



Republic of Macedonia
Ministry of Health

HEALTH SECTOR MANAGEMENT PROJECT (HSMP)

**FORMULATION OF A CO-PAYMENT POLICY UNDER SOCIAL
HEALTH INSURANCE**

INCEPTION REPORT

MAY 2007

By
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1. Background

1.1. Project Objectives and TORs

The objective of the consultancy is to revise the existing co-payment policy in Macedonia in order to contribute to the financial sustainability of the basic benefits package, without undue risk for the accessibility to benefits by the vulnerable population groups.

The project tasks are as follows:

1. Prepare a short overview of the international literature on the experiences with user fees and co-payments – including exemption and waiver policies – in otherwise publicly funded health care systems (based on general taxation or social health insurance).
2. Review the current system of user fees and co-payments in Macedonia: who collects the fees, what is the impact on the generation of revenues, and what are the positive and negative incentives of the system including the consequences for the accessibility of essential services.
3. Propose option for applicable exemptions and/or waivers from user fees, elaborating possible financial implications of various exemptions and waiver schemes. Examine financial and equity impact of any user fee exemption and waiver approaches with specific attention to socio-economic and gender related effects. Explore and advise upon mechanisms for identifying those eligible for waivers.
4. Propose options for the future system of user fees and co-payments that promote the effectiveness, efficiency and sustainability of the social health insurance system.

1.2. Plan for the Consultancy

The project will comprise three missions:

Mission 1: between 21st and 24th May – to undertake the inception phase

Mission 2: between 6th and 23rd June – to undertake work for the Draft Final Report

Mission 3: between 6th and 10th July – to complete the Final Report

Two workshops are programmed for the consultancy.

Workshop 1: on Tuesday 12th June to discuss the Progress Report

Workshop 2: on 21st July to discuss issues related to the Draft Final Report.

1.3. The First Mission

In preparation for the first mission, the consultant was provided with background information on the health insurance and co-payment framework in Macedonia including the latest report on BBP by World Bank project consultant, Kees Schaapveld.

The following meetings were held:

Monday 21 May:

Meeting with Katerina Venovska, Assistant Coordinator, Project Coordination Unit

Meeting with the members of the Basic Benefit Package Working Group

Tuesday 22 May:

Meeting with Romela Popovic, HIF Financial Director and her staff.

Wednesday 23 May:

Discussions with Katerina Venovska, and Zora Uzuznoska Assistant Coordinator, Project Coordination Unit

2. Summary of the current situation

2.1. General Situation

The Republic of Macedonia has a population of some 2.06 million and a per capita GDP of USD8,200 (PPP). The national unemployment rate is 36% and some 30% of the Macedonian population are below the poverty line¹.

According to the WHO total health expenditure in Macedonia as a percentage of GDP in 2003 was 6.8%. Some 85% of health expenditure is public and 15% is private. It is not clear whether informal payments have been included in the calculation of private expenditure on health.

¹ CIA Factbook

The Health Insurance Fund (HIF) is the main funder of healthcare in Macedonia expending over 90% of the total health budget. 35% of HIF revenues comes from the government and is paid on behalf of pensioners and unemployed. The remainder of HIF revenue is from employer contributions which are currently set at 9.2% (plus 0.5% for workplace accident insurance), co-payments and other income.

HIF procures primary healthcare services from GPs who are paid on a capitation basis. Secondary outpatient care is provided by specialists who work both in public and private practice. Hospitals which are mostly public, are paid according to historical budgets.

Like other countries in the region, the Macedonia is undergoing reforms in the health sector aimed at improving system efficiency, effectiveness and equity. Latest initiatives in the reform process have focused at improving the financial management and budget control of both the HIF and providers. It is understood that deficits have been arrested and steps are being taken to repay existing debts.

According to a recent report by World Bank project consultant, Kees Schaapveld there is general agreement by stakeholders that co-payments should be a part of the health financing framework in Macedonia.

2.2. Healthcare providers

2.2.1. Primary care

Primary care is delivered essentially by GPs who are contracted to the HIF and are paid on a capitation basis. GPs report their activities to the HIF on a monthly basis. The report is statistical and contains information about the types patients and their treatment. The only primary care treatment that attracts a co-payment are some types of injections. GPs are permitted to keep the co-payment income from these services.

2.2.2. Specialist care

Specialists work in both public and private practice and have contracts with HIF based on fee for service. Specialist services attract a co-payment which is proportionate to the cost of the healthcare service that is provided. Under the law, co-payment income must be remitted to the HIF but in practice, the regulations are often ignored, particularly by public sector specialist clinics.

Specialists are required to report their activity to HIF along the similar lines to the GP reporting system. HIF uses this data to calculate the co-payment that should be remitted.

A referral is required for a specialist consultation. The referral system is said to be effective in managing the demand on specialist time and the HIF will not reimburse providers without proof of referral.

2.2.3. Inpatient care

Although hospitals are funded through historic budgets, they are required to report their activity to HIF through a system of ‘invoices’ which are derived from a point based itemised priced list which was originally sourced from the German health system (it is understood that specialist care is priced using the same schedule). The consultant was given to understand that the price list has not been maintained over the years and its cost/weights may no longer reflect the real situation. The invoicing arrangements are being used by HIF to monitor budgets and calculate the co-payments that are due to the HIF.

2.2.4. Pharmacy

Drugs that are in the benefits package are described in the Positive List. The cost of the drugs on the list are based on a system of reference pricing which has been recently introduced. Drug co-payments are charged as a proportion of the cost of the prescription

In addition to reimbursing the pharmacy for the cost of the drug, the HIF pays pharmacies an administrative service fee for the dispensing work related to the prescription.

The co-payments collected by the pharmacies are sent to the HIF and the remittance of co-payments is a condition for the pharmacies to be reimbursed by the HIF.

It would appear that most drugs are freely available from pharmacies OTC without prescription.

2.3. Co-payments

In general terms co-payments are charged for the following services and therapies: specialist care; inpatient care; drugs, some injections, and special nominated services.

Table 1 Co-payment schedule for services provided by specialists and hospitals

Value of specialist outpatient and inpatient services (MKD)	Co-payment (MKD)	Co-payment as a percentage of top figure in the range
Up to 100	-	
101 to 300	20	6.7%
301 to 500	40	8.0%
501 to 700	60	8.6%
701 to 1,000	80	8.0%

1,001 to 2,000	150	7.5%
2,001 to 3,000	250	8.3%
3,001 to 4,000	350	8.8%
4,001 to 5,000	450	9.0%
5,001 to 6,000	550	9.2%
6,001 to 8,000	700	8.8%
8,001 to 10,000	900	9.0%
10,001 to 15,000	1,250	8.3%
15,001 to 20,000	1,700	8.5%
20,001 to 25,000	2,200	8.8%
25,001 to 30,000	2,700	9.0%
30,001 to 35,000	3,200	9.1%
35,001 to 40,000	3,700	9.3%
40,001 to 45,000	4,200	9.3%
45,001 to 50,000	4,700	9.4%
50,001 to 55,000	5,200	9.5%
55,001 to 60,000	5,700	9.5%
More than 60,000	6,000	10.0%

Source: MOH document and calculation

Table 2 Co-payment schedule for drugs on the positive list

Value (MKD) of the pharmacy item for every drug from the Positive List (for 1 prescription) and for every ampoule with syringes and needles (for full treatment of a certain disease after each order) in primary health care	Co-payment in (MKD)	Co-payment as a percentage of top figure in the range
Less than 25	0	0.0%
26 to 50	5	10.0%
51 to 75	10	13.3%
76 to 100	15	15.0%
101 to 150	20	13.3%
151 to 200	25	12.5%
201 to 300	40	13.3%
301 to 400	50	12.5%
401 to 500	70	14.0%
501 to 700	90	12.9%
701 to 1,000	120	12.0%
1,001 to 1,500	160	10.7%
1,501 to 2,000	240	12.0%
2,001 to 2,700	280	10.4%

2,701 to 3,000	300	10.0%
3,001 to 3,500	340	9.7%
3,501 to 4,000	390	9.8%
4,001 to 4,500	500	11.1%
4,501 to 5,000	550	11.0%
More than 5,000	600	12.0%

Source: MOH document and calculation

Table 3 Co-payment schedule for special nominated services

Service	Denars
Home consultation per visit	100
Transportation with an ambulance based upon medical indication, except for medical emergency:	
• within the area of the health care organization	50
• outside the area of the health care organization – up to 50 km one direction	200
• outside the area of the health care organization – over 50 km one direction	500
• outside the Republic of Macedonia	20% of the cost of the fuel
MRI after referral (from code 5360-5366 from the pricelist for health services)	2,000
Health services in gerontological institutes per day in hospital	10
Rehabilitation as extended hospital treatment in a specialized institution – per day in hospital	200

Source: MOH document

Collection of Co-payments

HIF data on co-payments collected from 85 hospitals and medical centres in the first the first 3 months of 2007 are indicated in the table below.

Table 4 Co-payment collection rates for specialist and hospital care

	Denars
Total three months invoiced amount by providers	2,493,915,995
Calculated co-payment that should have been collected by providers	143,716,047
Co-payment that should have been collected as a proportion of invoiced amounts	5.76%
Co-payments actually collected by providers	138,537,974
Co-payments actually collected as a proportion of co-payments that should have been collected	96.4%
Co-payments remitted to HIF by providers	11,641,363
Co-payments remitted as a proportion of co-payments should have been collected	8.1%

Source: HIF

According to table above, it would appear that providers are quite effective in collecting co-payments but are most inattentive in remitting the co-payment revenue to the HIF.

As a recourse to not being paid, the HIF adjusts the following years budgets of providers to compensate for the co-payment income that was not remitted.

It is understood that a policy is now in place which, as from 1st January 2008, will see the providers keeping the co-payment income with the provider facility budgets being adjusted in a formal and transparent manner.

2.4. Services and population groups exempted from co-payments

Co-payment exemptions in Macedonia are defined in a combination of laws and regulations. Below is a summary of the exempted areas.

2.4.1. Population groups exempted from co-payments

The following population groups are exempt from co-payments:

- Beneficiaries of social protection programs – except for prescribed drugs
- Mentally challenged people without parental care
- Children up to 1 year of age – except for prescribed drugs
- For blood donors donating blood over 10 times – except for prescribed drugs
- Military disabled persons, family disabled insurance beneficiaries
- Mentally ill patients in psychiatric hospitals

2.4.2. Health services and treatments for which no co-payments are charged

No co-payments are imposed for the following healthcare services :

- General practitioner medical services – except some injections
- Emergency care
- Compulsory immunization
- Student health check-ups
- Treatment of diabetic patients with insulin therapy
- Dialysis
- Cancer treatment including chemotherapy, radiotherapy and surgery
- Growth hormone therapy for children
- Medical services related to pregnancy
- Treatment for hemophilia
- For children up to 18 years of age and insured persons needing prostheses for upper and lower extremities, hearing prostheses, wheelchairs

Under special program for the uninsured (refer Attachment), the government subsidises the co-payments of insured people for conditions listed below. In effect, therefore, there are no co-payments for the treatment of the following conditions:

- progressive, nervous and muscular diseases:
 - Duchenne-muscular dystrophy,
 - Parkinson disease,
 - miotonia
 - mitochondrial miopathy
 - miastenia
 - spinal muscular atrophia
 - amitrophic lateral sclerosis- diseases of the motor neuron
 - hereditary sensomotor neuropathia;
- progressive systematic sclerosis (Sclerodermia)
- cerebral paralyses
- multiplex sclerosis
- cystic fibrosis
- epilepsy
- pemfigus and lupus epitematodes
- dyslexia , disgraphia and dislalia (rehabilitation exercises)
- communicable diseases: HIV/AIDS; Lyssa; Rabies; Typhus abdominalis; Rubella; Poliomyelitis anterior acuta; Brucellosis; Diphtheria; Dysentaria bacillaris; Tuberculosis; Echinococcosis; Meningitis; Encephalitis; Pertussis; Morbill; Varicella; Scarlatina; Tetanus; Hepatitis; Parotitis epidemica; Salmonellosis; Cholera asiatica; Malaria; quarantine diseases (smallpox, viral hemorrhagic fever, plague); Q - fever; rheumatic fever.

In addition, it should be noted that emergency care is available for all citizens whether they are members of the HIF or not. In other words, in an emergency, all people have access to the HIF funded healthcare system.

2.5. Safety-net

The Macedonian co-payment framework includes many safety net provisions to protect equity and the specifically the poor and the sick from excessive payments. Below is the description of the safety net provisions.

- If in any one year, co-payments for medical (specialist and hospital) services reach 70% of the level of the average monthly net salary in Macedonia in the previous year, then the insured is exempted from paying any further co-payments, except for primary care drugs and treatment abroad, during that calendar year.
- If the insured's family income is less than the average net salary in Macedonia and if in any one year, co-payments for medical (specialist and hospital) services reach 40% of the level of the average monthly net salary, then the insured is exempted from paying any further co-payments, except for drugs, during that calendar year.
- If the insured's family income is lower than 60% the average net salary in Macedonia and if in any one year, co-payments for medical (specialist and hospital) services reach 20% of the level of the average monthly net salary, then the insured is exempted from paying any further co-payments, except for primary care drugs and treatment abroad, during that calendar year.
- If in any one year, co-payments for medical (specialist and hospital) services for children aged between 1 and 5 reach 20% of the level of the average monthly net salary in Macedonia in the previous year, then the insured is exempted from paying any further co-payments, except for primary care drugs and treatment abroad, during that calendar year.
- If in any one year, co-payments for medical (specialist and hospital) services for children aged between 5 and 18 and people older than 65 reach 40% of the level of the average monthly net salary in Macedonia in the previous year, then the insured is exempted from paying any further co-payments, except for primary care drugs and treatment abroad, during that calendar year.

Table 5 Annual accumulated co-payment threshold as percentage of average annual salary beyond which no further co-payment is required

	Insured's income more than average salary	Insured's income up to 60% less than average salary	Insured income lower than 60% of the average salary
Children 1 to 5 years	20%	20%	20%
Children 5 to 18 years	40%	40%	20%
Population 18 to 65 years	70%	40%	20%
People over 65 years	40%	40%	20%

Source: Consultant's summary of MOH document

It should be noted that there is no safety net for drugs on the positive list.

To qualify for the safety net exemption, the insured has to demonstrate that they have made co-payments over the relevant threshold (see Table 5) by presenting receipt to HIF regional offices and if necessary, they need to show proof of their family income.

It is understood that in 2006, 9063 co-payment safety-net exemptions were granted.

2.6. Benefits package and coverage

Despite the fact that membership of HIF is in essence mandatory, it is estimated that some 150,000 – 200,000 people in Macedonia do not have health insurance. It is thought that many of these people may be in the higher income group, perhaps self-employed who are 'self-insured' and therefore pay for healthcare out-of-pocket.

Despite the law which stipulates a right of the population to a broad range of healthcare benefits, the community seems to be of the view that in practice, these entitlements are difficult to access. According to the national health strategy document² consumers view the following as problem issues in accessing the BBP:

- Insufficient drugs on the positive list, especially drugs for chronic conditions; a shortage of drugs is also reported in inpatient settings
- Need to make out-of-pocket payments for services that in the BBP – services specifically mentioned include drugs, laboratory tests, specialist visits and access to inpatient care.

² Health Strategy of the Republic of Macedonia, 2020, *Safe, efficient and just Health care system*, Skopje, February 2007

- Poor quality of healthcare services such as non-performance of necessary tests and use of inferior quality materials in dentistry.
- Disrespectful treatment of patients by staff and lack of information from doctors
- Poor food and hygiene in hospitals

2.7. Patient identification

All HIF members have a HIF membership ‘card’, which is a booklet that includes the individual’s personal details and their healthcare record. On presentation for treatment, HIF members must also be in the possession of a ‘blue coupon’, which is issued by their employers to demonstrate that their contributions have been paid for the relevant period.

2.8. Private initiative

The following are the key features of the public/private mix in the delivery of healthcare in Macedonia:

- GPs work as private practitioners with contracts with HIF
- Specialists can work in either public and private settings – they are permitted to work in both settings although this is regulated
- Most hospitals are publicly owned – there are three private hospitals in Macedonia

People with sufficient disposable income can circumvent the HIF contracted healthcare provider system and obtain care in both public and private settings through direct out-of-pocket payments.

It is understood that informal payments to providers (through cash or presents) are a common practice and recently, the government has taken steps to address the problem by opening a complaints help-line and prosecuting providers suspected of illegal practices.

3. International experiences with co-payments

3.1. Impact of Co-payments

Co-payments are a fixed fee at point of service which by definition decrease equity, in that they necessarily put a greater strain on household budgets of lower income groups

when compared to higher income group people who have more disposable income³. Moreover, co-payments been shown to discourage lower income individuals from seeking necessary care⁴ and thus reduce equity of access⁵.

Figueras et al⁶ provide some anecdotal country evidence about the impact of co-payments and other direct charges.

In Belgium, for example, the reduction of certain co-payments for selected vulnerable groups lead to a marginal improvement in the equity of access. Despite this adjustment however, it was observed that the less-well-off, who often were the elderly, still had to make considerable payments both for co-payments and out-of-pocket for the full cost of non-reimbursable medicines. Supporting these findings, the first Belgian Health Survey of 1997 revealed that one-third of the Belgian population claimed to experience difficulty in paying for medical care. The survey also showed that 8% of the respondents occasionally postponed medical care for financial reasons, with visits to the dentist most likely to be sacrificed.

German policy initiative in 2004 was aimed at managing demand. In 2004, Germany introduced a co-payment of €10 per quarter for the first contact at a physician's or a dentist's office. Apart from contributing to revenue to the health insurance system, the co-payment aimed at altering the patients' behavior toward more self-responsibility. A result of the new co-payment, physician contacts declined and there is some evidence that the introduction of this co-payment may have contributed to a reduction of unnecessary physician visits, without endangering equity of access⁷.

According Busse et al⁸, patient cost-sharing in the form of co-payments has been increasing in all Western European countries since the early 90ies. All EU countries for example impose a co-payment on inpatient stays of between €4 and €10 per day. All of these countries also impose co-payments on pharmaceuticals.

Despite the fact that co-payments can be highly regressive as revenue-raising mechanisms⁹ and are considered by many to be inappropriate tools of demand

³ Barer, M., Evans, R.G., Hertzman, C. and Johri, M. (1998) *Lies, Damned Lies and Health Care Zombies: Discredited Ideas that will not die*. HPI Discussion Paper #10 (March). Texas: Health Policy Institute, University of Texas – Houston Health Science Center.

⁴ Kutzin, J. (1998) The appropriate role for patient cost-sharing, in R.B. Saltman, J. Figueras and C. Sakellarides (eds) *Critical Challenges for Health Care Reform in Europe*, pp. 78–112. Buckingham: Open University Press.

⁵ Rice, T. (1998) *The Economics of Health Reconsidered*. Chicago: Health Administration Press.

⁶ Figueras, J., Saltman, R., Reinhard Busse, R. and Hans F.W. Dubois, H., Patterns and performance in social health insurance systems, *Social health insurance systems in western Europe* published in the European Observatory on Health Systems and Policies Series

⁷ Grabka MM, Schreyogg J, Busse R. The impact of co-payments on patient behavior: evidence from a natural experiment, *Med Klin (Munich)*. 2006 Jun 15;101(6):476-83. <http://www.ncbi.nlm.nih.gov>

⁸ Busse R., Saltman R. and Duboi H., (2004) Organization and financing of social health insurance systems: current status and recent policy developments, *Social health insurance systems in western Europe* published in the European Observatory on Health Systems and Policies Series

⁹ Evans, R.G. (2002) Financing healthcare: taxation and the alternatives, in E.A. Mossialos, A. Dixon, J. Figueras and J. Kutzin (eds) *Funding Health Care: Options for Europe*, pp. 31–58. Buckingham: Open University Press.

moderation¹⁰, they continue to grow as health system policy-makers search for short-term solutions to shortfall in healthcare funding. Below are some examples of co-payment policies implemented over the past 15 years in the European region¹¹.

- In Austria: 1990 - Co-payment of about €6 per day was introduced for inpatient stays, payment for the first 28 days; 1997 - Co-payment was introduced for primary care doctor visits at a rate of €3.6 per visit; 2001 - a flat co-payment of €18.17 per outpatient hospital visit although only €10.90 was charged if referred by GP or specialist – these co-payments were capped however, at €72.67 per person per year.
- Germany increased co-payments in 1993 and 1997 although several were subsequently lowered in 1998.
- In 1996, Switzerland, introduced mandatory co-payments although the maximum co-payment was limited by law.
- Belgium increased out-of-pocket payments 16 times between 1993 and 1997, although, similar to Germany subsequently reduced them for certain groups of insured (see above).
- In 1997, the Netherlands increased co-payments for hospital stay and specialist care but the increase was revoked two years later.

3.2. Out-of-pocket expenditure

There is little international comparative data available on the scale of co-payments but there is data available on the size of out-of-pocket payments which, in addition to co-payments, also include direct payments for services that are not in the benefits package.

Out-of-pocket expenditure as a proportion of total health expenditure (summarized in Table 6) varies considerably among western European countries. Among the five social health insurance (SHI) countries assessed, the variation is much greater (in 2000 7.1% for Luxembourg contrasted with 33.3% for Switzerland) than it is among five northern tax-funded countries (in 2000 11.0% for Ireland contrasted with 20.6% for Finland). The data also indicate that between 1990 and 2000, the percentage of out-of-pocket expenditures fell dramatically in one tax-funded country (Ireland by 7.0%) and only slightly in one SHI country (by 1.5% in France – although the 2000 tax-based changes in funding in France would be felt more strongly since then). It is also significant that, while Finland's figure increased by 5% over the ten-year period, its absolute percentage at 20.6, as the

¹⁰ Robinson, R. (2002) User charges in healthcare, in E.A. Mossialos, A. Dixon, J. Figueras and J. Kutzin (eds) *Funding Health Care: Options for Europe*, pp. 161–83. Buckingham: Open University Press.

¹¹ Busse R., Saltman R. and Dubois H., (2004) Organization and financing of social health insurance systems: current status and recent policy developments, *Social health insurance systems in western Europe* published in the European Observatory on Health Systems and Policies Series

highest northern European tax-funded system, is only two-thirds of the figure in the highest SHI country which is Switzerland at 33.3%.

In Macedonia by comparison (which is a SHI country), out-of-pocket expenditures have been estimated to be 15% of total health expenditure, which is mid-range among the countries listed below.

Table 6 Out-of-pocket expenditures as a proportion of total health expenditure in 1990 and 2000

SHI:	1990	2000
Austria	14.6 (1995)	18.6
France	11.5	10.2
Germany	11.1	12.8 (1998)
Luxembourg	5.5	7.1 (1999)
Switzerland	33.0 (1995)	33.3 (1999)
Northern tax-funded:		
Denmark	16.0	16.4
Finland	15.5	20.6
Ireland	18.0	11.0
Norway	14.6	15.7 (1999)
UK	10.6	11.0 (1996)
Southern tax-funded:		
Italy	15.3	22.9
Spain	19.8 (1991)	26.4 (1999)
SHI Average	15.1	16.4
Northern tax-funded average	14.9	14.9
All tax-funded	15.7	17.7

Source: Figueras, J., Saltman, R., Reinhard Busse, R and Hans F.W. Dubois, H., Patterns and performance in social health insurance systems, *Social health insurance systems in western Europe* published in the European Observatory on Health Systems and Policies Series

3.3. Case Study - Croatia¹²

The Croatian 2002 Health Insurance Act changed the health financing framework in Croatia making the Croatian HIF the exclusive funder of mandatory health insurance. The 2002 act substantially enlarged the already existing co-payment scheme and patients were expected to contribute a greater proportion of healthcare costs than was the case before the reform. Furthermore, the law substantially decreased the number of individuals exempted from making co-payments, primarily by excluding the retired from the exempted group.

¹² Based on Internal Paper by the Adrija Stamper School of Public Health in Zagreb (2007) *Health Insurance in Croatia – balancing between Bismarck and Beveridge and financial sustainability and politics*

The 2002 Act also introduced a new product to be offered by the HIF which was named Complementary Health Insurance (CHI), which was an opt-in scheme which provided coverage of co-payments .

3.3.1. Croatian co-payment guidelines

1. The following benefits do not attract a co-payment under the Croatian BBP:

- preventive care for children, pupils, full time students and adults
- curative care and medical rehabilitation for children, pupils and full time students
- orthopaedic devices for children under 18
- preventive and curative primary health care for adults
- preventive and curative gynaecological care related to family planning, pregnancy, delivery and screening for malignant diseases
- preventive and curative dental care for children under 18 and pregnant women
- preventive and curative treatment for HIV infected patients and others with communicable diseases potentially threatening to the general population
- comprehensive vaccination, immunization and chemoprophylaxis programs
- diagnostic procedures provided at the primary health care level
- medical services provided in hospitals (not including accommodation and food costs)
- accommodation and food hospital costs for patients with chronic psychiatric diseases
- chemotherapy and radiotherapy procedures (including related hospital food and accommodation costs)
- medical care relating to organ transplantation procedures (including medical treatment, food and accommodation costs)
- emergency medical care (including food and accommodation costs during intensive medical care)
- emergency dental care
- emergency medical transportation
- home visits for acute diseases
- medical services provided in patients' homes
- community nursing programs
- medical transportation for a defined list of patient categories
- medicines from the "basic list"
- nursing provided in patients' homes

2. The following benefits attract a co-payment of 15%:
 - Outpatient medical treatments and consultation provided by specialists (including day hospitals, but not including medical rehabilitation)
 - Diagnostic procedures that can not be performed at the primary health care level
 - Orthopaedic devices
 - Medical treatment abroad (as regulated by the HIF)
 - Medical rehabilitation in patients' homes
 - Outpatient dental care provided by specialists of paradontology and oral surgery

3. The following benefits attract a co-payment of 25%:
 - accommodation and food costs during hospital care for chronic diseases;
 - dental prosthetic medical care for people over 65

4. The following benefits attract a co-payment of some 30%:
 - Outpatient medical treatments provided by specialists in medical rehabilitation
 - accommodation and food costs during hospital care for acute diseases

5. The following benefit attracts a co-payment of some 50%: dental prosthetic medical care for adults

3.3.2. Administrative fees

In 2005 amendments to the Croatian Health Insurance Law introduced a new form of user charges called "administrative fees" (deductibles). All insured must pay such administrative fees at the point of service with the exception of children under 18, people over the age of 80 and the disabled.

Administrative fees of HRK 10 (€1.4) are charged for the following services:

- medical consultations in primary health care,
- referrals to specialists
- prescriptions
- specialist medical examinations without a GP's referral
- orthopaedic and other aids.

Administrative fees of HRK 5 (€0.7) are charged for ambulance transportation.

The policy rationale for the introduction of the administrative fees was to provide additional funding for the Croatian HIF. It was estimated that they would raise about HRK 370 million (€50 million). The fees are seen to be small and therefore, not a

significant impost on the population. They are collected by providers and remitted to the HIF.

3.3.3. Complementary health Insurance

In 2004 the complementary health insurance (CHI) scheme begun to experienced financial difficulties and it went into deficit. CHI premiums were community rated and were set at HRK 80 (€11) per month (HRK 50 for the retired)¹³. Despite being tax deductible, in 2005, only 15% of the population purchased CHI.

Three factors contributed to the problems of CHI. Firstly, 1,258,886 people (28% of the population) were exempted from the co-payments and thus had no interest in CHI: secondly, the scheme suffered from the effects of adverse selection as the healthy had little motive in joining and the pool of the retired (many in ill health) increased; and thirdly CHI its benefits package was most generous, covering all co-payments, including pharmaceuticals.

CHI will cease to exist in its present form later in 2007. It will be replaced by an amended scheme which will no longer cover co-payment for pharmaceuticals.

3.4. Case Study - Slovenia

1. The following benefits do not attract a co-payment under the Slovenian BBP:

- a) All services
 - War invalids and civilian invalids of war
 - Other persons who rely on another person for activities of daily living
 - Invalids with at least 70% physical disability
 - Mentally or physically handicapped adults
 - Persons over 75 years of age
- b) Systematic and other preventative examinations
 - Pre-school-age children
 - School children
 - Students attending full time education
 - Women in connection with childbirth
 - Other adults in accordance with programs, except preventative examinations which employees are guaranteed by law
- c) Early detection and prevention of illness in accordance with programs - All citizens
- d) Treatment and rehabilitation

¹³ The 2005, the average monthly net salary in Croatia was HRK 4,376 (€600)

- All children
 - Students in full time education
 - Children and young people with disturbed mental and physical development
- e) Advice on family planning, contraception, pregnancy and childbirth - Women
- f) Prevention, detection and treatment of infection from AIDS and contagious diseases for which the law proscribes the implementation of measures for the prevention of their spread - All citizens
- g) Compulsory injections, immunoprophylactics and chemoprophylactics in accordance with programs - All citizens
- h) Treatment and rehabilitation of malign illnesses, muscular and nervous-muscular illnesses, paraplegia, tetraparaplegia, cerebral paralysis, epilepsy, hemophilia, mental disorders, developed forms of diabetes, multiple sclerosis and psoriasis - All citizens
- i) Treatment and rehabilitation for professional illnesses and injury at work - Employed citizens
- j) Health care in connection with the donation and exchange of tissue and organs for transplantation in other persons - All citizens
- k) Urgent medical assistance, including urgent transport by ambulance - All citizens
- l) Home visits, treatment and home nursing and in social care institutes - All citizens
2. The following benefits attract co-payments of up to 5% under the Slovenian BBP:
- a) Services in connection with the transplantation of organs and other more demanding operations, the extent relating to the cause - All citizens
- b) Treatment abroad - All citizens
- c) Services in connection with intensive therapy, radiotherapy, dialysis and other urgent more demanding diagnostic, therapeutic and rehabilitation interventions - All citizens
3. The following benefits attract co-payments of up to 15% under the Slovenian BBP:
- a) Services in connection with ascertaining and treating reduced fertility and artificial insemination, sterilization and abortion - All citizens

- b) Specialist surgery, hospital and health services as a continuation of hospital treatment, except for professional illnesses and injury at work - All citizens
 - c) Non-medical part of care and treatment in the context of a continuation of hospital treatment, professional illnesses and injury at work - All citizens
 - d) Services on the basis of health activities which are not included under point 1, and treatment of maladies of the teeth and mouth - All citizens
 - e) Orthopedic, orthodontic, hearing and other aids except in cases above - All citizens
3. The following benefits attract co-payments of up to 25% under the Slovenian BBP:
- a) Special surgery, hospital and health services as a continuation of hospital treatment - All citizens
 - b) The non-medical part of care in hospital and health resorts as a continuation of hospital treatment - All citizens
 - c) Orthopedic and other aids in connection with treatment for professional illnesses and injury at work - All citizens
 - d) Medicines from the positive list in all other cases - All citizens
4. The following benefits attract co-payments of up to 40% under the Slovenian BBP:
- a) Non-urgent rescue transportation of insured persons who are immovable or need transportation to and from dialysis, or in other cases where transportation by means of public transport or car would be harmful to their health or who, due to their health condition, need escort by a medical worker - All citizens
 - b) Medical treatment which is not a continuation of hospital treatment - All citizens
5. The following benefits attract co-payments of up to 50% under the Slovenian BBP:
- a) Medicines from the intermediate list - All citizens
 - b) Orthodontic treatment of adults - All adult citizens
 - c) Aids to vision for adults - All adult citizens

According to the above schedule, therefore, the following population groups in Slovenia are exempted from co-payments:

- War invalids and civilian invalids of war
- Other persons who rely on another person for activities of daily living – in other dependants
- People with at least 70% physical disability
- Mentally or physically handicapped adults – similar to the disabled category above
- Persons over 75 years of age

4. Issues for clarification and data requirements

4.1. Issues for clarification

The consultant received a considerable amount of information and seeks clarification on the following points:

Clarify the following co-payment rule which is in the schedule provided:

Value (in denars) of the pharmacy item for every drug from the Positive List (for 1 prescription) and for every ampoule with syringes and needles (for full treatment of a certain disease after each order) in primary health care

Clarify the following exempted categories of people exempt from co-payments:

- *Military disabled persons, family disabled insurance beneficiaries*
- *For children up to 18 years of age and insured persons needing prostheses for upper and lower extremities, hearing prostheses, wheelchairs*

Clarify the following statement contained in the co-payment policy document provided to the consultant:

According to a Co-Payment Policy statement provided to the consultant, the co-payment for pharmaceuticals must not exceed 20% of the average costs of health-care services. This statement requires clarification.

Clarify whether outpatients specialist care payment is fee-for-service, and if so, what is payment schedule that is used.

It is understood that stakeholders are supportive of co-payments. Why is this so? If its to manage demand, to what extent is it though that the system now provides unnecessary services that are requested by the public?

4.2. Data requirements

4.2.1. Co-payment revenue

To calculate the average co-payment rate per service, the following annual statistics would be useful:

GP co-payments

- Number of GP injection procedures that attract co-payments
- Total value of injection procedures that attract co-payments
- The total expected co-payment revenue from injection procedures that attract co-payments

Pathology test co-payments

- Total number of pathology tests that attract a co-payment
- Total value of pathology tests that attract co-payments
- The total expected co-payment revenue from pathology tests that attract a co-payment
- The total co-payment remitted to HIF for pathology tests that attract a co-payment

Radiology test co-payments

- Total number of radiology tests that attract a co-payment
- Total value of radiology tests that attract co-payments
- The total expected co-payment revenue from radiology tests that attract a co-payment
- The total co-payment remitted to HIF for radiology tests that attract a co-payment

Specialist consultation co-payments

- Total number of specialist consultations that attract a co-payment
- Total value of specialist consultations that attract co-payments
- The total expected co-payment revenue from specialist consultations that attract a co-payment
- The total co-payment remitted to HIF for specialist consultations that attract a co-payment

Specialist procedures co-payments

- Total number of specialist procedures that attract a co-payment
- Total value of specialist procedures that attract co-payments
- The total expected co-payment revenue from specialist procedures that attract a co-payment
- The total co-payment remitted to HIF for specialist procedures that attract a co-payment

Hospital admission co-payments

- Total number of hospital admissions that attract a co-payment
- Total value of hospital admissions that attract co-payments
- The average length of stay per admission
- The total expected co-payment revenue from hospital admissions that attract a co-payment
- The total co-payment remitted to HIF for hospital admissions that attract a co-payment

Pharmaceutical co-payments

- Total number of prescriptions that attract a co-payment
- Total value of prescriptions that attract co-payments
- The total expected co-payment revenue from prescriptions that attract a co-payment
- The total co-payment remitted to HIF for prescriptions that attract a co-payment

Dental co-payments

- Total number of dental services that attract a co-payment
- Total value of dental services that attract co-payments
- The total expected co-payment revenue from dental services that attract a co-payment
- The total co-payment remitted to HIF for dental services that attract a co-payment

Co-payments for other services

- Total number of other episodes of care (not listed above) that attract a co-payment
- Total value of other episodes of care (not listed above) that attract co-payments
- The total expected co-payment revenue from other episodes of care (not listed above) that attract a co-payment
- The total co-payment remitted to HIF for other episodes of care (not listed above) that attract a co-payment

4.2.2. Exemption categories

How many people are there in each of the co-payment exempted categories listed below?

1. Beneficiaries of social protection programs – except for prescribed drugs
2. Mentally challenged children without parental care
3. Children up to 1 year of age – except for prescribed drugs
4. For blood donors donating blood over 10 times – except for prescribed drugs
5. Military disabled persons, family disabled insurance beneficiaries
6. Children 1 to 5 years who co-paid to the value greater than 20% of average salary in the last year

7. Children 5 to 8 years who co-paid to the value greater than 40% of average salary in the last year
8. Children 5 to 8 years whose total family income is less than 60% of the average salary and who co-paid to the value greater than 20% of average salary in the last year
9. Population group 18 to 65 years who co-paid to the value greater than 70% of average salary in the last year
10. Population group 18 to 65 years whose income was up to 60% less than average salary and who co-paid to the value greater than 40% of average salary in the last year
11. Population group 18 to 65 years whose income is less than 60% of the average salary and who co-paid to the value greater than 20% of average salary in the last year
12. Population group over 65 years who co-paid to the value greater than 40% of average salary in the last year
13. Population group over 65 years whose income is less than 60% of the average salary and who co-paid to the value greater than 20% of average salary in the last year

ATTACHMENT

Program for health protection of certain groups of population and different diseases of citizens who are not health insured¹⁴

This program is designed to assist the uninsured but in need, namely: pregnant women, infants, children from 1-18 years of age, persons over the age of 65 and the indigent.

The estimated numbers of people qualifying for this program are:

- 2.880 pregnant women, as many infants
- 5.000 uninsured children
- 8.000 uninsured people over 65
- 5000 people who are indigent

The program funds the following sub-programs:

1. To uninsured pregnant women and infants until 1 year of age: delivery; - medical examinations of the newborn; orthopedic medical examination of the newborn with EHO.
2. To uninsured children from 1 to 18 years of age, as well as for the persons older than 65: medical examination (general and specialist); basic diagnostic tests; emergency medical and dental care; as well as ambulatory and hospital treatment.
3. For people who are indigent healthcare for the treatment of the following diseases: rheumatic fever; progressive, nervous and muscular diseases; progressive systematic sclerosis (Sclerodermia); cerebral paralyses; multiplex sclerosis; cystic fibrosis; epilepsy; pemfigus and lupus epitematodes; dyslexia, disgraphia and dislalia (rehabilitation exercises); and communicable diseases

The costing of the program is as follows:

Table A Pregnant women and infants up to 1 years of age

Item	Cost
Non-operative delivery (15.000 x 2.400)	36.000.000
Operative delivery -caesarean (40.000 x 480)	19.200.000
Medical examinations of infants up to 1 year of age (320 denars x 2.880 x 4)	3.686.400
Medical orthopedic examination with EHO of the newborn up to 1 year of age (500 denars x 2.880 x 1)	1.440.000
Total	60.326.400

¹⁴ Summary of MOH document

Table B Uninsured children from 1 to 18 years of age

Item	Cost
General medical examination (320 x 8.000)	2.560.000
Basic diagnostic examinations-laboratory and RTG (500 denars x 5.000 x 50%)	1.250.000
Emergency health care (800,00 x 5.000 x 30%)	1.200.000
Treatment in hospital conditions (900 hospital day x 5.000 x 30% x 5 days)	6.750.000
Emergency dental health care (250,00 x 5.000 x 30%)	375.000
Total	11.175.000

Table C Uninsured persons older than 65

Item	Cost
General medical examination (320,00 x 8.000)	2.560.000
Basic diagnostic examinations-laboratory and RTG (500,00 denars x 8.000 x 50%)	2.000.000
Emergency health care (800,00 x 8.000 x 30%)	1.920.000
Treatment in hospital conditions (900,00 hospital day x 8.000 x 20% x 10 days)	14.400.000
Emergency dental health care (250,00 x 8.000 x 10%)	200.000
Total	21.080.000

Table D Sub-program 3

Item	Cost
General medical examination (320,00 x 5.000)	1.600.000
Basic diagnostic examinations-laboratory and RTG (500 denars x 5.000 x 50%)	1.250.000
Treatment in hospital conditions (900 hospital day x 5.000 x 20% x 5 days)	4.500.000
Total	7.350.000

The total funds required for the activities described in the tables A,B,C and D is 99.931.400 Denars.

In addition to the above services and patient groups, the program covers the co-payments of the insured persons in relation to the treatment of the diseases defined in Sub-program 3.

Table E **Co-payments of the insured for treatment of diseases covered in Sub-program 3**

Item	Cost
12.000 insured persons (estimated to be suffering with the relevant conditions defined in sub-program 3) x 4.917 denars co-payment	59.004.000

The total funding needed for the implementation of the whole program in 2006 was 158.935.400 Denars.