4. Private Sector Policies – Description and Evaluation

Incentive structures in the health care sector are central to both the behavior of physicians and the effectiveness of policy reforms. These incentives are established by, and embedded in, the institutions of the health sector; the organizations, laws, informal rules, and the relationships between them (e.g., North, 1991; March and Olsen, 1989). As the previous chapters describe, reforming these institutions and developing new ones for the task of maintaining a market-oriented economy are the heart of CEE reform programs.

This chapter examines the incentives faced by PHC physicians, and private physicians in particular. It describes policies governing PHC and the private sector, both currently and those proposed by the reform program and delineates the economic and regulatory incentives that determine physician behavior. The description of the existing policy environment provides the essential context for interpreting the results of the quantitative analysis contained in later chapters.

Following the summaries of current and proposed PHC policies, I adapt the objectives of privatization (outlined in Chapter 3) to the specific case of the Macedonian health sector. Thus, this review highlights specific issues that successful reforms must address and also provides guidance in designing and implementing the privatization reform program.

INFORMATION SOURCES

Descriptions and analyses of the emerging private sector are based on several primary information sources gathered for this research. First of these is the Capitation Evaluation Program (CEP) Facility Survey (described in detail in Chapter 5) which provides basic descriptors of private providers. Second are elite interviews conducted with heads of several important organizations: two Ministers of Health; the Director and former Deputy Director of the HIF, and directors of two HIF branch offices; President of the Medical Chamber and President of its affiliate, the Sub-chamber of Private Physicians. These organizations also provided access to official communications concerning their efforts to influence policy. Finally, I conducted structured interviews with 20 private physicians and owners of private
clinics from the CEP municipalities and the capital, Skopje, to gain a deeper understanding of the issues faced by physicians entering private practice.

**PRIVATE PROVISION OF HEALTH CARE**

The relationship between private sector providers and other segments of the Macedonian health sector are complex. These relationships, including the process of establishing a private practice, are governed by many rules and regulations not directly addressed by the reform program. To facilitate a discussion of this policy environment and its relevance to the success of further privatization, a system model of private and public PHC is shown in Figure 4.1, depicting flows of physicians, patients (and referrals to non-PHC), and funds from the HIF. Individual policies and processes depicted in Figure 4.1 are introduced briefly here and described in detail in following sections.

**Figure 4.1 – System model of private and public PHC**

Upon completing medical training a physician may enter either public or private sector practice; dual public/private practices are not legal. However, reflecting the transitioning nature of the health sector, the most common entry path to the private sector is via public...
sector practice. An important factor driving this is that, as discussed in Chapter 2, obtaining specialty graduate medical training is highly prized by physicians. Since public sector physicians may receive free graduate training, securing a position in a public clinic is often the preferred career choice of young physicians.

To enter the private sector, physicians must first obtain a license to practice privately from the MoH. With a license physicians may then apply for a HIF contract to provide PHC reimbursed on a FFS basis. Over 90% of all practicing private physicians have contracts with the HIF. A considerable part of establishing private practice is financing capital investment for the clinic itself. The arrow indicating the flow of capital resources to private clinics shows that investment occurs prior to obtaining the HIF contract. This reflects the fact that a clinic must be shown to meet minimum physical requirements before a contract is granted.

Fund transfers from the Health Insurance Fund to public clinics are depicted in Figure 4.1 as Capital Investment flows and Salary flows. Fund transfers from the HIF to private clinics are FFS reimbursements. Patient flows are shown in Figure 4.1 as entering either public or private PHC clinics or as presenting at public secondary and tertiary care clinics; this reflects the fact that the gatekeeping function of PHC physicians is new and it is not clear that it is enforced. Patients also may obtain public secondary and tertiary care via referrals from PHC physicians.

**Growth of Private Sector**

The private sector in 1997 consisted of 380 physicians licensed to practice privately (refer to Table 2.1). However, the MoH records on which this is based are limited as a source of individual level information on physicians in actual practice. It lists those that have licenses to operate and does not reflect physicians whose clinics have closed since registration. Drawing on a census of 94 private doctors conducted in 8 municipalities across Macedonia (approximately 25% of all private physicians in Macedonia), Figure 4.2 shows the number of physicians that entered private practice each year from 1991 through October 1997.
Figure 4.2 – Private practice growth trends in 8 Municipalities
(of those open in Oct 1997)

Growth was steady the first 5 years, rising to a high of 27 physicians entering private practice in 1995. New entrants fell quickly, to just 2 during 1997 through October. The large drop in observed number of entrants may have arisen in part if recently opened clinics exit the sector at a higher rate than other clinics. Comparisons with MoH and municipal Medical Center registries of private physicians show that only about 8% of private clinics closed during 1996-1997 (see below).

Private practice has drawn physicians with widely differing levels of experience. Figure 4.3 depicts the distribution of the years of experience of individual PHC physicians in both sectors. The experience level of public physicians exhibits a smooth distribution with a plurality of physicians in the 10-14 year range. The private sector curve shows at least two distinct groups: younger physicians with less than 10 years experience and older physicians with 15 or more years.
These results reflect the careers of those private physicians participating in the structured interviews. Respondents fell into two general categories. First were the experienced doctors who practiced for several years in public clinics. Several served as heads of clinical departments prior to entering private practice. Most of these were popular physicians in public practice whose private practices reportedly grew quickly as their former patients sought care in their private clinics. One, formerly a leading figure in the local hospital, had a roster of over 4,000 patients in his first year of operation. The second, smaller group consisted of young doctors with little or no experience prior to entering private practice. This mirrors private respondents of the Facility Survey in which a substantial minority (22%), all young, had only practiced in the private sector. Many in this group reported that they could not find jobs in the public clinics, some even after “volunteering” for several years.1 These younger doctors are more likely to work as employees in clinics owned by another physicians. In Skopje, with the largest population of unemployed physicians, physicians are required to pay a “deposit” of up to 2000 DM (1500 USD in 1997) to secure employment at some private clinics. This practice reflects the extent of the physician labor surplus in Skopje.

Two important groups of physicians are not represented in Figures 4.2 and 4.3. First, are those physicians that entered and exited private practice prior to the survey. This group is

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1 Volunteering is a common practice as young physicians gain experience and clinics receive free labor.
likely small. Of the 122 private physicians identified as potential respondents in the Facility Survey\(^2\), a total of 28 were not in practice at the time of the survey: 18 of those were on leave, had retired or were deceased. The remaining 10 physicians (8% of the sample frame) had left private practice. However, not all private clinics that do close actually cease operations entirely. Occasionally, clinics will “pause” due to cash flow problems and reopen when conditions improve; there were six such clinics in the original sample frame for the survey. Second, there are those that have not overcome the barriers to entering private practice. Several public physicians reported that they or their colleagues were deterred from establishing a private practice for a variety of reasons. As we show below, significant barriers to entry do exist which introduce distortions into the developing health care market.

**Private Sector Policy Environment**

Growth of the private sector depends to a high degree on government policies (Orosz, 1995). That is, policies establish the barriers to entry and fix expected income for physicians considering entry into private practice. For example, the government pay freeze in the public sector and relative benefits of FFS payment over salary are large inducements to enter private practice. Government policies can also affect the demand side by setting fees and, indirectly, in the relative quality of public clinics. As in other low- and middle- income countries, development of these policies has been non-strategic and haphazard (Bhat, 1993; Bennet, 1992). Rather, policy toward the private sector has been developed incrementally in response to growth of private provision the continued poor condition of public sector finances. The policy environment that has emerged is mixed in its effectiveness. On the positive side, however, Macedonia has avoided some of the pitfalls of private sector provision other low-middle income countries have made such as: allowing dual public/private practices; doctors selling medications that they prescribe; lax licensing resulting in poorly qualified practitioners; and, unregulated laboratories (Berman, 1997; Bennet et al., 1994; Bhat, 1993; Roemer, 1984).

This is a significant achievement. But, as we show, policies in the Macedonian health sector have also lead to market distortions, reduced overall efficiency and often hampered the

\(^2\) The sample frame was drawn from registries of private physicians from the MoH and local Medical Centers; see (Nordyke and Peabody, 1999).
ability of the private sector to advance national health goals. Left unaddressed the layers of policies may obstruct further reforms.

**Health Care Law and Sublaws**  The Health Care Law and Sublaws (regulations promulgated by the Ministry) establish the basic regulatory foundation for private practice. The MoH controls licensing for private practice. Licensure is conditioned on meeting minimum requirements, the first of which is an appropriate medical degree. Secondly, private clinics must meet the same minimum facility standards set for public clinics. Sublaws define sanitary standards, equipment and staffing level requirements for all clinic types. Provision is made for physical inspections and standards are enforced rigorously in private clinics. However, standards are not enforced in public clinics. Preferential standard enforcement may lead to differences in structural quality between the two sectors.

The physical plant standards and minimum equipment requirements private clinics necessitate an initial capitalization estimated at 20,000 DM. Due largely to the low pay of physicians in CEE, financing private clinics is a significant barrier to private practice, as has been noted in even in the richer Czech Republic (Chermak, 1996). The situation in Macedonia is more prohibitive. Over 1 billion USD of Macedonian deposits have been stranded in Belgrade banks since independence, depressing available capital and eroding faith in banks. Individual physicians considering a bank loan face 6 month terms, 20% interest rates, and up to 100% collateral; onerous terms for the purchase of medical equipment. Similar to other CEE countries, access to bank loans is eased for those with the right political connections (Hersch et al., 1997). Consequently, most private physicians self-finance or rely on donations of wealthy friends. The equity implication is that only affluent physicians can afford to enter private practice. These regulations help ensure a level of quality of care in private clinics. However, coupled with the poor condition of the financial system in Macedonia, these place barriers to entry to private practice that call into question the ability of privatization to leverage significant amounts of private resources to advance national health goals.

**HIF Contract**  Contracts to provide reimbursable primary care are awarded by the Health Insurance Fund, with final decision authority resting with the HIF Director. Fee-for-service
contracts are written with individual physicians and follow the German model in that HIF rules define a list of allowed services and corresponding values for each service item. Private physicians are not allowed to provide preventive services, such as immunizations. Each physician-day is allotted a fixed number of minutes, with different types of patients consuming standard amounts of time. For example, a patient in for a follow-up visit counts as 15 minutes against the total of 480 minutes in a day. This effectively limits the number of patients each physician can see (or be reimbursed for) each day. These procedures are monitored by HIF branch offices which collect and review invoices and approve charges to be reimbursed by the HIF. Branch offices have discretion to make changes in the list of allowed services, and have done so retroactively without notice in some municipalities.

A significant barrier to private practice arises from the requirement that private clinics be shown to meet the HIF minimum physical standards before a contract is granted. This effectively means that the full financial investment in a private clinic must be made prior to generating income by providing HIF-covered care. With the condition of financial markets in Macedonia, this places a large risk on prospective private physicians and may restrict the number of physicians entering the private sector.

The HIF contract is virtually necessary to practice as a private primary care physician. The HIF does not keep track of information on physicians with contracts. However, 1997 survey data showed that 93% of primary care doctors had contracts and another 5% had them when they entered private practice. In the structured interviews, all private PHC physicians had contracts at the time of the interview or had contracts in the past and also relate that a contract is essential for sustaining a successful practice. Indeed, both public and private physicians in the facility survey reported that over 90% of patients had insurance coverage through the HIF. Reflecting the centrality of the HIF contract to their practices, private physician consistently volunteered information on contract cancellations, denials of new contracts, and delays in reimbursement.

The few doctors that did not have contracts had them canceled in the previous two years. During the first years after legalization virtually all eligible applicants received contracts and reimbursements were prompt, helping to fuel growth. But by 1996 growth in the private
sector began to slow, concurrent with deepening insolvency of HIF. Physicians who experienced cancellations reported only vague notifications of what violations they committed. As evidence of the lack of violations, they cited that the MoH did not rescind their licenses to practice privately. Many more physicians complained that their efforts to obtain an additional contract for their offices had failed. All had hoped to hire another physician to expand their practices into unused office space or to reduce their work hours. Contract cancellations are difficult to deal with due to the lack, or cost, of legal recourse. A grievance board was established by the HIF to handle physician complaints. The Director of the HIF, however, disbanded this in 1996. The remaining avenue is the legal system, which is so costly and time-consuming that only the most egregious infractions are pursued (Rapaczynski, 1996). Arbitrariness of reimbursements and contracting procedures are not unique to the Macedonian HIF; Orosz (1995) calls the Hungarian system “highly discretionary” and unstandardized.3

Delays in reimbursement from the HIF are also a common complaint. Legally, terms are 60 days, but by late 1998, reimbursement delays had increased to 6 months, putting many private clinics at risk of closure (Ilievski, 1998). Several of the physicians interviewed also mentioned the discretion of HIF branch offices in making changes to allowed services, denying charges and not informing physicians of this until reimbursements are made.

Together, MoH and HIF rules and regulations define much of the policy environment of the private sector. However, other policies and practices, often established at lower levels of the health sector, also have important effects on growth and performance of the private sector.

**Referrals.** Referral policies, which are generally established by local Medical Centers, extend the bifurcation of the two sectors into clinical practices. Private physicians, for example, cannot see their patients while in hospitals. This has clear implications for private practice. First, this rule makes private practice less attractive to potential patients, especially those patients who feel they may be more likely to require hospitalization. It is also a disincentive for private physicians to refer for in-patient care. Many of the private physicians interviewed noted that they often “lose” patients they refer for inpatient care since, without

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3 In this regard, Transparency International’s 1999 Corruption Perception Index rates Macedonia 63rd of 99
private physician access to hospital medical records, the patients require follow-up care available only from their new public doctor.4

Outpatient referrals between public and private physicians are also restricted. Many Health Centers forbid public doctors to refer patients to private physicians. In one urban Health Center, public primary care doctors are subject to financial penalties and possible dismissal if they make referrals to private specialists. Even where referral prohibitions are not explicit, referrals from public to private are low.

**Education.** The HSTP reform program proposes several changes that involve medical education. One of the priorities is to reduce the oversupply of doctors by cutting enrollment in medical school (World Bank, 1996b). Also, there is an emphasis on enhancing the status and quality of PHC education. In the existing system, specialties are overproduced and GPs and family practice physicians are undervalued. The greatest effect is a misallocation of resources, but this also has consequences on the growth of private practice. There are two components to this problem. First is undergraduate medical education. The Medical Faculty has reduced enrollment in fully subsidized education to the recommended 110 (Nordyke and Peabody, 1998). However, they also accept an additional 110 students who pay full tuition. Often these are more wealthy students who do not qualify for the competitive scholarship positions. The second main problem is that specialty post-graduate education is free for those public doctors nominated by their clinic. Many young physicians serve in Health Centers only waiting for a specialty education position to open. Private physicians, conversely, must pay out of pocket for specialty education. Owners of several clinics cited this as a problem in finding highly capable physicians willing to work as GPs in private clinics.

The ultimate results of these policies are an oversupply of specialists and a reduction in the attractiveness to GPs of private sector practice. Therefore, young physicians tend to seek out public sector positions leading to specialty education which may allow them to enter the private sector as a more highly paid specialist.

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4 PHC physicians in Macedonia do not treat patients in hospital. However, public physicians have access to hospital medical records and are able to provide follow-up care.
Discrimination. Patients of private doctors are discriminated against in public clinics, a practice not uncommon in poor countries (Thomason, 1994). Patients of Macedonian private physicians are treated with animosity, are refused care, or given poor quality care in public clinics. Discrimination occurs in public pharmacies too, where patients of private doctors are often told that their prescription, which would be covered by insurance, is unavailable and that they must purchase it out of pocket at a private pharmacy. Several public sector providers cited patient discrimination as a strong factor discouraging many of their public sector colleagues from establishing a private practice.

Private physicians also report resistance from their public sector colleagues. A common public clinic practice noted by several interviewees is assigning a patient of a private doctor to a public doctor if the patient visits a public clinic for a school medicine check or emergency care. Some private-sector respondents felt that if their practice failed they wouldn’t be hired back in public sector clinics, though in one study municipality there was one instance of a public doctor who previously operated a private clinic for two years. Private specialists also noted instances of the MoH thwarting private sector initiatives to develop cardiac surgery and in-vitro fertilization services, two specific items that the capital clinical centers and Ministers have been actively pursuing for several years.

Evaluation of Existing Policy Environment

Disparate policies between the public and private sectors are common, and perhaps even be justified, in transition economies. Such policies, however, appear to hinder the functioning of the private sector and do not advance the goal of improving the overall efficiency and quality of the national health system. This section evaluates the PHC policy environment with respect to the demands of introducing market forces into transition economy health sectors and identifies key areas for improvement.

Role of Government The current health Insurance Fund rules effectively control provided services and numbers of patients seen by private physicians, which may counter the expected tendency of private doctors to simply and quickly process patients to increase income (known as churning). However, the fundamental problem of overprovision in a FFS system remains (Miller, 1996). Branch office HIF actions, while arbitrary, can be seen as an attempt
to control rising costs due to supplier induced demand or to cut HIF expenditures in a period of growing deficits.

MoH rules preclude private physicians from providing vaccines and childhood immunizations. This complete reliance on state provision of public health goods pre-empts any leveraging of private resources to advance public health goals. Quality and efficiency could be improved by establishing competition between private providers allowed to also provide a basic public-health oriented services. Fair and equal enforcement of standards would further ensure high structural quality in both private and public clinics. However, safeguarding against using inspections as a coercive tool or uneven enforcement would have the opposite effect and maintain the poor condition of all clinics.

There is very little integration of services across the private and public sectors: policies on referrals, inspections, discrimination, and pay differentials all contribute to separate and unequal systems. At the municipal level, referral policies, especially denial of hospital privileges to private physicians, may unnecessarily burden the public system. This problem may arise if less healthy patients, knowing that their private physician cannot see them in a hospital, self-select into the public system if they believe they require hospitalization.

In the Public sector there are several additional important failures of policy including: 1) oversupply of physicians and weak mechanisms for allocating human capital within public clinics; 2) symbolically low co-insurance and extensive exemptions that reduce demand-side incentives for efficient utilization; and, 3) there is very little integration of services across geographical regions and tiers of the public system that negatively impact allocative efficiency.

**Financial Discipline** Current rules are effective in forcing private clinics to exercise financial discipline. However, in Public clinics, managers and physicians have little or no incentives for financial discipline in the use of resources in public clinics. Managers’ incentives are distorted by the arbitrary allocation of funds from the HIF and by the politically appointed nature of Medical Center management councils. Physicians’ incentives are severely constrained by their low salaries, lack of any meaningful performance review, and secure job tenure. From the standpoint of improving efficiency in health care provision,
financial discipline is central to the reform program and will be considered in more detail in later chapters.

**Competitive Markets** There is competition between physicians within the private sector. Increased entry barriers due to contract problems, education subsidies to public doctors, patient discrimination and professional pressures, may have restrained the level of competition, however.

In terms of competition between the private and public sectors, HIF rules can be seen as restricting entry to the private sector and, coupled with referral and hospital privilege policies, constraining the competitiveness of physicians once they do establish private practice. The result is that there is no effective competition between private and public sector physicians. Fixed salaries, and rigid hiring and firing policies preclude competition. Furthermore, neither physician utilization or patient selection of doctors has any effect on job performance or pay. With the establishment of the private sector in 1991, there have been shifts in demand toward private doctors. However, this has not resulted in effective competition between public and private sectors in part because public clinics have not reacted to this shift in a positive way by raising quality. Rather, public physicians are seen as protected from competition by HIF limits on private sector growth and Medical Center rules that also constrain private practice.

These practices are not unique to Macedonia. The HIF attempts to protect public sector physicians are analogous to thos of the American Medical Association prior to the 1975 Anti Trust case (Costilo, 1985). The “medical monopoly” limited price competition between physicians and was seen as protecting jobs as well (Kessel, 1958). Now, however, U.S. practitioners recognize competition as a positive force for efficiency and quality. They have responded with longer hours and less waiting time to improve patient satisfaction. Also, innovative forms of clinic organization and service delivery have been experimented with to improve both efficiency and quality (Costilo, 1985).

**Corporate Governance** Many private clinics are proprietorships or partnerships (over 90%) and thus there are few principal/agent problems in terms of managing private clinics. Until recently, public clinics were managed by the old-style management councils that in 1998
were changed to politically appointed management boards. In addition, politicized management hinders effective governance as managers have incentives to ensure tenure and secure fund allocations from the MoH rather than by focusing on efficiency and quality in the clinics. Health Center responsibility and authority are further diluted as they report administratively to Medical Centers.

**Property Rights** The right of physicians to privately own the physical clinics and related equipment is clear. However, the right to use these facilities is de facto dependent on possession of an HIF contract. That is, the HIF has power to “seize” the right-to-use private clinics and it can exercise this power with little recourse since the HIF Grievance Board was disbanded at the discretion of the HIF director in 1996. As a consequence, the HIF has a monopoly on contract awards, complete discretion over the contracts, and little or no accountability in its decisions.

**Political support** Unlike large scale privatization of state enterprises, the initial limited development of private markets in health care had, and required, little political leadership. As the private sector grew and problems with public finance compounded, the distributional concerns became clear.

Private practice offers higher income than the national median salaries of public sector physicians. Obtaining an HIF contract is the key entry barrier to achieving these higher incomes. Thus, the current private sector policies create large rents that HIF bureaucrats may be tempted extract. One prominent physician who had his contract canceled reported publicly that he had been told that his HIF contract could be reinstated by paying a “fee” of 7,000 DM (Tacev, 1996). The HIF may further be threatened with a loss of power if contract granting and review procedures become more transparent and as the flow of public sector funds are directed more by market forces, in contrast to bureaucratic decision-making.

**PROPOSED REFORM PROGRAM**

The HSTP is developing both demand-side and supply-side strategies to improve the quality and efficiency of primary HC provision across Macedonia. The HSTP program is reviewed in Chapter 2. In this section we discuss the components of the supply-side reforms and evaluate how well they advance to goals of developing markets in PHC provision. These
reforms have the potential for significantly improving the financial incentives to PHC physicians. However, the reform program does not address a number of policy issues that may hinder the effectiveness of the reforms. I discuss these in detail below. As an illustration of this point, Figure 4.4 depicts the PHC system model as defined by the HSTP reforms.

![Figure 4.4 – System model of private and public PHC under HSTP reforms](image)

The supply-side of the reform program currently focuses on physician payment incentives, resulting in little fundamental changes in the system of PHC provision. Of course, if the MoH follows through on preliminary proposals to sell public PHC clinics, the PHC system will be significantly altered. In this study, I examine the more concrete plans for payment system reforms in greatest detail.

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5 That health sector regulations must be revised to meet demands of new payment systems is not restricted to transition economies. In the US, much current fraud and abuse regulation was implemented during the 1970’s when FFS payment was the norm. Now, these regulations are inadequate and potentially counterproductive as managed care and capitation have become dominant (Blumstein, 1996).

6 Continuing Medical Education and limits on the annual number of subsidized medical school students are also including in the supply-side reforms.
The primary changes from the existing policies are that payments from the HIF to individual physicians will be in the form of capitation payments. As discussed below, this does not necessarily mean that payments to current private and public physicians will be comparable. Additional uncertainties include how contracting issues with the HIF will be dealt with. It is unclear whether contracts, similar to current FFS contracts between the HIF and private physicians, will be required by physicians in both existing private clinics and public clinics. How contracts are issued and managed, as in the past, will have major influence on the effect of the reforms. Below, we discuss features of the proposed capitation payment system.

**Payment Levels and Physician Income**

One of the key outcomes of the proposed demonstration project is information to help establish the level of physician payment under capitation.\(^7\) Pay level is a central issue because it sets the maximum expected revenue for doctors. There are several issues under consideration that determine physician pay. Some features will have little differential impact between the two sectors such as maximum monthly payments to physicians and case-mix adjustments for age and sex of patients. However, other features may have important implications for the functioning of the market under capitation including: creating a base salary component of pay; a provision for outlier payments; disincentives for over-referrals; more sophisticated case-mix adjustment; and maximum monthly payment.

**Salary** Under one proposal, physicians in public clinics will receive a portion of their pay in a fixed salary with the remainder in capitated payment.\(^8\) Private physician pay would be 100% capitation, fully dependent on the number of patients enrolled. As the size of salary portion of public sector pay increases, variation in income due to productivity will decrease. While there are good reasons to phase in radical changes to allow physicians to adjust, this carries the risk of weakening efficiency and quality incentives for public physicians. Moreover, there is also the likelihood of weak incentives becoming a de facto fixed policy as changing it would be politically too difficult.

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\(^7\) Payment level issues are reviewed in Carter et al., 1997.

\(^8\) As mentioned earlier, physicians in low-utilization public clinics will receive a salary.
**Outlier payments** These allowances limit financial risk arising from legitimate extraordinary care expenses. This is an alternative to more administratively intensive risk pools that could be phased in over time as capacity improves (Peabody et al., 1997). While such provisions are necessary to reduce adverse selection on the part of physicians, rules for outlier payments will need to be very transparent and well-defined. Most likely the HIF will be responsible for outlier payment decisions. Significant levels of discretion in making these payments, however, could be used to confer favors on groups of physicians.

**Referral Incentives** Another common component of capitation systems is the incentive to either over-refer or referral more often to costly specialist care. Typically, bonuses or penalties are assessed to limit this practice. These incentives are based on comparisons for physician referrals over a fixed time period to allowable ranges of referral rates. Some portion of the capitation payment is often withheld and released when the physicians meet referral targets for a time period. Penalties for inappropriate referrals may also be used, though the proposal for Macedonia suggest using referral audits be conducted before penalties are assessed. Similar to facility structural standards and enforcement actions, it is important the application of referral incentives and audits be equitable across sectors. Also, if public sector referral restrictions on private physicians continue, private physician referral practices will not be comparable to those of public physicians.

**Eligibility and Selection**

Coverage under capitation, in terms of the specialties and number of doctors included, will determine the level of potential savings under capitation. It will also indirectly determine the type of services available under capitation. This is true chiefly in public clinics where there is a distinct segmentation between preventive care providers (Labor and School medicine) and curative care providers. Labor and School Medicine providers under the current proposal may be exempt from capitation and retain most or all responsibility for preventive care. If such distinctions persist, the status of PHC will be undermined and integration of the two sectors – and therefore overall system efficiency – will be reduced. Additionally, fairness between sectors will be compromised if private physicians cannot provide preventive care; they will be less attractive to patients and their enrollment may suffer.
Patient selection and switching will also condition potential improvements in competition within and between sectors. In keeping with existing law, current proposals allow patients to switch public physicians once each year, while private physicians can be changed at will. While such open selection of private physicians increases competition and patient choice, the restrictive public sector policies have the opposite effect.

Financial Responsibility

Under capitation, private physicians will continue to assume the financial risks of their practices; costs of operating the clinic facility, capital investment, staff expenses, and other costs of care including lab costs. Private physicians will also bear the costs of specialist referrals. The financial responsibilities of public physicians are different under current proposals. Laboratory costs are one important difference. Many public clinics, especially the larger health centers and polyclinics, have substantial laboratory capacity. Health center budget allocation are made on a department-basis, and laboratories function under separate budgets. Until investments are made in information systems that allow patient-level billing, individual public PHC physicians will not bear direct financial risk for ordering tests. Departments within the Health Center may be able to make some adjustment to physician pay based on lab use, but this too has similar problems with information intensity and weakened incentives.

Facility costs and, more importantly, capital investments are also a critical point of difference. Public health clinics are generally considered to be in poor condition. As reviewed in previous section, this is due both to the lack of funds available and to unaccountable management systems. Even if capitation shifts resources to PHC, with public health center management structure unchanged it is not at all clear that capital improvement decisions will change. If in public clinics those physicians bearing financial risk are not allowed to make resource allocation decisions one of the central efficiency and quality improving mechanisms of privatization will not function.

Care for the Uninsured

Policies on care for the uninsured are a minor point in the proposed payment structure, but it has important equity implications. Those patients who do not subscribe to insurance must
pay out of pocket. Private physicians are able to retain 100% of such payments as revenue. In public clinics currently, clinic management retains all such payments and may not use them for salaries. Under the reforms, if public physicians do not receive part of this payment equivalent to that for capitated patients, they have little incentive to treat the uninsured. It is interesting to note that this is one exception to the general rule of the proposed reforms that favor the public sector over private physicians.

**Evaluation of Proposed Reform Program**

This section evaluates the policy environment, as defined by the proposed reforms, with respect to the goals of CEE privatization that were developed in Chapter 3. While the reform program is not yet finalized, this analysis points out additional elements of the policy environment that must be considered as part of policies further privatizing primary health care.

**Role of Government** Current reform proposals do not resolve the problem of complete reliance on state provision of public health services. Under reforms, private physicians will still be barred from providing childhood immunizations and vaccinations for all patients. Under capitation, all physicians have equal incentive to provide preventive care to ensure that their patients remain healthy and less costly to care for – one of the key advantages of capitation. Prohibiting any group of physicians from providing this type of care exposes them to an inequitable risk of their patient becoming ill from a preventable disease while also making it more difficult for their patients to get the care they need. Furthermore, this preempts, to a large degree, any possible leveraging of private resources to advance public health goals.

Another issue unresolved from the current system is the uneven quality assurance role of the MoH and HIF. Regulations and enforcement of standards may keep structural quality (such as equipment and supplies) high in private clinics. However, the interviews with private physicians indicated that inspections may be used as a coercive tool. Also, enforcement is not applied equally, which may help to maintain the poor condition of public clinics. To ensure quality and fairness, enforcement of quality and sanitary standards should be strictly
and evenly enforced for all clinic types, perhaps with lengthy grace periods for under-capitalized clinics to make investment over time.

Integration of the existing private and public sectors, allowing coordinated service delivery and patient flows, is only partially addressed by the reforms. While a uniform capitation payment system for PHC physicians will level performance incentives, the issues that implicitly thwart integration remain. Ending punitive referral policies, hospital privilege denials, educational subsidies, inspection policies, and patient discrimination would allow the private sector to better serve patients and advance national health goals.

**Financial Discipline** The lack of adequate management information systems in public clinics is a challenge to reforms. Until MIS capacity is in place, there is significant potential for induced demand in public Health Centers for services that are subsidized or for which physicians bear no cost. Interim measures, similar to the financial incentives for specialist referrals, may be developed to control test ordering as well.

**Competitive Markets** Capitation has the potential for improving competition within and between sectors to the benefit of service quality. However, the fraction of public physician pay that is based on a fixed salary coupled with public sector labor practices and patient-physician selection periods of one year will weaken competition both within the public sector and between the private and public sectors. In addition, referral and hospital privilege policies could be liberalized and discrimination against patients of private physicians could be eliminated to open the public sector to competition and reduce the discretion of public agencies to shield public sector physicians from competitive pressure.

Competition could also be increased by reducing barriers to entry arising from the financial risk of establishing private clinics. Rather than requiring a private clinic to be fully operational prior to granting of a contract, a probationary contract award could be formalized that would convert to a full contract if physical standards are met within a certain period. Such a probationary period would not allow reimbursement for providing patient care but would significantly reduce the financial risk taken by prospective private physicians.
**Corporate Governance** In the private sector there is no immediate change likely, though if barriers to private sector entry are sufficiently lowered, physicians may begin to experiment further with private group practice organizations, use of non-MD staff, and other practices. In the public sector the key issue is the reorganization of Health Center management and how it will be structured. Financial and clinical performance incentives are separated between management and physicians. Without appropriate controls between physicians and clinic management, the rent-seeking behavior of the HIF may be shifted down to the Health Center level as management will have discretion over allocation of clinic resources. This will entail drawing enforceable contracts covering physician use of nearly all inputs to their practices including office space, staff, labs, supplies, and entrances and waiting areas for patients. Doing so may prove to be a difficult problem if Health Centers remain publicly held, depoliticizing the appointed management boards is crucial. This is particularly so to ensure fairness and transparency if physicians and other services operate on a contractual basis. In a more indirect manner, the government can encourage good governance by developing management capacity through education programs and also fostering an information infrastructure that allows common standards to develop between private and public sectors.

**Property Rights** Macedonia has enacted privatization laws, successfully sold many former state assets, and is building the legal capacity to enforce property rights. Thus, the main issue in terms of clinic ownership is not the legal infrastructure, but the political will to depoliticize clinic ownership and management. One additional property rights issue lies in that HIF maintains discretion over contracts with physicians. It will be important to make HIF transactions transparent and improve accountability.

**Political Support** It is difficult to identify the distributional consequences of capitation before important aspects are finalized. However, early experience of the reform program suggests that there is opportunity to improve support. The HIF will have a large role in determining the function of health markets under reforms, as they have in the existing private sector. Securing their participation is essential to program success. Gaining the participation of physicians is also critical to reform implementation. Some Health Center employees are resistant to reforms since they feel threatened by having their pay based on productivity. Public sector specialists may also react negatively if their income is threatened by a decrease
in referrals or in the numbers of hospital patients. If the ranks and pay of specialists are maintained or increased to gain their support for the reforms, the shift of resources from specialty care expected under capitation will be difficult to realize.