

# **Macedonia Health Sector Reform Project**

## **HEALTH INSURANCE FUND GOVERNANCE REFORM COMPONENT**

**FINAL R`EPORT  
(Draft Version 1.1)**

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## ABBREVIATIONS

CFAA	Country Financial Accountability Assessment
DfID	Department for International Development (UK)
DRG	Diagnosis Related Groups
EBF	Extra Budgetary Fund
EC	European Commission
GDP	Gross Domestic Product
HIF	Health Insurance Fund
HSRP	Health Sector Reform Project
IPSAS	International Public Sector Accounting Standards
MoF	Ministry of Finance
MoH	Ministry of Health
MoLSP	Ministry of Labour & Social Policy
NEB	National Employment Bureau
PDF	Pension & Disability Insurance Fund
PHC	Primary Health Care
PRO	Public Revenue Office
PSMAC	Public Sector Management Adjustment Credit
PSMAL	Public Sector Management Adjustment Loan
SAO	State Audit Office
SLI	State Labour Inspectorate
SPIL	Social Protection Implementation Loan
TA	Technical Assistance
ToRs	Terms of Reference
TSA	Treasury Single Account

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## PREFACE

This report presents final recommendations to the Government of Macedonia for strengthening Health Insurance Fund governance, designed to assist the Ministry of Health (MoH) and the Health Insurance Fund (HIF) in the preparation of the new Health Sector Reform Project (HSRP), to be jointly funded by the World Bank and the Government .

This is the first version of the report, which will be circulated to all key stakeholders and interested parties for review and comment. Ultimately, this report has been prepared to assist the HIF and the MoH to define their priorities for support under the HSRP and start planning for future technical assistance. Therefore, your feedback would be greatly appreciated, and may be provided in one of the following ways:

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All comments will be carefully reviewed and, where appropriate, incorporated into the final version of the report.

I would like to thank staff in the HIF, MoH and the PPU for their assistance and enthusiasm during the preparation of this report. I wish Macedonia the best of luck with its health reform agenda.

Katherine Burchfield

8 March 2004

# 1. INTRODUCTION

## 1.1 Background

Recognising the need to address some of the existing inefficiencies in and improve the performance of the Macedonian health system, the Government of Macedonia has commissioned the preparation of a new Health Sector Reform Project (HSRP), which will be undertaken with the support of the World Bank. The Project is intended to support a range of activities that will strengthen various aspects of the health sector, including strengthening of the health insurance system and the operations of the Health Insurance Fund (HIF).

Over the period from October 2003 to February 2004, an analysis of the governance structures and operations of the HIF has been undertaken, identifying opportunities for strengthening current arrangements.

This report presents the final recommendations for improving Health Insurance Fund governance and organisational capacity in Macedonia, which can be used by the Ministry of Health (MoH) and the HIF to plan future activities under the new Project. It should be emphasised that the aim of this assignment was not to design final solutions, but rather to advise on priority areas and further assistance that should be supported under the Project.

## 1.2 Objectives

Bearing in mind the overall objective to strengthen the governance and institutional capacity of the HIF, the assignment has focused on five specific aspects of HIF operations, as defined in the Terms of Reference (ToRs) for this work:

1. Financial Management;
1. Effective Purchasing;
2. Revenue Collection;
3. Resource Allocation; and
4. Audit and Oversight.

Consideration was also given to broader issues that affect the effectiveness of the HIF in performing its core function, to operate the compulsory health insurance scheme.

## 1.3 Approach

A review of the current situation in each of the five areas listed above was conducted, the results of which are detailed in the Inception Report (see Attachment 1) and were presented to the Ministry of Health (MoH) and the Health Insurance Fund (HIF) in November 2003.

The review was used to identify key weaknesses and opportunities for improvement. A set of possible options for strengthening current arrangements was provided in the Mid Term Report (see Attachment 2). A workshop was held at the end of January 2004 with representatives from all key stakeholders to present and discuss these options. Feedback received during and following this workshop was taken into account when formulating the recommendations contained in this report, which are the consultant's own.

## 1.4 Structure of the Report

The report concentrates on practical solutions and the requirements for implementing them. Covering each of the five areas identified above, the report provides:

1. A description and rationale for the proposals for strengthening arrangements;
2. An implementation plan for each proposal, linked to the planned duration of the HSRP;
3. Draft ToRs and timeframe for further technical assistance;
4. A brief analysis of the costs and benefits of the proposed changes; and
5. Assessment of changes to the legislative and regulatory framework to support the proposals, where applicable.

Section 2 provides a brief overview of the current environment revisiting the key weaknesses that the recommendations aim to address and highlighting other factors which have influenced the recommendations. The recommendations themselves are provided in Section 3, supplemented by implementation plans and ToRs for future assistance in Appendices 1-7. It is important to recognise that these ToRs are indicative only, and will need to be refined once the future Project structure and working arrangements are clear, and reports from other consultants working in this preparatory phase, as well as the support currently being provided through the Public Sector Management Adjustment Loan (funded by the Dutch Trust Fund) have been finalised.

Finally, Section 4 draws conclusions about priorities for Macedonia with respect to improving the governance and institutional effectiveness of the HIF, and commenting on the integration of these recommendations into the structure of the HSRP.

## **2. CURRENT ENVIRONMENT**

### **2.1 Review of Existing Weaknesses**

Macedonia spends a relatively high percentage of GDP on health care as compared with other countries at the same stage of economic development. However, there are a number of inherent inefficiencies in current financing and resource allocation methods, which provide perverse incentives to health care providers in the form of low productivity, excessive referrals and overproduction at the secondary and tertiary care levels. Further, until recently, the HIF has showed little interest in how or where insurees' and Government money was being spent, with finances regularly being misappropriated. As a result, there has been considerable waste and poor value for money in the health sector.

The recent introduction of new methods of paying health care providers, and the development of a contracting mechanism, will go some way towards addressing the inefficiencies (both technical and allocative) that were inherent in the previous method. However, further refinements are required to ensure that the providers have the right incentives, and efficiency and quality gains can be achieved.

There are a number of fundamental weaknesses in current HIF operations, which are well recognised, and which the new management team is keen to address. This should not detract from the progress that the HIF has made over the last two years. The HIF is a relatively new organisation, which has had to build a capacity to manage its health insurance operations, with no prior experience in the field. Nevertheless, there are some fundamental changes that do need to be made if the HIF is going to improve its performance, relating particularly to governance. Some of the main weaknesses that need to be addressed through the HSRP include:

- q Poor financial management practices;
- q Weakness in provider payment mechanisms and contracting;
- q Limited capacity in purchasing health services;
- q Insufficient use of services standards and evidence based medicine;
- q Weaknesses in revenue collection & inefficient administration of health insurance entitlements;
- q Under-funding of Government health sector obligations;
- q Flawed procurement practices within HIF;
- q Insufficient patient access to cost-effective drugs and medical supplies;
- q Inadequate management information systems;
- q Limited managerial capacity within the HIF;
- q An inadequate oversight framework for the HIF;
- q Unclear roles and responsibilities of the MoH and the HIF; and
- q Absence of overarching health sector strategy & weak capacity of the MoH.

In addition, the benefits package for compulsory health insurance, as it is currently implemented, is too broad, and represents an imbalance between affordability and social expectations. Further, the current number of staff (both clinical and non-clinical) employed in public sector health facilities is excessive. There is evidence of considerable under-utilisation of staff in certain areas and large inefficiencies in the delivery network. As the HIF is currently required to pay for all salaries of employees, the excessive workforce represents a barrier to improving efficiency of care and obtaining greater value for money. This is also contrary to the move towards output-based and capitation-based funding models for hospitals and public primary health care providers respectively, which should see the HIF move away from payment of providers on the basis of inputs, including salaries.

## 2.2 Governance

Governance has been identified by the United Nations and others as one of the key factors in country development and growth. There are many definitions of governance in use, and the purpose of this report is not to facilitate an academic discussion on this point, but rather to identify what is meant by improving the governance of the HIF and how this can be achieved.

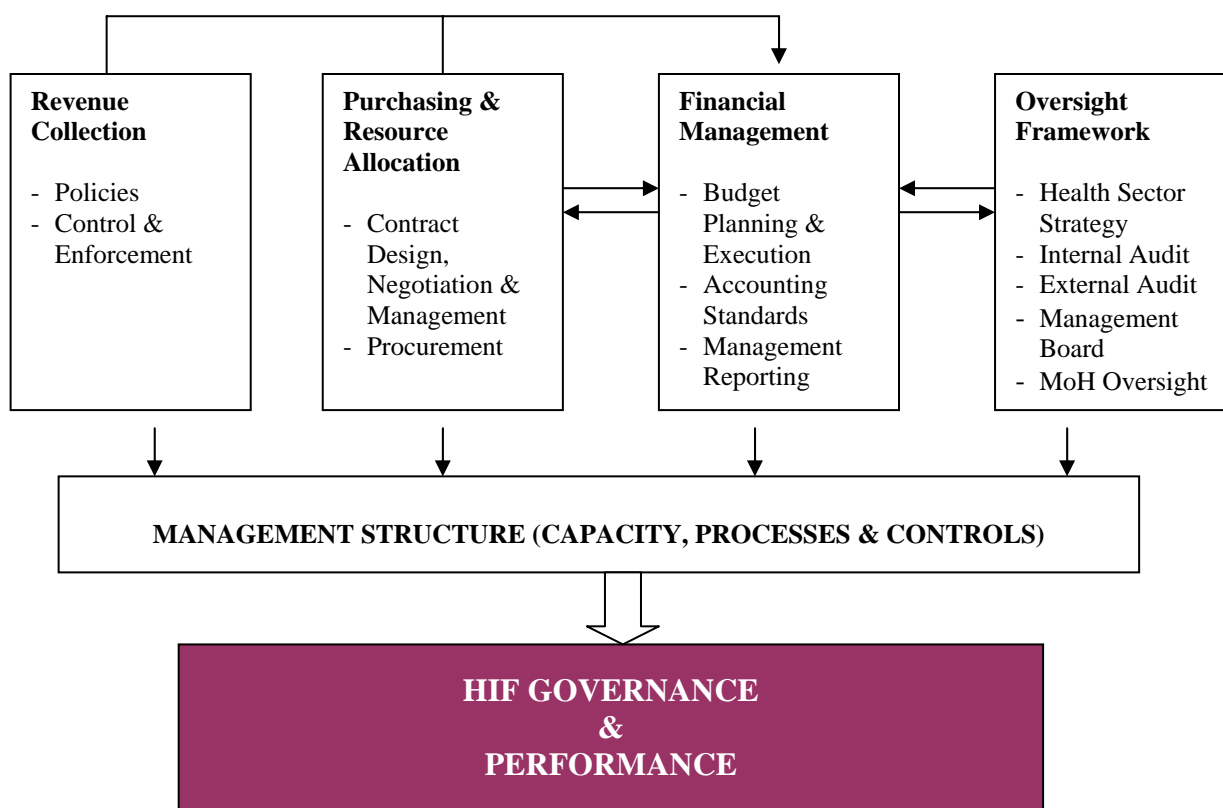
Essentially, governance in this context is referring to the process by which the HIF makes its decisions, who is involved in this process and how it is made accountable. Some of the fundamental principles of good governance, as outlined by the United Nations, include:

- q Participation;
- q Consensus-orientation;
- q Strategic vision;
- q Responsiveness;
- q Effectiveness & Efficiency;
- q Accountability;
- q Transparency; and
- q Fairness.

Good governance is closely linked to the effective performance of an organisation, and this is essentially what is the issue with the HIF. There is a need to improve the effectiveness of HIF operations and its accountability for efficient expenditure of public funds, and improving governance is a key part of this. The key areas that were addressed as part of this assignment

impact on different aspects of the governance of the HIF and are themselves inter-linked, as illustrated in Figure 1 overleaf.

**Figure 1: Influences on HIF Governance**



These areas need to be strengthened in order to improve HIF governance and performance.

## 2.3 Key influences

The recommendations for improving HIF governance in Macedonia that are documented in this report have been shaped by various factors, including the general environment in which the proposed HSRP will take place. In particular, they have been influenced by:

- Government and stakeholder priorities for reform, notably those highlighted by the MoH and HIF;
- Complementary activities that are being supported under the parallel Public Sector Management Adjustment Loan (PSMAL) and work being planned under other project components (particularly the hospital management, pharmaceutical and information systems components);
- Experiences of the stakeholders with previous health reform projects in Macedonia;
- The approximate budget available to support Health Insurance Fund Governance activities (budget constraints), as defined by the World Bank and the GoM; and
- The highly politicised nature of the civil service in Macedonia, which influences the independence and management capacity of the HIF, MoH and the health care institutions (affecting stability and priorities).

On the whole, there is a need to be realistic in what should be achieved and prioritised through this project over the next three years, building on developments to date and concentrating on strengthening the foundations for effective health insurance reform.

### 2.3.1 Priorities for Reform

The Government of Macedonia (GoM) has prioritised reform of the HIF, with particular emphasis on governance issues, and HIF is keen to improve the effectiveness of its operations. The main priorities appear to be improvements in financial management and information systems, and effective implementation of the new hospital contracts. The HIF also prioritises capacity building of its staff and overall human resource development. As the recommendations in this report will indicate, these priorities are well directed, although there are other areas which need attention if the governance and institutional capacity of the HIF is to be improved.

Meanwhile, strengthening the MoH, although equally important in developing a well-functioning health system (including health insurance), does not seem to have been given the same priority. This is not unusual in transition countries, where the purchasing function is separated from the MoH and supported by a newly formed Extra-Budgetary Fund, such as the HIF, and the MoH is left with insufficient resources and weak political power. There are, of course, political (and financial) reasons why the MoH remains in a weak position, but they need to be overcome if the objective of strengthening the health system is to be achieved. A stronger MoH will ultimately support efficiency savings in the health sector, through holding the HIF accountable for its actions, championing a quality improvement agenda and developing more effective strategies for delivering health care in a more efficient and cost-effective way, amongst other things.

From the perspective of the consultant, the priorities for improving HIF Governance that should be addressed through the Project are:

1. Strengthening the HIF purchasing function (including refining the design and implementation of the provider contracts);
2. Improving financial management in the HIF (including process re-engineering, staff training and information systems);
3. Developing management capacity in the HIF (including systems of control, and internal audit); and
4. Building the capacity of the MoH.

Of course, other areas do need to be addressed if the governance and institutional capacity of the HIF is to be improved, such as revenue collection control and enforcement; external audit; procurement; and strengthening of the Management Board, not to mention work in parallel areas such as strengthening the management and autonomy of health care providers.

However, in the consultant's opinion, the four areas listed above are those where activities are most likely to generate sound and sustainable improvements and which should be prioritised for inclusion in the project.

### 2.3.2 Complementary Activities

As noted in previous reports, in addition to the various project components being consistent and reinforcing, the work planned under the HSRP needs to integrate with other support being provided in the health sector. In particular, activities planned under the Public Sector Management Adjustment Loan (PSMAL) need to be considered, to avoid overlap, and ensure that the two projects are mutually reinforcing. In particular, this affects activities related to revenue control, contracting, procurement and the audit framework.

There is also likely to be some overlap with the Public Administration Reform Project being supported by the UK Department for International Development (DfID), with respect to strengthening the Ministry of Health (MoH). Activities in this area will need to be coordinated.

Some of the recommendations for strengthening HIF governance will not be viable (or will be less effective) unless parallel work is being undertaken by other project components. In particular, the importance of developments in the following areas needs to be reinforced:

- Strengthening hospital management & autonomy
- Pharmaceutical reform
- Primary Health Care reform
- Upgrade of health information systems
- Health Technology Assessment
- Quality Improvement

Priority developments in these areas, from the perspective of strengthening the HIF, are discussed further in Section 3.7.

### 2.3.3 Technical Assistance & Budget

The view expressed by several stakeholders that the majority of funding available to support this project should go towards hard investments, notably medical equipment and information systems, is concerning. While recognising that the health sector does need significant investment in these areas, and that there is some scepticism about the usefulness of consultants in the health sector, based on previous experience (as well as perhaps an attitude of independence), provision of equipment alone will not be sufficient to achieve the objectives of the project. There are many examples in other countries of projects which place a strong emphasis on hard investments, only to find that the equipment is not used effectively, or not used at all, because the requisite training, processes or policies are not in place.

Such examples can even be found in Macedonia, such as computer equipment for the HIF that has remained unused for long periods, and medical equipment lying idle in health facilities because the skills do not exist to use it. Similarly, training is unlikely to be beneficial unless it is accompanied by institutional change, as can be seen from efforts under the previous project to training primary health care doctors in family medicine. While the doctors themselves benefited from the training, they were unable to apply it once returning to their work places.

The project as a whole must have a strong capacity building focus and implementation, otherwise there is a risk that the new policies, processes and systems that are necessary in order to improve the functioning of the health system will not be sustainable. This requires a package of training, skills and knowledge transfer (through use of consultants), and equipment which will support institutional change.

The inputs must be balanced with the proposed budget that is available to support HIF governance activities, which is limited, and an awareness that the GoM is borrowing funds to support these activities and as such it is vital that they are well directed and managed. At present, the majority is allocated to upgrading of Management Information Systems (MIS), which is the expressed priority of most stakeholders. However, findings from the HIF governance component suggest that simply upgrading MIS, although a fundamental part of improving operations, will not be sufficient to make much progress in improving the governance and effectiveness of the HIF.

Despite the achievements of the HIF in the last few years in the area of provider payments and contracting, for example, and the HIF's confidence that they need assistance, it is the consultant's opinion that the HIF is underestimating what is required to implement these systems effectively. The approach to implementation is vital, much more so than the design. Countries across the region and in developed countries elsewhere recognise this, and are seeking assistance from experts. If the HIF genuinely wants to do this right, senior management should be supportive of further assistance.

Therefore, while this budget and stakeholder preferences have been taken into account, this report focuses on recommending to the Government the priority activities that need to be undertaken, recognising that budget constraints and the preferred emphasis on hard investment, but ultimately striking a better balance between consulting services, training and equipment in the design of further assistance to the HIF under the HSRP.

The Health Sector Reform Project must provide the valuable opportunity of learning from other countries experiences, and avoiding some of the mistakes that have been made in the past, as well as utilising technical expertise that is not available in Macedonia to assist with re-engineering processes and systems. Recommendations have concentrated on providing sustainable programs of support to the HIF and the MoH.

### **2.3.4 Civil Service Reform**

One of barriers to progressing health sector reform (and public sector reform in general) in most transition countries is the politicisation of the civil service and the lack of attractiveness of public sector jobs, a legacy from the former command economy. This is very much the case in Macedonia. Effective health sector reform is constrained by the current obstacles to strengthening human resources and management structures, including:

- filling senior positions on political grounds; and
- a high staff turnover, related to politicisation of staffing structures.

These issues have affected both the MoH and the HIF in the past. Capacity building exercises for the MoH and the HIF have little chance of being effective unless some steps are put in place to address these broader issues of civil service reform, which is necessary for introducing stability in, and strengthening, health sector management. Similarly, efforts to strengthen hospital management autonomy will be undermined unless Hospital Director positions are depoliticised.

Civil service reform issues are not within the scope of this assignment. However, steps need to be taken to ensure that:

- Civil service laws clearly regulate the roles and responsibilities of civil servants and the professional standards that they are expected to comply with;

- Remuneration schemes are transparent and promote performance;
- Administration processes are strong and support control of staffing levels and pay costs, independent from politics; and
- The relevant bodies have sufficient capacity to support effective civil service policymaking, regulations and monitoring of personnel management.

Some countries in Europe have established a 'senior management service' for personnel in higher non-political positions. The GoM should review current arrangements in these areas and identify improvements that could be made to the management of the civil service to support health and other public sector reforms that are underway.

## 3. RECOMMENDATIONS

### 3.1 Overview

The final recommendations made here reflect the judgement of the consultant about the interventions that could best improve HIF governance and institutional effectiveness in the current environment. As noted earlier, implicit in the recommendations is a process of prioritisation. In order to be realistic, the focus must be on changes that should be prioritised within the proposed project timeframe (from 2004-2007), and the overall financial envelope.

Sections 3.2 to 3.6 outline recommendations for each of the five areas defined as the scope for this assignment. Despite this categorisation, the areas are interdependent and mutually reinforcing (as discussed earlier in Section 2). For example, introducing internal audit and new provider contracts will not be effective without strengthened financial management

The recommendations fall into two categories –activities to be directly supported under the HSRP, and other tangential activities that the GoM needs to consider. Where activities are proposed for inclusion in the project, an implementation plan, proposal for technical assistance, simple analysis of the costs and benefits and comments on the impact of the proposal on the legislative and regulatory framework are provided. Some performance indicators against which to measure progress are also recommended.

Implicit in these recommendations is a belief that the fundamental structure of the health financing system in Macedonia, and the role of the HIF as a single purchaser in this framework, is sound. There has been some debate about the need to consider a radical reform of the health financing system in Macedonia – for example, the introduction of competing health insurers providing the compulsory benefits package or substantial involvement for private health insurance, with the government covering only essential health care or catastrophic care.

In the opinion of the consultant, the current organisation of the health financing system is the most likely to deliver effective health care without compromising equity or access. There are a number of weaknesses in the structure, but there are ways to address them without radical reform. Large-scale reform is often a politically attractive option when faced with a system that is not performing effectively. However, a major change in the structure of the health system will not help to make it any easier to address the essentially difficult problems faced by the health sector. Fundamentally, performance depends on implementation, rather than design. Macedonia needs to build its managerial capacity in the health sector, and attention needs to be paid to the details of implementation (rather than legislative and design issues).

## 3.2 Financial Management

Considerable progress has been made in recent years in strengthening public sector financial management in Macedonia, with the support of the Public Sector Management Adjustment Credit (PSMAC). Strengthening of this framework has had very little impact on the HIF to date, however, as the HIF is an Extra Budgetary Fund (EBF) operating outside Treasury control.

The financial management practices of the HIF are recognised as being weak. As recently as 2001, the State Audit Office found the HIF's annual financial statements to be inaccurate and misleading, and the Government considers the HIF to be one of the biggest fiduciary risks to its operations. Insufficient information systems, limited staff capacity in modern financial management, poorly designed budget planning and execution processes have all contributed to weak financial management practices, and both revenue and expenditure control are of particular concern in the absence of appropriate processes. The complex (and redundant) invoicing system and practice of procuring pharmaceuticals and medical supplies on behalf of health care providers have further complicated the situation and made transparent reporting difficult.

Not only does poor financial management undermine the confidence of the Government and the public in the HIF, it also makes it very difficult for the HIF to use its resources and manage its business efficiently, and this has been reflected in the HIF's financial performance to date.

Considerable work is required to bring the financial management practices of the HIF in line with international standards. International practice in the area of public sector financial management varies considerably, with some countries moving to accrual budgeting and accounting (Australia, New Zealand and the United Kingdom), together with the reorganisation of resource management towards an outputs basis. However, these financial management standards are a long-term goal for the HIF, one which cannot be contemplated within the next three years. In any case, most European countries continue to use cash-based budgeting and accounting.

The emphasis on improving financial management in the HIF during the HSRP should be to initially align the HIF to the Macedonian public sector financial management framework, according to cash-based accounting principles, and then to move incrementally towards the adoption of applicable international practices. Activity-based costing, performance management and output-based budgeting are not immediate priorities, and the HIF should seek to evolve, with the general public sector framework, towards these more complex and advanced international trends. Another medium-term priority that needs to be considered is the devolution of budget management to the Branch offices and key departments in Central Office.

The objectives with respect to changes in financial management practices include:

- Increasing the transparency and accuracy of the HIF financial position;
- Establishing a stable financial position, including meeting legal requirements for reserve;<sup>1</sup>
- Effective control of the budget; and

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<sup>1</sup> Current legislation specifies that the HIF should have a reserve, but does not require a minimum limit. Consideration should be given to modifying the legislation to require a minimum reserve level (for example 5% of the budget).

- Technical efficiency of resource allocation.

There are a number of parallel developments that need to occur to support improvements in financial management. As a priority, the HIF needs to phase out the redundant invoicing system for health care providers, which is adding complexity to accounting and the management of liabilities (see Section 3.3.2). Secondly, the development of a sound health sector strategy or national plan, providing a policy framework as the basis for sound budget preparation, is fundamental to improvements in financial management and oversight (see Section 3.6.1), particularly if the Government wishes to pursue a Medium Term Expenditure Framework (MTEF) approach.

The following paragraphs describe the requirements for improving specific areas of financial management in detail, as well as providing recommendations for future technical assistance in this area.

### 3.2.1 Budget Process

The HIF needs to introduce improved processes for budget planning, execution and monitoring, which apply sound financial management principles and are consistent with MoF guidelines. In addition, changes need to be made to incorporate the recent move towards contracting with care providers.

The following steps should be considered.

#### Health Insurance Fund:

1. Review possible data sources to support budget preparation using currently available information systems, and modify data collection processes to improve data available to support budget planning;
2. Develop clear documentation on the budget planning process, covering the steps that need to be followed and clear responsibilities;
3. Establish processes to link provider contracts with the budget planning and preparation process, using previous hospital contracts to inform budget planning, and ensure that the contracts and associated budgets for providers reflect the planned HIF budget;
4. Improve the revenue forecast and resource allocation process and ensure that forecasts and targets are realistic through incorporating all key assumptions into the methodology;
5. In the absence of a strategy or national health plan, the MoH needs to ensure that there are clearly articulated health sector objectives and priorities and the HIF needs to incorporate these into its planning process;
6. Review financing of capital expenditure, develop a clear policy, and ensure the budget is linked to the investment plan prepared with the MoH, and where appropriate, translated into hospital contracts;
7. Introduce a process for monitoring the execution of provider budgets (planned versus actual) and associated performance indicators, and improve monitoring of overall budget performance, establishing clear processes for escalation and corrective actions;

8. Review management reporting requirements, and develop a stronger system of reporting which ensures that financial management information is made available on a timely and regular basis, enabling managers to assess progress towards and the likelihood of achieving desired outcomes, and identify measures to get back on course;
9. Introduce clear lines of responsibility and accountability for effective budget management with the HIF Central Office and branches, ensuring that at operational level, managers have the flexibility to take decisions within their areas of competence with an overall framework of rules and controls; and
10. Establish proper systems for contract management (also see Section 3.3), which effectively track commitments and deliveries and ensure that payments are priorities on the basis of due date and order of precedence (and avoid advance payments).

The establishment of internal controls, which are currently lacking in the HIF, and a well-functioning internal audit function (see Section 3.6.4) will support better expenditure control and overall improvements in financial management.

In addition, fragmented organisation structures with weak coordination across departments and poor communication channels are obstacles to effective budget management. These characteristics are currently found in the HIF, and need to be addressed (see Section 3.6.2). In particular, greater information exchange and cooperation is essential.

#### Ministry of Health:

1. Develop a national health strategy or plan to provide a policy framework against which to plan and monitor the HIF budget against the set objectives, or at minimum ensure that health sector objectives and priorities are clearly articulated (see Section 3.6.1 on strengthening the MoH);
2. Establish processes for greater involvement in the HIF budget planning process, particularly with regard to services planning, setting global budgets for different care types (primary health care, hospital care (inpatient, specialist outpatient), pharmaceuticals, diagnostic and so on) and defining budgets for the vertical health programs;
3. Establish processes for monitoring budget execution on a monthly basis according to broad expenditure categories as well as individual health care providers.

There is a fundamental link between improving financial management in the HIF and strengthening capacity in the MoH to plan and execute the health budget, and be able to make effective trade offs among ongoing programs, and appraise new policies and programs.

#### Ministry of Finance:

1. Ensure that guidelines related to the budget process are clearly defined, communicated and understood and check compliance with guidelines. There is little advantage in introducing sound rules and regulations to support financial management if there is no compliance; and
2. Ensure that the HIF receives the Fiscal Policy document and takes its contents into account during the planning process.

### 3.2.2 Accounting standards

A sound financial management system requires that a reliable accounting system is in place, which utilises appropriate accounting standards (International Public Sector Accounting Standards) and procedures, in line with MoF guidelines. This is likely to have the single biggest impact on financial management. Unless appropriate standards are in place, regardless of the data available and methodologies applied to budget planning and execution, the financial affairs of the HIF will remain distorted.

Therefore, priority improvements in financial management should focus on sound accounting, ensuring:

1. Accurate & complete monitoring of liabilities;
2. Transparent reporting of payments; and
3. Clearly defined and enforced accounting procedures.

Key areas that the HIF needs to address are the current practice of recording the liabilities of health care providers for procurements that are paid for by the HIF, and the reconciliation of provider invoices; and the accounting of expenditures on an accruals basis and revenues on a cash basis. The HIF can adopt an accruals-based accounting system for its own internal use, but it must report on a cash-basis and have special mechanisms in place for controlling cash flows.

The classification of expenditures and the Chart of Accounts may need modifying to better serve internal purposes. The system should comply with MoF guidelines but also facilitate effective budget management within the HIF, including policy formulation, effective allocation of resources, compliance with legislation and administration.

The current expenditure classification supports compliance budgeting (inputs and administrative units) and to some extent policy formulation and program management. However, it is not possible at present to track resource allocation and expenditure effectively across, for example, the vertical health programs.

It is not clear whether the HIF has the capacity to understand and implement the necessary changes on its own. At a minimum, the MoF needs to work closely with the HIF Accounting Department to ensure that the accounting guidelines are clearly understood and to assist with implementation. However, it is likely that additional support will be required to help establish systems that support internal requirements.

### 3.2.3 Training

The current level of knowledge and skills in modern financial management is low within the HIF. All financial management functions are performed at Central office, while the Branch offices have responsibility for regular accounting functions. Capacity in financial management needs to be strengthened in both the Central and Branch offices, with a view to developing a stronger role for Branch offices in budget management.

Training needs to be provided to core finance staff to support the changes in financial management on two different levels:

1. Basic training in specific areas (for example, training accountants in the branches to use the new accounting procedures); and
2. General training in financial management theory, or in computer skills.

Some of the topics that might be covered include:

- Budget planning
- Financial analysis
- Management reporting
- Resource management
- Performance management

However, precise training needs would need to be identified in parallel with the design and implementation of new budget and accounting processes.

Training may be delivered through a combination of tailored courses provided by local or international companies; internal courses; and workshops. However, in the longer term, training should be linked in with the broader public sector training program in financial management, and ideally tied to financial management institutions in the country, such as the Institute of Chartered Accountants, so that staff receive certification. If the MoF proposal for the development of a financial management training centre is progressed, then the formal training of HIF staff in financial management should be at least partially provided through this avenue.

### **3.2.4 Financial Management Information Systems**

The current information systems in the HIF do not support effective financial management. The need to upgrade financial management information systems (FMIS) has been recognised for some time, and was part of the information systems needs that were identified under the previous health reform project.

To contribute to overall financial control and operational efficiency and provide access to reliable and timely information, information systems need to be appropriately designed and integrated. A financial management information systems needs to be developed on the basis of a review of budgetary procedures, expenditure classification and the chart of accounts.

Therefore, the timing for developing an improved and integrated FMIS needs to be carefully considered, as there are potentially going to be significant changes in the current budgetary procedures, and potentially in expenditure classification and the chart of accounts. It makes little sense to develop information systems prior to process-re-engineering. However, if specific software is procured or developed in the interim, it will need to be sufficiently flexible to adapt to any impending changes.

A detailed audit of current information systems in the HIF is being performed under the *Information Systems Component* of the project preparation, so detailed comments on requirements are not provided here. However, some broad principles can be established for reference against current systems and development plans.

To support sound financial management, the HIF's information systems need to effectively support:

- Budget preparation & implementation (information to forecast revenue and expenditure including personnel, services, progress of investment projects, systems to record budgets, distribute budgets across programs and departments)

- Budget execution, accounting and financial reporting (ledger, data on revenues, liabilities, financial assets, commitments, production of necessary accounting and management reports)
- Payment administration (printing of cheques and payment orders)
- Debt accounting and forecasting
- Cash planning
- Management of payables and procurement
- Personnel and payroll management systems
- Program management
- Revenue accounting

The design will also need to take into account future MoF requirements when the HIF account moves to Treasury (refer to Section 3.2.5.4).

The core of the FMIS is the ledger for recording inflows and outflows and recording transactions. Designing the core system well, and ensuring proper exchange of information between core systems and other systems is fundamental. The ledger must be informed by payroll and systems on payables/receivables, and other management systems (for example, procurement and asset management). Ideally, the system should allow for reporting of transactions at a very detailed level, to support program management as well as budget requirements, while remaining cost-effective.

Given the current capacity of the IT Department in the HIF, software to support the above functions will need to be built for the HIF by a software company or procured 'off the shelf' and modified for HIF purposes. However, sound project management within HIF will be required if an integrated FMIS is to be achieved.

### **3.2.5 Other Issues**

#### **3.2.5.1 Debt Restructuring**

In recent years, health care facilities have built up considerable levels of debt, which are financed in part through deferring payments to suppliers, and in part through the HIF. Trying to place the blame for the accumulated debts is pointless and likely to be unfair. The HIF may argue that it is a result of poor management or excessive staffing of the health care providers; the providers may argue that they have been receiving insufficient funding, perhaps because the HIF is misusing resources. Both parties will argue that the Government, in the form of the MoF, has consistently failed to meet its own obligations to fund certain types of health services (vertical health programs, exclusions from copayments) and as a result health services are considerably under-funded.

This kind of blame shifting has little point. Looking forward, the HIF has established a new method of paying health care providers, a new contracting mechanism, and is making an effort to improve its governance and become an effective purchaser under new management. Initiatives are being introduced to strengthen the management of hospital facilities. However, the existence of accumulated hospital debts, in particular, means that neither the HIF nor the health care providers have a solid foundation for improving their management and the new contracts are unlikely to yield much benefit in this environment.

A strategy for restructuring or writing off the existing debts of health care institutions that are being contracted by the HIF needs to be considered. The most sensible approach would be for the budget deficits to be eliminated by a one-off government grant. However, the

Government needs to make it clear that this not a repeatable option in the future, and that future deficits will result in removal of management, scaling down of operations or other penalties. Otherwise, providers will have no clear incentive to avoid budget deficits, since they are confident that the Government will bail them out. This is difficult, in practice.

Other alternatives for debt renegotiation or debt restructuring may be considered. The Slovak Republic has recently approved a strategy for restructuring hospital debts, which may be a useful reference point for Macedonia. This issue has been around for some time, and has also been flagged by the team working on *Hospital Contracting and Modernisation* and the *Pharmaceutical Policy* expert. Recommendations for additional technical assistance in this area have been provided, although Macedonia should have the capacity to undertake this on its own.

A small Working Group, comprising HIF and MoH representations should be established to:

1. Estimate existing debt levels for each health care institution;
2. Develop a strategy for renegotiation/restructuring of debt; and
3. Promote the strategy to the Government.

Once implemented the Working Group should evaluate the impact of the strategy on the financial position and management practices of the hospitals concerned.

### **3.2.5.2 Performance Measurement**

Performance measurement is becoming increasingly important in a financial management framework within Europe. It requires clearly stated goals and objectives for the organisation as a whole and for specific activities and programs and places more emphasis on assessing outcomes. A performance measurement approach can contribute to organisational learning and strengthen managerial accountability. On the flipside, the imposition of norms, standards and targets can make managers focus too closely on achieving the performance targets (as has recently been a concern in the UK health system, for example). A strong performance focus can also lead to misrepresentation of information, strategic and counter-productive management techniques, and tunnel vision. Therefore, a performance measurement framework needs to be handled carefully.

The HIF has defined performance indicators for specific programs (notably for primary health care and hospital contracts, which are actually specified in various by-laws (see Section 3.3.1). However, no such indicators or measures have been established for the HIF, to monitor the effectiveness of the organisation as a whole.

This is not a priority for the HIF until sound budget planning and execution procedures are in place, along with a sound set of internal management controls. Only once this foundation is in place can performance measurement contribute to better financial management.

### **3.2.5.3 Activity-based costing**

Activity-based costing requires:

- Identifying activities within the organisational unit
- Assigning resources to the activities
- Identifying outputs of the activities

- Assigning activity costs to outputs

This is effectively the approach that the HIF needs to apply within hospitals in order to set appropriate payment rates for hospital services ‘activities’. However, only a few countries are implementing cost measurement in public agencies on a large scale. It can be complex and time-consuming. Therefore, it is not a priority for the HIF to attempt activity-based costing in the medium-term for its own activities. However, it does need to improve costing of programs (through proper expenditure tracking) and hospital services (through an all-product hospital costing study) in the immediate future.

#### **3.2.5.4 Role of the Ministry of Finance**

The MoF, as the custodian and manager of all public money, is strengthening its role in Macedonia. As an Extra Budgetary Fund (EBF) with its own revenue stream, the HIF is currently outside the public sector management financial framework, but it is a primary vehicle for achieving the Government’s health sector objectives. From the perspective of good public expenditure management, EBFs like the HIF pose problems for the effective allocation of resources and present opportunities for fraudulent behaviour where transactions are not subject to the same level of financial discipline and scrutiny as line ministries.

Despite its EBF status, then, the HIF must remain accountable to Government. At present, the MoH has responsibility for its oversight and ensuring it contributes to health sector objectives. The problem is that the MoH is failing to provide this oversight, and is unlikely to have the capacity to do so effectively in the near future. It is understandable, then that the MoF would seek to tighten its control.

Initiatives under PSMAL are supporting incorporation of the HIF accounts into the Single Treasury Account (STA), both to support the MoF’s cash management objectives and to provide a greater level of scrutiny of HIF financial affairs, and eventually incorporation into the budget.

The HIF maintains that it should remain separate from the budget so that it can operate its business effectively and ensure that it is responsive to insurees. The MoF and Treasury can also be subject to corruption and poor management, and unless these organisations are operating completely transparently, moving the HIF accounts to the STA will only transfer the problem.

Good practice in fiscal transparency requires that the government sector is clearly distinguished from the rest of the economy, and this should include EBFs. The OECD maintains that the compulsory nature of social security schemes and their contribution to social and economic objectives require that their funds are managed through the budget, except where management involves employers and trade unions. In Macedonia, although employers are in principle represented on the Management Board, in practice there is minimal influence on management (see Section 3.6.3), and it is certainly not at the level envisaged by the OECD, such as in Germany.

The MoF needs to strike a balance between having sufficient power to ensure Government objectives in the health sector are met, and minimising interference to allow the HIF sufficient flexibility to manage operations and meet the needs of insurees. To justify maintaining its independence from the MoF, however, the HIF would have to improve its operations. For example, it needs to be able to measure and monitor performance, have sound financial management practices in place, have a strong ethics and accountability framework, and support competitive recruitment, none of which are in place at present.

In any case, with the current PSMAL conditionalities, it is inevitable that the HIF will need to be brought into the STA.<sup>2</sup> However, this will require deeper consideration of the impact on the HIF, and the best approach for achieving the move (for example, the Central Bank does not have enough flexibility to support current HIF financial operations at branch level). It will also require considerable time commitment from the HIF Finance Department, which needs to prioritise improvements in financial management. In the opinion of the consultant, the move of the HIF accounts to the STA should not be an immediate priority in 2004.

### 3.2.6 Summary of Recommendations

The principal recommendation in the area of financial management is for the implementation of a comprehensive Financial Management Improvement Program within the HIF, covering:

- Design and Implementation of Improved Budget Planning and Execution Processes
- Introduction of accounting standards in line with MoF standards, moving towards the International Public Sector Accounting Standards (cash-based)
- Training in Modern Financial Management Techniques
- Upgrade of Financial Management Information Systems

The implementation plan for the Financial Management Improvement Program that should be supported by the Health Sector Reform Project spans a three-year period (2005 – 8). The initial focus will be on improving the budget preparation and accounting procedures in line with the recommendations from the Ernst & Young Audit Report that should be finalised in March 2004 and according to the principles contained in this report. The implementation of reporting procedures aligned to recognised accounting standards will be an iterative process over the three-year period, accompanied by a widespread program of awareness building and staff training throughout the HIF. The training will include a module examining the cost profiles of the services being funded by the HIF and recommendations as to how cost-based financial management control procedures can be introduced into the work of the Fund. In parallel to all the above initiatives, consideration will be given to the information and data flows required to support the improved processes and procedures and a strategic plan for the development of the HIF's Financial Management Information Systems (FMIS) agreed and implemented.

#### Implementation

The first priority is that the HIF establishes commitment to these changes and introduces a framework for achieving them. Achieving improvements in HIF financial management, will require that operational staff understand and support the change, and that the process is championed and supported by the MoF. Middle management needs to participate and be aware of the changes, with staff viewing the changes as a strengthening exercise of long-term benefit to the organisation and its staff. The HIF should:

1. Designate a responsible manager in charge of the financial management improvement program, who will in turn establish working groups as necessary to support the activities;

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<sup>2</sup>A move to the European Union would also require tighter control of expenditure and borrowing of EBFs, including the HIF, which may require bringing the HIF on-budget.

2. Ensure that changes are communicated across the organisation through seminars and other mediums; and
3. Carefully plan phasing out and transition arrangements.

A time-bound implementation plan is shown in Appendix 1.

#### Technical Assistance

Technical assistance will be required to support the Financial Management Improvement Program, comprising international and local consultants and a training package. It is anticipated that support for the development of an upgraded Financial Management Information system, including procurement of software, will be provided separately as part of the activities to upgrade the HIF's Management Information Systems.

Terms of Reference for the consulting services to assist the HIF to deliver the program are provided in Appendix 2. The technical assistance has been designed as a package to be provided by an individual or firm. If necessary, it could be broken up into individual assignments covering budget planning and execution, accounting, training and support for the design of the FMIS, but this is not recommended.

#### Analysis of Costs and Benefits

A budget of US\$ 319,000.00 should be allocated to the Program from the HSRP to cover the cost of necessary consulting services and training. There will also be an opportunity cost to the HIF, in terms of resources that need to be dedicated to managing and supporting the change program. However, it is expected that this work can be absorbed within the HIF's existing staff capacity.

Benefits are expected to include greater efficiency through improved management of resources, and a reduction in fraud. This is difficult to quantify.

#### Legislative Changes

It is not expected that the Financial Management Improvement Program will require any changes to the supporting legislation or the regulatory framework, unless there is a need to tighten accounting and budget preparation regulations for the HIF.

#### Indicators

Examples of indicators that might be used to measure progress of the HIF in improving financial management over the course of the project include the following:

- Is there significant variance between planned and actual expenditures across different categories?
- Are revenue forecasts realistic?
- Is there a reduction in HIF arrears?
- Does the HIF budget support health sector policy objectives?
- Are new accounting standards in place and procedures clearly documented?

### 3.3 Purchasing

The HIF has responsibility for ensuring that the package of health care services covered by Macedonia's compulsory health insurance is provided to the beneficiaries of the scheme (including hospital care, primary health care, positive list drugs, prostheses, rehabilitative care and so on). Purchasing health services is therefore a core function of the HIF. It needs to be able to perform this function efficiently and transparently, achieving value for money on behalf of those who contribute.

Until recently, the HIF was effectively funding health care providers rather than purchasing health services, paying all public providers on the basis of their input costs, with no regard for the efficiency or quality of production, or whether the services were actually necessary.

Considerable progress has been made in this area, with the introduction of global budgets, development of a new payment models for primary health care and hospital services (based on capitation and hospital outputs), and introduction of a contracting mechanism, whereby annual contracts are negotiated and signed between the HIF and care providers for the provision of a certain level of services for a given price.

These are important steps, moving the HIF towards a potentially more efficient and equitable purchasing model. However, the objectives of the new approach - to generate greater efficiencies in the provision of care, to encourage quality improvement and to provide greater transparency and equality in the payment of health care providers – will only be achieved if it is implemented effectively. To date, the biggest achievements have been in the design, while implementation has been less successful.

In terms of implementation, within a model of purchaser-provider separation, as exists in Macedonia, effective purchasing requires:

1. Ability to establish relationships with providers based on trust;
2. Willingness to move contracts between providers;
3. Ability to make decisions in a way that commands the confidence of the public and health care professionals;
4. Cost-effective information systems, which support good information on volume, cost and quality of services;
5. Technical skills in planning, implementing and evaluating contracts; and
6. Ability to encourage and reward clinical practice improvements.

The HIF meets few, if any, of these criteria. This is not entirely its fault, considering that the changes have been introduced in a difficult environment where the HIF has little flexibility in key areas (for example, the Government still requires that it cover all salaries of employees in public health facilities). In any case, very few purchasing organisations in countries with similar funding models (such as Slovenia, Slovakia, Germany, UK and New Zealand) do meet the criteria. Purchasing of health services is a difficult task, and in general, the experience of separating the purchaser and provider function, in order to encourage a more 'business-like' approach to funding health services and improve efficiency and quality, has been somewhat disappointing.

In Macedonia, the challenge of developing an effective purchasing function is even greater, as the capacity to undertake this function has not been developed and prerequisites for success, such as sufficient provider autonomy and management capacity, are not in place.

It is a complex area to address. Nevertheless, there are some essential steps that the HIF needs to take to improve its performance and move towards a more effective purchasing role. In particular, the HIF needs to:

1. Refine the design of existing payment models and contracts;
2. Improve implementation processes; and
3. Build its capacity as an effective purchaser.

This section addresses requirements in these three areas. In addition, procurement processes are considered as a separate issue that needs attention.

To achieve these tasks, the HIF will need to upgrade its information systems so that they effectively support a purchasing function; build staff capacity in key areas, such as contract design and negotiation, performance monitoring and benchmarking; and possibly rework the organisational structure. An increase in staff numbers will not be required, at least in the early stages of these developments, and it is anticipated that improvements in efficiency and automation of processes should free up resources to support purchasing and contracting in the future.

There will be an opportunity to further refine the design and implementation of provider contracts in 2005, building on the developments and experience in 2004.

### ***Roles & Responsibilities in the Health Sector***

One important issue that needs to be addressed in Macedonia is the clarification of the respective roles of the MoH and the HIF in the health sector, particularly in areas related to purchasing.

Several individuals have expressed their confusion about the role of the HIF to the consultant. For example, one view is that the HIF should only be responsible for the mechanics of payment, and that policies and planning should be entirely the remit of the MoH. Others feel that the role of the MoH should be marginal and that the HIF should lead on policies related to health financing and purchasing, such as pricing and planning of services. This confusion is largely due to the weakness of the MoH in policy formulation and stewardship of the health sector, as discussed in section 3.6.

From the perspective of good health financing principles, having the HIF act merely as an administrator of the compulsory health insurance scheme is not an effective arrangement. The HIF should be responsible for monitoring the population's need for services that are covered under the compulsory scheme, procuring a range of outputs, making best use of its resources to improve health and prevent illness, and to monitor the performance of providers. At a minimum, its role includes:

- Making priority decisions according to need, which are used to allocate resources to particular services and providers; and
- Specifying, negotiating and monitoring contracts with providers to facilitate these resource allocation decisions in a way that maximises value for money and equity for health insurance beneficiaries.

If this more extensive role is to be assumed by the HIF it must have the flexibility to determine volumes and prices. However, the MoH still needs to be involved in this process in order to perform effective oversight.

In any case, the MoH and HIF should make an effort to:

1. Clarify the respective responsibilities of the two organisations in practice with respect to planning, financing and purchasing health care; and
2. Communicate these responsibilities to stakeholders, particularly health care providers.

### **3.3.1 Refinement of Existing Payment Models & Contracts**

This section addresses issues around improving the design of provider payment models and contracts for primary health care, hospitals and pharmacies. Dental care has not been considered specifically, although the HIF is aware that it will need to design a new payment model following the planned privatisation.

In general, the HIF should follow an approach of incremental change in the design of payment models and contracts, accompanied by efforts to evaluate progress and the impact of these changes.

#### **3.3.1.1 Development of a comprehensive health financing strategy**

One of the activities that could benefit the HIF in its ongoing refinement of payment models and contracts for different care types is the development of a health financing strategy. This is distinct from, but potentially a part of, a national health strategy and mid term financial planning/budgeting model, and would specifically provide a framework for the evolution of the HIF's purchasing framework in the long-term.

The strategy would set out principles of future financing and purchasing activities, including:

- A comprehensive classification and definition of major care types that the HIF must purchase (primary health care, specialist outpatient care (consultations, diagnostics), inpatient hospital care (acute, non-acute), rehabilitation, home care, nursing home care, intensive care, emergency care, pharmaceuticals and so on.
- Clear principles for reimbursing providers/purchasing services in these care types – for example, what aspects of long-term care should be funded through the HIF and according to what classification and payment model;
- Requirements for meeting these principles – information systems, staff development, increased resources and so on.

Amongst other things, it would provide a framework for the refinement of the PHC and hospital contracting process.

#### **3.3.1.2 Primary Health Care**

The HIF needs to address some of the limitations in the design of the payment model and contracts for primary health care.

Firstly, as the HIF is aware, consistent payment principles need to be introduced for public and private providers of primary health care. To date, the HIF has introduced contracts, with payment based on a mixed capitation model, for private providers. Fairness, efficiency and equity principles require that the HIF pays and contracts with all primary health care providers on the same basis. The current differential payment models are providing a set of

perverse incentives for primary health care providers undermining efficiency gains, patient registers and quality of care.

Introducing a mixed capitation model for public PHC providers will not be an easy task, particularly as this function is performed in 'health homes' which also provide specialist care, and consideration needs to be given to funding of infrastructure and other additional costs that these organisations face in the provision of primary health care. Further, serious progress will not be made until there is a review of the needs for primary health care providers and staff, and the network of public provision is rationalised accordingly, of the HIF is devolved of its responsibility for covering the salaries of all employees in these institutions, allowing payment on a mixed capitation basis.

In parallel, the HIF needs to refine the design of the payment model and contracts to:

1. provide incentives for private primary health care doctors to establish group practice;
2. refine performance indicators so that they are more descriptive and focused on quality, including in areas such as preventative health programs and prescribing (which currently focus only on volumes);
3. remove incentives to provide ampular therapy, for which a copayment is currently required from patients; and
4. define clear standards of care for primary health care services, including general standards in areas such as cleanliness, and specific guidelines on performing the preventative health program, which has traditionally not been the role of GPs.

The main focus should be on introducing an equal basis for funding private and public providers of primary health, and on addressing some of the implementation issues which are discussed in Section 3.3.2. In the area of service standards, the HIF should coordinate with the MoH and developments in the area of quality improvement, supported by the Project.

### **3.3.1.3 Hospitals**

Contracts for hospital care were only introduced at the end of 2003, on the basis of the new by-law for contracting and paying specialist-consultative and hospital care, and they have only been completed for specialist hospitals and other hospitals with a simple services structure, covering only a few specialties. During 2004, contracts will be introduced for all hospitals in Macedonia, and all hospitals should be issued contracts for the full year in 2005.

As this is a reasonably new development, there is not much basis on which to judge the existing contracts. However, there are already some areas of concern from the design perspective:

1. Differential payment rates for services have been established for different hospitals, which is inconsistent with the essential principle of "equal payment for equal work". The main reason for these differential rates is to cope with facilities that have excess staff and which require a transition phase in which to downsize their capacity. However, it would have been more transparent and equitable to define standard prices and factor in a clearly defined transition payment, and a tertiary payment to reflect organisations that are using more sophisticated methods of care.
  - In 2005, the HIF should aim to establish standard prices for all hospitals based on actual costs of care, with supplementary payments for complexity and transition.

2. The performance indicators which are established in the contracts (and by-law) as the basis for payment of the performance-based component are quite complex for hospitals to understand and produce, and are difficult for the HIF to interpret properly, given that none of these organisations have worked in a performance monitoring framework previously and hospital information systems do not currently support the data requirements.
  - In 2005, the HIF should consider simplifying the performance indicators to a key few that hospitals can report on reasonably easily, and halt the transition to greater payment based on performance, which is a dangerous and unfair approach when hospitals have not yet been able to develop their management capacity.
3. It is not clear whether the HIF currently differentiates between specialist outpatient contacts and inpatient admissions in contracting with and paying hospitals. These service types need to be clearly distinguished, with separate pricing and payment models and eventually distinct service classification structures. As the payment model increases in sophistication, inpatient care should be separated into acute, non-acute and rehabilitation services.
  - If not already in place, the HIF should clearly distinguish between outpatient and inpatient care in the 2005 contracts, in terms of volume of services contracted and differential payment methods and pricing.
4. Although performance indicators have been identified, there are no clear services standards in place for hospital contracts. In particular, the consultant recommends that the HIF include general services standards in all hospital contracts, introduces the Appropriateness Evaluation Protocol (AEP) for hospital admissions, and supports the development of clinical pathways in hospitals for high cost and high volume cases.
  - In 2005, the HIF should ensure that clear services standards are in place for all hospital contracts, as a condition of contract.

The first priority of the HIF is to address these issues, preferably in time to be incorporated into the 2005 contracts. Only once the basic payment models and contracting processes are well-established, applying the principle of equal payment for equal work, should efforts be made to increase the sophistication of the services classification and costing techniques – for example, adopting a classification such as Diagnosis Related Groups (DRGs).

### ***Performance indicators***

It is worth making some additional comments on the use of performance indicators. A system of performance-based incentives can easily be misused and therefore must be introduced with caution.

While the use of performance indicators is a sound idea in practice, there is a danger that tying progress to financial information will encourage hospitals to misreport, and manipulate data to meet these indicators, and that payment will in fact be made on an incorrect basis (and potentially open to political influence). If early experience indicates that performance indicators are in fact subjective, it may be worth continuing the reporting requirements, but untying the financial link, until the management capacity of health care providers increases. As part of the HIF's early evaluation efforts, a review should be conducted to determine:

- Relevance and usefulness - in particular, does the manager have control over the area(s) covered by the indicator?

- Clarity – are the indicators clear, well defined and understood? In cases where calculations are required, are definitions and methodologies provided to all health care providers to ensure consistency?
- Cost-effectiveness – can the indicators be established at a reasonable cost? In some cases, the indicators identified in the hospital contracts are not currently collected, and there may be costs associated with collecting the necessary data (in terms of time and changes to information systems). Reporting of performance indicators should not detract from efforts to introduce data collection and reporting mechanisms that support sound clinical practice (the core activity of each health care provider).

Benchmarking, comparing the performance of an organisation against a standard, is an effective tool for assessing performance and identifying areas where improvement is needed, and the HIF should certainly evolve this practice. The questionable area is tying the results of this benchmarking to payment.

### ***Standards of care***

In terms of quality of care, it is not sufficient to specify performance indicators. Minimum quality standards need to be established for hospital care.

For example, providing information to patients and their carers is a very important part of good health care. It has been shown to improve a patient's well-being, by providing a clear understanding of what will happen to them during their hospital episode. The HIF could require, as a standard, that information is provided to patients on a simplified description of the care process, general information (eg. parking, visiting hours) and complaints procedures.

The HIF could also require that care providers use a patient satisfaction questionnaire to measure the quality of the patient's experience. Ideally, a given survey instrument, such as the Picker questionnaire, would be modified for use in Macedonia and established as a national standard.

Finally, the HIF could establish a standard requiring all care providers to establish processes for internal clinical audit, and conduct at least one audit during the contract period. The resulting report should cover efficiency (length of stay, nurse hours per patient day, diagnostic tests per stay), process and outcomes, and indicate any corrective measures.

Appendix 9 provides an example of general services standard for hospital use, as used in the UK.

### Appropriateness Evaluation Protocol (AEP)

The Appropriateness Evaluation Protocol (AEP) is one instrument that the HIF could introduce as a means of testing the appropriateness and quality of services provided by contracted health care institutions. It was developed for use in auditing admission practices in US hospitals over 20 years ago, and is now widespread in its use. While other protocols exist to measure the appropriateness of admissions, the AEP is the most widely used and has been shown to achieve relatively higher levels of consistency.

The list in Figure 2 is based on a version of the AEP used in Australia. It serves as a standard for care and an audit tool, enabling discrimination between hospitals in terms of their overall admission practices, rather than to make decisions about individual patients.

The HIF could use the listed criteria to judge a hospital's eligibility for payment, according to the extent that each of its admitted patients meets one or more of the listed criteria. For example, a separate payment pool could be set aside for each hospital, paid only when there is

no evidence of unnecessary admissions (or they are within an acceptable margin). The basis for qualification for receipt of payments could be evidence from a sample survey of admissions, making use of the AEP.

**Figure 2: Basic criteria for appropriateness of admission, general patients**

Criterion	Notes	
1	Sudden onset of unconsciousness	Includes coma or unresponsiveness which represent acute change in the patient's normal state. Includes loss of consciousness from trauma, which occurred during referral to hospital. Excludes disorientation or confusion.
2	Abnormally high or low pulse rate	A rate below 50 bpm or above 140 bpm, recorded on at least two occasions five minutes apart.
3	Abnormally high or low blood pressure	A systolic level below 90 or above 200 mmHg, and diastolic level below 60 or above 120 mmHg.
4	Acute loss of sight or hearing	Loss which is severe or total, and which had a sudden onset, and which is present at time of admission.
5	Acute loss of ability to move major body part	Includes injuries from serious trauma (fractured pelvis, paralysis, whole leg or arm), cervical spine fractures with risk of spinal cord injury, acute dysphagia with risk of inhalation). Excludes injuries of only foot or hand.
6	Persistent fever	Fever for 5 days or more with temperature over 38°C.
7	Active bleeding	Includes continuous haemorrhage from any site, not able to be treated in Casualty Department. Also includes suspicion of internal bleeding.
8	Severe electrolyte or blood gas abnormality	Measure taken at time of arrival in Casualty Department, as follows: Sodium <123 or >156 mEq/L Potassium <2.5 or >6.0 mEq/L Bicarbonate <20 or >36 mEq/L Arterial pH <7.3 or >7.45 PCO <sub>2</sub> >50 mmHg Serum Ca >3 mmol/L PO <sub>2</sub> <50 mmHg
9a	Electrocardiogram abnormality	Results of ECG taken on presentation which suggests acute myocardial ischaemia, and that the change is recent.
9b	Suspicion of acute myocardial ischaemia	Medical judgement of acute myocardial ischaemia, in the absence of ECG or biochemical enzyme changes.
10	Wound dehiscence or evisceration	Only includes post-treatment complications of wound splitting or rupture requiring reclosure.
11	Incapacitating pain	Severe pain with suspected medical emergency, unable to be diagnosed or adequately treated in the Emergency Department.
12	Parenteral medications and/or fluid replacement	Includes IV, IM, IT, and intra-arterial at least 8-hourly. Also includes PRN order for IV medication at least 8-hourly. Also includes stabilisation by insulin for young patients with brittle severe diabetes.  Excludes order to keep vein open.
13	Significant procedure within 24 hours of admission	Significant means requiring general or regional anaesthesia, and performance in a specialised facility (such as operating room).
14	Inpatient care required which is only available in acute hospital	Care requires the use of equipment or facilities, or the conduct of a procedure only available in an acute inpatient setting.
15	Vital sign monitoring at least	Includes temperature, pulse, respiration, blood pressure, neurological

	every 2 hours	observations on a coma scale, telemetry or bedside cardiac monitoring. Also includes nurse monitoring under medical orders at least five times daily for patients with history of coma, severe abdominal pain, or suspicion of internal bleeding.
16	Intermittent or continuous use of a respirator	Intermittent means at least every 8 hours.
17	Elderly frail patients with severe dyspnoea	Relates to the combination of frailty and the clinical diagnosis.
18	Severe breathlessness due to bronchial asthma	Includes patients where the FEV1, after treatment, might not rise to 70% of predicted normal.
19	Social admission, patient needs overnight accommodation	Includes patient who needs hospital care, and who cannot afford to accommodate self.
19	Social admission, unsafe home	Includes fear of abuse of child or female, elderly patient with problems of safety such as cold.
20	Other social admissions	As defined by ICD codes.

### Clinical pathways

Clinical pathways, if used appropriately, are an excellent tool for improving cost-effectiveness, encouraging multidisciplinary teamwork and providing for greater consumer involvement. They can also be used as the basis for pricing a package of care, using standard costs.

The HIF should encourage the development of clinical pathways, ideally through the work on clinical guidelines and protocols that is being promoted through another component of the Project. Importantly, however, it is not necessary to have clinical guidelines in place to develop clinical pathways. Although informed by clinical guidelines, pathways reflect how care should be carried out for a certain type of patient for the majority of cases in a given setting, and therefore usually differ between facilities.

Eventually, once clinical pathways become an established tool in Macedonia, they could be established as a condition of contract with the HIF. For example, a provider must show efforts to develop and use clinical pathways in order to receive a contract with the HIF – and checking that a provider is using clinical pathways well could be a basis for audit.

In some respects, this is quite an ambitious plan, as clinicians and managers currently have little incentive to spend additional time working on tools to improve service delivery. Furthermore, it will likely be many years before the HIF is in a position to selectively contract with health care providers, and until then having clinical pathways as a condition of contract will not be effective.

Nevertheless, clinical pathways have a strong capacity to improve clinical practice, and it is worth developing capacity in this area amongst interested hospitals as early as possible. Ultimately, clinical pathways should not be limited to hospitals, but rather should span settings and encourage coordination of care. However, hospitals are a good place to start, as there are significant opportunities for improving quality of care and generating savings.

This process should be led by the HIF and MoH, dove-tailing with work that is planned in the area of clinical guidelines. Initial steps might include:

1. HIF and MoH to prepare and distribute documentation on clinical pathways;
2. Establish pilot sites at health care institutions interested in the development of clinical pathways;

3. Provide necessary support for the design and testing of clinical pathways;
4. Distribute examples between hospitals for comparison and comment.

It is possible that funding for clinical pathway development may be provided through the Competitive Grant Facility that is being set up to encourage innovative developments to improve service delivery.

### ***Diagnosis Related Groups (DRGs)***

Only once the essential elements of the hospital payment and contracting model are in place should the HIF start with the introduction of a more sophisticated payment model for acute inpatient care, using a Diagnosis Related Groups (DRG) classification.

The implementation of a DRG classification is unlikely to be feasible during the Project, simply because the main building blocks are not in place at either the purchaser or provider end. There are various steps that need to be taken early, to build the capacity to introduce a DRG classification.

Some key pre-requisites for implementing a DRG classification as the basis for payment are listed in the table below, as well as an indicator of the status in Macedonia:

Good diagnosis and procedure classifications for coding hospital services (ICD-10), supported by sound coding guidelines and practices	N
Clearly defined national data definitions, covering concepts required for a DRG classification, such as acute inpatient care, hospital episode etc.	N
Reliable hospital information systems that can produce the minimum dataset with an acceptable degree of accuracy and support a robust costing study	N
HIF information systems able to support processing and analyse of hospital datasets	N
HIF staff capacity in costing techniques and statistical analysis	N
Clinician capacity (in terms of skills and time) to evaluate alternative DRG classifications/build a new classification	N
Clinician support	?

It is fairly clear that Macedonia meets very few of these criteria at present. However, the general intention to move towards a DRG classification for use in paying for acute inpatient care is sound. It is the timing and the sequencing that may be ambitious, and it is likely that the HIF will have to revise its timetable. The HIF should try to avoid some of the mistakes made by other countries in the region that have implemented DRGs, and adopt a careful and measured approach if it wishes to achieve the potential benefits. The costs associated with introducing a DRG classification are often underestimated.

Some fundamental steps need to be taken before introduction of DRGs can begin in earnest. These include

1. Upgrading diagnosis and procedure coding classifications (using 5 digit ICD-10 codes and adopting the ICD-10 procedure classification)
2. Development of coding guidelines and training in sound coding practices.
3. Modification of HIF information systems to process and analyse hospital data;

4. Conduct of a national costing study for hospital services (of particular importance here is whether hospital accounting systems support a sufficiently robust costing study)
5. Formal evaluation of options for introducing a DRG classification (adoption of an existing classification, development of a unique Macedonian DRG classification).

These activities also support the overall development of a purchasing capacity, and could be developed through the HSRP.

#### **3.3.1.4 Pharmacies**

The privatisation of pharmacies (and dentists) in Macedonia is currently high on the political agenda, and a new draft Health Care Law has been prepared to facilitate this. Even if the planned privatisation of pharmacies is not progressed in the immediate future, the HIF does need to develop a new payment model as the basis of contracting with pharmacies for the supply of positive list drugs. The incentives inherent in the current method of funding public pharmacies encourage various inefficiencies and an excessive staffing structure.

It is fundamental that the HIF properly evaluates the impact of the new payment model on itself and on pharmacies, also taking into account likely changes in the regulatory framework governing pharmaceuticals. For example, regulations to discourage pharmacies from dispensing drugs without prescription will lead to an increase in the number of drugs dispensed that are eligible for HIF subsidy (as illegal over the counter dispensing practices will be reduced). This will increase HIF drug expenditure unless it is able to save through lower drug prices (as a result of international tenders) and increased efficiency of pharmacies.

This is a complex issue and the HIF will require support to develop the new payment model for pharmacies. This support is planned under PSMAL, and additional support in the design phase will not be required under HSRP.

### **3.3.2 Implementation**

As mentioned earlier, the HIF has had some success in the design of new payment models and contracts, but the implementation of these has been weak.

#### **3.3.2.1 Primary Health Care Contracts**

Primary health care is the only area where the new payment mechanisms and contracts have been implemented for any period of time. Discussions with HIF staff, private primary health care providers contracted with the HIF, and patients have shown that improvements in how the contracts are implemented are needed. It also appears that arrangements are not in place within Central Office to evaluate the process, and identify and address problems. There is no overarching and comprehensive monitoring of the contracts, payments and provider behaviour within Central Office, which despite the lead role of the branches in this area, does need to be established.

The dangers are that unless effectively implemented, the new contracts will not achieve the desired improvements in efficiency, will increase provider and patient dissatisfaction, and will ultimately hard quality of care.

Examples of the improvements that need to be made in the implementation of PHC contracts are:

- Ensure that contracts are in place for all private PHC providers prior to payment
- Ensure that payment of the performance supplement of 30% is clearly linked to meeting the agreed criteria;
- Tighten invoicing procedures and payment criteria (address faulty software)
- Upgrade monitoring processes (currently only briefly checking data for validity and conducting inspections).
- Review the HIF policy on paying doctors for patients who are not up to date with their contributions – unless the HIF is providing frequent advice on entitled beneficiaries to their registered doctors, the doctors should not be punished for treating these patients in the absence of information on their status;
- Improve accuracy of registered patients eg. reporting on deceased patients from relevant sources on a monthly basis;
- Tighten procedures for changing selected doctor.

Some of these existing weaknesses are specific to primary health care. Others reflect some of the areas that HIF needs to address generally.

The HIF needs to clearly assign responsibilities and develop an implementation plan for addressing the weaknesses in PHC contracts. Additional resources in Central Office need to be assigned to overseeing contract management and monitoring provider behaviour.

Some of the more general areas, which affect not only PHC but also hospitals and other care types are discussed below.

### **3.3.2.2 Reporting & Billing**

The burden of current reporting and invoicing requirements on health care providers and HIF branch offices is a key concern. The current 'invoicing' system has a ridiculously high administrative burden, which detracts from other more productive activities. It is also negatively impacting on effective financial management.

This is even more frustrating given that it is largely redundant. Concerned about changing these processes too quickly and losing valuable information, the HIF has not phased out this system for newly contracted PHC and hospital providers. The HIF's concerns can be avoided through careful planning and design of the new reporting and invoicing system, ensuring that all potential users of the information are consulted prior to the change to make sure their needs are met.

It is a priority that this is addressed during 2004, with new reporting requirements implemented for 2005.

The HIF needs to:

1. Review data requirements and redesign reporting requirements for health care providers;

2. Redesign copayment policies, which are linked to the current invoicing process and price list <sup>3</sup>;
3. Obtain feedback from the MoH and health care providers on the proposed changes;
4. Provide written guidelines on the new reporting processes;
5. Implement new processes in HIF branch offices and areas of Central office which are affected (such as the Accounting department); and
6. Support implementation of new processes at health care provider level.

Generally, the aim in Macedonia should be to achieve a single and integrated reporting process, covering requirements for reporting to the HIF, the Republican Institute for Health Protection and the MoH. Agreements need to be made on the frequency of submission, data editing processes and so on.

In the case of hospitals, a good reporting arrangement to aim for would be contracted hospitals to provide electronic reports on a monthly basis on all hospital episodes for insured patients discharged within the given month classified. The following data fields might be provided:

- Insurance number
- Date of Birth
- Gender
- Date of Admission
- Date of Discharge
- Diagnosis (ICD-10)
- Procedure (ICD-10)

A separate quarterly report would then be provided on performance indicators, as specified in the contract.

The HIF could consider withholding a small percentage of the budget against receipt of timely and accurate data.

At present, there are serious constraints to this kind of reporting mechanism – notably weak information systems in hospitals (including poor accuracy of data) and limited capacity of the HIF to process datasets of this nature. Nevertheless, in order to monitor provider behaviour effectively, and ensure correct payments, the HIF needs to work towards this kind of reporting process. It is also a pre-condition for introducing a DRG classification.

Reporting requirements should be specified in the contract. It is recommended that the HIF considers the steps required for a gradual transition to this kind of reporting structure.

Privacy issues would need to be explored, particularly in light of the new legislation that is being prepared.

### ***Information Systems***

Related to the above comments on reporting, cost-effective information systems need to be designed to support the monitoring and evaluation of care provided under contracts. Detailed reporting for each care episode, such as has been practiced in Macedonia to date, is

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<sup>3</sup> Note that the consultant has made no value judgements about what copayment structures should look like in Macedonia. Rather, the need for the redesign is practical – that is, the current basis for calculating copayment needs to be replaced for the purposes of new reporting mechanisms.

unconstructive. It is expensive in terms of resources and time, and it is not cost-effective to conduct retrospective audits of individual episodes.

Requiring providers to report data that is not collected as a by-product of routine activities has a high cost associated with it, and should be considered carefully. An ideal information system will be designed around the data required to support the patient care process, with additional reporting requirements kept to a minimum.

Meanwhile, it is essential that the HIF improves the data available to support planning, contract design, negotiation and monitoring, and the capacity of staff to utilise this information. This is likely to require substantial upgrade of HIF information systems. However, it will also involve identifying additional data that is already available to support these functions, but not currently utilised.

Planning of information systems for health care providers and the development of a national health information system strategy will be addressed through one of the planned components of the HSRP. The purpose of these comments is to emphasise important principles that should be adhered to in the future.

### 3.3.2.3 Planning

The HIF needs the capacity to plan what needs to be achieved in a given period prior to contracting for it. At this stage, planning consists of identifying the services provided in the previous year, and is not linked to beneficiary needs. The planning stage in Macedonia needs a lot more time and resources that have been devoted to it to date, and a more careful approach.

Successful planning requires that current health sector objectives be taken into account (which means that the MoH needs to define them) and that opportunities for the proposal of significant changes are provided at an early stage. Judgements will need to be taken about the priorities for change (ideally on the basis of evidence, such as cost-effectiveness analysis). It also requires that as many stakeholders as possible are included in the planning process, and have the opportunity to comment.

A comprehensive plan for any given year would include:

- Financing (how much should be spent, how will it be raised)
- Resources (what kind of resources will be needed by type and quantity, eg. the number of hospital beds)
- Products (what kind of services are required to be produced by type and volume eg. number of organ transplants)
- How the services will be provided (timing, setting)
- Value of Products (including quality of care, health outcomes)
- Responsibilities (who will be responsible for each activity in the Plan)
- Monitoring and Evaluation Processes

A draft should be established early on in the financial year and circulated for discussion. Finalising the plan should be an iterative process, based on improvements to several drafts.

In Macedonia, the HIF and MoH would ideally lead the process of planning jointly, with both parties providing significant input, as well as health care associations and potentially consumers. It will likely take some years before it is feasible to adopt such a comprehensive planning process to support contracting. However, the HIF should begin to introduce the basic processes required.

### 3.3.2.4 Pricing

Effective contracting depends to a large degree on pricing. Current approaches to price setting for services purchased by the HIF do not appear to be rigorous, and the resulting prices do not provide the incentives that the HIF is aiming for. Pricing should encourage provision of cost-effective care in an appropriate setting that offers value for money. For example, if patients are best treated through day surgery, or best discharged to a home care setting, then payment rates should encourage this. The pricing structure should also provide for a minimal level of quality.

For example, the HIF has done some work to determine that the capitation value for private primary health care contracts is sufficient. However, private physicians would disagree that the reimbursement levels are sufficient for them to provide a quality service – and there are clear barriers to establishing group practices (due to rent costs), something which the HIF and MoH should be seeking to encourage.

In the case of hospital services, differential prices have been set for the same types of services provided by different facilities. There does not appear to be any sound methodology behind the price levels – rather, they have been set primarily to maintain previous income levels. Moreover, as noted earlier, this differential pricing undermines the objectives of transparency, equity (same payment for same work) and efficiency.

Given that the HIF has only just introduced these new payment models and is still developing its capacity in contracting, it is not surprising that pricing methodologies are less than ideal. However, HIF staff need support to develop improved methodologies through various capacity building techniques, including training.

In the case of hospital contracts, the HIF needs to consider conducting a national hospital costing study, using a sample of carefully selected hospitals, which would be used to establish actual average costs for services and define standard prices. If carefully designed, the data collected during this study would also support costing by DRG (using another country's classification), which would help the HIF in its planning process for DRG implementation.

### 3.3.2.5 Contract Design

It is important that both parties understand and accept their responsibilities under the contract, and that there is a clear definition of what is required (which includes clear categorisation and definition of services).

The contract should cover:

- Laws & definitions
- Services to be provided (by care types and volumes in the case of hospital care - it may be necessary to have some high cost specialist services 'unbundled' from the per case payments because the classification of services is highly aggregated)
- Standards eg. information for patients, clinical pathways, patient feedback
- Reporting requirements
- Clinical audit
- External audit
- Payment method
- Price per case
- Clear penalties for not meeting the agreed contract
- Contract management - Individual contact point and delegates for contract issues

- Clear methods for dispute resolution
- Contract termination.

Many of these areas are already covered in the version of the HIF contract that was made available to the consultant. However, the HIF could consider providing more detail on reporting requirements, clinical audit, standards and contract management.

Towards the end of 2004, the HIF should make efforts to discuss the contract design with health care providers and obtain feedback on improvements that could be made

### **3.3.2.6 Monitoring & Control**

The HIF needs to move away from controlling health care providers through physical inspections to an approach concentrating on targeted reviews of smaller samples. An alternative process would consist of the following steps:

- an automated check should be made of every episode of care in the data file at the HIF branch office, checking that the patient was eligible for coverage, the care that was provided and whether the type of services has been correctly identified
- during the automated check, a pattern analysis should be made, looking at comparisons over time and across similar providers, and identifying inconsistencies that might be targeted for further checks (for example, there might be a sudden change in the proportion of patients with a secondary diagnosis, which under a DRG-based system, could mean the provider was ‘gaming’, changing coding practices to increase the complexity of patient care in order to attract higher payment)
- Based on inconsistencies in the pattern analysis, select the hospital for audit and the specific records that should be audited (arrange for these records to be assembled prior to a site visit).
- Individual records are then audited with respect to whether the care was appropriate and of good quality.

This kind of monitoring and audit process, involving monitoring through pattern analysis of provider behaviour will result in more effective control, and is essential for the effective introduction of a payment model with services defined according to a more sophisticated classification such as DRGs, and where there is a greater risk of ‘gaming’ – for example, using coding to shift patients to a DRG that attracts a higher payment rate.

A parallel process for monitoring of performance indicators submitted on a quarterly basis according to current arrangements would support the evaluation of overall performance.

Of fundamental importance is that there is a process in place to address the results of the monitoring process and modify contracts and payments accordingly. A much stronger role needs to be played by the Central Office in future to support overall contract management and monitoring functions.

#### ***Prescriber Feedback Program***

In order to control pharmaceutical expenditure while ensuring quality of care, the HIF has an important role to play in influencing prescribing behaviour in Macedonia, providing both financial and non-financial incentives for cost-effective drug utilisation. The design of a new payment model for pharmacies should include such incentives, but it is also sensible to provide feedback to physicians on rational prescribing practices.

It is recommended that the HIF consider the introduction of a Prescriber Feedback Program. Targeting primary health care physicians, a Prescriber Feedback Program would utilise the

existing database on drug prescriptions from the positive list to provide feedback to prescribers on:

- the volume and cost of the drugs they are prescribing in a given period (quarterly, annually);
- variances in their prescribing patterns as compared to their peers; and
- their compliance with therapeutic guidelines and drug management programs established at the national level.

Prescriber Feedback Programs have been applied in several countries with a universal health insurance system, and have been shown to improve the cost effectiveness of prescriptions and introduce significant savings in drug expenditure. Good examples of effective prescriber feedback programs can be found in Estonia and Australia.

This will become increasingly important for the HIF as increasing pressure is put on pharmacies to stop dispensing drugs without prescription, resulting in a likely increase in the number of prescriptions for positive list drugs to be subsidised by the HIF. Put simply, the HIF is currently paying for drugs used to treat conditions where there are more cost effective drugs available for that condition (same cost for a better outcome, lower cost for the same outcome, or even lower cost for a better outcome). Unless utilisation becomes more cost-effective, HIF drug expenditure is likely to rise significantly.

The Program should be introduced in parallel with the development of drug management programs for high cost, high volume drugs (where there are large opportunities for savings); national therapeutic guidelines; and other recommendations made by the pharmaceuticals consultant for improving hospital drug management. This activity should be part of the HSRP component looking at rational drug use and pharmaceutical reform and requires strong coordination with the MoH (see Section 3.7).

### **3.3.2.7 Evaluation**

Evaluation involves drawing conclusions about the effectiveness of the contract design and implementation process, in order to identify opportunities for improvement in the future. It can look at how effective the planning process or routine management supporting the contract was, or whether it provided value for money. The HIF does not currently perform any routine evaluation of its annual contracts with providers, and has not formally evaluated the impact of the new contracting mechanism for private primary health care providers, which has been in place for several years now.

Very few countries have an effective, systemic system of evaluation established. However, it is important that, in the future, the HIF begins to identify the goals and objectives of its various 'programs' – for example, purchasing hospital services – and evaluates comprehensively whether the way they have been implemented is effective. A structured approach involves:

1. Identify the goals of the evaluation
2. Define the scope of the evaluation
3. Identify the questions to be asked with regard to implementation and service delivery;
4. Set benchmarks (against which to assess the value of the program)
5. Identify data requirements and methodology
6. Prepare work plan
7. Select evaluation team

Formal evaluation can be a costly and time-consuming process. However it is important that the HIF and the MoH begin to look at some crude approaches to evaluating the new payment models and contracts. Some examples include surveys of staff and patient attitudes, comprehensive review of the monitoring reports, ratings of participants in the process.

### 3.3.2.8 Contract Negotiation

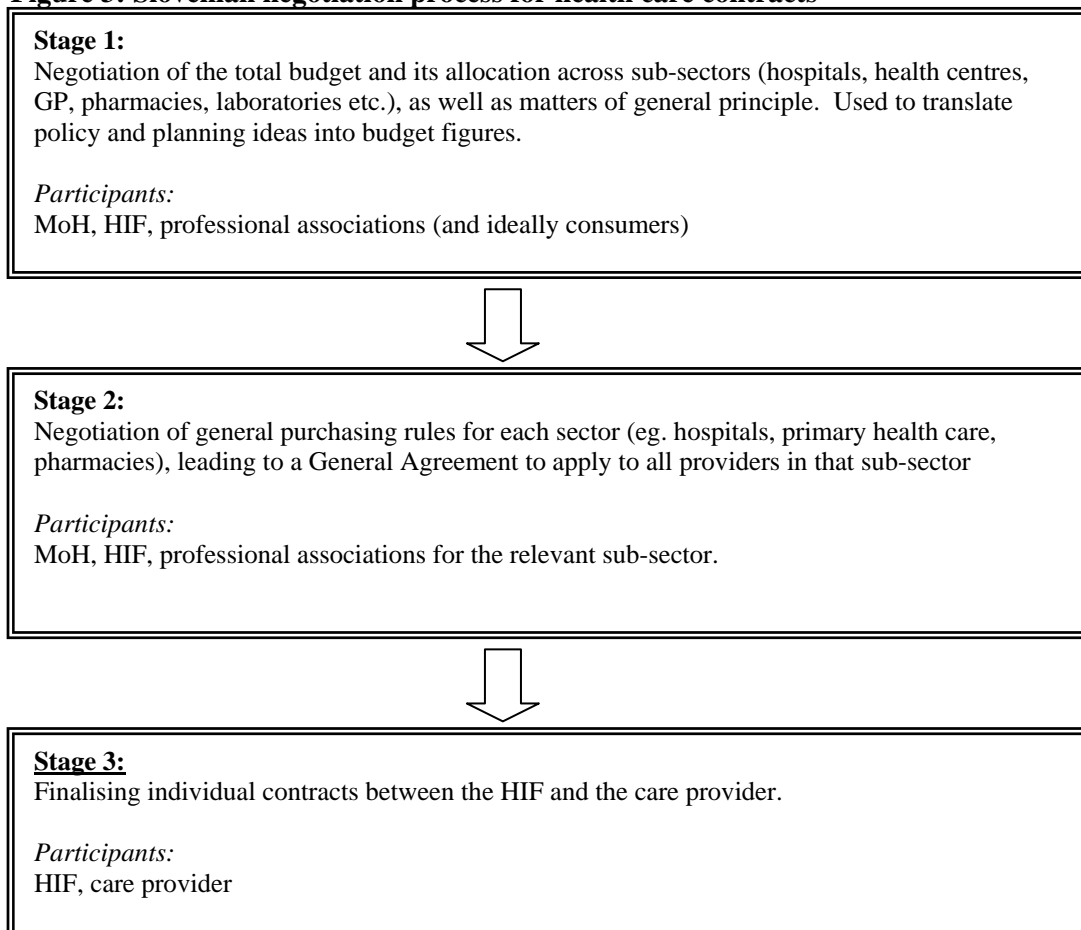
One of the major characteristics of a well functioning health system is strong collaboration between purchasers and providers, built on a relationship of trust and respect. This has not yet been established in Macedonia.

Although contracts have only been recently established, the negotiation process has many limitations that need to be addressed. For the most part, the current process consists of the HIF dictating its terms to individual care providers, who have no bargaining power as they are reliant on the HIF for income and do not have sufficient capacity in contract negotiation or management.

Effective contracting requires that the two parties are equal. The HIF needs to consider introducing a more consultative and transparent negotiation process that allows discussion about the overall funding levels and general principles behind the contracts, as well as the content of individual contracts.

The HIF should consider other models for negotiation for application in Macedonia. One option for consideration is the approach taken in Slovenia, which has a similarly structured health system to Macedonia, with a single national health insurance fund operating as an independent agency, and primarily public health care providers (see Figure 3).

**Figure 3: Slovenian negotiation process for health care contracts**



The main concerns with the Slovenian process are lengthy negotiations and difficulties reaching agreement within an acceptable period of time. This problem is likely to be even greater in Macedonia, where the divide between the HIF and providers is wider. Also, direct involvement of care providers in the budget allocation process makes it difficult to make strategic changes (for example, it is difficult to allocate more funding to primary health care to support a certain policy direction when decisions are influenced by the more powerful hospital managers).

However, countries tend to improve the efficiency of negotiations with more experience, and there are some key strategies that can be adopted. Most important is that the HIF sets a precedent for collaboration as early as possible (rather than the non-collaborative approach currently taken)

### **3.3.2.9 Developing sound relationships with providers**

This section has been primarily concerned with technical issues so far. However, one of the 'softer' areas where the HIF needs to concentrate is establishing an open relationship with health care providers that is built on trust. Studies of purchasers internationally have shown that the process of building a relationship with providers is probably more important than the contract process itself. The main reason that this is important is that it is too costly to write and audit a contract for each health care provider that covers all eventualities, and there must be an element of trust in the contracting process. Involving providers in planning, sharing information and showing a willingness to compromise, are some of the approaches that can contribute to building and maintaining trust.

This will be a challenge for the HIF, particularly as purchasers worldwide find it difficult to recruit and retain clinical experts who can relate to providers and command their respect. The current situation is closer to a competition, meaning that there is a long way to go to achieve an integrated view of shared problems requiring collaborative actions. It may also not seem important to the HIF at the moment, as the balance of power lies with the HIF as the single purchaser of health care and providers need to sign contracts. However, as providers improve their management capacity, this balance of power is likely to swing, as the providers have the clinical expertise to define what is provided, and the HIF will find it difficult to argue.

A good starting point would be to review contract negotiation processes as recommended in the previous section, ensure each contracted care provider has a contact point within the HIF (who is not the Director), and establish a practice of open dialogue and mutual support with care providers. To ensure the contact point has sufficient time to address concerns, it would be necessary to have more than one person managing contracts on the HIF side.

### **3.3.2.10 Encouraging clinical practice improvements**

Many public purchasers of health care, such as the HIF, do not recognise their role in encouraging improvements in clinical practice. This is the single most beneficial contribution that a purchaser can make to the health sector. However, changes must be supported by evidence and subject to scientific evaluation.

The HIF needs to have access to and be able to interpret a range of information of the cost-effectiveness of services and technologies (such as the Cochrane Collaboration and Medline). A culture of shared information between providers and the HIF around evidence-based care should be developed.

A separate activity on Health Technology Assessment that is being proposed under the HSRP would take this one step further and develop the capacity of the HIF (and possibly the MoH) to perform its own cost-effectiveness studies.

However, the most important step at this stage is for the HIF to realise its obligation to influence clinical practice and develop a capacity for relating to providers on this level.

### **3.3.2.11 Competitive Tendering**

Finally, one area that the HIF will need to look at in the future is the development of competitive tendering for the provision of health services.

In order for a model which separates the purchaser and provider functions to be successful, there has to be some likelihood that competition between providers, or the threat of competition, will occur.

At present, the HIF has been essentially sole-sourcing, with no competition between health care providers over provision of services. This applies less to primary health care providers than other providers, such as hospitals. So far, the contracts with hospitals are little more than global budgets which allow them to operate as before.

It is likely that the HIF will need to continue providing annual contracts to all public health care providers (hospitals, at least) to provide services under the compulsory health insurance scheme for several years, without the need for competition. Competition is not a desirable feature where providers are the only source of care in an area, and if they were not provided contracts, the community's access to care would suffer. It also tends to have large transaction costs, and adversely affects cultures of public service and information sharing to support research and innovation.

However, lack of competition can stifle initiatives to improve efficiency and take a patient-focused approach.

One approach that may be considered by the HIF in the future is to introduce competition amongst public and private providers in instances where there are clear benefits to the community. Examples include where new services are required, additional services are required for a short period of time, infrastructure costs are low (and therefore duplication is less wasteful), or there are imbalances in utilisation of existing capacity. In this case, tenders could be conducted for specific set of services.

This is not an approach that the HIF would consider for several years, until a strong capacity in planning and tendering (see Section 3.3.4) is in place, and it is unlikely to occur in the lifetime of the HSRP. Once this is in place, the HIF will need to carefully define criteria under which competition is acceptable and for sole-sourcing.

### **3.3.3 Building Capacity in Effective Purchasing**

In the previous section, requirements for improving processes in the areas that are important for effective purchasing were outlined. In order to develop, implement and refine these processes on an ongoing basis, the HIF needs to have sufficient capacity in certain areas which support an effective purchasing function.

An effective purchaser must be able to:

- Measure needs (plan health services)
- Rate investments in terms of value for money
- Conduct tendering processes
- Prepare and negotiate contracts
- Monitor and evaluate performance

There are key areas in which the HIF needs to build capacity (be it through training, mentoring or knowledge transfer). These include:

- Planning
- Contract design
- Negotiation
- Costing techniques
- Statistical analysis & reporting
- Monitoring and evaluation
- Clinical quality improvement

The HIF will need to develop a strategy for building staff capacity in these areas.

It is also likely that some organisational restructuring will be required, particularly in Central office, if the HIF is going to perform its purchasing function effectively. Increased resources will need to be dedicated to contract planning, management and monitoring in Central office to support the branches and provide effective coordination in these areas.

One of the main priorities is to ensure that the current processes supporting the introduction of the new hospitals contracts are institutionalised during 2004. The process should still be supported by a Working Group (albeit perhaps with broader participation), but there should be more communication with HIF staff about developments, and changes in process should be integrated into normal operations.

### **3.3.4 Procurement**

The HIF is currently responsible for procuring drugs, medical supplies and non-medical supplies (including amenities, such as electricity and wood) on behalf of health care facilities, as well as supplies and services for its own internal use. It is an area that offers significant opportunity for waste and fraud. Certainly, there is evidence that the HIF has, in the past, provided special treatment to certain suppliers, and conducted unplanned and unnecessary procurement, and generally misused funds in various ways, at least up until 2003. In addition, the prices of the drugs and medical supplies that the HIF is procuring are known to be high by international standards, and offer poor value for money.

Firstly, there is no legislative basis for the HIF performing procurement on behalf of health care facilities. It has adopted this role informally, and its centralised role has proved inefficient and disruptive to clinical practice at the facility level. The question of whether the HIF should be undertaking procurement on behalf of health care facilities, at least in the short-term while health care providers develop the capacity to manage it themselves, needs to be addressed as a priority. If the HIF does retain this function in the short-term, then it needs to introduce more effective systems of managing the procurement process, including better financial management.

This issue aside, there are a number of changes that need to be made to the generic procurement processes within the HIF.

The right steps are being taken with regard to establishing a national procurement framework, with the Government introducing important changes to the Law on Public Procurement and establishing a central procurement agency. In response, the HIF's own procurement processes need to be modified to ensure better transparency and efficiency, and meet the legal requirements. In addition, staff have limited experience with modern procurement practices and need to be properly trained to perform their roles effectively, with adequate handbooks and documentation on procurement procedures in place. Relatedly, from 2004, the HIF is

committed to performing international tenders for the majority of positive list drugs and hospital drugs, and other supplies for the health sector, in order to achieve reduced and international comparable prices. Staff have very little experience in international tendering and their capacity in this area needs to be strengthened. In addition, awareness raising seminars on procurement practices should be held for all HIF staff so that they are aware of the correct processes.

An international consultant has been hired under PSMAL to work with the HIF to strengthen procurement (and distribution) practices and support the use of international tendering. This work will cover technical support for procurement and pricing, as well as capacity building in procurement. The consultant is also expected to work with the HIF to develop a future strategy for procurement of pharmaceuticals and medical supplies, looking at possibilities for devolution of procurement responsibilities back to health care institutions, in line with legislative requirements, or identifying an alternative strategy that maximises efficiency savings while ensuring providers have sufficient flexibility to manage their affairs.

While this support will cover most of the procurement issues, it is likely that additional training will be required in modern procurement practices for all staff with key procurement responsibilities. With the current restructuring of human resources in the HIF, it is difficult to identify numbers, but it is expected to involve approximately 5 staff.

At the end of the work supported by PSMAL, it is recommended that the procurement consultant conducts a skills audit and training needs assessment to formalise the nature of additional training requirements and considers how it is best provided. Training areas may include tender design and evaluation, supplier debriefing, contract management, monitoring procurement performance, stores and inventory control and dispute resolution.

Options for delivery include tailored training courses in Macedonia provided by local or international trainers and internationally offered courses for individuals. However, ideally, the Government will develop a training network under the Procurement Agency using national institutions, which will in turn support training for HIF staff.

### **3.3.5 Summary of Recommendations**

The previous paragraphs have comprehensively defined the areas that the HIF should address with respect of strengthening its purchasing function. The main area that the HSRP should support is the improvement of provider payment models and contracting, and the overall strengthening of the purchasing function

#### ***Improving Provider Payment Models & Contracting***

Core recommendations comprise:

- Strengthening the design of payment models and contracts for primary health care, hospital care and pharmacies, covering:
  - Improved incentives for PHC providers and introduction of consistent payment models for public and private providers;
  - Refinement of the hospital payment model to reflect principles of equal payment for equal work;
  - Development of more precise standards for services provided under PHC and hospital contracts;
  - Establishing foundations for the development of a DRG classification (such as upgrading hospital coding practices);

- Design of a new payment model for pharmacies and introduction of a contracting process;
- Introducing improved processes to support implementation of these contracts, including:
  - Phasing out the current system of reporting and invoicing, replacing it with a more cost-effective reporting process which facilitates effective contract management and monitoring of provider behaviour;
  - Improving data availability to support effective purchasing and the capacity of HIF staff to utilise it effectively;
  - Improved planning process prior to the design and negotiation of provider contracts which includes the MoH and clinical representatives;
  - A more robust approach to costing of services, including the introduction of a national hospital costing study;
  - Minor improvements in contract design, based on sound contracting principles;
  - A more equitable and effective process of contract negotiation between the HIF and health care providers;
  - An effective monitoring system for contracts and provider behaviour, including the introduction of a Prescriber Feedback Program;
  - Introduction of a basic process for evaluation of provider payment models and contracts as the system evolves; and
  - Development of improved relationships with health care providers, including steps to encourage clinical practice improvements; and
  - Eventual establishment of competitive tendering amongst health care providers for certain health services (where it is in the interest of the community).
- Capacity building for HIF staff to support an effective purchasing function, including training and skills transfer in:
  - Planning
  - Contract design
  - Negotiation
  - Costing techniques
  - Statistical analysis & reporting
  - Monitoring and evaluation
  - Clinical quality improvement
- Institutionalising HIF processes for hospital contracting, and improving the organisation structure and division of responsibilities to support an improved purchasing function.

It is also felt that developing a health financing strategy would be beneficial for the HIF, despite the HIF's own doubts of the benefits of this framework.

Improving the design and implementation of provider payments and contracting models supported by the HIF and building the capacity of the HIF to be an effective purchaser is one

of the highest priorities for the HIF. Therefore, it is strongly recommended that HIF capacity in this area is reinforced and enhanced through the provision of comprehensive technical assistance under the HSRP.

An indicative implementation plan is provided in Appendix 1.

#### Technical Assistance

The development of the HIF's purchasing capacity should be supported by an integrated technical assistance package, including sustained consulting services provided by a specialist consulting firm, a structured training package, which will be organised by the consultants, software to support key activities such as costing, and potentially a study tour to a country in the region with a similar model to Macedonia but slightly more advanced in the development of its purchasing function. An estimated 60 staff months will be required, with 24 staff months provided by international consultants.

Draft ToRs for this comprehensive technical assistance package are provided in Appendix 3.

#### Analysis of Costs and Benefits

A budget of US\$600,000 should be allocated to the Program from the HSRP to cover the cost of necessary consulting services and capacity building, including training. A further US\$265,000 has been allocated to the HIF to support internal training in contracting, and a contingency amount of US\$100,000 has been defined to support potential software requirements.

There will also be an opportunity cost to the HIF, in terms of resources that need to be dedicated to managing and supporting the change. However, it is expected that this work can be absorbed within the HIF's existing capacity in the immediate future.

Benefits are expected to include savings in hospital, primary health care and pharmaceutical expenditure through efficiency gains, as well as improved provider and patient satisfaction, and ultimately better health outcomes.

#### Legislative Changes

It is anticipated that minor changes may be required to the by-laws on primary health care and hospital contracting to support design changes.

#### Indicators

Examples of indicators which might be used to assess the effectiveness of interventions in this area include:

- Increasing satisfaction of health care providers with the payment model and contracts (primary health care/hospitals);
- Reductions in the Average Length of Stay in acute hospitals and the number of hospital admissions;
- Increased patient satisfaction with PHC and hospital care;
- HIF staff are trained and competent in costing and statistical analysis;
- Annual reports on performance indicators (of reasonable accuracy), benchmarking hospitals within Macedonia are distributed to all hospitals;
- Clinical pathways are adopted in at least five hospitals; and
- Realistic implementation plan in place for the introduction of DRGs.

#### ***Procurement & Tendering***

Formal training in modern procurement and tendering practices is likely to be required in addition to the support to be provided under PSMAL by the procurement consultant working

with the HIF. The need for and nature of this training needs to be reviewed in late 2004, at the end of this consultancy.

As the nature of the training required can only be determined towards the end of 2004, when the existing consultancy will be complete, it is difficult to define a precise implementation plan or specify ToRs, so details have not been defined in this report.

However, an indicative training budget of US\$85,000 has been allowed. This may include hiring a local consultant to support a formal training needs assessment, if required.

The benefits will be derived from greater efficiency and less waste in the HIF's procurement practice, as a result of improving staff competency in modern procurement. These savings are difficult to quantify, as it depends on the future procurement strategy of the HIF and the extent to which sufficient capacity building has already taken place. However, the overall savings in the long run will certainly exceed the costs.

The main output will be a procurement unit in the HIF that is sufficiently trained to perform their functions in accordance with the legislation, in a manner that provides value for money.

Indicators for assessing the effectiveness of the training could include:

1. Internal and external audit reports showing effective systems of control for procurement and identifying that procurement has been legally compliant.
2. An average reduction in prices for pharmaceuticals and medical supplies procured by the HIF as compared to the previous year.

### **3.4 Revenue Collection & Administration**

The main focus in terms of collection and administration of health insurance contributions is to increase the revenue of the Fund. There is a need to address weaknesses in the control and enforcement of contributions, with a focus on private sector employers and improved coordination and data exchange on insuree status across the different social insurance programs and the Public Revenue Office (PRO).

In addition, there is a need to clarify funding provided directly from the state budget to cover particular types of health services, for which the government currently has an obligation but insufficient funding is received by the HIF.

The current system of 'blue coupons', which is used to administer health insurance entitlements, also needs to be replaced. A specialist consultant has been procured under PSMAL to look specifically at the options for replacing this system and moving to a more conventional single health insurance entitlement card used for accessing all health care services with different types of providers. The consultant will also look at options for using a single beneficiary card to cover multiple entitlements (for example, employment benefit and health insurance entitlements for the unemployed person and their dependents). Therefore, this issue has not been specifically addressed as part of the preparation of the HSRP, although the results of this additional consultancy will certainly impact on planned activities in revenue collection and other aspects of strengthening the HIF.

#### **3.4.1 Improved Revenue Control**

One of the main issues that needs to be addressed is the control of employer contributions. As of October 2003, it was estimated that there were approximately 2.5 billion denars worth of unpaid contributions. It is essential that the issue of employers and employees who do not register, who under-register numbers, and/or under-report salaries and therefore do not pay the required contributions, is addressed.

Meanwhile, there is little or no control exercised over contributions from public sector employees or state budget transfers. With regard to the latter, the HIF is reliant on the accuracy of registers held by the National Employment Bureau (NEB) and the Pension and Disability Fund (PDF), in particular, and the calculations of contributions due that are made at their end, and no additional checks are performed.<sup>4</sup>

There are three key areas that need to be addressed:

1. Control processes for employer contributions and state transfers;
2. Enforcement of employer contributions; and
3. Coordination and crosschecking between the HIF and other social insurance and state institutions to ensure consistent definition of beneficiaries.

With regard to the controls performed by the HIF branches and the Control Department, there are number of improvements that should be made. The HIF needs to:

1. Introduce more stringent reporting requirements for private sector employers, in particular, requiring a breakdown of the total contribution amount by individual employee;
2. Revise the design of controls, particularly for stronger monitoring of private sector employers, more comprehensive checks of employee status, and formal procedures for site visits to check contribution payments (including clear criteria for selection of the sites based on risk profiles);
3. Ensure there is written documentation and guidelines on procedures for control of contribution payments; and
4. Assess the feasibility of reorganising the Control Department at Central Office so that there is an individual contact point for the branches and specialists in revenue control.

Note that recommendations for upgrading the management information systems of the HIF that are being prepared under a separate component will have an impact on the capacity of the branches to conduct revenue control effectively. A more automated solution is required, including tools to better track employer contribution history and payments against individuals. The nature of the changes proposed for the information systems will influence the extent to which this can be achieved.

There are currently not enough resources available for the HIF branches to perform a sufficient number of site visits to employers to check their health insurance contribution payments. Thought needs to be given to whether it would be cost-effective to dedicate more resources to this task, or whether there is a better alternative, such as outsourcing the responsibility for physical controls to another organisation with a stronger inspectorate function (see the discussion of enforcement below).

The Ernst & Young systems audit is expected to provide detailed recommendations with respect to improving revenue control. In addition, PSMAL is supporting an internal training course in revenue control, aimed primarily at strengthening capacity in the branch offices. Additional support to strengthen controls should not be a priority under the HSRP. However, it is expected that additional formal training in revenue control, provided by an external

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<sup>4</sup> The HIF also receives revenue in the form of copayments received in health care facilities, and with the current collection process that is in place, there is a risk of potential revenue loss. However, as this comprises a relatively small revenue stream, this has not been addressed in this report.

provider, would be beneficial for HIF staff and would support the design and implementation of stronger controls. It is anticipated that training would be required for around 40 staff (35 from the branch offices and 5 from Central Office).

### **3.4.2 Enforcement of Contributions**

Related to the above issues of control, the HIF does not currently have the power under legislation to enforce payment of contributions when under-payment or non-payment is identified. The main recourse for action is through complaint to the PRO about non-compliance. However, the PRO itself does not have the capacity to check contributions compliance as part of its mandate, and has difficulty obtaining information in areas such as illegal employment. In any case, penalties for employers are very low and not systematically enforced.

Enforcement of health insurance and other contributions is a problem that needs a systematic solution. It makes little sense to establish a complete inspectorate function for employers in all of the agencies that collect payments, and give them legal entitlement to enforce payment. This is not a cost-effective solution.

On the other hand, the PRO has a reputation for being unreliable, and the HIF does not feel it could trust inspection and enforcement of its contributions to this organisation at present.

Nevertheless, an integrated solution needs to be found for enforcing employer payments, requiring systematic changes that involve the HIF, NEB, PDF, the PRO and the salaries register. The HIF could lobby for a legislative change to provide it with the power to enforce contributions in the interim, and this may be a sensible option, but this is only a short-term solution.

### **3.4.3 Harmonisation of Social Insurance Records**

In order to improve compliance with health insurance contribution payments and increase its revenue, the HIF needs to participate in greater exchange of data on the status of beneficiaries with the NEB, PDF and PRO. There needs to be a harmonised database of the beneficiaries and their contributions according to categories that can be utilised by all these organisations, through harmonising the definitions of different categories and exchanging data on beneficiaries and their contribution payments.

Efforts by the HIF to establish stronger cooperation with the PRO in particular have not been successful. The reason is not clear, but the issue needs to be escalated to a higher level of authority, and dealt with as a Government priority.

This concept of greater harmonisation and exchange of information links with the need for coordination on the enforcement of employer contributions. Both are priorities for improving contributions compliance and increasing revenue for the HIF. It is a complex issue, and a short-term consultant will be procured, again under PSMAL, to research the issue in more depth. Therefore, no specific recommendations for future action have been provided in this report.

### **3.4.4 Clarification of Government Obligations**

Governments are expected to maintain a degree of public infrastructure and support social security schemes, such as the HIF, even if it is not required by law. Despite the existence of the HIF as the main health financing instrument, the Government of Macedonia is still

accountable for developments in the health sector, which requires not only holding the HIF accountable, but meeting its own obligations for funding certain health care services which are core to health protection. In recent years, the Government has consistently failed to meet its obligations to fund certain health services directly from the budget (such as vertical health programs and copayment exclusions). In practice, the Government funds only a small percentage of these costs, with the remainder funded by the HIF or absorbed by the health care facilities.

There are faults on both sides. While the MoF is not prioritising these payments highly enough, the HIF does not have a system in place for tracking execution of these programs (for example, the allocation of resources across providers, actual expenditure on different programs). As a result, the MoF is wary of the estimates which the HIF and MoH provide when planning the annual budgets, considering them to be overestimates, and allocates a considerably lower amount, without any reference to actual costs. This situation needs to be remedied, in order to ensure that the HIF and the health sector generally has sufficient funding to support an acceptable level of health care provision to the population (and to improve the reliability of revenue estimates to support sound financial management within the HIF).

There are also a number of 'grey' areas around the Government's obligations for financing health. The issue of outstanding hospital debts has already been addressed in Section 3.2 of this report. In addition, there is the issue of coverage for otherwise excluded populations (particularly, employees of bankrupt companies and dependents of dependents). The Government has been providing 'blue coupons' to bankrupt companies without paying the contributions to the HIF, which is still required to cover health care costs for these individuals.

Government obligations for funding health care directly from the central budget need to be clarified; confirming a commitment to funding agreed obligations, and addressing the 'grey areas'. This will require a combination of changes:

- A more structured approach from the MoH and the HIF in the preparation of the program budgets may be required. At a minimum, to support budget requests for any given year, information submitted to the MoF should include:
  - Narrative statement on the program objectives, and the activities included.
  - Indicators of past and expected performance (eg. utilisation rates, outcomes)
  - Cost projections (supported by actual data from last year)
  - Contingencies and risks

The MoH should ensure that this information is formally provided to the MoF to support budget requests.

- An increase in the MoF role in preparation of the budget for preventative health programs (for example, through stronger communication and involvement in the budget preparation process), and a corresponding clarification of roles and processes for preparing the health budget.
- If the HIF is to continue acting as a channel for funds from the MoH to health care providers for government commitments, a proper system for monitoring program execution needs to be in place (tracking the allocation of these resources across providers and actual expenditure on different programs).
- An alternative that might reduce complexity while increasing transparency and allocative efficiency is to eliminate the involvement of the HIF in funding the vertical

health programs, with funding being provided directly by the MoH. This would ensure that budget funds are kept in a distinct pool and can be clearly accounted for.

- Finally, more effort should be made to justify Government funding through stronger monitoring and evaluation of health programs. If they are not already in place, basic indicators should be used to monitor performance of each health program. For example, if the diabetes treatment program has led to unsatisfactory results, the MoH should be encouraged to redesign this program or the Government should reconsider its funding obligations.

Some principles for the review of government programs and establishment of a proper evaluation framework include:

1. Assess how the obligation fits the announced role of the state;
2. Assess the program risks, estimate the fiscal cost of the obligation and set additional reserve requirements;
3. Design the program to protect against risks;
4. Define and communicate the standards for and limits of government involvement (so as to limit moral hazard);
5. Budget and account for the potential fiscal costs;
6. Monitor the program risks;
7. Execute obligations within their pre-set limits and take lessons for future policy decisions;
8. Compare and report the actual fiscal cost against estimated costs, evaluate performance and sanction failures.

The MoF has already indicated its plans to become more closely involved in the process for determining budgets for the vertical health programs and other health expenditure funded directly from the central budget. Processes for this involvement need to be clearly defined and communicated so that all parties are aware and supportive, and there are no delays in budget preparation as a result.

The MoH and HIF should jointly review the current system of preparing budgets for health programs and other health expenditure funded directly from the central budget, and make any modifications necessary to comply with a structured approach such as the one outlined above. In addition the HIF should ensure that the Government prioritises this issue.

The result should be an increase in funding of the government program towards meeting the full cost of these programs, as committed to in the legislation.

### **3.4.5 Additional Revenue Sources**

Taxes on alcohol and tobacco consumption are widely used around the world to generate additional revenue for the health sector, including in the Central and Eastern Europe region. Although they are a regressive tax, hitting the poor hardest, they can have a positive influence on the population through encouraging lower smoking and drinking rates. In addition to revenue raising, therefore, an alcohol and tobacco tax contributes to health promotion and prevention activities.

It is recommended that consideration be given to such a tax in Macedonia, with the revenue from the tax ear-marked for the health sector – to provide additional funding for health

programs that are in the interest of the whole population, for additional preventative programs, or even for funding capacity building within the MoH.

The MoH and HIF need to lobby the Government for the introduction of an earmarked alcohol and tobacco tax. There will need to be a clear business case for the tax and justification for how the money is spent. Experiences of other countries in the region, such as Slovenia, could be used as a reference point. A proposal should be prepared, considering the appropriate level of tax (analysing potential revenue levels and the impact on different parts of the population and the economy), how the revenue would be used and the impact on different segments of the population.

### **3.4.6 Summary of Recommendations**

The HIF should build on the recommendations in this report and the independent systems audit report and modify its procedures for controlling revenue, collecting and utilising more information from different sources, and streamlining its controls. In addition to the internal training provided under PSMAL, HIF staff would benefit from external training courses to support its revenue control activities. However, this would not necessarily be a priority for support under HSRP. It is more important that the improved processes are put in place and the issue of enforcement is addressed.

A working group comprising representatives from HIF, PDF, NEB and the PRO should be set up to consider options for a systematic solution to the problem of enforcement. If no other solution is available in the short-term, then the HIF should seek a change in legislation to enable it to enforce contribution payments from employers.

Although it may be politically difficult, the MoH and HIF need to clarify the funding that the Government is prepared to provide to support core health programs, and in response the MoF needs to provide sufficient finance to cover those obligations.

In addition, the Government should consider the introduction of a tax on alcohol and tobacco consumption to provide an additional source of revenue to the health sector while contributing to health prevention and promotion activities.

The steps that the HIF and the MoH need to take to implement these proposals are described in the previous paragraphs.

#### Technical Assistance

Given the training and consultancy support being provided under PSMAL for the remainder of 2004, the procedural advice on process that will be provided in the Ernst & Young report, and the changes that need to take place at the system level, support for strengthening revenue collection and administration should not be a priority under the HSRP.

However, if the HIF does wish to have additional support in this area, advice and additional training for collecting and controlling revenue may be provided to staff in the branch offices and the Control Department to improve their capacity to identify and conduct control procedures. Training should ideally be provided by an existing institution in Macedonia and supported by the State Audit Office. However, it is not certain whether an appropriate training institution exists, and international assistance may be required to design tailored training courses. As a result, consulting services and training have been packaged together.

Terms of Reference for the consulting services are provided in Appendix 4. However, the training needs should be formally reviewed on the basis of recommendations provided by the Ernst & Young team.

### Analysis of Costs and Benefits

Should the HIF wish to proceed with consulting services and additional training in revenue control, an estimated US\$117,000 should be allocated for the package from the HSRP, assuming a budget of US\$45,000 for a short training program for 45 staff. There will be an opportunity cost to the HIF, in terms of time spent in training. However, this will be marginal and should be absorbed within the HIF's existing capacity.

Benefits are difficult to measure but the training should equate to an increase in revenue through better identification of evasion and under-payment, and improved employer compliance. Taking the estimate provided by the Control Department of the equivalent of USD 50 million in unpaid contributions, even changes that increase compliance by 0.5% would more than cover these training costs.

There is also likely to be increased staff satisfaction from the provision of training and attention to staff development which has been lacking in the HIF to date.

### Legislative Changes

Changes to the legislation governing the HIF, specifically the Health Insurance Law, will be required if the HIF is to have the power to enforce payment of contributions, impose penalties and collect them.

### Indicators

Examples of indicators which might be use to assess the effectiveness of interventions in this area include:

- Has there been a reduction in the estimation of unpaid contributions?
- Are HIF contributions effectively enforced by the HIF (or other)?
- Has the number of employers on which penalties are imposed increased?
- Is there written documentation on controls for revenue collection, which are followed consistently by HIF staff?

## **3.5 Resource Allocation**

Current methods of resource allocation in the Macedonian health sector are recognised to be inefficient and inequitable (particularly to health care providers). However, the consideration of a health-risk adjusted mechanism for allocation of health insurance monies across 'regions' should not be a priority in Macedonia at this stage. There is evidence to suggest that one of the most effective methods of resource allocation involves needs-based (risk-adjusted capitation) funding to regions, which must then allocate resources to all health services, in full view of the community. However, given the size of the country, the absence of 'regions' except in an administrative context, and the greater importance of implementing the new provider payment models and contracts effectively, the introduction of a regional needs-based resource allocation formula is unlikely to significantly contribute to improvements in the equity and efficiency of funding.

Efforts should concentrate on introducing contracts for all hospitals and for public primary health care providers, based on the principle of equal payment for equal work, which in turn should improve the equity and efficiency of health insurance funding distribution across the country.

As part of this process, a stronger role for the HIF branches should be developed, with an emphasis on contract design, negotiation and monitoring, enabling a stronger regional influence on resource allocation without actually changing the resource allocation model. Capacity building in this area will be supported by the project, but it also requires the introduction of new processes, guidelines and systems. It is recommended that these issues be addressed as part of the overall strengthening of the HIF.

### 3.6 Auditing & Oversight

The current oversight framework for the HIF is weak. A number of opportunities exist for strengthening arrangements for auditing and oversight of the HIF, increasing the accountability, transparency and control of HIF operations. The priorities that have been identified are:

- Strengthening the MoH, both in terms of its capacity to monitor the HIF and its overall capacity to perform its functions, including strategic planning;
- Improving the functioning and performance of the HIF Management Board;
- Overall organisational strengthening for the HIF;
- Establishment of an internal audit function within HIF.
- Strengthening of the external audit function provided by the SAO;

The first three priorities should be addressed directly as part of the HSRP. The last two points are being supported through the MoF and PSMAL, and at this stage no additional support is envisaged. However, the project should reinforce these activities where possible.

#### 3.6.1 Strengthening MoH

The MoH is the main policy making body within the health sector in Macedonia. It also has clear oversight responsibility for the financial and functional performance of the HIF, and is responsible for ensuring the health insurance program supports the goals of the health sector and contributes sufficiently to the protection of the population's health.

Separating agencies for public service delivery, like the HIF, from line ministries can be an effective way of improving efficiency and outcomes, through defining a precise function and mandate. However, it can also lead to fragmentation and inconsistency of policy, with the policy-making role informally being played by the service agency, especially if the budget of the MoH is not sufficiently increased. This is certainly the case in Macedonia.

In practice, the MoH is under-resourced and does not have the capacity to undertake its policy-making and oversight function. Separation of the purchasing function by creating the HIF has led to fragmentation in policy formulation. The MoH is currently unable to perform the 'stewardship' role that is so essential for a well-functioning health system.

A key concern is that the MoH has not established a strategic framework for health sector development in the form of a health sector strategy or national health plan, which outlines the sectoral direction for the next 5-10 years. Such a framework should be in place to underpin policy choice and design, ensuring that policies and financing decisions will contribute to objectives and the agreed strategic direction for health sector development. An earlier effort to develop a national health strategy in a consultative manner was not successful, partly due to

the implementation, as the design was outsourced to an academic research body. There is little support for a repeat effort, and yet it is very important that such a strategy is in place, and there is no reason why it should not be successful if the right process is put in place.

Similarly, the MoH does not have the capacity to evaluate and quantify policy options, which means trade-offs between different investments cannot be made on an informed basis. For example, investing in a new health facility or modern medical equipment might be less effective than increasing the wages of clinicians in terms of improving health outcomes. However, as physical investment has a concrete and measurable outcome and is politically preferable, with proper evaluation, this option may be chosen at the expense of long-term development. The MoH needs to be able to determine the relative value of these options and justify its case to the MoF and the Government.

Returning to the issue of HIF governance, the MoH does not have the skills and expertise necessary to oversee the financial and functional operation of the HIF, and hold it accountable to Government for its performance, interceding in areas where the HIF is threatening the achievement of health sector objectives.

Efforts have been made in the past to strengthen the MoH through focusing on specific areas, such as Monitoring and Analysis. These interventions have not been successful to date. Other more general activities, such as the functional review that was undertaken as part of the DFID Public Administration Reform Program, have not yet produced results.

To be fair, there are some large obstacles to improving the institutional capacity of the MoH. As with the HIF, staffing structures are political in nature, inappropriately skilled, and subject to frequent change. Political factors favour a strong HIF and a weak MoH, meaning that sustained efforts to improve the strength of the MoH are almost impossible.

Nevertheless, the need to improve the capacity of the MoH in its oversight and monitoring of the HIF is a pre-requisite for improving the governance framework, just as a stronger MoH is essential for moving towards a more effective health system. Efforts to strengthen the MoH must continue, but should take into account the aforementioned obstacles.

A comprehensive capacity building exercise for the MoH would be of considerable benefit to the Macedonian health sector, as well as strengthening the governance of the HIF. The exercise would concentrate on increasing staffing, looking first at the considerable number of unfilled positions and then considering additional resources that are needed to support key functions. It would support a review of the organisation, whether the structure of the various departments and supporting processes can effectively support delivery, and possibly reorganisation of the MoH. And finally, it would build the capacity of MoH staff to undertake those core functions, looking specifically at policymaking and monitoring and analysis, through a combination of formal and informal training, and mentoring, focusing on practical issues that the MoH will be expected to lead on over the next few years. For example, a team of specialist consultants may support the MoH in the conduct of a comprehensive review of the health sector and development of a national health strategy. There is a considerable push within the health sector for privatisation of most delivery functions in the future, without having properly considered the implications of this. Support could be provided to help MoH properly evaluate this policy decision.

However, a pre-requisite is that the Government recognises the importance of strengthening the MoH, and increases the priority of and the resources available to the MoH. Realistically, there are a number of barriers to achieving this, which are mainly political.

### 3.6.2 Strengthening HIF Management

Unless the HIF has sound management practices and an appropriate organisational structure in place, efforts to improve the governance of the organisation will have little impact. The HIF desires to maintain its distance from MoF controls, with the flexibility to operate more like a business. However, it does not currently have the mechanisms in place to operate in this manner.

Complementing efforts to strengthen the performance of the Management Board, establish internal audit, improve purchasing and financial management, there are a number of general areas where the HIF could benefit from improved practices and capacity.

Currently, the HIF has a business objective that is often stated as undertaking the role of the 'single payer' for health services covered by compulsory health insurance (established under the Health Insurance Law). However, this objective defines its function, not its goal. The HIF should have long-term goals and objective in place, as well as aiming to set its annual targets before the commencement of each financial year, as a basis for monitoring achievement both internally and by the Government. Without establishing these objectives, the HIF will have difficulty improving its performance, and potentially justify interference by external bodies like the MoF. The HIF needs to start:

- defining its objectives, key performance indicators and performance targets
- developing strategies to achieve these objectives and level of performance

As part of the same approach, the HIF should look to developing an annual business plan articulating these objectives and targets and identifying plans for achieving them. In order to clearly define its objectives, the HIF needs to be reasonably certain of the resources that it will have at its disposal, including from the Government.

It does not appear that the current organisational structure supports the HIF's core functions in an effective manner. For example, there is a need to institutionalise the processes related to the new model of purchasing and contracting in Central Office, and to ensure that clear responsibilities are in place for coordination, change management, monitoring implementation at the Central level and troubleshooting. There are other questionable areas. For example, does it make sense to have the Human Resources function in the Legal Department? Is having control and procurement functions under the same department effective? Should there be a new department for contract management in Central Office, which would ensure that the branches have sufficient support in this important area, or where should this function sit?

Relatedly, the roles and responsibilities of different departments in Central Office do not seem to be clearly defined nor authority clearly delegated. As an example, the Control and IT Departments appear to be involved in a whole range of activities, including the development of specialty groups for hospital contracts.

The HIF needs to review how departments in Central Office are defined, how functions are divided between these departments and branches, and the human resources and their associated skills and qualifications that are in place to support these functions. It is likely that the HIF would benefit from organisational restructuring, in parallel with the current redundancy program that is underway. Responsibility, authority and accountability need to be clearly articulated. It is suggested that process re-engineering to facilitate greater delegation of authority within the HIF would be of benefit.

A related area is human resource management. The HIF has suffered in the past from a high staff turnover, and insufficient attention to staff development. Senior management positions are highly politicised, and until recently, many positions were filled without reference to appropriate skills and experience for the role. Although the HIF has been making some inroads in this area, it needs greater attention. This is true for the entire public sector in Macedonia, not just the HIF, and is a legacy from the former system. Principles that should be adopted by the HIF include:

- Staffing linked to plans and work requirements;
- Staff have appropriate skills and qualifications;
- Staff performance is regularly assessed;
- Staff development and career plans in place;
- Training strategy and plans for provision of training in place.

The HIF also needs to address its public image. Purchasers are often associated with cost cutting and bureaucracy, as opposed to promoting the public interest. Certainly, its current public image is not positive, and the HIF needs to do more to address this, perhaps through establishing and implementing a formal public relations strategy. Alternatively, small changes can be made. While the HIF annual report is currently available on the website, the HIF should consider reformatting the report so that it is targeted at the public as well as Government. It should also consider holding insuree forums at local level to improve community participation and obtain more feedback from this most important group. These could be organised and run annually by the branch offices, according to a clear structure. As the HIF introduces the important changes described throughout this report, it is important for the sustainability of the compulsory health insurance scheme that it does more to convince insurees that they are working in the public interest.

Finally, building on the recommendations provided through the independent systems audit that is currently being conducted, the HIF needs to establish the processes that are required for an effective internal control environment. The purpose of this report is not to second-guess those findings, however one area where work is clearly required is communication. Internal communication structures have been poor to date, and there is a culture of hoarding information. Staff perform better if they understand the HIF's objectives, and the purpose of their own activities, and therefore strong communication channels are a priority, particularly with regard to the important changes that are taking place. This will also support a strong internal control environment.

There is a need for capacity building in modern management techniques to support these efforts to strengthen management practices within the HIF. Although the HIF would need to do a more systematic review, ideally based on staff development programs, some of the areas that have been identified include:

- Business planning
- Communication and teambuilding
- Consensus-building and motivation
- Setting targets and measuring performance
- Project management
- Time management
- Organisational stress management
- Problem solving
- Budget management (for managers, as opposed to the finance department)

- Human resources planning and management (planning of human resources, principles of staff motivation career policy, primary and secondary work conditions, evaluation of staff systems, the role of unions and employee associations).

HIF senior and middle management would benefit from formal training in some of these areas, assuming that the staffing structure remains stable and that human resources can be sufficiently depoliticised so that Assistant Directors, at least, are systematically recruited on the basis of skills and qualifications, measured against clearly-defined and appropriate selection criteria. In fact, any comprehensive strengthening of HIF management requires this stability and independence from Macedonian politics.

### **3.6.3 Performance of the HIF Management Board**

This is an area where HIF management does not see a great need for change, as superficially the Management Board appears to be functioning reasonably well, and there are other priorities for improvement that need attention.

However, the Management Board of the HIF is a vital part of the governance structure, playing a key role in the oversight of HIF management and providing accountability to key stakeholders, including the Government, insurees, employers and health care providers. Over the years since the Board was established its performance has been poor, if measured against the right criteria. For example, the Board has failed to respond adequately to clear evidence of fraud and waste within the HIF in previous years, or clear examples of operations that are contrary to the legal framework in which the HIF operates. In the past, the Management Board has not provided a sufficient check on the Director, or executive management and is subject to excessive political influence, which prevents it from making independent decisions that are in the best interests of all stakeholders. Further, if we take the financial position of the HIF over the last few years as a proxy for effective governance, the Management Board has been ineffective.

The process used to select members of the Management Board greatly affects ownership and accountability. Currently all members are nominated directly by the Parliament. Although six of the thirteen members are supposed to represent insurees and two represent employers, in practice there are serious concerns about whether these groups are adequately represented by the chosen individuals.

Another part of the problem is that while the Management Board's activities are clearly defined, there are no criteria against which individual members and the Board as a whole can be judged. The Board, along with the HIF Director, should be held accountable for the performance of the HIF, but at present it is not.

A brief assessment of the performance of the HIF Management Board as part of this assignment indicates that steps need to be taken to improve the performance of the Management Board, if the HIF and the Government are serious about improving the governance and effectiveness of the organisation. The Canadian Institute on Governance (IOG) has developed a governance effectiveness checklist, shown in Table 2, which gives a quick indication of the effectiveness of Board operations. This may be useful for interested parties in conducting their own assessment.

**Table 2: IOG Governance Effectiveness Quick Check**

5	4	3	2	1	0
Agree Strongly	Agree	Indifferent	Disagree	Disagree Strongly	Don't Know
1. The organisation's orientation for Board members adequately prepares them to fulfil their governance responsibilities					—
2. The Board is actively involved in planning the direction and priorities of the organisation					—
3. The Board does a good job of evaluating the performance of the Director (measuring results against objectives)					—
4. This organisation is financially sound (viable and stable)					—
5. Board members demonstrate clear understanding of the respective roles of the board and the Director					—
6. The organisation's resources are used efficiently (good value for money spent)					—
7. The board has high credibility with key stakeholders (Government, insurees, employers, staff, health care providers, community)					—
8. Board members demonstrate commitment to the organisation's mission and values					—
9. Board members conduct themselves in accordance with key elements of the governance structure (bylaws, policies, code of conduct, conflict of interest, etc.)					—
10. The board's capacity to govern effectively is not impaired by conflicts between members					—
11. There is a productive working relationship between the board and the Director (characterised by good communication and mutual respect)					—
12. I am confident that this board would effectively manage any organisational crisis that could be reasonably anticipated					—
13. Board meetings are well-managed					—
14. The Board uses sound decision-making processes (focus on board responsibilities, factual information, efficient use of time, items not frequently revisited, effective implementation)					—
15. There is a good balance between organisational stability and innovation					—
Total of the 15 items					—
Overall Score (Total divided by 15)					—

Source: Institute on Governance, [www.iog.ca](http://www.iog.ca)

It is recommended that the HIF take steps to improve the performance of the Management Board. Some of the mechanisms that should be considered include:

1. Introducing alternative methods for member nomination and selection – for example, consideration of an election process for employee and employer representatives involving consumer organisations and trade unions;
2. Defining a clearer mandate for the Management Board and the Director which establishes clear accountability for specific areas of operation, not just defining activities;
3. Introducing formal selection criteria for Management Board members;
4. Establishing indicators and performance evaluation for individual Board members, as well as criteria for assessing the overall performance of the Board;
5. Requiring disclosure of conflict of interest (for example, shareholders of a pharmaceutical company should not be allowed to sit on the Membership Board);
6. Introducing formal processes for evaluation of the Director of the HIF;
7. Improving communication with stakeholders (see Section 3.6.2).

Organisational governance is a difficult area to address, and many more established organisations in countries such as Canada, Australia, New Zealand and the United Kingdom still struggle with the development of an appropriate model. It is not necessarily proposed that the HIF needs to adopt best practice in this area, just that some fundamental issues need to be addressed and more attention needs to be paid to the performance of this important body.

Given the lack of expertise currently in the HIF and the public sector generally, it is recommended that external assistance be provided to introduce new processes that improve the performance of the Management Board.

### **3.6.4 HIF Internal Audit**

The HIF does not currently have effective internal controls in place to ensure that the structure, policies and procedures support achievement of the organisation's and the Government's objectives; that resource use is consistent with these aims; that waste, fraud and mismanagement is minimised; and that information is available to support decision-making.

Some of the risks that internal control is designed to address include misuse of resources (financial, human, technical), poor implementation of policy decisions, fraud and error, and failure to provide timely and reliable financial and resource management information to support management decision-making. These can be minimised through tools such as clear instructions to staff and sufficient training, clear definition of responsibilities, separation of functions of staff handling financial management transactions and an open culture of communication and reporting. An example of a control process is reporting of expenditure transactions which are outside the usual pattern.

The first step that the HIF needs to take is to assess the risks facing the organisation and identify useful controls, which is a difficult task. The independent and detailed systems audit is being undertaken currently by Ernst & Young will provide valuable support in this key area, but HIF management must remain closely involved, as the controls which are implemented

must be ones that management will use. It is also essential that the controls are cost-effective.

Once the identified internal controls are established, the HIF needs an internal audit function. It is widely considered to be best practice in public sector financial management that all government agencies have a fully functioning independent internal audit function that aims to provide reasonable assurance that the organisation's internal controls are functioning well and identifies problem areas. The HIF's Control Department currently performs controls of branch office operations, but it also provides adhoc support to the branches in their own controls for operational transactions, and is therefore not independent. In any case, it does not check the internal systems in Central Office itself of direct control of operational transactions (for health care providers, revenue collection and so on).

To be effective, the HIF internal audit unit must have functional independence; an adequate audit mandate and sufficient status in the organisation; use internationally recognised standards; and have systems in place to take action against irregularities. Moreover, it is essential that HIF leadership, particularly the Director, is committed to effective management and values the internal audit function. Without honesty and personal commitment at the top level, the internal controls and internal audit unit cannot be of much use.

Broadly, the main steps that need to be undertaken by the HIF are:

1. Develop a mandate and procedures for the internal audit unit;
2. Formally establish an internal audit function, separated from the existing Control Department, that provides independent information to HIF management on the effectiveness of its controls and risk management procedures, including allocation of sufficient resources in the HIF budget;
3. Ensure that an adequate number of appropriate staff are available to support the internal audit function and are trained in the necessary technical skills;
4. Ensure internal processes, indicators, accounting formats and reports are aligned to the internal audit function's requirements;
5. Familiarise management with the role and scope of internal audit and provide the adequate support and ratification required (status can be increased through establishment of an audit committee, which can identify areas to be covered by the internal audit and draw conclusions from the audit results);
6. Develop appropriate links and a communications strategy (if necessary) between the internal audit function and external institutions, such as the MoF Internal Audit Department, SAO, the International Forum for Internal Auditors and the public.

The internal audit unit should aim to conduct a financial and performance audit, which involves not only an audit of budgetary and financial systems through compliance tests and substantive tests of actual transactions, but also assessment of the extent to which objectives and programs have been achieved in a timely and efficient manner.

Establishing an internal audit unit within the HIF has been recognised as an immediate need by the Government and is a conditionality for the release of PSMAL funds. Therefore, this process is being championed and supported by the MoF Internal Audit Unit, which in turn is supported through the Dutch Trust Fund via training and technical assistance to update the audit handbook.

In addition, the Ernst & Young systems audit includes within its scope detailed recommendations on the establishment of the internal audit function within the HIF, as well as proposals for strengthening controls across the board.

It is envisaged that the recommendations provided by Ernst & Young, coupled with direct assistance from the MoF (and SAO, where appropriate) to set up the unit, will be sufficient to ensure that the internal audit unit is set up and strengthened. Therefore, further direct support for the establishment of the internal audit function through the HSRP is not a priority. However, support to strengthening the management of the HIF as recommended in Section 3.6.4 below, would contribute to strengthen the control audit and should take into account findings from the Ernst & Young work when defining target areas for support.

As there are no recommendations for supporting internal audit activities under the HSRP, and the Government is already committed to this move, no detailed work has been undertaken on the regulatory changes required, or the costs and benefits of the move. The introduction of an internal audit function does have the potential to reduce waste and generate efficiency savings, which can be translated into better health care services for HIF beneficiaries. However, it is not an end in itself and must be accompanied by a strengthened control environment and full support from Management. If these requirements are not in place, the establishment of an internal audit unit is unlikely to be cost-effective at this point in time (that is, the costs will outweigh the benefits).

### **3.6.5 External audit**

The State Audit Office (SAO) plays a fundamental role in the oversight framework of the HIF, providing an independent view to government (and other interested parties) on the effectiveness of HIF management and operations, with a particularly emphasis (at this point) on financial management. It is important that SAO performs this function effectively.

A solid foundation for external audit has been established in the SAO, based primarily on applicable international standards, and attest and compliance audits have been conducted of the HIF over the last three years. There are a few areas where improvements could be made. However, efforts to address these areas are underway with the support of PSMAL and the associated Dutch Trust Fund, including changes to the governing legislation and auditor training.

From the perspective of strengthening the external oversight function performed by the SAO, the priorities are:

- Conducting risk-based audits of specific aspects of HIF operations (using results from internal audit activities, once established);
- Identification and clear definition of corrective actions, ideally requiring a response from the HIF within a given time period, or at least stronger tracking and reporting on the government's progress in taking those actions;
- Broader communication of results (and recommendations) to organisations and persons with an interest in the findings; and
- Strong cooperation between the SAO and internal audit functions within both the MoF and the HIF (once established).

Some of the general areas alluded to in the World Bank-led Country Financial Accountability Assessment, such as stronger attest audit practices (perhaps requiring better selection of

sample transactions), and an annual external audit of the SAO itself, will be important in increasing the overall quality of the HIF audits.

Several stakeholders, including the IMF, have expressed a desire to see the annual audit reports published on the HIF website. A more acceptable option may be to ensure that organisations and individuals that apply to the SAO can receive the reports (unless restricted for reasons of national security), and that the results are disseminated to the public through the media. The effective use of the media is important, as on the whole the public is not likely to be interested or competent to read the reports themselves. This may require some training of the media to ensure that they are competent and proactive. The CFAA has recommended that the SAO provide a high level summary of its recommendations for corrective actions to the Parliament, which would then be made available to the public and the media.

Performance-based audits, looking at the overall efficiency of operations across the entire organisation and identifying areas of inefficiency and mismanagement, are not currently part of the SAO mandate. The SAO is considering the introduction of performance-based audits in the future. However, this does require considerable training and resources, and is not necessarily a priority at this point. Most European countries have not yet implemented effective performance-based auditing in the public sector.

Given the existing work underway, no additional recommendations for support to the SAO have been made here. Any areas not currently being addressed should ideally be incorporated into existing support mechanisms.

### **3.6.6 Summary of Recommendations**

Support should be provided through the HSRP to strengthen both the HIF and MoH, and to improve the performance of the Management Board. It is unlikely that sufficient resources will be available through the Project to provide technical assistance in all these areas, given the current emphasis placed on information systems and hospital management. However, the recommendation is that serious consideration is given to diverting resources towards these options, which have the potential to bring large improvements in health sector performance, if accompanied by civil service reform (see Section 2.2.4).

Although strengthening the State Audit Office is an important part of improving HIF governance, no additional support is necessary under HSRP. The support being provided under PSMAL to strengthening the external audit framework should be sufficient, particularly given the commitment of the SAO to this goal.

A similar argument applies to the establishment of an HIF internal audit unit. Assuming leadership commitment is in place, it is strongly recommended that the HIF develop a clear plan and timeframe for the establishment of an internal audit unit in the HIF, aiming to have an effective unit in place by 2005. Support should be provided by the MoF Internal Audit Unit, using recommendations from the independent systems audit as a guide.

#### ***Strengthening Institutional Capacity of the MoH***

It is strongly recommended that the Government of Macedonia implement a comprehensive strengthening program for the Ministry of Health, including support for the development of a national health strategy.

The MoH needs to develop precise strategies and implementation plans for a number of areas of the health sector, including primary health care, pharmaceuticals, quality improvement and

privatisation. However, there is also an urgent need to build an overall health sector strategy. These specific strategies should be part of an overall framework that encompasses these and other issues and identifies an integrated development strategy with clear priorities. This strategy should serve as the basis for analysing and evaluating policy options and investment decisions.

In order to ensure that these strategies have some practical use, the MoH needs to have the capacity to implement them, which requires both technical and managerial skills and increased resources.

A comprehensive Strengthening Program needs to be designed for the MoH, incorporating the redesign of management processes and systems, capacity building, training, mentoring and direct assistance to introduce new strategies and techniques. The objectives would be to:

1. Establish MoH as an effective policy-making body, through the development of technical capability and supporting information, allowing it to fulfil a 'stewardship' role in the health sector;
2. Develop capacity of the MoH to effectively oversee HIF activities, ensuring that they contribute to sectoral objectives.

Areas that this Program should address include:

- Development of a National Health Strategy (identifying goals, practical steps, and timeframes) and supported by a sub-set of strategies for:
  - Primary Health Care
  - Public/private mix in health financing & delivery
  - Quality Improvement
  - Health Information Systems
  - Pharmaceuticals
- Capacity building to implement and maintain these strategies;
- Development of tools and capacity in Policy Analysis and Monitoring, with particular emphasis on health financing;
- Organisation and HR development structures.

The national health strategy should cover the policy goals (objectives and outcomes), broad approaches, concrete policy measures and broad cost estimates. A suggested structure is provided in Table 3 below. Development of the strategy should be an inclusive and dynamic process, based on realistic assumptions and minimising complexity. This is essential for effective planning in the health sector, as well as for effective financial management within the HIF.

**Table 3: An illustrative structure for a Macedonian National Health Strategy**

1. Introduction	Purpose of Document, Development Process, Previous Plans
2. Overall Strategy	Vision; Mission; Organisational Values; Strategic Assumptions; Strategic Goals
3. Situational Analysis	Current service delivery network, organisation of the health sector, vital statistics, funding arrangements, workforce
4. Design	Aims, Actions, Expected Outputs for each strategic goal
5. Implementation	Critical success factors, timing, milestones, responsibilities, publicity, financing

Capacity building will be a vital part of this program to strengthen the MoH and should comprise a set of formal and informal training exercises in both technical and general management skills, mentoring and knowledge transfer. A training needs analysis should be undertaken as part of the program, but topics might include:

- Strategic planning
- Policy analysis
- Cost-effectiveness analysis
- Performance monitoring & evaluation
- Monitoring of health insurance activities
- Leadership & communication

Prior to any comprehensive efforts to improve capacity, the MoH needs to look at its current organisation structure and whether it supports performance of key functions, including existing versus required staff capacity in each area, the organisation and mandate of the departments and the management, communication and other processes that are in place. The outcome of this exercise would be plans for reorganisation of MoH operations, including a comprehensive recruitment strategy for unfilled and possible new positions (subject to approval from the Government) based on a set of clearly defined competencies and selection criteria.

An implementation plan for strengthening the MoH over the next three years is provided in Appendix 1.

### Technical Assistance

Given the limited expertise in health policy formulation and implementation currently in Macedonia, it will be essential for the MoH to have support from international consultants if the strengthening exercise is to achieve results. Local consultant support will also be necessary and at a minimum, it is anticipated that the MoH will need to recruit a new permanent staff member to coordinate and lead this process, which may be funded through the HSRP in the interim. Consulting Services (both foreign and local consultants) will support redesign of management processes and implementation of change in the MoH, as well as comprehensive capacity building, training and mentoring among MoH management.

A small provision has been made for computer and office equipment within the MoH to support this work.

Terms of Reference for consultants to support the strengthening of the MoH are provided in Appendix 5.

### Legislative changes

Fundamentally, this proposal involves improving the implementation of the current legislative framework, rather than changing the design. There is a strong chance that a change in the systematisation of the MoH will be required, as well as legislative changes to support strategic recommendations resulting from this strengthening program. It is, naturally, not possible to define these at this point, as the strategies have not been defined.

Obviously there are also implications for the Government, in terms of the constraints on public sector employment imposed by the IMF, which need to be addressed.

### Analysis of Costs and Benefits

A budget of US\$302,206 has been estimated to cover technical assistance, training and equipment to support strengthening of the Ministry of Health. A breakdown of these costs is provided in Appendix 8.

In addition, if the Government is committed to its health sector reform objectives, including improving HIF governance, it is anticipated that staffing capacity will need to be increased by at least 10 individuals, over and above filling currently unfilled positions. This is expected to an additional recurring cost to the Government of US\$ 102,000 per annum.

Benefits are, once again, difficult to quantify. Strengthening the MoH should contribute to improved efficiency of care, and improved health outcomes through better quality and appropriate of care.

### Indicators

Examples of indicators that could be used to identify the success of interventions in this area include:

1. Existence of a comprehensive and consensus-based national health strategy by 2006;
2. Clearly documented and implemented procedures for monitoring the HIF, including clear responsibilities with regard to planning of the annual budget;
3. A 25% increase in filled staff positions within the MoH;
4. An increase in the annual budget allocated to the MoH and to government funded health programs; and
5. An institutionalised process for analysis and evaluation of policy options within the MoH.

### ***Strengthening HIF Management Practices***

The lack of sound management practices in the HIF at present has contributed to its poor performance and unless this area is addressed other initiatives to improve governance will have little impact. Therefore, it is recommended that the HIF should introduce a comprehensive program of strengthening its management practices.

The program would cover:

- Business planning, including setting objectives and targets;
- Organisational restructuring, include clearer definition of responsibility, authority and accountability;
- Human resource management;

- Public relations; and
- Training in modern management techniques.

An indicative implementation plan is provided in Appendix 1.

### Technical Assistance

The HIF would require technical assistance to support organisational restructuring and development, and capacity building in modern management, as described above. It is anticipated that an international consultant and local consultants would be required to support developments, with sound experience in management development, ideally in a health care setting.

Given current budget constraints with respect to support provided through the HSRP, the technical assistance that is recommended here would cover design of new processes and a targeted training package to support those processes, but would not be able to support implementation.

Draft Terms of Reference for the consultancy services to support the strengthening of the HIF are provided in Appendix 6.

### Legislative changes

The only change that should be required as a result of this proposal is a change in the HIF Statute, which still has not been formally approved.

### Analysis of Costs and Benefits

A budget of US\$229,000 has been estimated to cover international and local consulting services and training, with the latter valued at US\$85,000, which assumes participation of a private sector Macedonian training firm with expertise in management training.

If the HIF does decide to upgrade its human resources and public relations functions, it is anticipated that around four additional staff will be required to support this in the future, with an approximate additional cost of US\$40,000 per year.

Benefits should include improved staff performance and improved efficiency of operations, including reduced waste and fraud through the application of appropriate internal controls.

### Indicators

Some of the indicators which could be used to identify the success of interventions in this area include:

1. HIF business objectives and business plan in place for 2006;
2. 20 HIF managers trained in modern management techniques, based on a comprehensive assessment of training needs;
3. HIF internal audit unit reports sufficient internal controls in key areas; and
4. Clear delineation of roles and responsibilities of HIF Departments, branches, and improved delegation of authority.

### ***Improving Performance of the HIF Management Board***

Despite the existing doubts amongst HIF management about whether there is a need to address the performance of the Management Board, it is strongly recommended that the HIF take steps to address priority areas to improve the functioning of this important body. The HIF should:

1. Review the alternative options that are available for nomination of Board members and make a proposal to the Government for amendment to the Health Insurance Law and introduction of these new processes;
2. Define a clear mandate for the Management Board and the Director, which clearly defines accountability as well as activities;
3. Define and introduce selection criteria for Board members, and performance evaluation for individual Board members and for the Board as a whole;
4. Design and introduce processes for the evaluation of the Director; and
5. Define and introduce secrecy standards and procedures for Board Members, along with requirements for disclosure of conflict of interest.

An indicative implementation plan is provided in Appendix 1.

#### Technical Assistance

Consulting services from one international and one local consultant should be procured to support the HIF with the introduction of processes to improve the effectiveness and participation in the Management Board.

Draft ToRs for this work are provided in Appendix 7.

#### Analysis of Costs and Benefits

A budget of US\$66,000.00 has been estimated to cover international and local consulting services.

No additional costs are foreseen, although the changes may require additional time from Management Board members.

Benefits should include improved participation, transparency and efficiency of HIF operations, as well as an improved public image.

#### Indicators

Some of the indicators that could be used to identify the success of interventions in this area include:

1. Documented accountability and performance evaluation processes
2. Improved financial position of the HIF

## 3.7 Other Considerations

### ***Strengthening Hospital management & Autonomy***

Improvements in the design of provider payment models and contracting will have little impact unless managers of public health care providers are accountable for the performance of their facilities. This is particularly relevant to hospitals. Hospital Directors and their management teams must have the capacity to respond to the changes and the new incentives that are provided, including sufficient management autonomy. For example, hospital managers should be allowed to retain revenue generated from user fees (while accounting for this income very clearly), providing incentives for improving efficiency. Similarly, the changes proposed by the *Hospital Contracting and Modernisation* team to encourage autonomy, notably the strengthening of management boards, the implementation of performance contracts for hospital managers and performance-based salary arrangements are vital.

Although the skills of clinical staff are strong from a clinical perspective, there is still a need to develop an understanding of the financial implications of their decisions, as well as building skills in team building and communication that will help build the more effective work culture that is required for quality improvement (for example, building stronger cooperation between doctors and nurses, or between senior and junior doctors). From the perspective of improving the efficiency and cost-effectiveness of services contracted by the HIF, attention to these 'softer' areas might be prioritised above the development of more sophisticated management tools, such as balanced scorecards, or training in areas where there are cultural barriers, such as customer services.

Finally, although it is fundamental that health care institutions begin to focus on measuring and evaluating performance, and that there are information systems to support this, the priority must be to design information systems that support sound clinical practice. Upgrading coding practices for diagnoses and procedures in hospitals is a priority, so that sufficient information is available to support, amongst other things, clinical review and price-setting.

### ***Reviewing the Benefits Package***

The compulsory benefits package provided under the health insurance scheme, as it is currently implemented, is unsustainable. The definition and implementation of the benefits package needs to be reviewed, supported by clearer efforts to measure the services that are provided by health care providers. To have an effective health system requires that hard decisions are made about priorities.

Health technology assessment is a tool proposed for development under the HSRP that could go some way to supporting improved decision making on investments based on cost-effectiveness.

### ***Pharmaceutical Reform***

Sound recommendations have been provided by the *Pharmaceutical Policy Consultant* on the priorities for pharmaceutical reform, including the strengthening of legislation to provide stronger sanctions for dispensing prescription drugs without a valid prescription; strengthening the State Drug Bureau and developing stronger coordination across the sector; capacity building for hospitals in managing their drug formularies and budgets; updating the positive drugs list based on therapeutic guidelines; and strengthening efforts to educate doctors on appropriate prescribing practices, including the use of prescribing guidelines and drug management programs. These changes are essential for improving the cost-effectiveness

and quality of care, and must be undertaken in parallel with efforts to improve the HIF purchasing function.

The HIF has an important role to play in supporting these changes and will also be impacted by them. For example, legislative changes that reduce the current practices of dispensing drugs without prescription will increase the volume of positive list drugs formally dispensed and qualifying for HIF subsidy, thus increasing HIF expenditure. The HIF therefore has an interest in encouraging cost-effective care, and needs to work with the MoH to develop guidelines on rational prescribing and drug management plans for high cost, high volume drugs. The Prescriber Feedback Program recommended in Section 3.3.2 would be an important part of this education process.

### ***Quality Improvement***

As noted earlier in this report, the HIF has an important role to playing in encouraging improvements in the quality of care in Macedonia, through providing appropriate financial and non-financial incentives (such as meeting services standards, developing clinical pathways and introducing the AEP for assessing appropriateness of hospital admissions, as a condition of contract).

In general, Macedonia is only just beginning to look at evidence-based medicine. Important quality improvement activities are being supported through other components of the HSRP, including development of clinical guidelines, protocols for rational drug use, and improving licensing and accreditation. It is important that the HIF dovetails its efforts to influence quality of care with these broader developments in quality improvement at the national level.

As an aside, draft plans for development of guidelines and pathways, which indicated something like twenty-five guidelines over three years, are way too ambitious. A well-considered clinical guideline will take at least 12 months to develop, and that is in countries with existing capacity and experience in clinical guidelines. Expectations in this area, if still at this level, need to be lowered considerably.

### ***Information Systems***

The previously implemented Health Sector Transition Project supported the procurement of a new information system package (equipment, software and services) for the HIF. The new system was intended to support the entire range of business functions, including health insurance contribution payments, expenditures on different programs, contract management, financial management and accounting and management decision-support. However, much remains to be implemented, and further support to strengthen Management Information Systems is anticipated through the HSRP.

Upgrading information systems is important for improvements in financial management and purchasing, both of which will introduce new information requirements as new processes are put in place. However, it is equally important that HIF staff have adequate capacity to (a) define their business needs and (b) utilise the information available.

The consultant working on the Information Systems Component, also part of project preparation activities, will provide a more detailed assessment of the HIF's needs in this area. However, from the perspective of improving HIF governance and effectiveness, while improved management information systems are important, large-scale investments are not a priority and should be considered with caution.

Efforts will need to concentrate on developing a cost-effective information system that supports key functions, and developing the capacity of staff to utilise the information effectively.

### ***Privatisation***

There is a strong push in Macedonia to privatise health care provision, in order to improve efficiency, quality and responsiveness of the health system. Competition among health care providers is desirable and essential for improving productivity and quality of care. However, it does not require privatisation of providers (unless it is in the best interest of society) or even separation of purchasers and providers. The experience in the Australian health system is an excellent illustration of this.

In Macedonia, it is questionable whether large-scale privatisation of health care delivery will offer sufficient benefits in comparison to the costs of the process, particularly given the lack of health care management capacity in either the public or private sectors. Therefore, the MoH needs to develop its strategy in this area very carefully, properly evaluating the benefits and risks based on experiences in other countries.

Large-scale privatisation should not be considered on the financing side, as it will contribute to cost escalation and place the health outcomes at risk.

### ***Rationalisation of the Labour force***

The size of the workforce employed in public health care facilities is excessive, making a considerable contribution to the inefficiencies that are inherent in the health sector. The HIF intends to use the new provider payment mechanisms to drive labour force downsizing in public facilities through funding them on the basis of outputs, regardless of inputs. There is a risk, however, that this approach will not be effective.

During recent discussions about the introduction of contracts for public primary health care providers, the MoH maintained that there was little point in introducing them at this stage, since the Government is obliged to cover salaries for all employees under legislation and, as such, funding levels for health care facilities could not be changed. Presumably, this applies to hospitals as well. In any case, healthcare facilities do not necessarily have the flexibility or capacity to effectively manage and reduce their clinical and non-clinical workforce.

This approach also fails to address the social implications of reducing the workforce by providing an adjustment strategy to assist those affected. Further, without effective planning, there is a danger that the resulting workforce numbers and structure will not meet future needs.

Although it is more politically sensitive, the Government of Macedonia should consider an explicit strategy for adjusting the size of the health sector workforce (clinical and non-clinical staff), based on:

1. A rigorous estimate of present and future staffing needs in the health sector
2. Explicit strategies for modifying the quantity, skills mix and distribution of human resources in health sector, including attrition (for example, early retirement, redundancy incentives, emigration) and retraining for deployment within the health sector or for alternative private or public sector roles

The Bulgarian government is currently using this approach to address excesses in their own health workforce, and the MoH would be wise to monitor their progress over the next twelve months.

## 4. CONCLUSIONS

To summarise, the main areas to be supported under the future Health Sector Management Project are:

- Financial Management Strengthening
- Development of a Purchasing Capacity
  - Refinement of existing models
  - Capacity building
- Capacity Building for the Ministry of Health
- Management Strengthening for the HIF

A summary of recommendations for further support in HIF Governance to be provided through the HSRP is provided in the table overleaf.

Recommendation	Comments
1. Introduce a 3-year financial management improvement program	Technical assistance package, including consulting services, training and software.
2. Refine existing provider payment and contracting models and build the capacity of the HIF to be an effective purchaser	Technical assistance package, including consulting services, training and software.
3. Strengthen procurement practices for pharmaceuticals and medical supplies	Training only
4. Strengthen Revenue Control through specialist training, tightening reporting requirements and process re-engineering	Consulting services and training
5. Implement a Management Strengthening Program for the HIF	Consulting services and training
6. Strengthen the Performance & Accountability of the HIF Management Board	Consulting services
7. Capacity Building for the MoH	Technical assistance package, including consulting services, training and software.

A summary of cost estimates for assistance (consulting services, training and equipment) to be provided under the HSRP is provided in Appendix 8.

In addition, important developments that are being supported through the Dutch Trust Fund under PSMAL or other components of the project include:

- Establishment of internal audit in the HIF (PSMAL);
- Clarifying government obligations for funding certain health services in the public interest;
- Strategy for hospital debt restructuring (hospital management component);
- Proposal for the introduction of a tax on alcohol and tobacco, earmarked to the health sector
- Systematic solution to enforcement of contributions and harmonisation of beneficiary categories across social insurance programs (PSMAL)
- Development of a prescriber feedback program (rational drug use component)

These recommendations for future support in the area of HIF governance under the HSRP aim to assist Macedonia with its future reform efforts. Ultimately, however, these reforms will not be successful unless there is commitment to these changes in Macedonia. The Government needs to mobilise committed and enthusiastic individuals in the health sector to promote and lead the change. Fundamentally, health sector reform is extremely complex, more so than any other sector, and the Government needs to realise this, and take collective responsibility for future successes and failures.

## **Appendix 1: Implementation Plans**

## **Appendix 2: Terms of Reference for Financial Management**

## **Draft Terms of Reference for Support to the Financial Management Improvement Programme**

### **Background**

The Government of Macedonia, with assistance from the World Bank, is initiating a Health Sector Reform Project (HSRP) to support reform of the country's health sector. Key to achieving this will be strengthening the capacity of the HIF, targeting specific areas relating to the improvement of its governance and overall management. One area that will be addressed is the financial management within the HIF.

Financial management in the HIF is currently weak and needs to be strengthened as a priority for improving governance and overall performance of the organisation.

It is recognised that improvements need to be made in budget planning, including new processes for setting global budgets (supported by improved access to the data required to set appropriate budgets), development of more extensive budget projections, clarification of expected revenue streams from the state budget, improvement in the criteria and clarification of responsibilities for financing of capital investment.

Similarly, in the area of budget execution and monitoring, there is a need to improve management reporting within the HIF and to upgrade procedures for the monitoring of actual expenditure against the budget, assessing progress, and identifying measures to get back on course.

Good financial management requires that HIF budget planning is linked to a health sector strategy and the HIF's own business plan. In general, there is a need for improved budget planning based on sounder data; clearer understanding and definition of management requirements; clearer lines of responsibility, including accountability for budget performance and outcomes; improved management reporting; and a better understanding of costs.

The MoF has issued guidelines stating that all public sector accounting should be done on a pure cash basis, with memorandum entries for accounts receivable and payable. The accounting rules that have been followed to date by the HIF are inappropriate, accounting for revenues on a cash basis, but expenditures on an accrual basis. This understates revenues, overstates expenditures, and makes it extremely difficult to see the true financial position of the HIF.

Accounting standards influence interpretation of financial reports and poor practices can lead to misinterpretation and non-transparent reporting. Good standards are essential for improved transaction reporting, which has the objective of ensuring the effective management of expenditure and revenue through the efficient and accurate recording of all transactions. Best practice is that clear and appropriate policy, standards and objectives are in place and International Public Sector Accounting Standards are applied.

Changes need to be made to accounting practices at the Central Office of the HIF, and particularly the branch offices, which is where the fundamental accounting functions of the HIF are performed.

The MoF intends to issue clearer guidelines to the HIF (and other EBFs) on the accounting procedures that should be followed, and to check compliance with these guidelines directly rather than through the SAO. They also intend to play a role with the consultants in educating

HIF accounting staff on the changes that need to be made in order to move to IPSAS when the HIF begins operating within the budget.

As the HIF adopts international accounting standards, it needs to develop a better understanding of the costs of programmes and services, to support pricing in contracts, to prepare the necessary analysis to justify budget allocations from the government, and to assist decision-making within the organisation and at MoH level.

To support improvements in budget processes and accounting, the HIF could benefit from an upgrade in financial management skills through formal training. A deeper understanding of good financial management practices needs to be developed, including the budget construction process (that every item should be based on volumes and prices and be part of a strategy to achieve stated outcomes), financial analysis, performance management and managing resources. There needs to be capacity to build, utilise and evolve a stronger system of management reporting, which enables managers to assess progress towards and the likelihood of achieving desired outcomes, and to identify measures to get back on course if variances are occurring.

Similar training needs have also been identified in the context of the broader public finance reform programme and there may be scope for co-ordinating the HIF training with more general financial management training planned for MoF staff. This could then be augmented with more specific training courses targeted at health insurance staff.

In parallel, the HIF clearly needs to improve its financial management information systems (FMIS), providing better information to support budget planning and execution and the necessary tools to facilitate effective financial management. The new FMIS should support integrated accounting and reporting systems, devolved budget management and improved financial management processes (which are yet to be defined). To support implementation of the new FMIS, the HIF will likely benefit from assistance with the design, particularly with identifying business requirements based on the new processes.

### **Project Aims & Objectives**

In the context of strengthening HIF management, this component aims to improve financial management practices within the HIF so that they are in line with the Macedonian public sector financial framework and are progressing towards international standards. In particular, the project should support:

- Improved budgetary procedures.
- Introduction of appropriate accounting standards and procedures.
- Increased capacity of HIF staff in sound financial management.
- An upgrade in Financial Management Information Systems.

### **Scope of Services**

#### *Budget Planning & Execution*

The consultant will work with HIF staff to review current budget planning and execution processes and develop an implementation plan for introducing improved processes. The review will be informed by the results of the independent systems audit that was conducted in the first half of 2004.

Some of the priority areas that the HIF needs to address and which the consultant will provide advice on include:

1. Review possible data sources to support budget preparation using currently available information systems and modify data collection processes to improve data available to support budget planning;
2. Develop clear documentation on the budget planning process, covering the steps that need to be followed and responsibilities;
3. Establish processes to link provider contracts with budget planning and preparation process, using previous hospital contracts to inform budget planning, and ensure that the contracts and associated budgets for providers reflect the planned HIF budget;
4. Improve the revenue forecast and resource allocation process and ensure that forecasts and targets are realistic through incorporating all key information into the methodology;
5. Ensure the budget is linked to the investment plan prepared in conjunction with the MoH, and where appropriate, translated into hospital contracts;
6. Introduce a process for monitoring the execution of provider budgets (planned versus actual) and associated performance indicators, and improve monitoring of overall budget performance, establishing clear processes for escalation and corrective actions.
7. Review management reporting requirements, and develop a stronger system of reporting which ensures that financial management information is made available on a timely and regular basis, enabling managers to assess progress towards and likelihood of achieving desired outcomes, and identify measures to get back on course.
8. Introduce clear lines of responsibility and accountability for effective budget management with the HIF Central Office and branches, ensuring that at operational level, managers have the flexibility to take decisions within their areas of competence with an overall framework of rules and controls.
9. Establish proper systems for contract management (also see Section 3.3), which effectively track commitments and deliveries and ensure that payments are priorities on the basis of due date and order of precedence (and avoid advance payments).

#### *Accounting*

The consultant will assist the HIF to implement appropriate accounting standards (IPSAS), based on MoF guidelines, and to develop clearly defined and enforced accounting procedures. A review of the current expenditure classification and chart of accounts should be undertaken, resulting in recommendations for improvement in design.

#### *Training*

A formal assessment of staff capacity and financial management training needs is required, in parallel with the design of new budget management and accounting procedures. The HIF requires medium-term training initiatives in the areas of financial management for both Central and Branch Offices. Training topics might include:

- Planning & budgeting;
- Forecasting
- Accounting standards;
- Financial analysis eg. variance analysis;
- Cost accounting/costing methodologies;

- Performance Management; and
- Managing Resources.

The output of this exercise will be a medium-term training strategy, which will address immediate training needs and well as ongoing staff development in this area.

The consultant will also support capacity building through a series of workshops on key aspects of financial management, to complement formal training and support the medium-term training strategy.

#### *Information System Design*

The consultant will work with the staff and management of the HIF, particularly in the departments responsible for finance, planning and analysis, procurement and control, and the branch offices, to clarify business needs and reporting requirements to be supported by the FMIS. High level senior decision makers and other individuals in the HIF will also be involved in the strategic planning of the FMIS.

The main outcomes from this assignment will be:

1. Budget processes in place which are consistent with sound financial management and incorporate the necessary controls;
2. Accounting standards implemented in line with MoF guidelines and international standards (IPSAS), and an expenditure classification in place which supports internal management requirements;
3. Clear documentation and guidelines on accounting procedures, with HIF staff (particularly in the branches) competent in their use;
4. A clearly-defined medium-term training strategy for key HIF staff to support effective financial management practices;
5. A set of core staff with sufficient training to introduce the new financial management processes developed through this assignment
6. A complete specification of all business needs to be met by the FMIS to support effective financial management.
7. Recommendations for improving the organisation, role and responsibilities for financial management in the HIF.

#### **Reporting**

Within the first month of the assignment, the consultant will provide an Inception report, documenting the findings of the initial review and containing an updated workplan for supporting improvements in financial management within in the HIF.

Technical reports will be provided to cover each of the seven areas mentioned above

A final report will be submitted by 31 December 2005.

#### **Duration of the Assignment**

The project is expected to run from January to December 2005. It is expected that approximately 27 staff-months of consulting inputs will be required, the majority of which will be provided by local consultants.

## **Qualifications and Experience**

The assignment should be undertaken by a small team of international and local consultants with a strong track record in financial management, preferably with experience in health insurance. The team should have experience working on health reform projects in transition countries, demonstrating a successful track record in skills transfer and formal training.

## **Linkages**

In undertaking these activities, the consultant will need to link closely with plans to phase out the system of invoicing and reporting for services provided by health care providers, as there is a considerable impact on financial management.

The consultant should also be aware of the broader developments supported under the Health Sector Reform Project, particularly the other activities which are underway to support strengthening of the HIF.

## **Appendix 3: Terms of Reference for Strengthening the Provider Payment & Contracting Mechanism**

## **Draft Terms of Reference for Strengthening the Provider Payment & Contracting Mechanism**

### **Background**

The Government of Macedonia, with assistance from the World Bank, is initiating a Health Sector Reform Project (HSRP) to support reform of the country's health sector. Key to achieving this will be strengthening the capacity of the HIF, targeting specific areas relating to the improvement of its governance and overall management. One of the most important areas that needs to be addressed is the strengthening of the provider payment and contracting mechanism used by the HIF and building the capacity of the HIF to be an effective purchaser.

Despite the good work done to introduce a capitation-based payment model and contracting mechanism for private primary health care providers, which has seen some positive changes in the behaviour of private sector physicians, there are several flaws in the design and implementation which need to be addressed.

Consistent payment principles need to be introduced for public and private providers of primary health care. To date, the HIF has introduced contracts, with payment based on a mixed capitation model, for private providers. Fairness, efficiency and equity principles require that the HIF pays and contracts with all primary health care providers on the same basis. The current differential payment models are providing a set of perverse incentives for primary health care providers undermining efficiency gains, patient registers and quality of care.

Contracts for hospital care were only just introduced at the end of 2004, on the basis of the new by-law for contracting and paying specialist-consultative and hospital care, and they have only been completed for specialist hospitals and other hospitals with a simple services structure, covering only a few specialties. During 2004, contracts will be introduced for all hospitals in Macedonia, and all hospitals should be issued contracts for the full year in 2005.

As this is a reasonably new development, there is not much basis on which to judge the existing contracts. However, there are already some areas of concern from the design perspective which need to be addressed, related to:

- Differential payment rates across different providers for the same services;
- An ambitious set of performance indicators tied to hospital payment;
- Unclear definition and separation of planning and payment of specialist outpatient consultations versus inpatient admissions;
- Lack of defined services standards

Meanwhile, the HIF has plans to introduce a DRG classification as the basis for funding inpatient care in future years. While the general intention is sound, the timing and the sequencing is ambitious. Efforts over the next few years should concentrate on establishing the pre-requisites for this more sophisticated model, such as improved information systems, capacity in costing, clinical coding and so on. The HIF should try to avoid some of the mistakes made by other countries in the region that have implemented DRGs, and adopt a careful and measured approach if it wishes to achieve the potential benefits. The costs associated with introducing a DRG classification are often underestimated.

There is scope to improve other aspects of implementation, such as the contract planning process, design and negotiation. The burden of current reporting and invoicing requirements on health care providers and HIF branch offices is a key concern. The current 'invoicing' system has a high administrative burden, which detracts from other more productive activities. It is also negatively impacting on effective financial management. Even prior to the new contracting processes, it was largely redundant, as providers were not paid on the

basis of invoiced amounts. Concerned about changing these processes too quickly and losing valuable information, the HIF has not phased out this system for newly contracted PHC and hospital providers. This can be avoided through careful planning and design of the new reporting and invoicing system, ensuring that all potential users of the information are consulted prior to the change to make sure their needs are met. It is a priority that this issue is addressed as soon as possible.

Related to the above comments on the design and implementation of the new provider payment and contract models, the HIF has little existing capacity at either Central office or branch level, to act as a true purchaser, and therefore implement the new model effectively. Unsurprisingly, staff have little experience in planning, pricing, negotiation, monitoring and evaluation, and capacity in these areas needs to be improved if the desired efficiency gains are to be achieved (whilst ensuring an acceptable level of quality). One of the priority areas is the development of processes for monitoring provider behaviour using statistical techniques, rather than relying on detailed inspections. Importantly, much of the new hospital contracting process is not properly institutionalised in the HIF at present, with the work being supported by a Working Group that is more or less isolated from routine operations. Therefore work needs to be done to reorganise HIF activities and function so that they better support the purchasing function.

The respective roles and responsibilities of the MoH and the HIF with regard to health financing also need to be clarified, particularly with respect to the extent to which the MoH is involved in the annual planning process for provider contracts.

Finally, one of the activities that could benefit the HIF in its ongoing refinement of payment models and contracts for different care types is the development of a health financing strategy, which would specifically provide a framework for the evolution of the HIF's purchasing framework.

## **Project Aims & Objectives**

The overall Project aims to improve the performance of the Macedonian health system, one aspect of which is the effectiveness and governance of the HIF. The main objective of this component will be to strengthen the purchasing function of the HIF through support for ongoing refinement of the design and implementation of payment models and contracts, and capacity building for HIF staff in areas that will support effective purchasing.

Specifically, the objectives would be to:

1. Refine the design and implementation of payment models and contracts for primary health care and hospital services
2. Improve the capacity of HIF to be an effective purchaser of health services.

These developments are expected to result in improved efficiency, transparency and fairness in the reimbursement of care providers, and better value for money with regard to services provided under Macedonia's compulsory health insurance scheme.

## **Scope of Services**

The consultant will provide advice to the HIF in the design and implementation of refined payment models and contracts for primary health care and hospital providers. The support will focus very much on practical assistance in the areas that the HIF needs to address, notably:

- Strengthening the design of payment models and contracts for primary health care, hospital care and pharmacies, covering:
  - Improved incentives for PHC providers and introduction of consistent payment models for public and private providers;
  - Refinement of the hospital payment model to reflect principles of same payment for same work;
  - Development of more precise standards for services provided under PHC and hospital contracts;
  - Establishing foundations for the development of a DRG classification (such as upgrading hospital coding practices);
  - Design of a new payment model for pharmacies and introduction of a contracting process;
- Introducing improved processes to support implementation of these contracts, including:
  - Phasing out the current system of reporting and invoicing, replacing it with a more cost-effective reporting process which facilitates effective contract management and monitoring of provider behaviour;
  - Improving data availability to support effective purchasing and the capacity of HIF staff to utilise it effectively;
  - Improved planning process prior to the design and negotiation of provider contracts which includes the MoH and clinical representatives;
  - A more robust approach to costing of services, including the introduction of a national hospital costing study;
  - Minor improvements in contract design, based on sound contracting principles;
  - A more equitable and effective process of contract negotiation between the HIF and health care providers;
  - A effective monitoring system for contracts and provider behaviour;
  - Introduction of a basic process for evaluation of provider payment models and contracts as the system evolves; and
  - Development of improved relationships with health care providers, including steps to encourage clinical practice improvements; and
  - Eventual establishment of competitive tendering amongst health care providers for certain health services (where it is in the interest of the community).
- Capacity building for HIF staff to support an effective purchasing function, including training and skills transfer in:
  - Planning
  - Contract design
  - Negotiation
  - Costing techniques

- Statistical analysis & reporting
- Monitoring and evaluation
- Clinical quality improvement
- Institutionalising HIF processes for hospital contracting, and improving the organisation structure and division of responsibilities to support an improved purchasing function.

## **Activities**

The consultant will be expected to:

1. Work with the HIF to develop a health financing strategy which defines the framework for long-term development of provider payment mechanisms, including clear definition of respective responsibilities of the health and social sectors;
2. Support the design and implementation of a payment model for primary health care providers which is consistent for both the public and private sectors;
3. Prepare and assist with the implementation of a plan for phasing out the current system of invoicing (if it has not already been achieved by the start of the assignment), clearly identifying the nature, timing and responsibilities for changes that need to be made to reporting and billing processes, financial management and copayment policies;
4. Provide recommendations on improving the planning process for contracting and the contract negotiation process with health care providers;
5. Assist the HIF to define data requirements for contract management and monitoring, and establish processes to better utilise the data available and apply statistical techniques in order to monitor provider behaviour;
6. Assist the HIF to develop more precise quality standards and tools to ensure appropriateness and cost-effectiveness of care, such as clinical pathways and the Appropriateness Evaluation Protocol (AEP), and other processes to improve ability of the HIF to reward improvements in clinical practice;
7. Advise on an implementation plan for developing a DRG-based payment model for acute hospital care and providing support for establishing the foundations required to introduce a DRG classification in the future;
8. Support the design and implementation of a costing study to refine payment rates for hospital services, ensuring that HIF staff have the capacity to repeat the study in future years;
9. Rearrange functions and resources in the HIF to better support the purchasing function; and
10. Define a capacity building strategy to improve staff capacity in key aspects of effective purchasing, including contract design, planning, costing, contract design and negotiation, statistical analysis, monitoring and evaluation and so on, and provide the necessary training and skills transfer.

## **Outputs & Reporting**

It is expected that the consultant will work closely with the staff and management of the MoH across the organisation. The following outputs are expected:

1. Inception Report, detailing the current status of the aforementioned topics, identifying, prioritising and qualifying the detailed activities for implementing next steps.
2. Reports on recommendations in each of the priority areas, including:
  - Design of the comprehensive health financing strategy;
  - Introduction of a new provider payment model and contracts for public PHC providers, which are consistent with the private sector;
  - Implementation plan for a new system of invoicing and reporting;
  - Implementation plan for the introduction of DRGs in Macedonia, and a mid-term progress report on developments in this area;
  - Recommendations on new contract planning, management, monitoring and evaluation processes;
  - Advice on organisation restructuring to better support the purchasing function
3. A training strategy for improving the capacity of the HIF in purchasing health services, and a report on the completion of training activities
4. Final report, outlining achievements in key areas and providing recommendations for future activities.

## **Duration of the Assignment**

The project is expected to run from the beginning of 2005 through to mid 2007. Estimated inputs during this timeframe are 60 staff months. At least 36 staff months should be provided by local consultants, who should be contracted by the consulting firm.

## **Qualifications and Experience**

The assignment should be undertaken by a consulting firm with previous experience supporting reform of provider payment mechanisms and contracting in the health sector, preferably in Central and Eastern Europe. Qualifications should include:

- Design and implementation of provider payment models for hospital services and primary health care;
- Experience in costing health services as the basis for setting payment rates;
- Experience with the design of effective contracting and negotiation processes;
- Encouraging clinical practice improvements in a purchasing model;
- Experience advising on health information and reporting processes to support an effective purchasing model; and
- Direct experience with capacity building in the health sector, ideally for a health insurance fund.

## **Linkages**

In undertaking these activities, consultant will need to link closely with other activities that are planned under the HSRP, particularly with regard to strengthening HIF governance.

Developments in financial management and information systems will be particularly important.

The consultant should also ensure linkages with work in the broader health reform agenda, notably quality improvement, primary health care and strengthening hospital management.

## **Appendix 4: Terms of Reference for HIF Revenue Collection and Control**

## **Draft Terms of Reference for Training in Revenue Collection & Control**

### **Background**

The Government of Macedonia, with assistance from the World Bank, is initiating a Health Sector Reform Project (HSRP) to support reform of the country's health sector. Key to achieving this will be strengthening the capacity of the HIF, targeting specific areas relating to the improvement of its governance and overall management. One important area that needs attention is the collection and administration of health insurance contributions from private employers, self-employed and farmers.

Private sector employees are currently required to make contributions to the compulsory health insurance scheme at the level of 9.2% of their salary, with payments made by employers on their behalf. Employer compliance with health insurance contributions is currently low, due to employers and employees who do not register, who under-register numbers and under-report salaries. There is also very little control over public sector contributions.

Part of the problem is the limited capacity of the HIF to effectively collect, control and enforce contributions. There is a need to re-design internal control processes, improve information systems to better support collection and control, and address enforcement of contributions systematically across the social insurance system. In addition, HIF staff in branch offices and the Control Department in Central Office, need training in revenue collection and control.

Internal training courses are already planned, with the support of PSMAL. However, the HIF will need initiate other activities to improve revenue control and collection processes internally, and to build staff capacity to a sufficient level.

### **Scope of Services**

An independent systems audit of the HIF was conducted in 2004 and looked in detail at revenue collection and control processes in the HIF. Recommendations for improving revenue collection and control were to be provided through that report. This assignment aims to assist the HIF in implementing those recommendations effectively, as well as providing additional advice to the HIF to improve capacity in revenue collection and control, including the development of a training plan to improve staff capacity in this area.

Support will be provided to the HIF to design and modify its procedures for collecting, controlling and enforce contribution payments and other revenue, collecting and utilising information from different sources and streamlining its controls.

The consultant is expected to provide advice and assistance to the HIF to:

- introduce more stringent reporting requirements and ex ante controls on contributions, particularly for private sector employers, which aim to address problems of underreporting of employee numbers and salary levels;
- design effective procedures and documentation for monitoring of revenue collection, including more comprehensive checks of employee status (through utilising other data sources), and formal procedures for site visits to check contribution payments (including clear criteria for selection of the sites based on risk profiles);
- advise on organisational restructuring to better support effective revenue controls in the branches and Central Office.

The consultant will also support the HIF to improve its enforcement of contributions, looking realistically at a systematic solution to the enforcement problem, which spans all social insurance agencies, not just changing the legislation to give the HIF enforcement power over health insurance contributions.

A formal training needs assessment should be undertaken to confirm the areas that should be targeted in the training programme. The consultant will:

- Design training courses, develop training material and provide theoretical and practical training courses for about 45 staff from branches and Central Office who currently work in the area of contributions control.

Examples of training topics that should be covered include:

- Establishment of revenue controls;
- Monitoring tools and tracking mechanisms;
- Debt collection; and
- Reporting and quality control processes.

### **Outputs & Reporting**

The main outputs from this assignment will be:

1. Report on design and implementation of improved revenue collection and control processes;
2. A formal assessment of HIF training needs; and
3. Design and delivery of training courses to improve revenue collection and control in the HIF.

The outcomes from the training should be carefully evaluated.

### **Duration of the Assignment**

The project is expected to run from March through to September 2005. Around 9 staff months of inputs will be provided over this period, 6 of which should be provided by a local consultant.

### **Qualifications and Experience**

The assignment should be undertaken by an international and a local consultant with specialist expertise in revenue collection and control in an insurance environment. Training delivery will be subcontracted to a specialist training firm.

### **Linkages**

The consultant should be aware of the broader developments supported under the Health Sector Reform Project to strengthen HIF, in particular changes that are taking place on enforcement and administration of contributions.

## **Appendix 5: Terms of Reference for Improving the Capacity of the Ministry of Health**

## **4.1 Draft Terms of Reference for Strengthening the MoH**

### **4.1.1 Background**

The MoH is the main policy making body within the health sector in Macedonia. It also has clear oversight responsibility over the HIF, and imposes accounting and financial management guidelines and reporting requirements relating to budget planning and execution. According to legislation the MoH is responsible for, amongst other things:

- Drafting health sector legislation
- Approving HIF annual financial plans;
- Approving Organisational and institutional arrangements of the HIF;
- Approving Programs and investments in the health sector;
- Defining drugs and medical devices covered under compulsory health insurance;
- Appropriate norms and standards for health services; and
- Agreeing prices paid for health services and level of co-payment.

In practice, however, the MoH is passive and unresponsive to the legal responsibilities and oversight role it is expected to play in the health sector. With respect to the HIF, the MoH has limited capacity to effectively monitor the HIF, exerts very little control over HIF operations and fails to enforce its own standards and requirements. As a result, the governance and accountability structure invested in the MoH as overseer of the HIF is seriously undermined. Further, the ability of the HIF to operate effectively is also impeded.

These findings are not new and several initiatives have been undertaken in the past to address the MoH's weaknesses in the past, for example, the PSMAC program recently attempted to strengthen the MoH's monitoring and analysis capacity. Unfortunately, most interventions to date have not been successful. Part of the problem has been that the approach has been fragmented, aiming to address one part of the problem (for example, lack of capacity in monitoring and analysis) without attention to the bigger issue – that the MoH as an organisation is weak and the conditions are not in place for targeted capacity building to be effective. The environment in which the MoH operates is particularly problematic, with staffing structures being political in nature, inappropriately skilled and subject to frequent change.

Regardless of these constraints, the need to improve the overall capacity of the MoH to undertake its core functions is seen as a key component of achieving effective and sustainable reform of Macedonia's health sector.

### **Project Aims & Objectives**

The Government of Macedonia, with assistance from the World Bank, is initiating a Health Sector Reform Project (HSRP) to support reform of the country's health sector. Key to achieving this will be strengthening the capacity of the HIF, targeting specific areas relating to the improvement of its governance and overall management. The Ministry of Health is currently responsible for financial and functional oversight of the HIF. However, this oversight function, and the overall status and capacity of the MoH in policy formulation and

stewardship, is currently weak. This threatens the viability of long-term improvements in the health sector.

The Project will aim to address the current limitations and weaknesses within the MoH that impact on its ability to design monitor and enforce health policy, including oversight of the HIF, and empower the MoH to provide leadership and strategic direction in the health sector.

A comprehensive Strengthening Programme will be designed and implemented for the MoH, incorporating redesign of management processes and systems, capacity building, training, mentoring and direct assistance to introduce new strategies and techniques. The objectives would be to:

1. Establish MoH as an effective policy-making body, through the development of technical capability and status, allowing it to fulfil a 'stewardship' role in the health sector;
2. Develop capacity of the MoH to effectively oversee HIF operations, ensuring that they contribute to sectoral objectives and that there is measurable improvement in both financial and organisational accountability

### **Scope of Services**

The consultant will provide advice and training to the MoH to support overall strengthening of the organisation. The focus of the consulting services will be targeted at the following areas:

#### *Strategic Planning*

The MoH suffers from lack of strategic direction. A national health sector strategy or health plan is not in place, and the capacity of the MoH to lead and implement such a strategy, were it in place, is questionable. As a consequence, its ability to lead on health sector reform is undermined. The consultant will assist the MoH to undertake a comprehensive review of the current situation in the health sector, and develop a national health strategy that provides a framework for current and long-term developments. It is expected that the consultant's role will be to establish appropriate processes for the development of the strategy, provide technical advice where necessary and mentor key managers in the MoH during the strategic development process.

The consultant should provide specific advice on a strategy for privatisation in the Macedonian health sector, which is currently high on the agenda within the MoH.

#### *Monitoring & Analysis*

There is a real need within the MoH to develop a capacity to analyse and prioritise alternative policy options, and establish stronger oversight of the HIF. The consultant will:

1. Develop processes and tools that support analysis and evaluation of policy options, and overall monitoring of the performance of the health system;
2. Develop processes and tools for effective monitoring and oversight of the HIF, including:
  - Processes that promote joint agreements and mechanisms for MoH approval of the HIF global annual budgets and stronger dialogue on the preparation of the HIF annual plan

- Reporting processes between HIF and MoH, including data requirements and indicator setting, that enable effective monitoring of expenditure patterns, resource allocation and implementation of provider contracts
- Processes and tools to facilitate effective monitoring and oversight of the HIF, including analytical techniques, setting qualitative, efficiency and effectiveness data points, reporting requirements etc.
- It is expected that the consultant will develop specific capacity and technical skills within MoH for undertaking effective monitoring and analysis functions, both generally and with respect to the HIF, including techniques that build staff incentives, confidence and overall capacity to effectively undertake monitoring and analysis (through the use of training and mentoring approaches).

#### *Institutional Capacity & Governance*

The MoH's organisational and human resource development functions are inadequate and are not aligned to its core functions. It is expected that the consultant will define and prioritise strategic interventions within the MoH's organisation structure that will address the current weaknesses in its role, including:

- Organisational and HR development structure
- Strategic leadership and management
- Communication and public relations

It is expected that the consultant will support MoH management and staff in implementing the strategic interventions

- Supporting change management processes,
- Providing mentoring, training and other capacity building activities

A key outcome from this programme should be strengthening of the overall capacity of the MoH in policy formulation and implementation.

#### **Activities**

Broadly, the consultant will be expected to:

1. Conduct a comprehensive review of current weaknesses in MoH, identify opportunities of improvement and agree on an implementation plan for strengthening the MoH.
2. Advise on the development of new processes and tools to support MoH functions in the core areas identified above, as well as any additional areas that are identified during the situational analysis;
3. Design and implement a comprehensive capacity building exercise to support developments in the core areas, as well as any additional areas that are identified during the situational analysis.

#### **Outputs & Reporting arrangements**

It is expected that the consultant will work closely with the staff and management of the MoH across the organisation. The following outputs are expected:

1. Inception Report, detailing the current status of the aforementioned topics, identifying, prioritising and qualifying the detailed activities for implementing next steps, including the:
  - development of appropriate monitoring and analysis tools and techniques,
  - approach to development of the national health strategy
  - institutional and individual capacity building program, including training requirements, mentoring, twinning and other capacity building techniques
  - required changes to processes, systems, communication mechanisms and staffing that are required to strengthen the management of the MoH.
2. Mid-term report, identifying progress with the strengthening activities;
3. Final report, describing achievements during the assignment and recommendations for future activities.

A series of technical reports will be produced on specific processes and initiatives that are being supported within the MoH.

### **Duration of the Assignment**

The project is expected to run from mid 2005 through to mid 2007. It is expected that approximately 12 staff months of international consulting time would be required and 24 staff months of local consulting time, over a period of two years.

### **Qualifications and Experience**

The assignment should be undertaken by a consulting firm with previous experience supporting capacity building in the health sector, ideally within a ministry of health. The team should have experience of advising on health reform in transition countries, demonstrating a successful track record in:

- Health planning (strategic and operational)
- Institutional change and capacity building
- Policy formulation and implementation
- Human resource and financial planning
- Training and mentoring others
- Participatory planning and project design
- Managing complex reform projects

### **Linkages**

In undertaking these activities, consultant will need to link closely with work on development of specific strategies that is being planned in areas such as primary health care, pharmaceutical reform, quality improvement and information systems.

The consultant should also be aware of the broader developments supported under the Health Sector Reform Project, particularly the other activities which are underway to support strengthening of the HIF.

## **Appendix 6: Terms of Reference for Strengthening HIF Management**

## **Draft Terms of Reference for Improving HIF Management Practices**

### **Background**

The Government of Macedonia, with assistance from the World Bank, is initiating a Health Sector Reform Project (HSRP) to support reform of the country's health sector. Key to achieving this will be strengthening the capacity of the HIF, targeting specific areas relating to the improvement of its governance and overall management. One of the areas that needs to be addressed is the strengthening of the management and organisation of the HIF itself.

Unless the HIF has sound management practices and an appropriate organisational structure in place, efforts to improve the governance of the organisation will have little impact. Complementing ongoing efforts to strengthen the performance of the Management Board, establish internal audit, and improve purchasing and financial management, there are a number of general areas where the HIF could benefit from improved practices and capacity.

Currently, the HIF has a business objective that is often stated as undertaking the role of the 'single payer' for health services covered by compulsory health insurance (established under the Health Insurance Law). However, this objective defines its function, not its goal. The HIF should have long-term goals and objective in place, as well as aiming to set its annual targets before the commencement of each financial year, as a basis for monitoring achievement both internally and by the Government. Without establishing these objectives, the HIF will have difficulty improving its performance, and potentially justify interference by external bodies like the MoF. The HIF needs to start:

- defining its objectives, key performance indicators and performance targets
- developing strategies to achieve these objectives and level of performance

As part of the same approach, the HIF should look to developing an annual business plan articulating these objectives and targets and identifying plans for achieving them. In order to clearly define its objectives, the HIF needs to be reasonably certain of the resources that it will have at its disposal, including from the Government.

At present the current organisational structure does not support the HIF's core functions in an effective manner. For example, there is a need to institutionalise the processes related to the new model of purchasing and contracting in Central Office, and to ensure that clear responsibilities are in place for coordination, change management, monitoring implementation at the Central level and troubleshooting. There are other questionable areas.

Relatedly, the roles and responsibilities of different departments in Central Office are not clearly defined, nor authority clearly delegated. As an example, the Control and IT Departments appear to be involved in a whole range of activities, including the development of specialty groups for hospital contracts.

The HIF needs to review how departments in Central Office are defined, how functions are divided between these departments and branches, and the human resources and their associated skills and qualifications that are in place to support these functions. It is felt that the HIF would benefit from organisational restructuring, in parallel with the current redundancy program that is underway.

A related area is human resource management. Although the HIF has been making some inroads in this area, including careful planning of the current redundancy program based on competency of staff to undertake their roles, human resource development has been seriously overlooked in the past, and needs greater attention. This is true for the entire public sector in

Macedonia, not just the HIF, and is a legacy from the former system. Principles that should be adopted by the HIF include:

- Staffing linked to plans and work requirements;
- Staff have appropriate skills and qualifications;
- Staff performance is regularly assessed;
- Staff development and career plans in place;
- Training strategy and plans for provision of training in place.

The HIF also needs to address its public image. Purchasers are often associated with cost-cutting and bureaucracy, as opposed to promoting the public interest. Certainly, the current public image of the HIF is not positive, and the HIF needs to do more to address this, perhaps through establishing and implementing a formal public relations strategy. Alternatively, small changes can be made. While the HIF annual report is currently available on the website, the HIF should consider reformatting the report so that it is targeted at the public as well as Government. It should also consider holding insuree forums at local level to improve community participation and obtain more feedback from this most important group. These could be organised and run annually by the branch offices, according to a clear structure. As the HIF introduces the important changes described throughout this report, it is important for the sustainability of the compulsory health insurance scheme that the HIF does more to convince insurees that they are working in the public interest.

Building on the recommendations provided through the independent systems audit that is currently being conducted, the HIF needs to establish the processes that are required for an effective internal control environment. One area where work is clearly required is communication. Internal communication structures have been poor to date, and there is a culture of hoarding information. Staff perform better if they understand the HIF's objectives, and the purpose of their own activities, and therefore strong communication channels are a priority, particularly with regard to the important changes that are taking place. This will also support a strong internal control environment.

The HIF senior and middle management would benefit from formal training in modern management techniques, assuming that the staffing structure remains stable and that human resources can be sufficiently depoliticised so that Assistant Directors, at least, are systematically recruited on the basis of skills and qualifications, measured against clearly-defined and appropriate selection criteria. In fact, any comprehensive strengthening of HIF management requires this stability and independence from Macedonian politics.

The HIF would benefit from external assistance to improve its management environment, particularly as a managerial culture is only just being established in the Macedonian public sector. Therefore, technical assistance will be provided under the Health Sector Reform Project, funded by the World Bank and the Government of Macedonia.

### **Project Aims & Objectives**

The HSRP aims to improve the performance of the Macedonian health system by addressing priority areas. This particular component will contribute to efforts to improve the effectiveness and governance of HIF operations, through strengthening its organisation and management practices. Support will be provided to assess key weaknesses, design new processes and provide training to HIF management in modern management techniques.

The objectives would be to:

1. Establish effective management processes in the HIF to support improved performance;
2. Improve the capacity of HIF to effectively manage its operations.

### **Scope of Services**

The consultant will provide advice and training to the HIF to support overall strengthening of the organisation. The focus areas will be

- Business planning, including setting objectives and targets;
- Organisational restructuring, include clearer definition of responsibility, authority and accountability;
- Human resource management; and
- Public relations.

In each of these areas the consultant will review current arrangements and assist the HIF with process re-engineering to support improved practices in line with modern management, providing practical recommendations in each of the above areas.

Secondly, the consultant will assist the HIF to implement the recommendations on internal controls resulting from the independent systems audit funded by PSMAL.

Finally, the consultant will work with staff to identify priority areas for management training, through a formal needs assessment if staff development plans are not in place by this stage. The consultant will then assist the HIF to establish a training plan and organise delivery. Actual delivery of the training will be contracted separately and is not part of this assignment. Some of the topics that might be covered include:

- Business planning
- Communication and teambuilding
- Consensus-building; motivation
- Setting targets and measuring performance
- Project management
- Time management;
- Organisational stress management
- Problem solving
- Budget management (for managers, as opposed to the finance department
- Human resources planning and management (planning of human resources, principles of staff motivation career policy, primary and secondary work conditions, evaluation of staff systems, the role of unions and employee associations).

### **Activities**

The consultant will be expected to:

1. Conduct a comprehensive review of current weaknesses in HIF organisation and management and agree on an implementation plan for strengthening the HIF;

2. Advise on the development of new processes and tools in the core areas identified above, as well as any additional areas that are identified during the situational analysis;
3. Assess training needs and design a comprehensive training strategy for HIF staff, including identification of the most cost-effective delivery strategies.

The consultant will build on recommendations provided during project preparation and the internal systems audit conducted with the support of PSMAL.

### **Outputs & Reporting arrangements**

It is expected that the consultant will work closely with the staff and management of the MoH across the organisation. The following outputs are expected:

1. Inception Report, detailing the current status of the aforementioned topics, identifying, prioritising and qualifying the detailed activities for implementing next steps
2. Reports on recommendations in each of the priority areas, including:
  - optimal organisation of functions, roles and responsibilities, authority and accountability
  - a framework for establishing business objectives and business planning, including support for the development of the business plan for 2006
  - development of the human resource management function
  - strategies for improving public relations and image
3. Training needs assessment and training needs strategy, agreed with HIF
4. Final report, outlining achievements in key areas and providing recommendations for future activities.

### **Duration of the Assignment**

The project is expected to run from mid 2005 through to the end of 2006. Over this period, the consultant will provide approximately 12 staff months of consulting time, with around 50% provided by local consultants.

### **Qualifications and Experience**

The assignment should be undertaken by a consulting firm with previous experience supporting management strengthening in the health sector, ideally for a health insurance body. The team should have experience advising on health reform in transition countries, demonstrating a successful track record in:

- Institutional change and capacity building
- Business planning
- Human resource and financial planning
- Management training development

### **Linkages**

In undertaking these activities, consultant will need to link closely with other activities that are planned under the HSRP, particularly with regard to strengthening HIF governance.

## **Appendix 7: ToRs for Strengthening the Performance of the HIF Management Board**

# **Draft Terms of Reference for Improving the Performance of the HIF Management Board**

## **Background**

The Government of Macedonia, with assistance from the World Bank, is initiating a Health Sector Reform Project (HSRP) to support reform of the country's health sector. Key to achieving this will be strengthening the capacity of the HIF, targeting specific areas relating to the improvement of its governance and overall management. One of the areas that needs to be addressed is improving the effectiveness of the HIF Management Board in its oversight of HIF operations.

The Management Board of the HIF is a vital part of the governance structure, playing a key role in the oversight of HIF management and accountability to key stakeholders, including the Government, insurees, employers and health care providers.

Over the years since the Board was established its performance has been poor, if measured against the right criteria. For example, the Board has failed to respond adequately to clear evidence of fraud and waste within the HIF in previous years, or clear examples of operations that are contrary to the legal framework in which the HIF operates. In the past, the Management Board has not provided a sufficient check on the Director, or executive management and is subject to excessive political influence, which prevents it from making independent decisions that are in the best interests of all stakeholders.

The process used to select members of the Management Board greatly affects ownership and accountability. Currently all members are nominated directly by the Parliament. Although six of the thirteen members are supposed to represent insurees and two represent employers, in practice there are serious concerns about whether these groups are adequately represented by the chosen individuals.

Another part of the problem is that while the Management Board's activities are clearly defined, there are no criteria against which individual members and the Board as a whole can be judged. The Board, along with the HIF Director, should be held accountable for the performance of the HIF, but at present it is not.

A brief assessment of the performance of the HIF Management Board as part of this assignment indicates that steps need to be taken to improve the performance of the Management Board, if the governance and effectiveness of the organisation is to be improved.

## **Project Aims & Objectives**

The Project aims to improve the performance of the Macedonian health system. This particular component will contribute to efforts to improve the effectiveness and governance of HIF operations, through strengthening the functioning of the HIF Management Board. Support will be provided to the HIF to design new processes for Management Board selection and operation, with a view to increasing accountability, performance and representation of key stakeholders.

## **Scope of Services**

The consultant will provide advice to the HIF to support strengthening of the Management Board. This will require a comprehensive review of the framework which defines Management Board operation against good practice in organisational governance, and identification of practical opportunities to improve performance and accountability of the

Board. Consideration of earlier findings on HIF governance during project preparation should be taken into account.

The consultant will then work with the HIF to design and document new procedures for the Management Board, and provide recommendations on the necessary changes to the Health Insurance Law and other relevant legislation. It is expected that recommendations will cover the following areas:

1. Alternative methods for member nomination and selection
2. Defining a clearer mandate for the Management Board and the Director
3. Formal selection criteria for Management Board members;
4. Establishing indicators and performance evaluation for individual Board members, as well as criteria for assessing the overall performance of the Board;
5. Requirements regarding disclosure of conflict of interest and secrecy standards
6. Introduction of formal processes for evaluation of the Director of the HIF;
7. Improving communications with stakeholders.

### **Activities & Reporting**

The consultant will be expected to:

1. Conduct a comprehensive review of the performance of the Management Board and the key weaknesses in its current structure and operations;
2. Advise on the development of new processes and tools to improve the functioning of the Management Board.

Reports will be provided on each of these activities.

It is expected that the consultant will work closely with HIF management and staff on these issues, as well as ensuring consultation and support from the Government.

### **Duration of the Assignment**

The project is expected to run for six months, from July to December 2005. Over this period, the consultant will provide approximately 6 staff months of consulting time, with around 50% of this provided by a local consultant.

### **Qualifications and Experience**

The assignment should be undertaken by two individual consultants with relevant experience advising on organisational governance in the public sector, ideally in a health reform environment in transition countries.

### **Linkages**

In undertaking these activities, consultant will need to link closely with other activities that are planned under the HSRP, particularly with regard to strengthening HIF management.

## Appendix 8: Cost Estimates for Technical Assistance

Health Sector Reform Project  
HIF Government Component  
Cost Estimates - Technical Assistance

	No. of staff months	Unit cost p. month	Total cost
<b><u>MoH Policy Development &amp; Capacity Building</u></b>			
<b>Consultant Services</b>			
1. Local Consultants (1)	24	2,000	48,000
2. Foreign Consultants (2)	12	20,000	240,000
<b>Sub-total: consulting services</b>			<b>288,000</b>
<b>Training</b>			
Included in the consulting services			
<b>Goods</b>			
Equipment for MOH			14206
<b>Sub-total: equipment</b>			
<b>Total</b>			<b>302,206</b>
<b><u>Eligibility and Revenue Collection</u></b>			
<b>Consultant services</b>			
1. Local Consultants (1)	6	2,000	12,000
2. Foreign Consultants (1)	3	20,000.00	60,000
<b>Sub-total: consulting services</b>			<b>72,000</b>
<b>Training</b>			
Training			45,000
<b>Sub-total: training</b>			<b>45,000</b>
<b>Total</b>			<b>117,000</b>
<b><u>Board Oversight</u></b>			
<b>Consultant Services</b>			
Local consultant (1)	3	2,000	6000
Foreign consultant (1)	3	20,000	60000
<b>Sub-total: consulting services</b>			<b>66,000</b>
<b>Total</b>			<b>66,000</b>
<b><u>Financial Management Improvement Program</u></b>			
<b>Consultant Services</b>			
Local consultant (2)	18	2,000	36,000
Foreign consultant (2)	9	22,000	198,000
<b>Sub-total consulting services</b>			<b>234,000</b>
<b>Training</b>			
1. Financial Management			85,000
<b>Sub-total training</b>			<b>85,000</b>

<b>Total</b>			<b>319,000</b>
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**HIF Management Strengthening Program**

***Consultant Services***

Local consultant	6	2,000	12,000
Foreign consultant	6	22,000	132,000
<b>Sub-total consulting services</b>			<b>144,000</b>

***Training***

1. Modern Management			85,000
<b>Sub-total training</b>			<b>85,000</b>

<b>Total</b>			<b>229,000</b>
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**Strengthening provider payment & contracting system**

(incorporates strengthening contracting skills from WB structure)

***Consultant Services***

Local consultants (2)	36	2,000	72,000
Foreign consultant (firm)	24	22,000	528,000
<b>Sub-total consulting services</b>			<b>600,000</b>

***Training***

Internal training in contracting			265,000
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(other training incorporated into consulting services - negotiating, monitoring & analysis)

<b>Sub-total: training</b>			<b>265,000</b>
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***Equipment***

Support software/information systems (contingency)			100,000
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<b>Sub-total: equipment</b>			<b>100,000</b>
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<b>Total</b>			<b>965,000</b>
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**Procurement/Tendering**

***Training***

Improve tender processes (training)			85,000
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<b>Sub-total: training</b>			<b>85,000</b>
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<b>Total</b>			<b>85,000</b>
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<b>GRAND TOTAL</b>			<b>2,083,206</b>
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## **Appendix 9. Example of Hospital Services Standards**

(Based on UK practice)

### **Organisational Development for Quality**

The Hospital will develop a practical program for creating quality awareness and commitment in staff at all levels and a culture of continuous improvement. The Hospital will make this program known to all staff and will demonstrate implementation of the first steps of this program during the period of this agreement. In particular, the HIF will wish to see a clearly stated plan for quality development covering objectives, responsibilities, training and incentives and created with wide participation of Hospital staff and including:

1. quality improvement targets for major care activities, specialties and departments including standards for outpatient and inpatient waiting times for appointments and admissions;
2. the introduction of quality development measures in job descriptions;
3. management structures for quality improvement including specific responsibilities, reporting and monitoring arrangements;
4. plans for the development of multi disciplinary clinical audit including arrangements, for implementation, monitoring and acting upon the outcome of audit activity
5. plans for ascertaining changes in consumer satisfaction, for seeking the views of consumers, for providing consumers with information and for dealing with consumer complaints and appreciation's
6. arrangements for the reporting and audit of untoward incidents and accidents.

### *Good Practice*

The Hospital will ensure that its services are based on good practice taking account of international standards and protocols, the recommendations of professional advisory bodies and guidance that may be issued by the MoH from time to time.

### *Service Quality Targets*

The Hospital will aim to ensure that the following targets are incorporated into quality planning and are being met by the end of the period of this PMA.

### **Accident & Emergency Services**

1. at least 90% of patients are to be clinically assessed within 10 minutes of arrival time and no patient is to wait more than 3 hours.
2. After initial assessment, treatment is to commence within 30 minutes (for urgent cases) and within 120 minutes (for others).
3. At least 50% of staff working in A&E Departments will have received training in A&E clinical care by year-end.

### **Outpatient Appointments**

1. Appointment systems will be planned and put into operation during the period of this contract
2. Patients are to be offered appointments within a maximum time period from first referral. This time period will be agreed between the HIF and the Hospital after a trial period and recording current time periods by department.
3. Cancellations of appointments will be recorded by consultant and specialty, explanation will be given to the patient and a new appointment offered at the same time.

**Outpatient Clinic Waiting Times**

1. at least 90% of attending patients are to be seen within 30 minutes of their appointment time; patients are to be provided with an explanation if their wait exceeds 30 minutes; and no patient is to wait for more than 60 minutes.

**Pharmacy Waiting Times**

1. Patient waiting times are to be reduced; targets will be set for 2005 following the collection of baseline data during 2004 by the Hospital and joint analysis with the HIF/MoH of causes contributing to delays.

**Elective Inpatient Admissions**

1. Patients are to be offered admission dates within a maximum time period from first outpatient consultation. This time period will be agreed between the Hospital and the HIF after a trial period and recording current time periods by department. An improvement of 20% over baseline waiting times will be sought by year end with HIF priorities set following needs analysis by major specialty
2. Where admissions are cancelled, patients are to be offered alternative dates within 7 days of cancellation for admission within 30 days
3. Neither children nor adults are to be admitted where home, day or social care is more appropriate.

**Consumer Relations**

1. 20% of staff are to have participated in basic training/sensitisation by year-end.
2. Total quality management (TQM) and consumer satisfaction components are to be included in all training programs delivered or purchased by or for the Hospital during the year.

**Information Generation**

1. The Hospital will develop information systems adequate to provide data for monitoring all performance indicators and quality targets and will provide the HIF with this information as part of the quarterly reports (end March, June, September, December) required.

## **Attachment 1: Inception Report**

## **Attachment 2: Mid-Term Report**