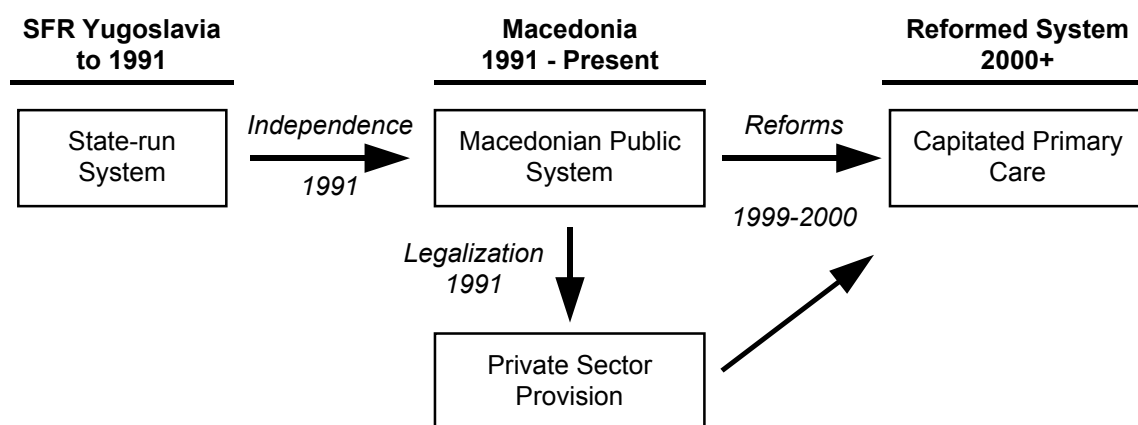


2. Survey of the Macedonian Health Care System

The roots of the efficiency and quality problems of health systems in the Yugoslav successor states lie in the heritage of the former Socialist Federal Republic of Yugoslavia (SFRY) health care system and broader economic structure (Istenich, 1995). This chapter describes the four major elements of development of the Macedonian primary health care system, the schematic of which is repeated here as Figure 2.1.

Figure 2.1 – Development of outpatient, primary care in Macedonia



This chapter opens with a brief introduction to the SFRY economic and health systems inherited by Macedonia. This is followed by a discussion of the existing public and private sectors and the role of each in PHC. A summary of the HSTP reform program closes this chapter. This chapter provides background for the remaining chapters which focus on private provision of primary health care.

HERITAGE OF THE STATE HEALTH SECTOR OF MACEDONIA

Economic Structure

Despite popular perceptions of former Yugoslavia's relative market openness, there was a large degree of state control. The Yugoslav economic system was built on the ambiguous concept of social ownership, which in reality was state ownership without the normal institutions of state property (Lavigne, 1995). Under this version of market socialism, production was politically controlled at the local level with broad federal influence.

Republics, largely dominated by a single ethnicity, were given a large amount of autonomy within the Federation. Firms operated under self-management in which workers, through “management councils,” ostensibly managed daily operations and monitored hiring and wages. Investment and production decisions were under political control and subject to federal approval (Lavigne, 1995; Uvalic, 1992). Limited decentralization of decision-making did not lead to free and competitive markets; local politicians were very protective of firms and shielded them from competition (Kraft, 1993).

The private sector was limited in the SFRY, consisting primarily of small commercial shops, and was “barely tolerated” by the state (Kraft, 1993). There were also strong feelings among the public that private profit was immoral; this bias against the private sector continues in many Yugoslav successor states (Bicanic, 1993; Kraft, 1993). Nonetheless, when output declined and inflation rose sharply again in the 1980’s, the government attempted market-oriented reforms that included privatization of SOEs. Privatization was strongly advocated by the rich republics while the poor republics opposed it, feeling that they would be at an even greater disadvantage in competition with their richer neighbors (Ramet, 1992).

Ultimately, the 1989 Law on Circulation and Disposal of Social Capital established some of the procedural steps required for large-scale privatization (Shukarov, 1993). Like the rest of the reforms, however, these procedures were very passive and had little real effect (Bicanic, 1993). Social sectors were unaffected by the 1980’s cycle of reforms which were, regardless, superseded by war and national independence drives.

Privatization started slowly in Macedonia. Initial drafts of the privatization law were based on the 1989 Yugoslav law, but its passage was held up in Parliament for two years. While the formal sale of state-assets stalled, spontaneous privatization of enterprises was widespread and new firm startups developed quite freely. The Law on the Transformation of Enterprises with Social Capital passed in April 1993 and made provision for case-by-case asset sales, though in practice the dominant method for larger firms has been management buyout (Hadzi Vasileva-Markoska, 1995; Nova Makedonija, 1998a). Over 1,400 firms were privatized by the time the law expired in December 1998. Without a re-enactment of this, or similar, legislation, further sales of public assets must be considered on a case-by-case basis.

State Health Sector

Social services were not a state priority in the SFRY since, like in other planned economies the productive sector was dominant and the “non-productive” social sector was seen as a consumer of income not as a producer of value (Orosz, 1995). The consequences were clear: low investment, low morale, and no national efforts to improve health sector performance. As part of a major economic restructuring in 1974, social service providers were reorganized into Self-Managed Communities of Interest (SMCIs). These organizations, based on the “socially owned enterprise” model were established at the municipality (similar to counties in the U.S.) level. They were intended to allow producers and consumers of social services to meet and exchange without state intervention (Svetlik, 1992). In reality, SMCI administration was highly bureaucratic, merely duplicating the state-level bureaucracy they were designed to replace (Istenich, 1995; Kraft, 1993; Parmelee, 1985).

As a result there was a high degree of fragmentation in services across regions (Istenich, 1995; McKee, 1991). Overlying this regional variation, health service provision was split into 3 tiers. Highly specialized quaternary care (e.g., organ transplants) was provided in federally organized clinics. Most specialty care, inpatient and outpatient, was provided in Clinical Centers of the Medical Schools in Republic capitals. Primary care was provided in SMCI-run urban Health Centers and Polyclinics and also in rural clinics. Finance for the Yugoslav system was managed by the federal Social Insurance Fund (SIF) which collected revenues and made provider payments based on inputs, such as number of beds or clinic visits, rather than health status or outcomes. The same institutional structures are still providing health care today in Macedonia.

CURRENT STRUCTURE OF THE HEALTH SECTOR

Finance

The Health Insurance Fund (HIF), organized in 1991 under the Ministry of Health, assumed the SIF’s overall management of health care financing. Lower levels of the financing infrastructure have remained in place. Branch offices of the HIF, for example, are renamed IPO branch offices and still process and approve invoices from providers in their region, distribute coverage certificates to insured persons, and keep registries of insured persons.

Health care is a constitutionally-guaranteed universal right for citizens. Insurance contributions to the HIF to pay for these services are compulsory. HIF coverage provides a package of basic health benefits. In principle, these benefits may be supplemented with private insurance, but this practice is still limited. The health insurance system is funded primarily by a payroll tax of 8.6%. Workforce contributions total about 65% of HIF revenues, government fund transfers make up most of the rest (Peabody et al., 1996). Running annual deficits from through 1992 to 1998 of \$16.4 M to \$27.8 M, the HIF was in a debt to providers of over \$100 M after 1998 (World Bank, 1995; Paterson et al., 1997). The HIF has been in arrears since independence largely due to the 40% drop in real wages and high unemployment; actual payroll contributions were 83% of expected in 1993 (Paterson et al., 1997). As a result of unemployment and evasion of contribution, the insurance rate falls short of universality; a nationwide household survey conducted in October 1996 showed that nearly 38% of the population was not covered by insurance (Farley et al., 1997).

The insufficient of public funding for health care services are further complicated by the payment system for providers. By law, both public and private provider *organizations* are paid by the HIF on an invoice-based fee-for-service (FFS) plan. Due to historical budgeting practices and the chronic deficit condition, the HIF does not strictly follow this. Actual determinants of the allocation decision are probably based on prior-year payments and there are large variations by municipality. For example, in 1995, the HIF paid only 75% of total invoiced amounts submitted by all public clinics, but the reimbursement rate from the HIF ranges from 46% to over 90% across municipalities (Paterson et al., 1997).

Capital investments for public providers are budgeted from a separate account within the HIF. These have been cut to near zero for the past few years. This compounds effects of the “legacy of low investment” in health care which communist systems have disproportionately neglected primary care (Healy and McKee, 1997). Capital investment was 1.6% of total expenditures for all public health organizations (Health Insurance Fund, 1996) and following historical practice much of this was probably concentrated in secondary and tertiary care.¹

¹ As a comparison, total direct capital expenditures as a percent of total expenditures for hospitals is about 8% for France (9.6%, 1988), Germany (6.9%, 1990), and the United States (8.0%, 1993). Source: Wiley et al. (1998).

Public clinics and providers

Likewise, the division of service provision between facilities has largely remained unchanged since independence. Nearly all tertiary care is provided in teaching hospitals in the capital, Skopje. The dominant form of provider organization is the municipality-centered Medical Center, based on the former SMCI. While there are some differences, Medical Centers typically consist of a general hospital often with stand-alone clinics providing specialist outpatient services. Medical Centers administer Health Centers or Polyclinics that provide preventive and primary care and limited secondary care; they comprise several departments. Some municipalities also have urban ambulatory clinics with only one or two departments. Rural clinics fall under Health Center management.

Compared to their West European counterparts, CEE physicians' pay and political power are quite low. This has consequences for reforms, which are discussed below. One reason for their current low status is that physicians emerged from the communist era without a coherent professional organization and thus had little significant political influence (Field, 1991). Doctors were viewed as components of the non-productive sector, serving the health needs of the productive workforce (Healy and McKee, 1997). The status of PHC physicians is further weakened by the fact that the medical profession is still dominated, numerically and politically, by hospital-based specialists. Under communism, primary care physicians were held in lowest regard and those attitudes still prevail (Orosz, 1995; Heitlinger, 1991; McKee, 1991). Even today, the concept of family practice is looked down upon, and PHC is considered "second class medicine" (Goldzweig, 1998; Tatar and Tatar, 1997). Nurses too suffer considerably less prestige than their Western counterparts; they perform no clinical duties and serve only as low-level administrators in the public sector. Physicians' status was also diluted by significant overproduction of physicians still the primary cause of high unemployment among physicians. Estimates of unemployment among physicians now in Macedonia range from 15% to 30%. Finally, without a history of strong professional organizations, the power of the medical profession lies in the Ministry of Health (Barr, 1996). This is typified in Macedonia where there are strong ties between the Medical Faculty and the Ministry and the influence of the Ministry also reaches into the municipalities as the directors of the Medical Centers are political appointees. Medical Centers are controlled by

management boards approved by Parliament and ownership of the Medical Centers and clinics is national (Ilievski, 1998).

There are three important implications of the physicians limited political power and low pay. First, primary care physicians, those most affected by the reforms, have little ability to positively influence the reforms. Medical lobby groups are growing, but they are still limited in power (Healy and McKee, 1997). In Macedonia, the Association of General Practitioners, for example has little influence over policies while a large majority of the group does not approve of the current reform strategy (Nova Makedonija, 1998b).

Secondly, quality and access to care may suffer in public clinics. Physicians in public clinics, paid on salary, work under essentially the same labor practices as in the SFRY. With little incentive for improving performance, the standard of care in PHC is referred to as “prescribe and refer,” with consequent poor primary care and an overuse of more expensive secondary care. Further, poorly paid physicians have obvious incentives to seek additional income. Currently, with PHC physician wages at about \$300 per month gratitude payments are still common, as they are throughout CEE (Healy and McKee, 1997; Saltman and Figueras, 1997; Istenich, 1995). Better care or shorter waiting periods, for example, often depends on side-payments or family and political connections (e.g., Ledeneva, 1998). Although under-the-table payments and corruption are very difficult to quantify, reports from other countries indicate that such payments are significant (Healy and McKee, 1997; Borrisov and Rathwell, 1996). These practices appear to be difficult to eliminate as many doctors have vested interests in the existing system.

Finally, low status and low pay also have important implications for private sector development. Salaried physicians practicing in public clinics may be attracted to the higher potential income of the private sector. Furthermore, the large pool of unemployed physicians is a supply of potential entrants into private practice. A government pay freeze on the public sector in 1993 only accentuates these effects.

Private health care provision

Privatization of health care provision in Macedonia has thus far been a gradual process. The 1991 Health Care Law legalized private outpatient practice, while still maintaining the

dominance of the subsidized public sector. Private inpatient facilities were not addressed by this legislation. Subsequent applications for private hospitals have been denied by the Ministry of Health.

Any physician legally licensed to practice in Macedonia may obtain a license to practice privately from the MoH. The Macedonian population is not rich enough to support a private sector on out-of-pocket payments for discretionary care, and an MoH license generally is not sufficient to maintain a private practice. Over 90% of private primary care physicians hold contracts with the HIF that are virtually identical to that for public health organizations. Under this fee-for-service plan private doctors provide basic out-patient care from a list of allowed services and receive reimbursement based on invoices. Private clinics are also required to meet the same structural and sanitary standards as public clinics, which are enforced via MoH and HIF inspections.

Payment incentives are markedly different in the private sector. Compared to the low fixed salaries in public sector practices, the FFS system payment to private practitioners offers the potential of much higher incomes to those entering private practice.² This, coupled with patient demand driven by the poor service in public clinics has fueled private practice growth. In 1994, three years following legalization, there were 217 physicians licensed to private practice, about 5% of all doctors. Growth since slowed and by late 1997 the Ministry of Health listed 380 licensed private physicians, about 8% of all doctors in Macedonia. As a comparison, nearly 50% of all physicians were private in the Czech Republic just two years after a very aggressive privatization program (Massaro et al., 1994). Slovenia, also richer than Macedonia but sharing its institutional heritage, had 3.3% of all doctors in private practice in 1994 (Istenich, 1995). Nearly all Macedonian private doctors are in solo practices or small partnerships, with the exception of the capital where there are a handful of larger group practices. Echoing other studies that find that private physicians locate in urban areas (Blumenthal, 1994; Bennet et al, 1994) only 10% of all physicians licensed to practice privately are located in rural areas (MoH, 1996).

² Since most private clinics are proprietorships, FFS payments to private organizations are essentially payments to individual private physicians.

The Primary Health Care System

Primary health care is undergoing changes in Macedonia. Indeed, a major aim of the HSTP is to strengthen the role and status of PHC. Currently, several specialties deliver what the Ministry refers to as primary care. Two of these, Labor and School Medicine, however do not provide what is commonly known as PHC but rather preventive and occupational health services. These specialties will be phased out or significantly reduced under the reforms. The intent of the HSTP is to ultimately designate as PHC those physicians that are candidate for participation in the privatizing reforms: General Practitioners, Gynecologists, and Pediatricians. Table 2.1 depicts the composition by specialty of primary care physicians. The second column lists all public physicians currently designated by the MoH as primary care. The third column lists all private physicians registered with the Ministry. The table identifies those physicians that are considered to provide PHC throughout this study.

Table 2.1 – Licensed Private physicians and Public primary care physicians, by specialty.

| Specialty | Percent of all Physicians | |
|--------------------------------|---------------------------------|------------|
| | Public | Private |
| <i>PHC</i> | | |
| General Practice | 55.6 | 68.2 |
| Gynecologist | 5.1 | 9.2 |
| Pediatrics† | 16.4 | 7.4 |
| <i>Non-PHC</i> | | |
| School Medicine | 10.6 | NA |
| Labor Medicine | 12.3 | NA |
| Other Specialty | 0 | 15.2 |
| Total number physicians | 1918 | 380 |

Sources: MoH Registry of Private Physicians, 1997; MoH, 1996.

† - Pediatrics in Public clinics serves only pre-school age (0-6 years) School Medicine is a preventive specialty.

Both public and private physicians play important roles in PHC. Most PHC is provided by public physicians. However, due to the nature of the HIF contract and the restriction to out-patient practice, most private physicians provide PHC and account for about 20% of all PHC physicians. As the table shows, there are relatively more GPs in private practice and fewer pediatricians than in public clinics. The smaller proportion of pediatricians in private

practice may be due to restrictions against private physicians providing preventive care. Note also that the practice of pediatrics is subdivided into two sub-disciplines; one for children 0-6 years and one for children 7-18 years. The predominantly preventive specialties of school and labor medicine are practiced only in public clinics.

HEALTH SECTOR TRANSITION PROJECT (HSTP) REFORMS

The HSTP is developing both demand-side and supply-side strategies to improve the quality and efficiency of primary HC provision across Macedonia. Demand-side strategies under consideration include a new basic benefits package, changed coinsurance rates and coverage policies, management of care and patient cost sharing. These strategies aim to increase utilization of PHC and other outpatient care and decrease total expenditures. Demand side incentives are reviewed in detail in Farley and Peabody (1997). Our focus here is on the supply-side; the capitation payment system designed to influence physician behavior (Carter et al., 1997).

Under the proposed capitation payment, physicians will be paid a fixed amount per time period for each patient enrolled in their practice. The defining characteristic of capitation is the transfer of financial risk from the insurer to the provider. Providers are responsible for the overall care of patients, make treatment decisions with generally fewer constraints than other payment systems, and are able to retain savings resulting from capitation payments exceeding costs. Advantages to insurers include reduced monitoring costs necessitated by other payment systems and more predictable expenditures (Latham, 1996). Capitation is also attractive to providers for two main reasons. First, they are able to regain some professional autonomy in being freer to decide on appropriate care for patients. Secondly, potential profits may be significant if costs are kept lower than total revenue from capitation payments from all patients. If structured correctly, these incentives are intended to improve the efficiency and quality of care. However, a common problem, which usually requires regulation, is the incentive to underprovide care that reduces overall efficiency and quality.

The reforms initially target improving delivery of PHC and include both existing public and private primary care physicians. Given the status of primary care in Macedonia, especially in public clinics, capitation could have a large positive impact. In addition to making patient

satisfaction important, capitation may also improve quality by raising the pay and prestige of PHC encouraging better doctors to choose PHC as a career. It may also have a large initial effect in efficiency if it allows providers to focus on true costs of practice, such as referrals to more costly specialist care. Finally, fairness in physician pay may improve. Public primary care physicians receive the same salary, regardless of volume or quality. With the reforms, physicians in public clinics will be rewarded for higher productivity. This will also level pay and enhance competition between the two sectors.

A demonstration capitation system will be implemented in 2000 to evaluate how the proposed reforms work in Macedonian primary care clinics. The design of the capitation system piloted in the demonstration program is preliminary. Supply side reforms consist of:

- PHC providers receive payment on a capitated basis for each patient they enroll in their practice, adjusted for case mix.
- Financial incentives to control excessive specialist referrals
- Enhanced financial responsibility for resource use among public physicians
- Tighter regulation of secondary and tertiary care while continuing salary-based pay for specialists.
- Physician selection whereby insurance subscribers choose a PHC physician and may switch providers periodically. Limits will be placed on the number of patients that PHC providers can have enrolled.
- A possible floor on public pay with a salary component set at some fraction of current salary.

Results from the pilot will be essential to finalize the specific incentive structures including: amount of capitated payments; physician eligibility; patient selection of physician; physician financial responsibilities for services and facility costs; and, regulation for the underprovision of services and overenrollment of patients. How these issues are resolved has substantial implications for the risks and rewards of practice under capitation. These will help determine the functioning of the primary health care markets including: improving efficiency and quality of care; introduction of fairness and competition; and, integrating the existing public and private sectors. In addition, there are other policy considerations that should be taken into account as the reform package is finalized and implemented nationally.