual performance although essential, it may involve high transaction costs. Constructive and continuous relations between Purchaser and providers are needed and are much better than requiring information that no one uses and this reduces the transaction costs. Necessary but not burdensome information in the context of information systems and formal monitoring ensures better contract performance evaluation. Monitoring and Evaluation thus include:
- ◆ **Performance Evaluation.** An on-going process that requires skills and adequate procedures and guidelines for both Purchaser and providers. The Purchaser needs to issue guidance, monitor and control contracting performance, gather statistical information, and evaluate contract performance and sanction providers that violate the contracts. Distinction would have to be made among non-profit and for profit providers. Information systems process relevant data on services provided, quality, personnel and material resources used, accounting and financial records. The more specific the contract in these regards, the less the risk for the Purchaser; however, the greater the burden to monitor performance. The Purchaser has to conduct periodic contract supervision and evaluations on site on their own or contract these functions to a third party. Contracts must have explicit clauses allowing monitoring quality and respect for accreditation, licensing and certification requirements and standards. Indicators must be objective, quantifiable, and easy to measure to reduce the administrative burden and have to measure outcomes that are within the contractor's control. Contracts should include indicators to measure administrative performance, customer service, and quality standards. In these regards, contracting has an obvious additional advantage, that of a regulatory function. Detailed and well-drafted contracts, with proper instructions serve as regulatory instruments for the types of services contracted, how they should be performed, targeted populations, and prices. Time and effort devoted to have good contracting forms, and adequate procedures for monitoring and supervision is a good investment in accountability and transparency.
 - ◆ **Reporting.** Reporting systems ensure transparency in the purchasing process. Contracts between the Purchaser and providers should contain detailed reporting requirements and guidelines for proper and standardized filling of the information. Reporting should cover subjects such as clinical interventions with diagnostic codes, recording of interventions in accordance with protocols, and drug prescription. Reporting on health care statistics and public health data is of utmost importance and should be an essential requirement. Critical are provisions for financial reporting in accordance with the guidelines indicated in the contracts.
 - ◆ **Fraud/Corruption.** Most health care systems in Transition Countries suffer from lack of probity. When a significant part of health expenditures comes from out-of-pocket, and are charged and collected with no accounting, a culture of under the table payments develops. It will be difficult to eradicate, as these payments may constitute a main source of income for individual and institutional providers. The Purchaser needs to approach this issue systematically. The pricing of goods and services has to be realistic and satisfactory to providers. This may not be attainable, however, because of scarce resources. If a balance is not reached, corruption most likely continues. Fraud (getting something of value under false pretences) and how to counteract against it may be a new element for the Purchaser worries in a contracting system. If not closely monitored and supervised, providers may feel tempted to deceive in classifying diagnoses and in reporting⁵. This happens in all countries⁶, and fraud and abuse, over billing are serious concerns and a source of financial losses.
 - ◆ **Claims.** Regardless how good inspections, monitoring and supervision are, there will always be ample space for disputes concerning classification of episodes, billing, and reporting. The Purchaser needs to establish objective, simple and expeditious internal procedures for resolving claims submitted by providers (patients can access the Purchaser's Office of the Ombudsman). A functional system of conflict resolution is essential if a contractual purchasing system is to operate. Contract enforcement is critical for the success of the system. Mediation and arbitration are non-judicial means for conflict solving that avoid the accessing the courts which takes time and effort due to complex procedures and the possibilities of lack of transparency. The Purchaser should establish internal administrative procedures to resolve claims, and encourage non-judicial means of conflict resolution before resorting to court. Ultimately, however, the court system has to be one to heal and solve contractions and conflicts in an objective, legally based, fair and swift manner. The bottom line is to avoid the perception that contracts may not be honored and that non-honoring contracts can go unsanctioned. If this happens, the contracting system collapses.
 - ◆ **Auditing.** In a contracting system, auditing is a basic monitoring, examining and correcting mechanism. It determines the extent to which the provider fulfilled the level and type of specified services; if the provider consistently invoiced for direct patient care and used the resulting revenues to fund the services specified under the contract; the adequacy and appropriateness of internal controls; the reasonableness of expenditures; and overall compliance with contractual terms and conditions. Retrospective audit determines whether overpayments on claims have been made. It allows recuperating overpayments when honest payment mistakes take place, and when this is not the case, it may lead to penalties and, eventually, to the elimination of the provider from the list of providers. The Purchaser should require institutional providers to have internal audit offices, and ask, as appropriate, for external

auditing. With small providers, random audit inspections by the Purchaser could be sufficient.

- ◆ **Intra-Public Sector Contracting.** It takes place when one level of government or a public institution (Ministry of Health) contracts with a lower level of government (region or a district) or with a public hospital. Intra-Public Sector Contracting introduces private sector concepts and business strategies into public sector management, such as competition and performance-based incentives. These contracts are usually difficult to enforce (The United Kingdom under the National Health Service Reform, Chile between the Ministry of Health and Regional Health Services, and Costa Rica where the Social Security Institute signs contracts with its own social security hospitals).

Conclusions On Strengthening the Purchasing Function Of the Health Insurance Fund Of the Republic Of Macedonia

Reforming the purchasing function of health care goods and services demand and perfecting the contracting mechanisms and payments systems for providers and suppliers, remains an unfinished agenda in all Transition Countries, including Macedonia. In the region of South East Europe Slovenia on the other side is a country where actually contracting was the basis for preserving hard-budget constraints throughout transition period.

Under the World Bank HSMP Project some key building blocks have been provided. That includes preparation of National Health Strategy, better governance of HIF, including establishment of budgets of individual HCIs, preparation of medical map that shall enable selection of providers, improvements in hospital management, imposing of IBC for drugs, implementation of reference prices etc.. Though important, all those measures are yet to be fully implemented.

It is thus critically important that the key measure within the new Government's 100 STEPS PROGRAM is that **HIF will have the role of the strategic buyer of health services** and that on this basis budgets will be defined. This demand is that within next year or two full budgeting/contracting process is put in place. Only in such a manner the Purchaser i.e. HIF will get necessary autonomy and authority and thus shall become more competent in managing the financing of health care, and will acquire experience for effective monitoring, supervision and regulation.

In **contracting process** the overall budget need to be appropriately allocated according to what called be call “**overall or general program apportionment of the budget**” into programs such as programs of institutions at:

- **Primary level, including health centers (as association of doctors) or to g.p. with concession**
- **Secondary level, including policlinics and special care like long-term cared etc., and**
- **Hospital level**

But the programs of individual group of HCIs could be further divided into

- **Preventive Care Programs,**
- **Curative Programs and**
- **Rehabilitative Care Programs**

Such program apportionment of the overall level of health care finances need to be result of result-oriented budgeting or towards output-oriented program expenditure management, focused on service delivery. That demands definition of volume and type of services, price levels and payments mechanisms. This is the core of an exercise in which demand for and supply of medical services is analyzed, reviewed, discussed and ultimately agreed for a particular budget (calendar) year. As explained later in this report during a process of contracting and negotiations what also need to be agreed is “**institutional apportionment of the budget**” as explained below:

- **Overall budget divided into special areas budget,**
- **Budgets for special areas i.e. for a group of similar HCIs and**
- **Individual HCIs' budgets.**

In addition given the ownership of individual HCIs by Government or local governments it is appropriate (up to the point that some of premises could be managed by private providers) that Ministry of Health provide necessary financing from the Central Government Budget for investment maintenance and new investments.

Such a program need to be clearly specified and should not be donors driven. Rather, donors when they finance in kind new medical equipment or rehabilitation of existing health care facilities shall become integral part of the overall Health Care Budget. Government should also provide financing in full for all preventive and promotion health care programs as well as other "national" health programs, including financing of medical schools, national health statistics development and co-financing of Health Sector Management Project activities and initiatives.

Since in Macedonia investments in medical centers at local level were done in the past by local communities, the Government shall re-consider in the view of decentralization policies and local government financing review its position on centralized investment decision making. Ultimately, mayors and local councils shall be made responsible for provision of basic services to their population. As in case of local infrastructure companies (garbage, sewage, water etc.) where a decisive move is needed to decentralization, there is non, but political reason, to not undertake a change.

Should that be done that Central Government in order to provide overall control over the structure of the health system needs:

- first, ensure approval of investment and
- second, provide for co-financing of 10 to 50 percents of domestic costs (in the overall project donors' funds should they exist, shall be included) of an investment. Percentage of co-financing shall vary depending on the level local community development compared to the level of major medical investments
Central Government

Central Government Health Care Budget need to finance all those programs because that is the basis for "limiting" health care capacities on one side and provide on the other side an appropriate policy input in assuring health for everyone in Macedonia.

It is also proposed in this context that "Ministarstvo za zdravstvo (Ministry for Health System) shall be symbolically renamed into "Ministarstvo za zdravlje".

Ad b) Health Care Services Provision Issues and Some Proposals for Republic of Macedonia

In reference to service delivery it shall be noted that up to recently all HCIs were Government owned and operated. Only since recently doctors have been able to obtain a concession to run general practice or specialist facilities at primary health care. But most of medical staff work as public employees in Government operated medical centers, specialist polyclinics or hospitals. There is a group of doctors that operate in double shifts: in addition to public job, they work in the afternoon un-regulated second shift at private premises. It shall be noted that development of private initiatives created couple of top quality medical facilities for out-of-pocket payments for affluent or those in with higher needs that cannot obtain services at public hospitals.

But success of private initiatives reflects at large malfunctioning of public system. It shall be appropriately to not make a difference between the type of HCIs providing health services. Government should actually look into options of out-sourcing management of public premises to health organizations in order to improve its efficiency and avoid labor market bottlenecks. But close supervision and enforcement of contracts need to be carefully managed by HIF as strategic purchaser.

In that context privatization or public private partnership in health care in Macedonia should instead on selling of assets concentrate on out-sourcing services and better management. Privatization would thus focus on purchase of services - once clear contracts on negotiated volume and prices could be spelled out, the ownership is less of an issue. Then the management of (public or private) HCIs would be in equal positions. The only difference remained is lack of flexibility of labor in the case of public employee status of medical staff. Purchasing of services, privatization of services, public private partnership and status of medical staff shall be closely reviewed and overall solution be identified.

As the level of medical capacities is concerned it shall be noted that in the past - before 1992 - the level of capacities before 1992 was defined with the plans of medical protection. That included number of hospital beds, number of doctors, dentists, medical assistants and overall staff employed in public primary care and hospital system. Now, preparations are underway for a new medical map that would also define available resources and capacities in connection with the preparation of National Health Strategy for Republic of Macedonia. There is a potential surplus of doctors and medical staff as well as surplus of capacities, especially when comparing with available financial resources. In this context among first steps in new budgeting and contracting approach would be to jointly define necessary capacities through "selection of providers".

In relations to provision of services on primary levels "domovi zdravlja" or health homes or medical centers and new, private concessionars are key suppliers of services. It is not clear whether doctors with good registry of patients could have better pay, but an aim shall be that doctors with good registry and good work as concessionars or as public

employees should be paid equally, though it is logical that concessioners expect better net income position. Private concessioners worked in their own premises or they hired public premises for individual or joint practice. It would be very important to ensure that local communities provide input into structure of primary care and the level of private and public concessioners. It is extremely important to ensure that private concessioners provide the same quality and scope of services, including weekend hours and emergency care as if they would act if public employees in medical services responsible for particular local community.

It is important to notice that at primary level private g.p. or specialists provide service for direct payments without contract with HIF. As with some private clinics at hospital level that is mainly the result of a lack of services not being provided by public HCIs. Thus affluent patients, despite being insured via HIF, demand services from private g.p. or private clinics, creating a parallel health care system. In this context it is extremely important to ensure that in a transparent manner health care services are provided to all insurers. If affluent and richer would like to have better services, then additional insurance schemes should provide for that service to be paid out of additional resources to all insurers.

For the secondary and tertiary care patients should be able to choose which HCIs would like to be referred to. Out-patient and specialist care is provided by polyclinics linked to hospitals or at local medical centers. Nevertheless hospitals provide for the most of secondary and tertiary care. Tertiary care is provided by Clinical Centre of Skopje, where clinics operate in closely interconnected environment, though sometimes Clinical Centre operates as a "holding of clinics". Clearly, an overall as well as individual budgets need to be prepared at the level of Clinical Centre of Skopje. Currently all hospitals, but few are publicly owned. One of major issues to be discussed in details and will be closely linked with the selection of providers, is whether and how profit-oriented hospitals shall be included into overall health care system.

In Macedonia it seems that number of beds and average length of stay is dependent more on the available resources and/or possibility to increase unpaid obligations (arrears), and not due to changes in approaches, in moving from in-patient to out-patient care or due to other incentives for higher efficiency.

In this context implementation of budgets as hard constraints, limiting expenditures at the level of available resources presents the first and necessary precondition for the health sector reforms.

On the drugs supply, there is an Office for Drugs and Medical Supplies that implements the nation policy on drugs and medical supplies and control the quality of those products. However the sheer presence of some 120 drug gross-suppliers shows that there is a lack of clear procedures and that public procurement rules and especially the protection of competition during bidding process should be carefully looked into.

In regard to some other issues of health care services provision it is important to ensure that social protection remains the responsibility of local communities or Macedonian "communes". Long-term care and protection is becoming important issue and thus re-specialization of hospitals is needed to cope with the problem of over-capacities at secondary and tertiary care. There is a lack of beds for long-term care and thus in addition to supporting private investments into older people and long-term care facilities existing premises of HCIs are to be converted into special long-term care facilities.

Ad c) Health Care Services Purchasing and Payments Issues and Some Proposals for Republic of Macedonia

In reference to purchasing and payment issues, it should be iterated that if purchasing of services and payments would have been well defined and organized, there would be no HSM project, neither there would be need for this work. In this context Republic of Macedonia is already among, a number of countries in both eastern and western Europe, that have already moved from integrated command-and-control models of publicly operated health care services towards one or another form of purchasing-based model.

To a certain mode, this model has been in Macedonia as part of former Yugoslavia developed in the past, during special HMO - Health Management Organization or so called Self-management Interest Community for Health (and for other social sectors), where supply and demand met to define level of contribution rate, as well as type and scope of services. These were well defined model, though operating in soft-budget constraints environment, resulting of hyperinflation in the last years of existence of former Yugoslavia. Thus some elements of supply and demand existed in the past.

What is important that in these models, public, or quasi-public, third-party payers are kept organizationally separate from health service providers. Thus HIF is separated from HCIs. The rationale for this purchaser-provider split model can be summarized in five main objectives⁷.

- First, services may be improved by linking **plans and priorities** to resource allocation, for instance, shifting resources to more cost-effective interventions and across care boundaries (such as from inpatient to outpatient care). Purchasing can thus be regarded as an alternative way to do some of the measures that have been traditionally pursued via planning.
- Second, population health needs and consumer expectations are to be met by **building them into purchasing decisions**.

⁷ See more into *Purchasing to Improve Health System Performance*, edited by Josep Figueras, Ray Robinson, Elke Jakubowski, draf World Bank Book.

- Third, providers' performance is to be improved by giving **purchasers levers, such as financial incentives or monitoring tools** that can be used to increase provider responsiveness and efficiency.
- Fourth, management can be decentralized and decision-making devolved by allowing providers to focus on **efficiently producing the services determined by the purchaser**.
- Finally, the separation of functions can introduce **competition or contestability** among providers and thereby use market mechanisms to increase efficiency.

Given the above let we provide in next section how in Macedonia a path toward such a model could be implemented. There are some guiding principles that we shall be looking into.

First, from now on and for each year, MoH, MoF and HIF should **agree upon on the overall budget for health care**, including the review of contribution rate, taking into account the long-term solution for accumulated debt. Objectively, MoH and MoF will be always on the opposite side of negotiations table, since it is inappropriately that a debate on the budget, i.e. funds of contributors to a health care insurance scheme is mixed with the debate on how collected taxes shall be devoted into civil service pay, roads, development projects etc...

In this context it would be appropriately to make HIF as funds of contributors to be legally independent entity but part of General Government Finances. For that however, solution of debt problem and strict respect of budget rules and development of good purchasing objectives need to be undertaken.

Second, on the basis of overall budget and assuming legal independence, HIF, MoH will on the demand side defined in cooperation **with all groups of HCIs** so called, **central or general agreement on the types and scope of health care services as well as on purchasing and payments methods**. Through such a formal and central agreement the overall "health care cake" is sliced into different types of services for groups of HCIs". Pls. do notice that donors' assistance should be perceived in this context as the icing on the cake, providing additional funds or equipment where and if needed and whether is affordable. It is wrong to get new medical equipment that will tomorrow present a major, unaffordable shift in recurrent expenditures.

In principle, a general agreement will include chapters on

- I. General provisions
- II. Health Care services programs
- III. Capacity of providers, necessary for production of agreed programs
- IV. Program evaluation and elements of health care services prices
- V. Defining of prices of the health care services
- VI. Planned value of the health care activities
- VII. Formation of the programs through regions and providers

-
- VIII. Special agreements
 - IX. Tender and selection of programs
 - X. Standards of bidding health care services
 - XI. Settlement of health care services
 - XII. Supervision
 - XIII. Assure the data for analyzing and planning
 - XIV. Arbitration
 - XV. Transitional and final provisions

Third, **on the basis of general agreement special agreements shall be made on individual group of HCIs, providers of particular type of services.** These negotiations and purchasing of individual group of HCIs are extremely difficult, since purchasing and payments is a complex process. For example for hospitals in Slovenia from 2003 to ensure move from hospital days to DRG, the following is the structure of the special agreement:

General part

- I. General articles
- II. Criteria's for forming and evaluation of programs
 - a. Specialist outpatient care
 - b. Hospital care
 - i. Acute hospital treatment
 - ii. Non acute hospital treatment
 - c. Tertiary care
 - d. Dialyze
 - e. Psychiatric care
- III. Rise of volume of the programmes
- IV. Settlement of the health care services
- V. Quality
- VI. Conclusion of contracts and termination of contracts
- VII. Settlement of disputes
- VIII. Transitional and final provisions

With a long supplement (Annexes) provides details on the following issues.

Supplements

- I. List of expensive lab examinations
- II. Standards for outpatient care
- III. Acute hospital treatment
 - a) DRG list and cost weights
- IV. Non acute hospital care
- V. Tertiary care
- VI. List of criteria and remarks for definition of appropriateness for hospital admission
- VII. Standard for day case in psychiatry
- VIII. Standards for transplantation

- IX. Standard for long term care, nursing and palliative care
- X. MRI and CT examinations
- XI. Standard for breast feeding mothers and accompanying persons

And, **fourth on the basis of the above contract are negotiated and agreed upon for each group of HCIs and with individual HCIs.**

Since the purchasing and payment of services will be always complex, it is important to notice that clear instruction that was or is to be issued by HIF toward HCIs is the basic budget instrument. Instructions as part of procedures here need to act in support of transparency and assuring access within solidarity based system. That includes procedures for issuing invoice and payments processes. Payments need to be based on type of HCIs, i.e. what type and scope of services a particular HCI provide.

Individual service or its portion will have a clear definition in unit points on the basis of either time spent and complexity of utilization of staff, drugs and other medical equipment. There would be certain methods for different types of HCIs, but in any case particular services and materials will be paid directly on capitation or different type of fee for service methods. But the most important is that there is an upper-limit total budget for each group of HCIs and for a particular HCI.

If that is well defined, then staff in public HCIs shall remain public employees. There will be pressure on increase of wages, but a collective agreement - well discussed and providing for bonus and malus, should enable that wages shall vary 25-20-30% depending on the stimulating better performance, upon decision of HCIs themselves. That shall be defined equally, for doctors and for medical assistants. They shall all remain public employees. Note that in many countries, full privatization have resulted in both lower quality, but also to higher wage bill, due to stronger negotiation power of doctors.

As far as payments at the **primary level**, a combination of capitation and fee for service is needed to ensure coverage of population and for paying of the services to be delivered. With fee for service component HCIs are stimulated to deliver services and thus payments are only made upon delivery of the scope of services. But in order to ensure gatekeepers role, malus and bonus should be imposed should there be a standard deviation from national average on referral to higher level. Pls. note that in Macedonia there is a specialist and team work at the primary level, and that include more complex methods of payments. If for example, budgets are 50% defined by capitation and 50% by fee for service, taking into account patients' age factor, it is important to support undertaking all preventive measures and thus implement incentives for effective preventive care. Thus a team shall be fully paid only if the plan of preventive measures had been undertaken, and referral rate isn't significantly different than from national average.

At **secondary level** payments shall be made by fee for services on the basis of units point linked with the size of team. The actual monetary value depend on the overall budget for that type of services and actual performance. It would be important to replace old ICB-10

with more modern version of DRG, diagnosis related groups, despite possible misunderstanding on details of particular DRG or clinical pathways.

At **hospital level** payments methods need to be ultimately defined according to DRG - Macedonian version, yet to be defined on the basis of experiences from abroad, taking into account domestic reality. DRG payments would mean purchasing of particular cases, including complete payments or undertaking procedures, diagnostics related activities etc.. That defines type and scope of a service in a much more clearly defined manner, than paying per-diem hospital day or similar payments per unit of production.

But payments via DRG are actually part of the overall budget for e.g. hospitals. In that context the price is calculated ex-ante, but revised ex-post as an average price per unit of DRG by dividing number of cases, 150.000 for example (330.000 in Slovenia in 2005) by up to 80-100 million euros of hospital budget (400 million euros in Slovenia in 2005) and then calculating individual DRG by actual complexity of a case. A case could be from 0,5 DRG to up to 4,0 DRG-in different cases.

On that basis hospitals shall be paid for actual and of delivered DRG and their complexity. Since that will take into account equal implicit costing, it is clear which are more efficient hospitals and which are not. Only in such a manner actual historical budgets or rather historical undertaking of services will define the actual budgets. That will also help to solve the basic dilemma of policy makers on defining the medical map. A minimum level of DRG related services requested is to be performed, otherwise keeping doctors and staff employed is absurd.

If all the above is well defined and implemented HIF would really become Strategic Purchaser of Health Care Services imposing hard budgeting constraints. It is all about defining supply and demand in health care sector. Of course, techniques are budgeting, better purchasing of services and better payment on which negotiations among different types of services is immediate next step. To summarize, the **next step, is decisive move to better budgeting and contracting in order to ensure qualitative purchasing of health services.**

Pls. notice also that the above proposals shall be first compared and then viewed as an expansion on details of the proposals in (TBD) Section 17 of the Draft of the Health Strategy for Republic of Macedonia for Period 2006-15 as prepared under another component of HSMP as defined in Box 2 below

BOX 2: DRAFT OF THE HEALTH STRATEGY FOR REPUBLIC OF MACEDONIA FOR PERIOD 2006-2015 (National Health Strategy -NHS), SECTION 17- PRIORITIES FOR IMPROVEMENTS OF FINANCING HEALTH INSURANCE

- **Financial Control Issues** including the following activities and controls:
 - Ministry of Finance will continue to annually propose the next year's HIF overall budget, to be approved by Parliament as the ceiling of HIF expenditures in the coming year.
 - The HIF will prepare a plan for allocating funds to all elements of the health care system in the coming year which needs the approval of its Board.
 - The HIF is not allowed to commit itself to expenditures over the agreed ceiling.

- **A change in the Budgeting approach** where:
 - During the coming decade, the HIF plan of expenditures will gradually change from a plan based on historical disbursements to one based on the purchase of the required volume of services at negotiated prices. All contracts between the HIF and the health care providers have a financial ceiling, which means that the financial responsibilities are shifted from the HIF to the providers.

- **Solving of the problem of existing arrears and debt** by the Government and the HIF will prepare a plan to solve the problem of the existing arrears and debt of the HIF, and submit it to Parliament.

- **Definition of the benefits package as a basic package with two options:**
 - Option 1: Defined basket of all medical services provided to the insured population for which the providers will be entirely or partially reimbursed by the HIF. For some categories of population coverage is insured by the Government
 - Option 2: Benefits Package is defined at two levels: obligatory package for all insured citizens to be paid by HIF and minimal package for all citizens also for non-insured, with services to be paid from Central Government Budget

- **Contracting and paying providers** with the HIF to continue to be the sole purchaser of services under the basic benefits package. Private companies can insure citizens for additional benefits on a voluntary basis. At the same time HIF will improve its purchasing function to contract the volume of services it needs for the insured population in each region of Macedonia. In case there is a surplus of providers of specific services in a certain region, the HIF will contract only a limited number of the existing providers.

- **Changes to Reimbursement System** - during 2006-2010, payments to outpatient and inpatient specialist providers will gradually be based on the volume of services provided and on certain performance indicators, rather than on the existing infrastructure.
 - Total disbursement will be limited by a budget cap. Legal measures will be introduced to prevent budget overshoots (creating arrears) by hospitals. Hospital managers will receive training in financial administration. Providers are responsible for their own financial administration, but they will also be regularly audited by the HIF.
 - The contracts for hospital services will contain a payment method that covers all expenditures including salaries, consumables, pharmaceuticals, maintenance, other recurrent costs, capital investments and depreciation, but payment will not be earmarked for these categories.
 - Primary care will be paid by capitation, adjusted for the age of the client and the geographical location of the practice. The HIF will continue to add financial incentives for high performance, on the basis of a high coverage of preventive activities, a low (but not too low) number of referrals, and a low number of prescriptions.
 - All contracts between the HIF and health care providers will specify which data must be reported

monthly or annually to the HIF. These are financial data, for which detailed forms are presented in the report by Ernst & Young (2005), and performance indicators, such as the number of office and home visits, referral rates, the number of hospital admissions and re-admissions, occupancy rates, and the average length of stay in a hospital.

- The Republic and regional Institutes of Public Health will negotiate annual contracts and budgets with the Ministry of Health, other ministries, local governments and the HIF for the implementation of agreed programmes of public health activities. They will be free to perform market activities in their field that do not compromise their public functions.

Once that is undertaken, it is strongly suggested that authorities take into account both the detailed proposal as explained above as well as set of ideas, including a preparation of the Health Strategy for Republic of Macedonia for period 2006-2015 (National Health Strategy - NHS), in Chapter 17 - Priorities for Improvements of Financing Health Insurance, and other inputs from HSMP work. Only on these basis authorities would be able to prepare and undertake next steps of actual Health Care Financing Reforms.

Summary of Missions and Conclusions on Budget Training

On the basis of the mandate defined under TORs for Budget Training Budget Training for Staff of the Health Insurance Fund, Health Care Providers and the Ministry of Health, the consultant first had familiarized himself with the prevailing financial/budget preparation environment within Macedonia pertaining to Health Insurance Fund and the health care Institutions.

Subsequently the training plan was developed with commensurate curriculum for budget formulation and implementation. On that basis a set of documents was provided to trainers on budget preparation, budget execution and budget reporting in accordance with the established MOF/HIF financial policies. The core document was provided both in English and in one of regional languages and is available at the following websites: The reference book of OECD - SIGMA Program on Managing Public Expenditure - A Reference Book for Transition Countries is available in English at the following web site of the main sponsoring agency OECD and that is: <http://www.oecd.org/dataoecd/46/35/35066562.pdf>. The version of the reference book of OECD - SIGMA Program on Managing Public Expenditure in **Bosnian language** is available at the following web sites of Macedonian Ministry of Finance http://www.finance.gov.mk/mk/brosuri/javni_sredstva/managing_public_expenditures_1.pdf (first part) and (second part) at http://www.finance.gov.mk/mk/brosuri/javni_sredstva/managing_public_expenditures_2.pdf.

On that basis and with other on-hand instructions the training of around 20 trainers designated and as organized by the MOF/HIF was organized in two workshops. Subsequent to the training of the trainers, a training plan was developed for the trainers to train of around 230 Health Care Institutions personnel, including specific modules in training techniques and training style approaches. Consultant had guided and monitored the delivery of training by trainers.

As confirmed at the last workshop on October 13, 2006 the trainers are fully operational and are able to present their views, ideas, approaches, instructions and recommendations in professional manner.

In regards to the indicative future on-going training plan in budget formulation and implementation, the consultant had provided during a final wrap-up workshop a proposal that a major next steps need to be undertaken. Consultant claimed that unless out of budget training an exercise on budget formulation that shall also include negotiations process among key stakeholders groups (on demand side HIF, MoH and MoF and on supply side group of HCIs) that will result into an consensual or arbitratve (on basis of the Government of Macedonia reached arbitration) agreement how to allocate to different programs and institutions within limited overall health care budget, no major improvements in financial management could be achieved. For this reason consultant provided a separate presentation (Annex 1)

In the next section we provide overviews and some details on missions held under TORs Budget Training. Detailed reports have all been provided to authorities upon mission. In this find report we provide summary in two Annexes power-point presentation during the second training the training workshop, described in the previous section of this Final Report a proposal for a **Follow-up Activities in the area of Health Care in Macedonia linking Budgeting, Contracting and Purchasing**

Overview of Missions held under the Existing Contract

During the course of 2006 under TORs for Budget Training for Staff of the Health Insurance Fund, Health Care Providers and the Ministry of Health international consultant Milan Martin Cvikl undertook as envisaged the following missions:

- **The first preparation mission** under above mentioned TORs for Budget Training for Staff of the Health Insurance Fund, Health Care Providers and the Ministry of Health and for preparation of the Train the Trainers Training Plan under above mentioned project was conducted from **February 12th to February 16th, 2006**.

The mission reviewed the prevailing financial/budget preparation environment within Macedonia pertaining to Health Insurance Fund and the health care Institutions in order to start preparation of the Training the Trainers training plan. This plan and agreed curriculum for budget formulation and implementation was discussed and agreed upon with major stakeholders, especially the HIF Governance Team, consisting of the representatives from HIF, MH and MF.

- **The second preparation mission** took place A second preparation mission under TORs for Budget Training for Staff of the Health Insurance Fund, Health Care Providers and the Ministry of Health and preparation of the Train the Trainers Training

Plan under the above mentioned project was conducted from **March 18th to March 23rd, 2006.**

The mission, based on the first preparation mission and taken into account the prevailing financial/budget preparation environment within Macedonia pertaining to the Health Insurance Fund and the Health Care Institutions, continued with the preparation of the Workshop for Training the Trainers that is to be conducted in early May, 2006. The workshop structure and particular presentations were thoroughly discussed and agreed with the key group of trainers from Ministry of Finance and Ministry of Health, Health Insurance Fund, Clinical Centre of Skopje and State Audit Institution.

During the de-briefing session, Mr.Cvikl presented a major presentation on the Development of Public Expenditures Management - Experiences of Slovenia and other CEE countries for Reforms of Budget Process and Health Management Process in Macedonia.

- **The third mission** under TORs for Budget Training for Staff of the Health Insurance Fund, Health Care Providers and the Ministry of Health including execution of the Train the Trainers Training Workshop in Ohrid from May 3-6, 2006 under the above mentioned project was conducted from **May 1st to May 7th , 2006.** The mission included Milan Martin Cvikl, International Consultant with the able assistance of dr. Zora Uzonoska, Assistant Coordinator Project Coordination Unit, Ministry of Health.

The mission, based on the two preparation missions and taking into account the prevailing financial/budget preparation environment within Macedonia pertaining to the Health Insurance Fund and the Health Care Institutions, concluded final preparation and undertook the Workshop for Training the Trainers. At the workshop more than 30 presentations on different topics of overall health sector reforms and budgetary issues were prepared, presented and thoroughly discussed and agreed within the key group of trainers from the Ministry of Finance and Health, Health Insurance Fund, Clinical Centre of Skopje and State Audit Institution.

The workshop was well prepared and provided an important forum for exchanging views among different institutions. It thus provided a forum for exchange among politicians and technocrats and enabled a formation of the key Group of Trainers for Budget Training in 2006 and in later years. In this context the workshop was a key building block and a major step forward in the formulation of appropriate budget training to be performed by Macedonian stakeholders.

- **The fourth mission** under TORs for Budget Training for Staff of the Health Insurance Fund, Health Care Providers and the Ministry of Health that included the execution of the Workshop for Education on Budgeting for High Level Personnel of Health Care Institutions and District Offices of Health Insurance Fund in Ohrid from May 31st to June 3rd, 2006 took place in Macedonia from **May 30th to June 5th, 2006.**

During this mission, based on the two preparatory missions and the Training the Trainers mission held in early May 2006, the international consultant led the first in a series of workshops for Education and Training in Budgeting for Health Sector Personnel. At the workshop a group of Trainers from MoH, HIF, MF and some HCIs presented via two dozens of presentations all major issues of health sector reforms and health budgetary issues in Macedonia. In a form of interactive presentations and discussions all major budgetary issues were thoroughly discussed among key stakeholders.

It shall be emphasized that at the workshop for the first time in “about a decade” (quote by participants) all key stakeholders met and discussed in a single workshop. On one side at the workshop politicians and experts (trainers) from the Ministry of Finance, Ministry of Health and the Health Insurance Fund presented the need for an overall health sector reform and the introduction of budgetary reforms and of imposing strict budgetary rules. In addition trainers from the Clinical Centre of Skopje and Ohrid "Erasmus" Hospital presented two cases of successful preparation of budgets and of business plans. On the other side of the table, there were high level personnel from some 10 key HCIs - hospitals and from District Offices of HIF from throughout Macedonia. They all actively participated in presentations and discussions on all main issues.

As evaluated by participants the workshop provided first, an extremely useful forum for exchanging views and standing points of different institutions. Second, it provided initial knowledge needed for preparation of better budgets and thus created an impetus for continuation of communications, exchange of views, further workshops etc. Many proposals were given by participants on a particular presentation, but there was a clear message given that a change in health financing techniques and formulas is needed that will include methods like capitation fee and payment based on DRG basis for scope and type of services. Expectations were raised by participants and therefore the training needs to continue.

On the next steps, since over a couple of months the key Group of Trainers for Budget Training was established and since Health Sector problems are critical, it is extremely important **in the view of the results of elections**, that the new health sector team familiarize themselves with the details of the Health Budget Training Issues. It is proposed that the next round of workshops is organized to incorporate the existing Training team and new policy team at the Ministry as well as at the HIF (if the new Government will assess the need for a new team) as soon as possible, preferable in September 2006. To organize the follow up training it was in the report on fourth mission proposed that international consultant should visit Skopje by the end of August 2006 for a brief with the new policy team and to meet with the team of trainers to organize the remaining round of trainings

- Such a mission, **the fifth mission** under TORs for Budget Training for Staff of the Health Insurance Fund, Health Care Providers and the Ministry of Health which included because of the change of the Government of Republic of

Macedonia also the preparation of the Second Workshop on Training the Trainers for Education on Budgeting for High Level Personnel of Health Care Institutions and District Offices of Health Insurance Fund took place from **August 27th to August 31, 2006**. This second training the trainers' workshop is to be organized as early as possible in September, 2006 upon appointment of key officials at the Ministry of Health, Health Insurance Fund and Ministry of Finance.

During the mission consultant met with new high level officials and the team of budget trainers, including all top officials of the new Government, including Mr. Nikola Gruevski, Prime Minister, Mr. Zoran Stavrev, Deputy Prime Minister (responsible for developmental issues, including health sector reforms), Mr. Imer Selmani, Minister of Health, Mr. Trajko Slaveski, Minister of Finance, Mr. Vladimir Lazarevik, to be appointed Deputy Minister of Health, Mrs. Angelina Bačanović, Chairwoman of the HIF Supervisory Board, Ministry of Health, Mr. Andrea Arsovski, Director of Clinical Centre, and representatives of other institutions, including the core of Health Care Governance Group from the Health Insurance Fund. The consultant also met with Mrs. Sandra Bloemenkamp and Mr. Evgenij Najdov of the World Bank Representative Office in Skopje to get briefed on recent developments and to agree on the follow-up activities. He also met with the parallel mission under Dutch Trust Fund project to develop Macedonian Medical Map to be utilized to strengthen contracting of health services. Consultant would like thank authorities to their hospitalities and substantial discussion.

The main purpose of the mission was to brief the new policy team on health sector budgeting and contracting issues and to meet with the overall team of trainers to organize the remaining round of workshops. All this shall ensure continuation of activities on Budget Training as well as on health care financing reforms. The main conclusion of the mission is that the new Government is highly committed to continue and to strengthen the health sector reform process. This has been proved with clearly defined Health Care objectives and measures within the "100 STEPS PROGRAM" of new Prime Minister, Nikola Gruevski (see **Annex 2**). The proposed measures actually announced new round of health sector reforms that shall deepen existing reform initiatives and to strengthen the strategic purchaser function of HIF.

As far as budget training is concerned it was agreed during the mission that in order to ensure continuation of the budget training process that the second training the trainers' workshop need to be organized as early as possible in September, 2006 upon appointment of key officials at the Ministry of Health, Health Insurance Fund and Ministry of Finance. In such a manner the existing group of trainers and new key policy makers will be merged into a single team of **budget-contracting trainers** during forthcoming workshops. During the workshop the exchange of information on key health care financing issues will be ensured between existing group of trainers and new policy makers. This will enable full synchronization of next steps in budgeting and contracting process /see

for more details below/ and thus strengthen HIF's strategic purchasing function. The proposed structure of the workshop includes both discussions on a new set of policy measures and activities as well as on implementation of strengthen budgeting/contracting approach.

During meetings with high level officials consultant also discussed modalities of providing further assistance to the HIF management in strengthening its management capacities. Since the prime minister intend **to introduce professional management with professional agreement, selected through international bid, according to the principle of two directors with so-called bind signature, actually four eye principle** it was discussed how to ensure appointment of foreign expert and how to provide him with support from consultant and his team from Slovenia on contracting/negotiations and budgeting issues.

In the conclusion of meetings it was agreed that as a first immediate next step is for the minister of health to issue invitation to the second Training the Trainers' workshop in September upon appointment of key officials at the Ministry of Health, Health Insurance Fund and Ministry of Finance.

- During his last, **the sixth mission** under TORs for Budget Training for Staff of the Health Insurance Fund, Health Care Providers and the Ministry of Health which took place from October 11 to October 16, 2006 the second Training the Trainers' workshop was undertaken. The last mission was in the course of September 2006 agreed with Deputy Minister of Health Mr. Vladimir Lazarevik, and the mission was to be focused, as agreed during the previous mission in order to ensure continuation of the budget training process, on the second training the trainers' workshop need. Based on appointment of key officials at the Ministry of Health, Health Insurance Fund and Ministry of Finance the workshop aimed to ensure that existing group of trainers and new key policy makers was merged into a single team of **budget-contracting trainers**.

During the workshop the exchange of information on key health care financing issues was ensured between existing group of trainers and new policy makers. This had enabled full synchronization of next steps in budgeting and contracting process /as presented below/ in order to strengthen HIF's strategic purchasing function. During the workshop both discussions on a new set of policy measures and activities as well as on implementation of strengthen budgeting/contracting approach was well discussed.

Finalized in Ljubljana, on October 31, 2006

Milan Martin Cvikl

Annexes:

- **Presentation from Second Training the Training Wokshop, Skopje 13th-14th, October 2006 - Power-point separate files**