THE BENEFITS OF COMPULSORY HEALTHCARE INSURANCE

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Abstract

Compulsory healthcare insurance scheme as part of the social protection system has been set up in order to prevent and overcome social risks standing in the way of health care services financing. The compulsory health care insurance scheme is based on the philosophy and principle of solidarity consisting in covering the whole population with health services benefits. This project aims to make an analysis of the right to health insurance, its features, legal instruments to realize this right, the division of responsibilities between different stakeholders, especially between the Compulsory Healthcare Insurance Fund and health service providers. This analysis also provides an important feedback in order to understand the effectiveness of the legislation on health insurance and importance of the realization of the constitutional right to health insurance. The project also intends not only to provide a theoretical analyses of problems in this area, but also concrete practical suggestions since it is intended that the respective legislation should be improved in order to become commensurate with European standards and parameters.

Keywords: *healthcare insurance, health services benefits, health service providers*

Introduction

According the Law no.10383, dated 24.02.2011, "On compulsory healthcare insurance in the Republic of Albania", as amended, the compulsory insurance finances the compulsory insurance services packages that include:

a) medical check-ups, examinations and treatment in public primary health care centers and public hospitals;
b) medical check-ups, examinations and treatments in private primary health care and hospital providers.
c) drugs, medical products and treatments by contracted providers of health services.

Compulsory health insurance is based on the contributions of employees, employers, state and other sources for other people, as provided for in this law, based on the principle of solidarity. Compulsory health care insurance scheme intends to cover the population with health care services, financed by the public and private sector, according to health insurance law.

The right to health insurance of citizens is included in the group of economic and social rights in the Constitution. This right is a positive one just like most of the rights that

are part of this group[1]. This conclusion is arrived based on the reference made by constitutional provisions when it conditions the application of this right to a special law which shall establish rules and its application procedure. Compulsory healthcare insurance scheme aims at health care coverage of the population through the following principles:

- Mandatory and voluntary insurance;
- Solidarity[2];
- Equal access for all citizens;
- Efficiency and quality in health care service financing;
- Free choice of the doctor;
- Partnership relations between the purchaser, provider and beneficiary

Compulsory healthcare insurance and related contributions payments are mandatory for all economically active persons, residing permanently in Albania as, employees, self-employed persons, unpaid family workers and other economically active persons[3]. The Compulsory healthcare insurance covers, also, the following categories of economically inactive persons, whose payment of contributions is financed from the State Budget or other sources as provided for in the law[4].

- Persons who benefit from Social Insurance Institute;
- Persons who receive social assistance or disability payments in accordance with relevant legislation;
- Persons registered as unemployed - job seekers in the National Employment Service;
- Foreign nationals that are asylum seekers in the Republic of Albania;
- Children under 18 years;
- Pupils and students under the age of 25 years, provided they do not have income from economic activities;
- Categories of persons as defined by special laws.

Persons who are not included in compulsory health care insurance are entitled to voluntarily join the compulsory scheme. Voluntarily insured persons have the same rights and obligations as persons subject to compulsory insurance[5].
Participation in the scheme is based on the payment of contributions. All persons participating in the scheme are considered insures. Health insurance contributions are personal, so it cover only the person who pays or which pays the contribution and not cover their member of families.

Since 1995, after the insurance scheme was enforced and up to 2006, the scheme covered only the costs of the services provided by family doctor (GP) in primary health care[6].

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[1] Constitution of the Republic of Albanian, article 55
[2] Article 4, "Compulsory health care insurance" Law No. 10383 dated 24.02.2011 "On compulsory health insurances in Albania" amended
[3] Article 6 "Obligation to pay contribution", Law No. 10383 dated 24.02.2011 "On compulsory health insurances in Albania" amended
[4] Article 5 "Insured person", Law No. 10383 dated 24.02.2011 "On compulsory health insurances in Albania" amended
[5] Article 5/3"Insured person", Law No. 10383 dated 24.02.2011 "On compulsory health insurances in Albania" amended
[6] World Bank, Problems, Issues, and Alternative Approaches, Technical Report on Primary Health Care development in Albania, page 3

These costs included physician payment and coverage of simple checkup costs. Each ensured individual is registered at the family doctor and they have the right to change the family doctor to his/her discretion, but not more than once a year. This section of the scheme doesn't provides for co-financing, which means that the insured person does not pay anything for visits and other services in outpatient primary service. Uninsured person pays according to the rate approved by the Council of Ministers. The health service benefited once the insured person submits the health booklet[7].

At the end of the visit, the doctor prescribes prescription with full or partial refund to the insured and unreimbursed prescription for the uninsured. The relations of the physicians with insurance scheme is regulated by a contract[8] that clearly defines the obligations of the parties whose main element is the obligation of the physician to meet the provision of health services for insured persons under the procedures established by the insurance scheme. This service is paid by the insurance scheme under the terms of the contract.

An expansion of health benefits for insured persons through hospital services is regulated in detail with DCM. 1661 dated 29.12.2008 " For the financing of hospital health services from the compulsory health care insurance scheme"[9]. The scheme is currently extended only in public hospitals[10] and procedural requirements for the insured are two: provision of proofs of the insured status through health booklet and implementation of the referral system, which means addressing to the hospital with a recommendation from the primary health system. Persons that do not comply with these procedures, receive the hospital services after paying the relevant fees.

It is intended that the procedures of benefiting hospital health service on the part of the insured become as simple as possible, by shifting the weight of formalities and documents on the hospital or service provider. The decision provides for the drafting of a contract between the hospital and health insurance institute in which the parties define the respective obligations regarding delivery of services to the insured persons and the payment for rendered services.

The scheme covers drugs contained in the "List of reimbursed drugs". This list is approved on annual basis and the list approved by DCM. The list contains 476[11] reimbursed medicines as well as their alternatives. If for a drug exist so many other alternatives, the scheme will cover the price of the less expensive drug.

The principle of participation or co-payment is implemented in the drugs coverage. According to this principle, health insurance scheme covers a part of the drug price and the rest is paid by the insured persons at the pharmacy. The insured individuals profit drugs in the pharmacy through full or partial refunded prescriptions, or no refunded prescriptions. Ministry of Health and Fund set rules both for the manner of fulfillment and execution of

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[7] DCM no. 86, " The health Booklet"

[8] DCM no. 857,dated 28.12.2005 "On the financing of primary health care services from the scheme compulsory health insurance", 2006, amended

[9] World Health Organization Statistical Information System: Core Health Indicators, page 45

[10] DCM. 140 dated 17.02.2010 " For the financing of hospital health services from the compulsory health care insurance scheme"amended

[11] Council of Ministers Decision no. 135, dated 03.12.2014, "On approval of the drugs list reimbursed by the Compulsory Healthcare Insurance Fund and the scope of their price coverage."

prescription from pharmacies that have a contract with Fund. While reimbursable prescription format is defined by Fund itself.

Prescriptions with full refund are issued to certain protected categories just like veterans, children 0-12 months, pensioners, people suffering from some serious diseases such as cancer, tuberculosis, blood diseases etc.. The co-payment for these prescriptions is zero, which means that the insured pay nothing. For other categories, partially refunded prescriptions are issued for the most part of drugs, which means that these drugs are received through co-payment. Uninsured persons pay the full price of the drug. Only individuals supplied with health booklet are benefiting through receiving reimbursed drugs.

Social rights have played a very important role in European development during the last century, but despite progress in many areas, not all Europeans enjoy them. Council of Europe began work on projects in 1999 to find solutions to the many problems faced by individual citizens when they try to seek the right to social protection, housing, health and education[12]. One of the legal instruments of the Council of Europe is the European Code of Social Protection.

European Code of Social Security and its Protocol guarantee minimum protection, including among other things, medical care, health insurance, compensation for work injuries, maternity, unemployment, invalidity and survivors' benefits, family allowances and pensions. Revised Code (1990) takes into account recent changes in the social security legislation in the member states and improves the protection guaranteed at national level.
Code and protocol were adapted from the Council of Ministers on 11 March 1964, they opened for signature at 16 prill1964 and entered into force on March 17, 1968

As a result of the need to revise the code for the purpose of updating it in line with the trends and developments of national and international legislation of the field, was proposed and proceeded to review this code. The revised European Code was adopted and opened for signature on 6 November 1990.

European Code of Social Protection represents a minimum standards. It's aim is not the standardization of national social protection systems[13]. Standardization would require all contracting parties to provide the same benefits for the same categories of the population, to the same extent and in the same conditions. Instead, the Code recognizes the will of harmonization of social protection systems and the establishment of minimum requirements that must be met by the states. This scope is guaranteed at least a certain minimum level of social protection[14]. If states can and want to provide more than this minimum conditions, they are free to do that.

Code respects the diversity and individuality of the national defense of social systems le features products, the economical, social, and political tradition among which are developing countries. In this way the code determines what should be achieved and at the same time allows each state to decide how to achieve those goals. The particularity is that the

[12] Dr. Paul Schoukens, European Union competencies in the field of social security, EU publication
[13] Lindenlaub Yvonne, Manthei Galina and Schulte Ortwin, EU - Health insurance systems in comparison-Differences and Common Denominators –A Study for the GTZ Consultancy Project on Health sector reform in Albania, Berlin
[14] Witter Sophie and Ensor Tim, An introduction to health economics

goals are desined in such a way that can be applied to all types of social protection systems, whether it refers to employment protection, certain categories of employees, all economically active population or the entire resident population.

European code for each branch defines the scope of application (contingencies covered, protected persons), the level of benefits; qualifying for benefits; benefit period; period until the beginning of the benefit recipient. The particularity of the albaninan scheme is that if there is delay in the payment of contributions of more than 1 month, the person is not entitled to benefit from the scheme for the period that is covered by contributions.From this overview of the compulsory insurance scheme health care, we conclude that the right to health insurance as a socio-economic right, guaranteed not only by the constitutional provisions but also by specific legislation which establishes specific procedures how this right, the body responsible for its security and regulates relations arising between persons benefiting from this right, health care providers and the administration responsible for health insurance.

Health insurance is a compulsory and universally insurance scheme and as covering all RA citizens with permanent residence in Albanian. Participation in the scheme is based on the payment of contributions. Also, benefits from this scheme are given equally to all insured persons who have the same health needs, regardless of the the contribution that has made each of them.

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