



Economic Analysis of the Purchasing Function of the Health Insurance Fund with Focus on Methods of Payment

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Abstract

The subject of research in this master's thesis is purchasing function of insurance fund, the manner of execution of the function, its characteristics, methods of payment, and the reform of public health affecting its function and how it is connected with other functions in public health while the aim of the research is to create future recommendations and suggestions to improve the purchasing function and methods of payment, or a plan of measures to be taken for its development. Public health is a social, economic, political and legal concept which aims to improve health, prolong life and improve the quality of life of the population through health promotion, prevention of disease and other forms of public health activities and interventions. Health Insurance Fund (HIF) is the main finansierpokrivajkji over 90% of the total budget for health 35 % on the Fundof revenues derived from government and come from pensioners and the unemployed. The rest of the income of the Fund from employer contributions 9.2% (plus 0.5% for accident insurance rabotnotomesto) fee and other revenue. Fund primary healthcare services to general practitioners sefinansiraat based on kapitacija. The secondary outpatient care is secured from specialists working in public and private health protection. The hospitals which are mostly public funded based on historical budget. In the thesis the focus of research will be put towards purchasing function of HIF.

Keywords: HIF; Methods of payment; Public Health; Health Management; Insurance; Purchasing function.

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1. Introduction

Public health is one of the most fascinating educational endeavors that set a number of thematic, scientific and ideological issues, which are critical reviews to the terms relating to its operation, and then move to the level of health care in the country, and challenge us on the following analysis:

- Analysis of the primary health care, through which are undertaking activities for primary prevention, which aim to improve the quality of life, promote health and prevent disease and damage to health will certainly be analyzed in both groups, i.e. the preservation and improvement of health measures to prevent the occurrence of disease;
- Analysis of the level of health care, through which to undertake activities for secondary prevention, which aim for early detection of a disease and treatment of disease, the analysis of the following groups: measures for early detection of disease and early treatment measures.
- Analysis of tertiary level health care, through which to undertake activities for tertiary prevention, which aim higher and proper care for those states that cannot be treated, or that despite the therapeutic treatment left permanent consequences on health people, and measures for rehabilitation and support measures.

Health care in Macedonia is delivered through a system of health care institutions. It is organized into three levels: primary, secondary and tertiary. However, still it remains to be determined functionality between these three levels. Recent years we have been seen significant growth in the private sector, particularly in primary level. Most of the dental offices were privatized, and this process later conveyed to pharmacies. Priorities of the institutions which manage health sector are: Improving the health institutions, reform of human resource policies and further regulation of the pharmacies sector; Overseeing the management of health institutions which performance are the boards that consist of seven members: three employees of the health institution and four members appointed by the Government. In the primary sector institutions of two members of the board are representatives of the community. CEOs of health institutions sideways are proposed by advisory board and are appointed by the Minister of Health. Most of these places have frequent replacements as many appointees are not having the necessary qualifications and skills. Every health institutions have its Statute, which is adopted by the management of the board. The statute regulates the structures and defines the functions of the Health system and should be approved by the Government. Health institutions in Macedonia are licensed, although in theory the license can be revoked when not the levels are not satisfied. There are institutions, especially in rural areas that have equipment that is in very poor condition and haven't got many natural materials. Most of the health organizations have problems resulting from the deterioration of their capital. This is especially serious problem in the primary health sector. Health care in Macedonia also delivered by private health organizations are working mainly in the primary sector of the primary health clinics (general practice, dentistry). The doctors working on a public sector are permitted to work in the private or public private institutions. There is a potential for conflict of interest, given that regulatory framework that clearly defines the working conditions is still under preparation.

Reviews to the principles of public health in the country, its characteristics, and competencies and carry out the facts of theoretical and methodological approach to research on the impact of the thesis, is purchasing power of the health insurance fund.

While according to the WHO in 1999 and Donald Acheson 1988 "Science and art of preventing disease, the continuation of life and promoting health through the organized efforts of society is called public health" [1]. The process of concluding a contract and strategic purchasing of the health insurance, and the ranking of priorities for strategic purchasing. The main values of the health system the Government determines the basic characteristics of the European health systems, such as solidarity, equality and citizen involvement in decision making. The content of the program of the Government indicates that it will strive to maintain, deepen and promote these European values in all aspects of the organization of the health system of the Republic of Macedonia. In its implementation of that part of the program, the Government shows great interest to protect the poor and vulnerable population groups from further financial costs associated with their care. An example is the recent changes made to the Law on Health Insurance that open opportunity for all unemployed persons on any grounds not exercise their right to health insurance, to be included in the system. Thus, the Government tries to provide greater access to health insurance for the entire population living on the territory of Republic of Macedonia. In addition, it takes measures to reduce private consumption patients for treatment in the hospital sector by providing all necessary medicines and medical supplies. Each country develops its own health system and modify according to their needs and cultural means. But the health sector is in a state of constant evolution, so that developing countries can take a number of examples of health systems in developed countries, they are examples to implement in its health system and realize the evolution of the health system in their country. The provision of health care, there are certain disorders over the provision of health care that can be geographic, cultural, social, psychological and finance. Equal access to quality health care with minimal interregional and socio-demographic differences and essential to good public health standards. Under the needed services are not solely those services available at the request of the patient, but also services for the entire population, especially vulnerable groups who often have the least chance to come up with appropriate treatment. Program that provides equal access to health care for all, can caught in achieving its goal - improving health - if not backed by adopting legislation on healthy environment and safety, nutrition and food products, standards drinking water, improving health care in rural communities, higher education and health information to the public. To promote health and reduce specific risk factors forcibility and mortality, additional national health programs. Responsibility and health not only bears a physician or other medical personnel, but also society and its executive instruments, government and non-governmental organizations, and individual and his family.

In Macedonia there are following methods of buying the health insurance: Capitation; Recovery service; Payment by personal income and other funds from sources of funding health care. As in other sectors, investment in information systems grow in the health sector to work with disabled people. Information systems provide a significant contribution to improve health outcomes in deciding the places of delivery of health services, as well as in the planning and financing of health care.

2. Methods of payment of health insurance

Methods of payment include rules on contracts to be known in advance. Under payments shall mean the allocation of resources (usually money) to the organization of the health sector in return for some activities (e.g., service delivery, management of organizations) [2].

Buyer must give instructions for the type of contract (contracts for work or contracts for health and other services) as well as methods for stimulating integrated into any kind of agreement. Stimulative methods should be focused on improving the quality of health care. For example, the formulas for calculation of the payment for each service; level of funds available to the supplier by type of service; financial incentives based on results; definition of the financial year (particularly important when there are year-round tenders); submission of financial reports; reporting requirements (clinical, financial, administrative); billing schedule; when to make required payments; responsibilities and interests; procedures and timing of payments and payment and claim procedures. The main methods of payment of medical services or the providers of health care services include: Capitation; Payment Service; Payment by personal income and Other funds from sources of funding health care. Each of these methods of payment of medical services has its advantages and disadvantages. Very often, the methods of payment of medical services can be mixed, that is combined with the predominance of capitation as a payment method. Criteria against which to assess these methods are: Costs of management and monitoring; Ability to maintain overheads; Degree of impact on technical efficiency and Quality health care. Administrative costs and the monitoring costs are to establish a system that would allow control of current expenditure in payments, as well as providing the conditions in which the contract will be fulfilled. The ability to keep overall costs is expressed with payment system that allows control over costs and prevent unnecessary treatments. Technical efficiency is defined as a stimulus that will encourage providers in the use of resources in the most effective way to provide a service. What kind of service will be provided depends on the demand of customers, and it is quite another matter. The last criterion is the way the system encourages providers to provide quality health service patients. Quality health services can be provided by two sectors: ambulatory and inpatient. Health care concerns publicly or privately provided care and protection provided it is regulated in the context of a system based on taxes or a system based on social health insurance. Functioning health system, state and / or social security institutions do administrative costs.

2.1 Capitation (Capitation)

Capitation is a tax or a fee that is paid per capita, or donation or budget that determines per capita of the specific population of which follows this type of service. Capitation is taken as one of the bases for securing the budget for healthcare facilities or healthcare professionals who work as doctors in primary health care. A capitation payment for certain health services at individual registered as a recipient for a specific period of time [2].

The amount of capitation adjusted for various factors, age and gender-specific mortality, which express the different health needs. It can be combined with other methods of payment as payment for a service. It is a mechanism through which service providers, whether it comes to GPs or hospitals receive payments tied to any individual who is covered by the social health insurance or private health insurance. Based on this uniformly paying patients are entitled to predetermined package. As a method of payment used in many European countries including Austria, Denmark, Finland, Hungary, Ireland, Italy, the Netherlands and England. Capitation can be used in combination with the method of payment for a service such as in Denmark, Italy and England. The main feature of this method of payment is that it is not directly related to costs incurred for consumption of health services by the individual patient. Or, in other words, providers are paid according to the quality and scope of health services provided to the individual patient.

With capitation physician is paid according to the number of patients registered with him regardless of how many treatments performed. Payment shall be performed for each individual patient for a period of time, usually one year. For example, the GP receives a certain amount of money per registered patient, whether the patient comes to the doctor during the year or not. The purpose of this method of paying doctors to pay them to ensure adequate coverage of patients, not to provide specific treatments and interventions.

2.2 Payment service

Payment service is a way of paying for each service unit, as medical examination or surgical intervention. This method is typical for ambulatory and hospital care, especially in a system based on social health insurance, as is the case in Western Europe, Canada and Japan, and also be used in mixed systems as is the case in the US .

Doctors entered the service account, and hospital funds pay them, or compensate for the expenses of patients. This is a common form of payment for self-employed doctors, as for ambulatory care and hospital treatment. In some countries the collection service is the method of payment of medical services (such as examination, consultation, examination or diagnostic tests) in accordance with fixed tariffs negotiated between insurance funds and representatives of health professionals. This tariff model is applied in specialized medicine, and less at the level of primary health care. The doctor is encouraged to give acceptable service with an attractive room or office, its timely delivery and kindness. This method gives rise to the doctors to take unnecessary or marginal employment. Doctors are reluctant to give advice pertaining to smaller and less serious health problems and because they tend to provide services as possible. This method encourages doctors to provide more advice and expensive procedures, and most of them may be inappropriate. Hence, its drawback is that encourages high volume of unnecessary health services, which may not be consistent with the benefits arising from them, or use of expensive medical procedures. Service users who have health insurance can an easier way to bear such costs to those users who have no insurance.

2.3 Payment by personal income

Payment by personal income is based on the time the doctor spends in the workplace. For countries in transition characteristic is the system where doctors are paid a fixed annual salary regardless of the volume of work frequency and quality of treatment.

Salary is determined by negotiation between the two sides. On one side is the state or the insurance paid by doctors, and the other by their professional associations. The level of wages varies depending on age, experience, quality and level of responsibility of the physician [2]. This is an advantage for the physician because he is sure of the revenue, while reducing the tendency of the doctor and other medical staff in encouraging unnecessary interventions. Therefore it is believed that this method of payment does not encourage increased workload, nor giving an increased number of health services. The salary, in itself, does not give finansiska incentive for increased productivity. In this case requires additional incentive fees for additional services provided that will allow reducing costs and increasing efficiency.

Health services are charged with personal income is often criticized because of reduced patient identification physician and insufficient attention is given to the patient. The method of payment of the salary of the doctor is present and where there are already two other methods of payment, such as payment for service and capitation. In different countries use different combinations of these methods, however, capitation is the dominant method of payment for health services. The salary of doctors is used as a method of payment in several OECD countries, including Greece, Spain (60% of doctors have income that is based on the amount of salary plus capitation), Portugal, Finland and Sweden. Advantages of this method of payment:

- Lack of economic incentives for longer given more services than method of payment for service;
- Doctors are encouraged to work in group counseling, especially when it comes to complicated cases;
- Financial planning services to healthcare easier and administrative costs are low compared with other methods of payment, especially in comparison with method of payment for a service.

The shortcomings of this method in the public sector are [2]:

- Do not encourage doctors to work productively
- May lead to low conscience for those who work more and harder and not feel rewarded for their additional commitments

Doctors working more can be encouraged to undertake additional work in the private sector or to completely abandon the public sector. Therefore, not surprisingly us doctors they want to replace payment by way of salary payment method for service. For the provision of health services in primary health care to the insured, the Fund contracts with health institutions that provide primary health care if: Indicates health services within the activity for which it is registered, There are conditions for performing the relevant activities (facilities, equipment and personnel in accordance with the Law on Health Care who are approved to carry out an activity of the Ministry of Health, To point to health services in accordance with the Law on Health Care, Law on Health Insurance, Law on Records in the field of health, interstate agreements on social security regulations of the Fund and evidence-based medicine, Regular payment of contributions for compulsory health insurance, Foster good business relations. The fee for health services is determined on the basis of: Number and structure of insured persons who chose physician; Gender and age; Preventive measures and activities that need to be achieved in terms of rezultatite of work performed by a midwife or doctor; Additional incentives for health services provided to insured persons in the rural areas.

The main activity capitation general medicine as an insured person the Fund is determined according to age and gender, multiplied by points for each of these categories of insured persons as follows [3]: Children up to age 6 - 3.1 points; Children older than 6 years and younger than 18 years - 1.2 points; Insured persons older than 18 and younger than 34 years - 1.0 points; Insured persons over 34 and under 65 years - 1.6 points; Insured persons older than 65 years - 3.7 points. Points are determined based on the data from the previous period for the insured, the predictions based on evidence-based medicine, and prioritete in implementing preventiajta, health protection, care for communicable and non-communicable diseases and other targets.

Depending on the number of points achieved for general practice activity, the value of points is calculated as follows [3]: 2500 points 100% of the determined value of the points; For each additional point from 2501 to 3500 points, 70% of the determined value of the points; For each additional point from 3501 to 4500 points, 45% of the determined value of the points; For each additional point of 4501 points, 30% of the determined value of points; The main activity gynecology capitation per insured person of the female sex is determined by the Fund depending on Voras multiplied by points; Insured persons over 12 years - 1 point.

Table 1: Prices of packets of services in preventive health care protection and emergency medicine help with home healing

Code	Health service	Referent price	Official public
IMP1	Emergency help	177,000	151 from 31.10.2011
PRE1	Home healing	136,500	151 from 31.10.2011
PRE2	Rescue service	76,500	151 from 31.10.2011
PRE3	Systematic examination, vaccinations and counseling	94,700	151 from 31.10.2011
PRE4	Preventive dentistry	113,000	151 from 31.10.2011
PRE5	Emergency dentistry	96,200	151 from 31.10.2011
PRE6	Patronage by sister	40,000	151 from 31.10.2011
PRE7	Review and expert opinion on the health of the insured by the medical board	638,000	171 from 2010
PRE8	Rural team	90,300	138 om 17.09.2014

Depending on the number of points earned for activity gynecology ppulacija for women aged over 12 years to the end of life, the value of points is calculated as follows [3]: By 4000 100% of points determined value of points; For each additional point from 4001 to 5000 points, 70% of the determined value of the points; For every point ordered from 5001 points to 6000, 45% of the determined value of the points; For each additional point of 6001 points, 30% of the determined value of the points

The main activity gynecology capitation per insured person of the female sex is determined by the Fund depending on Voras multiplied by points: Insured persons over 12 years - 1 point. Depending on the number of points earned for activity gynecology ppopulation for women aged over 12 years to the end of life, the value of points is calculated as follows [4]: By 4000 100% of points determined avrednost of points; For each additional point from 4001 to 5000 points, 70% of the determined value of the points; For every point ordered from 5001 points to 6000, 45% of the determined value of the points; For each additional point of 6001 points, 30% of the determined value of the points

For the chosen doctor who first contract with the Fund for the first time has been granted to the facsimile number or has issued a number of facsimile by the Fund that is not active for more than five years, the method of calculating capitation performed in stimulating worth 800 points, for a period of 18 months.

For the first six months selected doctor receives incentives totaling 800 points. For the second and third six months amount of capitation as an incentive is calculated depending on the number of insured persons who chose physician multiplied by points for each age category and if it [4]: For the second six months selected doctor goes with getting stimulation if: The total number of points by insured persons who chose physician is more than 199 points are calculated capitation 800 points; The total number of points of insured persons who chose physician is greater than 49 points to 199 points is calculated capitation 400 points; The total number of points is 49 points is not the principle of stimulation but capitation calculated according to the number of insured persons who chose physician; The third six months selected doctor goes with getting stimulation if the total number of points of insured persons who chose physician is more than 399 points are calculated capitation 800 points; The total number of points of insured persons who chose physician is a larger than 99 points to 399 points is calculated capitation 400 points; The total number of points is 99 points is not the principle of stimulation but capitation calculated according to the number of insured persons who chose physician

In rural areas according to the criteria of the Fund, with only one doctor in primary health care, total Capitation FZM increases with points on the basis of rural areas depending on the number of insured persons who have committed the most choice to 1800 points. Rural area includes the settlement in which there is a doctor who provides primary care to uninsured people and who gravitate toward more populated areas that lack health facilities. We as rural areas or rural areas can establish those who meet the following conditions [4]: At least 5 kilometers from the settlement which is located nearest health institution of primary health care; At least 15 kilometers of the settlement which provides specialist - consultative health care, emergency care, and notwithstanding the distance from the settlement of at least 5 km of inaccessible terrain that may be inaccessible at certain times of the year; The very rural place if at least 50 residents; Area is a place where the health facility is built by decision of the Government of the Republic of Macedonia for construction of clinics in rural areas are determined for a rural area; Populated areas or places that isplnuvat conditions stipulated in the decision of the Board of the Fund shall be established as rural areas or places and can not be more than 100 rural areas and areas.

Capitation for rural areas or areas are only paid to insured persons ruralntoo area or township who chose physician. The amount of capitation is calculated depending on the number of insured lcia who chose physician multiplied by points for each age category and if it: The total number of points of insured persons who chose physician is less than 100 points to 1200 points paid; The total number of points of insured persons who chose physician is more than 100.01 points to 300 points paid in 1300; The total number of points of insured persons who chose physician is more than 300.01 points to 350 points paid in 1400; The total number of points of insured persons who chose physician is greater than 350,01 to 700 points paid 1500 points; The total number of points of insured persons who chose physician is more than 700.01 points paid 1800 points; If the amount of the total number of points of insured persons who chose physician in rural area is higher than 1800 points, in which case the Fund continued payment of capitation. Fund health institution chosen doctor paid up to 100% monthly fee which includes 70% fixed amount of capitation and 30% variable amount depending on the fulfillment of objectives. In the monthly capitation fee, includes costs for [4]: Maintenance of equipment for surgery and appropriate standards; Providing continuous primary care for acute cases within 24 hours every day for the insured persons who chose physician at the health facility; Payment of salary leakrskiot team (doctor and nurse).

Travel to and from the place of residence of the insured persons for providing health services; Maintenance of the necessary medical equipment; Running the computer records and submission of data and reports to the Fund and public health centers; Medications, medical and non-medical potroshoni other materials; Charges for utilities; Other regular expenses.

The variable remuneration for the fulfillment of the objectives (preventive measures and activities) are paid every month depending on the performance of the following activities: Preventive measures and activities for early detection of diseases; Preventive measures and activities for early detection of malignant diseases; Rational utilization and rational drug prescribing; Specific medical education for early diagnosis of diseases; Rational and justified prescription of sick leave; Preventive measures and activities to monitor the proper growth and development of the population 18 years of age; The health institution shall submit quarterly reports on the activities carried out to fulfill the purposes and they are controlled annually; If the control finds failure to activities or failure to meet targets in the specified rate, the variable compensation will be reduced by the corresponding percentage for a particular activity in a given quarter.

For students aged amongst 7 and 26 years, despite the chosen doctor choose another doctor in the place where they are studying, or studying the fixed amount of capitation fee is distributed in the following ratio: Up to 70% of the chosen doctor in the place where the student or the student is educated or studying; 30% of the chosen doctor in the place where the student or the student has a permanent place of residence.

In areas where there is no organized emergency medical assistance in an emergency service or in the same can not be implemented due to insufficient number of medical teams and thus do not meet the conditions stipulated in the rules of space, equipment and staff, it is done in shifts the practitioner of the area organized a public health institution. Public Health Institution conclude a separate agreement with selected doctors for providing facilities to carry out continuous care. Payment of the fee duty of elected doctors performed medical center.

The fee for the realized awareness of the chosen doctor fps eshto no organized emergency medical assistance or it can not be implemented because it lacks a sufficient number of medical teams and thus do not meet the conditions stipulated in the Regulations for space, equipment and staff are paid from the health home, based on the submitted invoice, according to the decision on pricing of duty, achieving awareness and birth in health centers. In areas home treatment is performed by a physician selected by that region by order of a physician specialist, performed provided by the Fund and are reimbursed based on the invoice submitted by the health institution selected doctor according to price list of health services of the country [5]. For deliveries performed in maternity hospitals that perform selected gynecologist and pediatrician checks, payment of compensation is performed according to the medical center with the decision on pricing of duty, achieving awareness and birth in health centers. Health facilities selected physician contracted with the Fund to provide primary health care in accordance with the rules of payment, be able to provide health services to the insured persons who need them while on vacation or out of the residence, and can use health services chosen doctor. For persons covered by signed international social security agreements - foreign insurers, health institutions of primary health care provides zddravstveni services based on contractual interstate bilingual form or a European Health Insurance Card (European Health Insurance Card - EHIC).

Health institution to the regional office of the Fund submitted a separate calculation for services provided by the prices determined by the Fund with the displayed calculated and paid tuition [5].

3. Methods of research

The object of research is the function of purchasing insurance fund, the manner of execution of the function, its characteristics, methods of payment, and the reform of public health affecting its function and how it is connected with other functions in public health. The aim of the research is to create future recommendations and suggestions to improve the purchasing function and methods of payment, or a plan of measures to be taken for its development. The study used the following methods: Observational method - Apply in gathering the necessary literature and selecting the most appropriate literature processing thesis; Analytical method - Apply to analyze theoretical contents pertaining to the health system of the Republic of Macedonia; Descriptive method - Implementation of the purchasing function in the health system of the Republic of Macedonia; The comparative method - make a comparison - a comparison between the functions of purchasing function before reform after health care reform.

4. Results

1. Conclusion of Contract and payment in primary dental care

For providing dental care to insured persons Fund contracts with hospitals that perform primary dental care if: Indicates dental health services to insured persons providing specialized medical rehabilitation to improve or restore lost or damaged functions of the body as a result of acute illness or injury, medical surgery, congenital anomalies, worsening of chronic disease. Specialized medical rehabilitation as extended hospital treatment provided conducting an intensive program of rehabilitation which is necessary multidisciplinary team working within the medical treatment, to eliminate functional barriers and improving health. Within the activity for which it is registered and licensed under the Law on Health Care [5]: There are conditions for performing dental care (facilities, equipment, staff); Integrates with the needs of the population in the area of healthcare institution; Get paid contributions for compulsory health insurance; Cultivate a good business relationship.

Payment of dental health services of the health institution or selected doctor dentist primary dental care performed by point made by an insured person according to the number of insured persons who chose physician dentist (capitation) pomnzen determined by the amount of capitation. Any insured person who chooses the doctor dentist has won 1 point. Capitation is a potential monthly amount of the compensation of the chosen dentist or medical institution is paid for providing services to insurers. The fee for health services capitation is determined based on the planned funds for primary dental health institution, which includes [5]:

- The costs of salaries and allowances of the dental team (physician's assistant)
- Material costs incurred in providing dental health service
- General operating costs
- Optimal number of patients over a team dentistry 2000 insured persons

The amount of capitation by the Steering Committee of the Fund. Depending on the number of points earned, the value of points is calculated as follows:

- Up to 2000 points 100% of the determined value of the points
- For each additional point from 2001 to 3000 points, 70% of the determined value of the points
- For each additional point from 3001 to 4000 points, 45% of the determined value of the points
- For each additional point of 4001 points, 30% of the determined value of points

In settlements that are defined as rural areas, the amount of capitation is determined for at least 1600 insured persons. The amount of capitation chosen doctor dentist is paid 100% which includes 80% fix export and 20% variable amount of capitation if they achieve the goals set out in the contract concerning [6]:

- Execution of the planned number of preventive examinations
- Compliance with the obligation of rational prescribing of recipes
- Referral to a higher level of dental health care
- Justified approval of sick leave

If the selected doctor dentist fails to meet the objectives specified amount of capitation is reduced as follows:

- Up to 10% (2% for CIT, 3% and 5% CP LF) for failure of the anticipated number of preventive examinations for specific target groups
- 4% for irrational prescription of recipes
- 4% of irrational referral to a higher level
- 2% for the unjustified approval of sick leave.
- The amount of capitation presemetuva are based on the results achieved for each quarter

The method of funding, which applies to private dental clinics established based on the transformation of public to private dental offices confirmed that compensation is determined by the amount of the net capitation per insured person and predodniot fee to the amount of which is calculated as follows: The period of compensation, First month 100%, Second month 90%, Third month 80%, Fourth month 70%, Fifth month 60%, Six months 50%, Seventh month 40%, Eighth month 30%, Nine month 20%, Tenth Month 10 and Eleventh Month.

2. Conclusion of contract and payment in hospital care

As health services in hospital health care are considered basic health services specialist - consultative health care, hospital and tertiary care of the Health Insurance Act. Hospital care provided by university clinics, clinical bolnici, general hospitals and special hospitals. Tertiary health care provided by university clinics. Health facilities, except hospital care and provide specialist - consultative health care. Insured, health care specialist - consultative and hospital health institution is performed by a referral from a doctor chosen by primary care.

Table 2: Paying in secondary health protection

Number.	Code	Package of Health service	Referent price	Official paper	
	DBO1	Daily Hospital (housing, meal and working staff) for application of chemotherapy and / or biological treatment under and over 4 hours	460	181 from 27.12.2011	From 1th April 2012
	DBO02	Daily Hospital (accommodation and meal) application drug therapy over four hours	200	181 from 27.12.2011	
	DBO3	Day hospital (accommodation, meals and working staff) Psychiatry involved with health services and drug therapy over 4 hours	670	138 from 06.11.2012	The new reference price of 670 denars shall enter into force on the eighth day of its publication in the Official Gazette i.e. 14.11.2012 year. Until that date applies the old reference price of 560 denars
	DBO4	Daily hospital application of drug treatment in the 4 hour	130	63 from 23.05.2012	From 31th May, 2012
	DSO1	Hospital day in hospital (accommodation, meals and working personnel) involved with health services and drug therapy in psychiatry for patients	960	138 from 06.11.2012	The new reference price of 960 denars shall enter into force on the eighth day of its publication in the Official Gazette i.e. 14.11.2012 year. Until that date applies the old reference price of 710 denars in force since April 1, 2012
	DSO2	Hospital day in hospital (accommodation, meals and working personnel) involved with health services and drug therapy for chronic and prolonged hospital treatment plants and special hospitals for patients after decision of the Fund	1,200	181 from 27.12.2011	
	DSO3	Hospital day in hospital (accommodation and meals) for companion sick child aged up to 3 years	350	181 from 27.12.2011	
	DSO4	Hospital day in hospital with included health services and medical treatment for the sick in gerontology	760	63 from 23.05.2012	From 31th May, 2012

For providing health services to the insured persons in hospital health care the Health Insurance contracts with health facilities. The agreements are concluded if the health institution meets the following criteria:[4]

- To point to health services within the activity for which it is registered
- Do the conditions for performing the relevant activity (space, equipment and personnel)
- Have a set plan and program for providing health services to the insured
- To have set financial plan funds necessary to provide a certain type and scope of health care services to insured
- To fit the needs of the population in the area of the health institution
- To pay contributions for compulsory health insurance
- To nurture a good business relationship

The agreements concluded by the Fund, if established means in the budget of the Fund for that purpose in bid for concluding dogovor accompanied by the necessary documentation showing the validity of the contract for the current year. Agreements signed for implementation of health care for certain activities of inpatient care and with them, specifying the type, scope, validity, manner and deadlines for achieving the agreed services under the mandatory health insurance for certain activities specialist - consultative and hospital tertiary care, using evidence-based medicine, determined prices agreed amount of money for an agreed type and scope of health services, method of payment and orokovi, monitoring and control over the exercise of contractual health services, contractual penalties and Suslov under which terminates the agreement [6]. The fee for the medical services for each fiscal year shall be determined by agreement between the Fund and the health institution, based on the planned funds for bolichka care provided in the budget of the Fund.

5. Conclusion

Government and the Fund prepare a plan to resolve the problem of the existing arrears of the Fund and submit it to the Assembly. The law stipulates that the Fund must make new debts in the future. The basic package of health services is the basket of health services provided to policyholders which providers will be fully or partially reimbursed by the Fund. This means that the patient either not pay for these services at the point of service, or pay a fixed fee. They use several methods for balancing the revenues and expenses of the Fund: Redesign of the basic package of health services by establishing health priorities; Periodically review the contents of the basic package of health services depending on available funds; A thorough assessment (including determining the marginal cost-effectiveness) of new drugs and devices before they can be added to the basic package of health services; Defining priority preventive health services that will co-payment; Bargaining between the Fund and health care providers about the type, scope and cost of curative services in the basic package of health services; Introduce greater participation for specific forms of specialist advisory services in ambulatory - polyclinic and hospital care (exempting certain categories of the population), which will reduce informal payments out of pocket allowing the provider to keep additional revenue; Periodically review the positive list of essential drugs and medical devices included in the basic package of health services; Taking responsibility from the Fund for payment of funds for cases of sickness and maternity leave by the respective institutions.

Adjusting the rates for health insurance for different categories of beneficiaries if possible and necessary. Periodically updated basic package of health services must be approved by a decision of the Board of the Fund and received approval from the Ministry of Health. Users of health services in the future will have to pay for their health services outside the negative list of the package of services, in some cases at regulated prices, and in other cases at market prices. In general, all Macedonian citizens registered in the Birth considered insured regardless of who pays contributions for health insurance: employers, the citizens or social funds. Fund is the sole purchaser of services from basic package of health services. Private companies can insure citizens for additional benefits on a voluntary basis. Fund will improve its function of a buyer of health services and health care service payment will be done only on the basis of contracts for a certain type and scope of health services with defined price they need to policyholders in all areas in the country.

Acknowledgements

Considering the rivalry between doctors in primary care and specialists assumed that specialists will have different perceptions of the effectiveness of the health system in the country. This is particularly concerned that these two groups of doctors would have to have different opinions regarding the referral of patients and the way to overcome overburdened secondary and tertiary health care at the primary health care system remains underused. In order to find out why the secondary and tertiary health care is overburdened (73% of the doctors-specialists working in secondary healthcare institutions believe that the secondary and tertiary health care is overburdened), asked about the role of doctors in primary health care in the treatment of patients which should be referred to higher health institutions. Over one third of doctors working in secondary health facilities have the wrong idea about the layout of the health system in Macedonia. Thus, 34% of specialists believe that the role of doctors in primary health care is prescription and referral. Fortunately, 60% believe that doctors in primary health care should play an active role in the treatment of patients when this approach would be applied more frequently it would rationalize health services and reduce costs. I concluded that patients who are referred to secondary health facilities should be diagnosed and treated should be carried out at primary health facility.

But few patients return to primary health care - patients want treatment or monitoring of their health status by secondary health institution. In fact, 39% of specialists believe that after prescribing the therapy less than 10% of patients are controlled and examinations by doctors in primary health care. So we concluded that instead, patients return to the doctors-specialists from secondary health care.

Few doctors-specialists believe that their patients are regularly treated and examined by doctors in primary health care. Only 5% believe that more than 90% of the patients examined by doctors in primary health care. Also, specialists were asked why doctors in primary health care again send patients already diagnosed review of other specialists. About 39% believe the main reason is the worsening of the patient status, while 37% think it is because of lack of proper diagnostic for patient monitoring during treatment. According to the survey, since independence, Macedonia has gone through a difficult period marked by economic decline in GDP, wage cuts, increased poverty and high unemployment. The tax revenues are reduced due to high unemployment, low wages, large informal economy and weak capacity for collecting taxes and contributions. The payment of high social premiums by a limited number of employers is hampering economic development.

All this means that at present the long system of social health insurance is under serious pressure, and the actual situation shows that certain preconditions for the country in general have such a system are not met. Such prerequisites country has low unemployment, most of the formal economy (as opposed to gray), and there is good capacity for collecting health premiums. Rates of health insurance contributions will remain at the same level and improve the collection of contributions and the funds will be used for more effective and efficient health services. Ministries of Finance, Health and Labour and Social Affairs will continuously collaborate to improve the collection of contributions to the Fund for health insurance through the introduction of the joint collection of pridonositelociran in the Public Revenue Office. The advantage of this method of financing health care rather than directly from the state budget that the government will be loaded with supplies and financial administration and promote the development of the purchasing power of the population.

Health insurance is based on individual membership and contributions, which provides a better opportunity for less political influence in health care financing. Health Insurance Fund has been strengthened and reorganized in order to fulfill the basic function in the provision of health insurance for insured persons to manage the assets of the insured efficiently and effectively and in their best interest, according to an action plan for improving the functioning of Fund. Treasury each year proposes the budget of the Fund for the following year, based on plans for raising revenues. This budget must be approved by Parliament as the upper limit of expenditure of the Fund in the coming year. The Fund prepare a plan for the allocation of funds to all elements of the health care system in the coming year, which should be approved by the Board. Fund must not take payments of costs over the agreed limit. All agreements between the Fund and health care providers have a financial ceiling linked to a certain limit for the activities, which means that financial responsibilities are transferred from the Fund to the providers. The management structure and degree of autonomy of the Fund were recently adapted in order to provide greater control of the government. Since 2005 it has conducted a detailed action plan to improve the functioning of the Fund. The implementation of the agreed action plan for the Fund under the new structure in 2006-2008 will be evaluated in 2009 to see if changes are necessary.

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