Overview of Health Insurance in EU and North Macedonia

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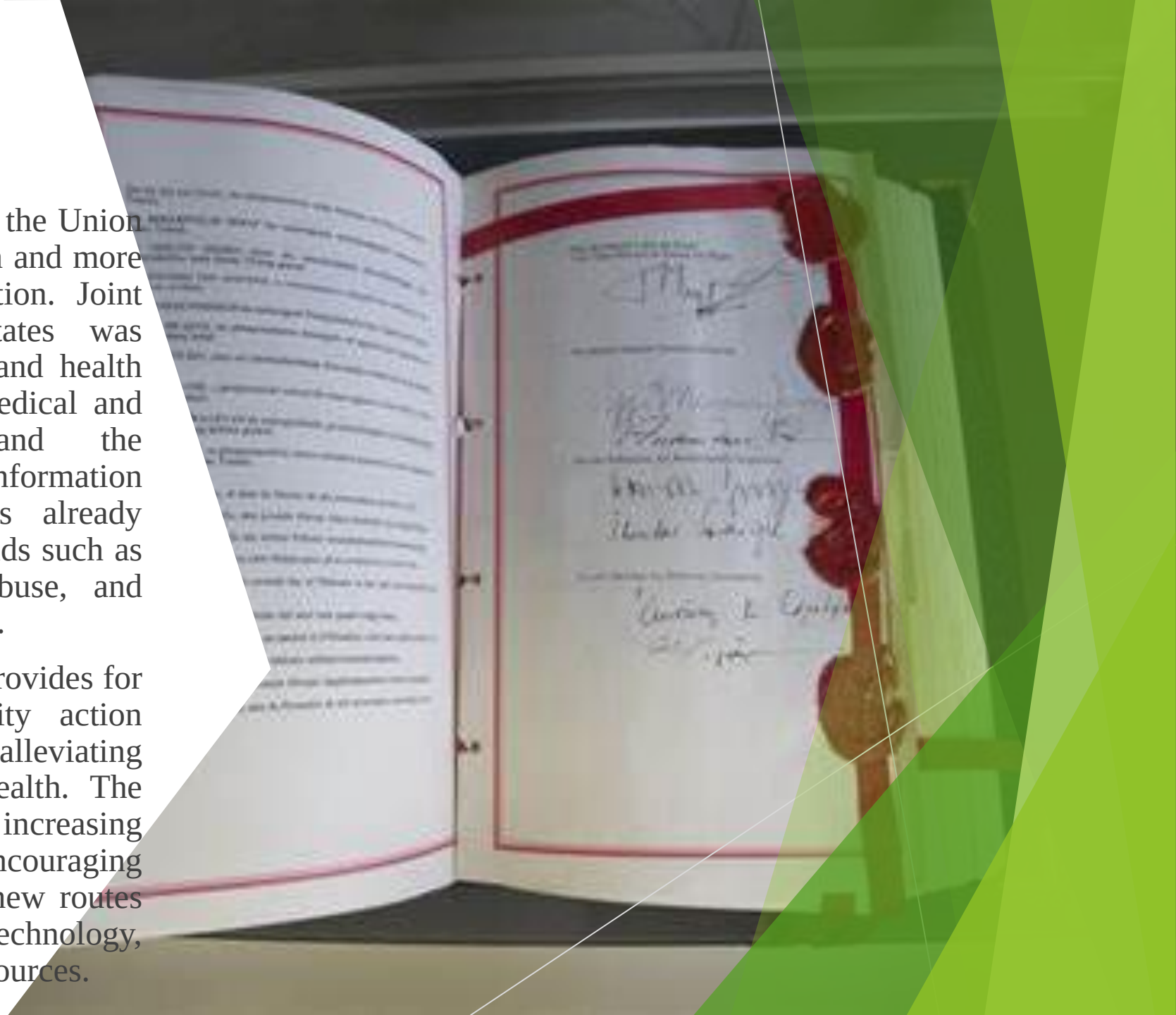
Introduction

- Health policy-making is firmly guided by the principle of subsidiarity.
- The harmonization of national laws is specifically excluded in Article 129 of the European Union Treaty.
- Health care systems stem from specific political, historical, cultural and socio-economic traditions. As a result, the organizational arrangements for health care differ considerably between Member States - as does the allocation of capital and human resources.
- In essence, the health care systems in the EU reflect a variety of different philosophies and approaches and retain their own peculiarities. Comparative studies of these systems aid the process of learning from one another to improve the health of all citizens of the Union.

Introduction

- The 1991 Maastricht Treaty gave the Union new competences in public health and more scope for international cooperation. Joint action with the Member States was identified for health promotion and health protection, the subsidizing of medical and health policy research, and the establishment of international information systems. The Commission has already developed specific policies in fields such as AIDS, tobacco and alcohol abuse, and environmental causes of ill-health.
- The 1997 Treaty of Amsterdam provides for a new direction of Community action towards illness and diseases, and alleviating sources of danger to human health. The single European market and increasing migration within the Union are encouraging further policy convergence and new routes for the exchange of medical technology, health services and manpower resources.



General overview – EU Health Care policy

- Public policy in EU member states has generally aimed to preserve the principle of health care funded by the state or social insurance and made available to all citizens, regardless of ability to pay.
- This has led to the development of health care systems broadly characterized by near universal coverage, mandatory participation, the provision of comprehensive benefits (including vast majority of the health care servicis) and high levels of public expenditure (the percentage of the budget that is spent for financing health services)

Health Insurance Coverage

- The existence of near universal coverage by the statutory health care system reduces consumers' need for additional coverage through voluntary health insurance in many member states. In 1997 universal rights to health care could be found in Denmark, Finland, Greece, Ireland, Italy, Luxembourg, Portugal, Sweden and the United Kingdom, and near universal rights (99% coverage or higher) in Austria, Belgium, Germany, France and Spain (OECD, 2001a). Statutory health coverage was lowest in the Netherlands (74.6%), but this does not account for the fact that everyone resident in the Netherlands is automatically covered for long-term care, including mental health care and care for disabled people.
- Data for 1999 were only available for Austria, Denmark, Finland, Ireland, the Netherlands, Sweden and the United Kingdom, but they showed the same levels of statutory health coverage (OECD, 2001a).

Public expenditure – public policy

- Increases in public expenditure on health care are also likely to occur in member states that are trying to increase statutory coverage by extending it to groups that were previously excluded.
- Example 1: In 1999 the French government passed a law on universal health coverage to enable those who did not benefit from any health insurance (estimated on 31 December 2000 as 1.1 million people) to be covered by a basic, compulsory, statutory health insurance scheme
- Example 2: The Dutch government has announced in 2001 widespread reform of its health care system, including plans to extend statutory coverage to the whole population by merging the existing health insurance schemes into one universal, compulsory, public health insurance scheme (Ministry of Health Welfare and Sport, 2001)

Health care systems

There are three predominant systems of health care finance in the European Union.

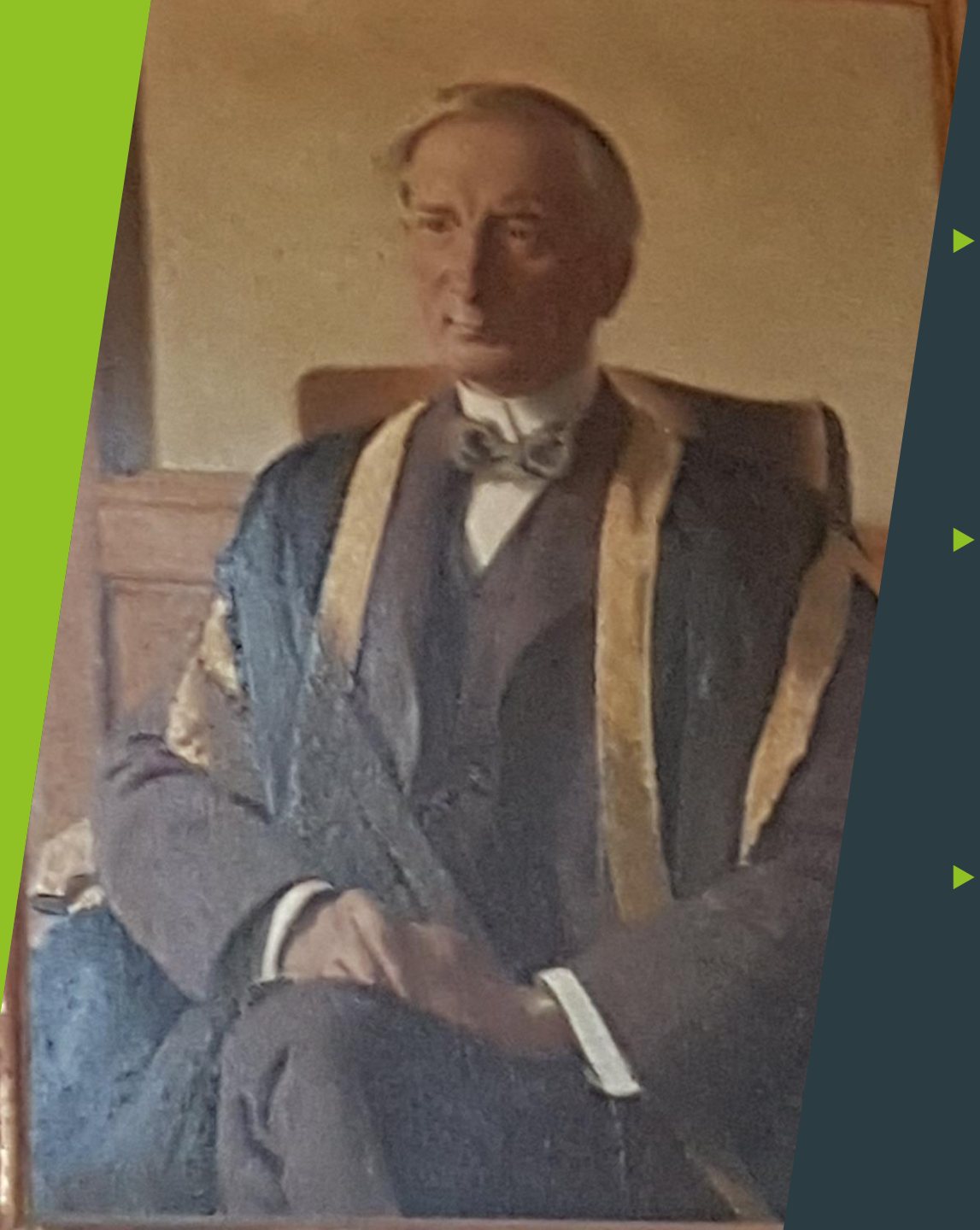
The first is public finance by general taxation (often referred to as the Beveridge model).

Secondly, there is public finance based on compulsory social insurance (the Bismarck model).

Thirdly, there is private finance based on voluntary insurance, which covers only a small minority of EU citizens entirely, but which also operates on top of social insurance as a supplementary form of funding health care

Beveridge Model

Beveridge Model: A model system for health care organization by a national health service system under which health care is financed mainly by general taxation and delivered under the supervision of a central public institution.



origin

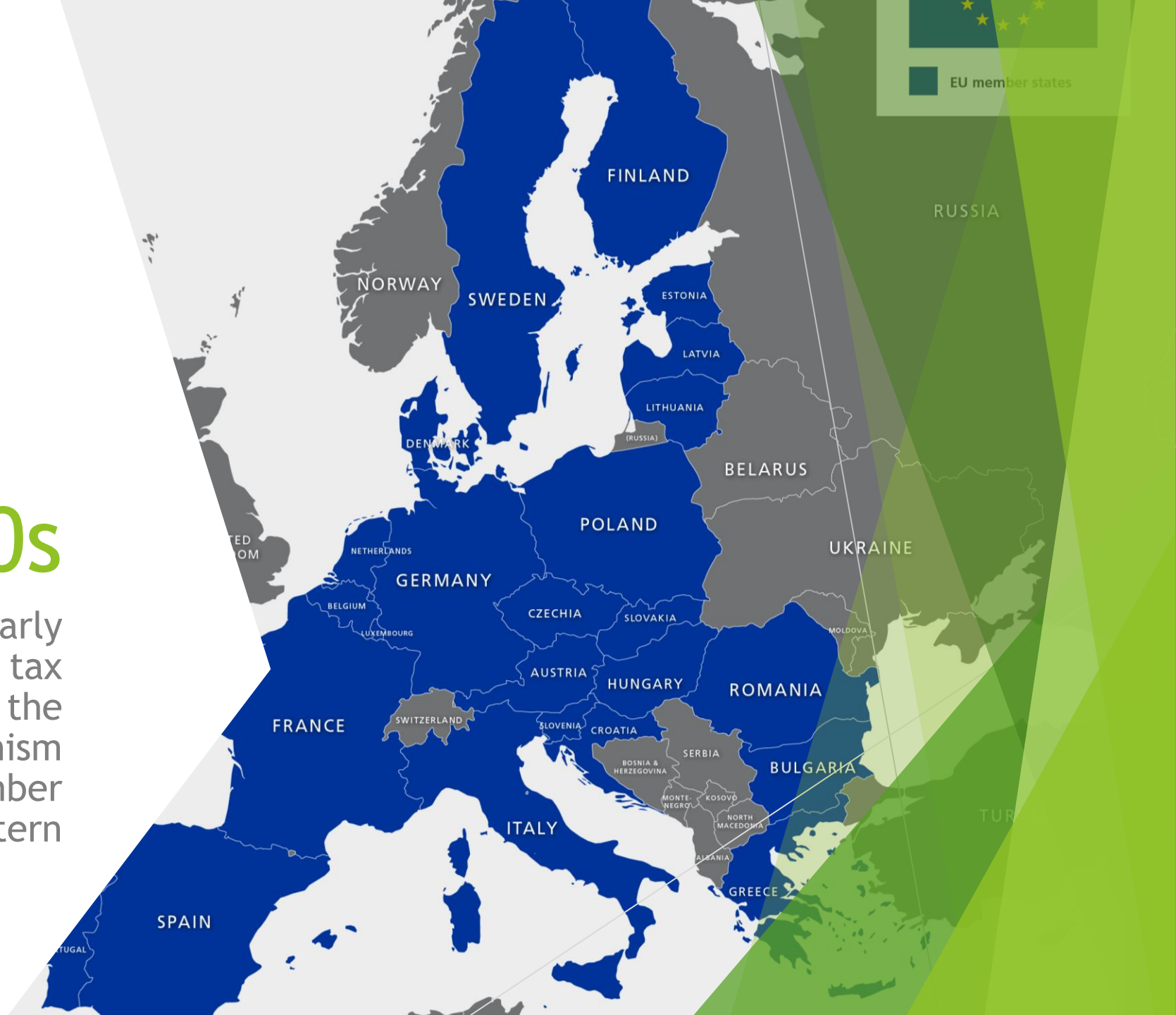
- The Beveridge Model was created by William Beveridge, an economist and social reformer whose ideas led to the creation of Great Britain's National Health Service (NHS) in 1948. Beveridge's idea to provide high quality medical care rather than to seek profits was widely popular with the public after the emotional and financial turmoil of WWII.
- The Beveridge Model is a nationalized health care system. Similar to how public libraries and police forces are financed by the government, health care is controlled through citizen tax money. Citizens of countries who utilize this health care plan do not directly pay for their medical or other health-related bills. The goal of this plan is to provide quality health care regardless of people's ability to pay for their care.
- The majority of hospitals and their staff are considered government property and employees, respectively. Private doctors and clinics also receive their fees from the government instead of from the citizens. According to Physicians for a National Health Program (PNHP), this health care system has low costs per capita because the national government determines what doctors can do and what they can charge for their services.

participation

Because health care systems in the European Union are mainly financed through taxation or contributions from employers and employees, participation in the statutory health care system is usually mandatory.

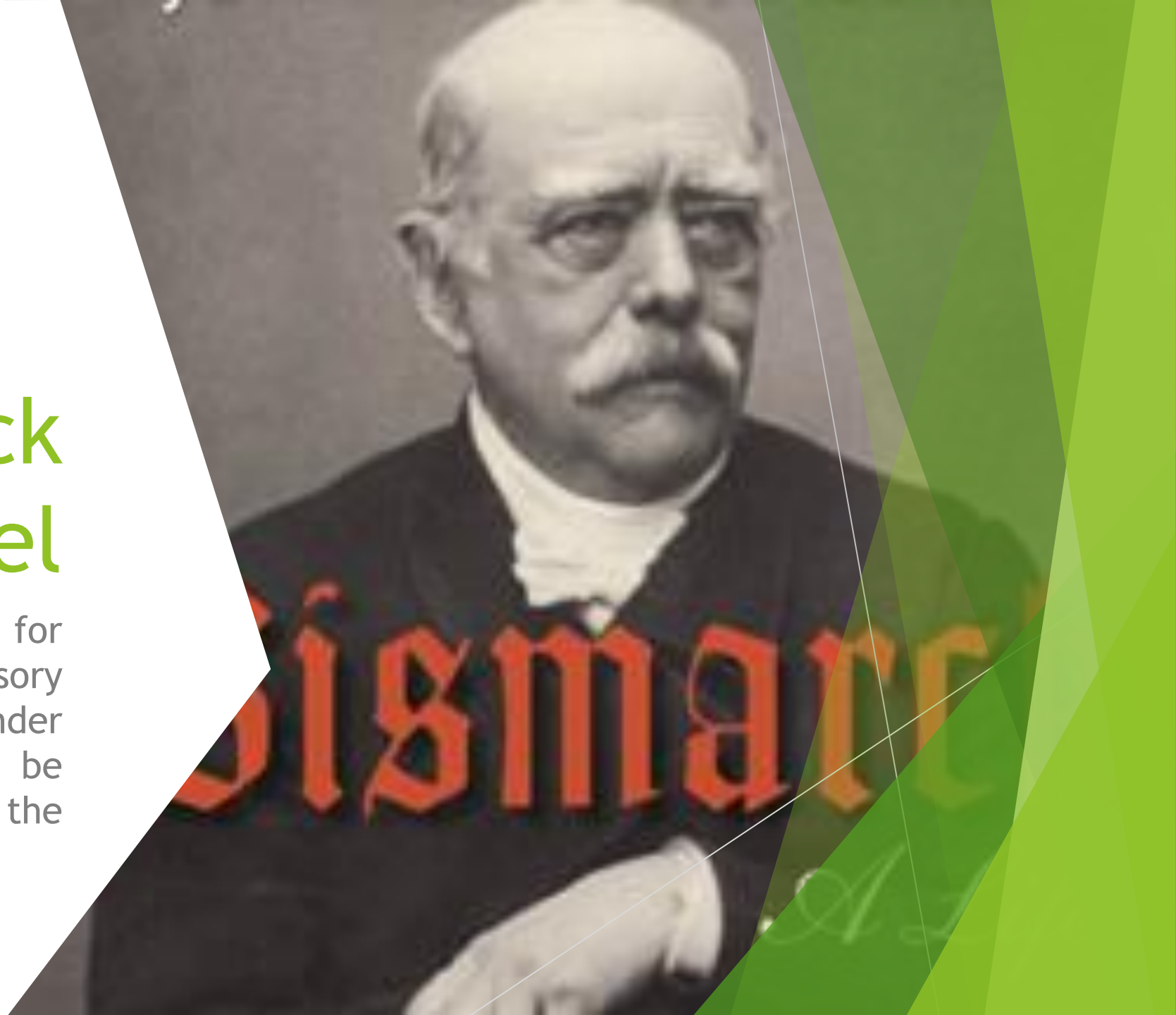
early 1990s

A major change since the early 1990s has been the shift from tax to social insurance as the dominant contribution mechanism in many of the newer Member States of central and eastern Europe



Bismarck Model

Bismarck Model: Model system for social security with compulsory health care insurance under which insurance funds may be independent from the government



The German health care system

- The German health care system is a model system of compulsory social insurance. The system has experienced no fundamental structural change since its foundations were laid by Bismarck in 1883, although it has expanded significantly and there have been some fundamental reforms in health insurance structure.

In practice

pros

- The system has managed to achieve comprehensive health care coverage and provides for equal access to a high volume of advanced medical services. A majority of the German population seems to consider its health care system as either very or fairly satisfactory (sample survey in the European Union).
- The reason for this success has been attributed to the highly decentralized decision-making and an effective negotiation system between provider parties and third-party payers at central, state, and local level.

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- The system however suffers from some substantial problems. An ageing population jeopardises the stability of the pay-as-you-go basis upon which social security is based. In considering the growth and level of health care expenditure, per capita as well as by share of GDP, the German health care system is amongst the most expensive in the EU. This translates into a high level of health care resources which have to be evaluated in the search for cost-stabilisation and efficiency gains, requiring further health care reform.

Voluntary Health Insurance

Health insurance which is taken up and paid for at the discretion of individuals or employers on behalf of their employees. It can be offered by private or public entities

Differing terms

Social Health Insurance

- Public protection for health risks in granting a defined package of services. The framework is set by the government and mandatory for the whole population (universal coverage) or part of the population e.g. with earnings below a certain income threshold or with a certain professional status (nearly universal coverage). Funding is usually pooled by income related contributions administration is by one or several sickness funds.

Private health insurance

- A form of voluntary health insurance with a private insurer.

Contributions

Payment method for compulsory health insurance mostly shared by employees and employers. Often set as a fixed proportion of income with a floor and ceiling level of income

Public vs. private finance in EU

public

- General taxation
- Compulsory social insurance as Health insurance under an obligatory public scheme, usually borne by employers and employees. Contributions are usually income-related.

private

- voluntary insurance, which covers only a small minority of EU citizens entirely, but which also operates on top of social insurance as a supplementary form of funding health care.

Main reasons for voluntary health insurance

- the exclusion of certain health services from statutory coverage (particularly dental care and pharmaceuticals) and
- the rise in co-payments for statutory services have led to the development of a market for complementary VHI in many member states
- Supplementary VHI has developed to increase consumer choice and access to different health services. It is particularly prevalent in member states with national health services (where it is often referred to as " double coverage"), although it is available in some form in most member states.
- This type of VHI generally guarantees:
- a wider choice of providers,
- faster access to treatment and
- superior accommodation and amenities in hospital (rather than improved clinical quality of care)

Methods of Financing Health Care in the Member States of the EU

Country	Predominant system	Main supplementary system
Finland, Greece, Ireland, Italy, Sweden, Spain, United Kingdom	public: taxation	private voluntary insurance, direct payments
Denmark, Portugal	public: taxation	direct payments
Austria, Belgium, France, Germany, Luxembourg	public: compulsory social insurance	private voluntary insurance, direct payments, public taxation
Netherlands	mixed compulsory social insurance and private voluntary insurance	public taxation, direct payments

EU trends since 2006

- Privatizing social security benefits has been a popular measure in EU countries in recent years. This is particularly the case not only for pension systems but also concerns national health financing systems. According to the European Commission (2005, 2008), enforcing private health insurance (PHI) seems to be an appropriate method to enable a rational use of health resources and to maintain affordable health expenditures. Following their rationale, it might be promising to introduce a basic statutory health insurance (SHI)—either financed by taxes or contributions—supplemented by voluntary PHI covering additional benefits.

Trends in EU

European Health Data Space (EHDS)

- The EHDS will help the EU to achieve a quantum leap forward in the way healthcare is provided to people across Europe. It will empower people to control and utilise their health data in their home country or in other Member States.
- It fosters a genuine single market for digital health services and products. And it offers a consistent, trustworthy and efficient framework to use health data for research, innovation, policy-making and regulatory activities, while ensuring full compliance with the EU's high data protection standards.

EHDS expectations for achieving goals Block of European Health Union

Putting people in control of their own health data, in their country and cross-border

- people will have immediate, and **easy access to the data** in electronic form, free of charge. They can easily **share** these data **with other health professionals in and across Member States to improve health care delivery**. Citizens will be in full control of their data and will be able to add information, rectify wrong data, restrict access to others and obtain information on how their data are used and for which purpose.
- Member States will ensure that patient summaries, ePrescriptions, images and image reports, laboratory results, discharge reports are issued and accepted **in a common European format**.
- **Interoperability and security** will become mandatory requirements. Manufacturers of electronic health record systems will need to certify compliance with these standards.
- To ensure that citizens' rights are safeguarded, all Member States have to **appoint digital health authorities**. These authorities will participate in the cross-border digital infrastructure (MyHealth@EU) that will support patients to share their data across borders.

Improving the use of health data for research, innovation and policymaking

- The EHDS creates a **strong legal framework for the use** of health data for research, innovation, public health, policy-making and regulatory purposes.
- The access to such data by researchers, companies or institutions will require **a permit** from a health data access body, to be set up in all Member States.
- Access will only be granted if the requested data is used for **specific purposes**, **in closed, secure environments** and **without revealing the identity** of the individual. It is also strictly prohibited to use the data for decisions, which are detrimental to citizens such as designing harmful products or services or increasing an insurance premium.
- The health data access bodies will be connected to the **new decentralised EU-infrastructure** for secondary use (**HealthData@EU**) which will be set up to support cross-border projects.

Eurostat 2019

Analysis of current healthcare expenditure, 2019
(%)

	Financing			Functions			Providers			
	Government schemes	Compulsory schemes and saving accounts (²)	Other financing agents (including unknown)	Curative and rehabilitative care	Medical goods (non-specified by function)	Other functions (including unknown)	Hospitals	Providers of ambulatory health care	Retailers and other providers of medical goods	Other providers (including unknown)
EU (¹)	*28.2*	*51.5*	*20.3*	*53.5*	*18.4*	*28.1*	*36.4*	*25.5*	*17.5*	*20.6*
Belgium	22.0	54.8	23.2	55.0	13.0	31.9	38.3	32.3	11.0	18.4
Bulgaria	10.4	50.2	39.4	53.9	36.1	10.0	37.5	15.0	35.7	11.8
Czechia	13.0	68.8	18.2	54.7	17.8	27.5	41.7	21.5	15.0	21.8
Denmark	83.3	0.0	16.7	55.1	10.6	34.4	43.5	28.8	10.6	17.1
Germany	6.5	78.1	15.4	49.1	19.4	31.6	27.6	31.4	19.2	21.8
Estonia	8.1	66.4	25.5	54.8	19.1	26.1	44.4	22.8	19.1	13.7
Ireland	74.0	0.6	25.4	56.4	13.2	30.4	38.2	20.0	12.7	29.2
Greece	28.6	31.2	40.2	62.3	28.9	8.9	44.5	18.6	28.9	8.0
Spain	66.6	4.0	29.4	58.4	22.1	19.4	44.2	21.8	22.1	11.9
France	5.5	78.2	16.3	53.9	17.4	28.7	38.0	22.8	16.8	22.5
Croatia	5.2	76.7	18.1	57.8	22.8	19.5	47.6	19.8	22.4	10.2
Italy	73.8	0.2	26.1	54.0	20.9	25.1	44.0	23.2	16.7	16.1
Cyprus	42.1	14.4	43.5	63.8	17.1	19.1	44.5	26.7	14.3	14.5
Latvia	60.8	0.0	39.2	53.2	27.6	19.3	34.8	26.4	26.5	12.4
Lithuania	8.2	58.2	33.6	55.2	27.8	17.0	33.9	26.7	27.4	12.0
Luxembourg	4.7	80.3	15.1	56.2	13.2	30.6	33.4	30.0	11.5	25.1
Hungary	8.6	59.8	31.7	53.8	30.2	16.0	37.5	21.2	30.2	11.1
Malta (²)	63.5	0.0	36.5	49.9	21.3	28.8	41.0	19.3	13.7	26.1
Netherlands	6.5	76.2	17.4	50.8	11.2	38.0	33.5	18.0	10.7	37.7
Austria	30.5	44.8	24.8	59.5	16.9	23.6	38.6	23.0	15.6	22.7
Poland	9.9	61.8	28.2	63.5	21.8	14.8	41.7	24.9	21.5	11.9
Portugal	58.6	2.4	39.0	64.8	19.1	16.0	42.0	25.6	19.2	13.2
Romania	15.4	65.0	19.6	56.8	26.9	16.3	45.2	15.5	26.2	13.1
Slovenia	4.2	68.6	27.2	58.3	21.2	20.6	40.7	23.2	20.8	15.2
Slovakia	2.4	77.4	20.2	55.2	32.0	12.8	34.7	20.2	32.0	13.2
Finland	63.9	13.9	22.2	60.2	14.5	25.3	37.2	29.8	14.9	18.1
Sweden	84.9	0.0	15.1	51.2	12.5	36.2	38.8	23.9	11.3	26.0
Iceland	82.9	0.0	17.1	60.7	13.5	25.8	39.1	26.7	13.5	20.7
Liechtenstein	17.2	47.8	35.0	61.9	11.1	27.0	7.0	27.0	3.5	62.5
Norway	85.8	0	14.2	48.8	10.2	41.0	39.3	28.1	9.8	22.9
Switzerland	22.5	44.3	33.2	54.4	14.5	31.1	36.8	27.0	9.0	27.2
Bosnia and Herzegovina	2.5	67.7	29.7	59.9	27.7	12.5	36.0	28.9	27.7	7.5

(¹) 2019 EU calculated with 2018 Malta data
(²) Compulsory contributory health insurance schemes and compulsory medical saving accounts.
(³) 2018 instead of 2019.
Source: Eurostat (online data codes: hlth_sha11_hf, hlth_sha11_hc and hlth_sha11_hp)

eurostat

North Macedonia

- Article 39 of the Macedonian Constitution states that “every citizen is guaranteed the right to health care” and that “citizens have the right and duty to protect and promote their own health and that of others” .
- Article 34 further provides that “Citizens have the right to social security and social insurance, determined by law and collective agreement”

Health Insurance System in North Macedonia

mandatory

- Law on Health Protection from 2012 with more than 10 amendments
- Law on Health Insurance from 2000 (amended more than 10 times)

voluntary

- Law on Voluntary Health Insurance from 2012, amended in 2015
- Insurance companies' terms (general and special conditions for health insurance)

In 1990

- The health insurance system of the Republic of Macedonia was introduced by the Health Protection Law, which was adopted in 1991 and modified and supplemented by the amendments in 1993 and 1995. According to this Law, health insurance was established as an obligatory, supplementary obligatory, and voluntary insurance for certain kinds of health care. This report gives an insight into the specificities and practice of all three types of insurance in the Republic of Macedonia.
- A person can become an insured to the Health Insurance Fund on the basis of 23 modalities. Payroll contributions are equal to 8.6% of gross earned wages and more than 70% of health sector revenues are derived from them.
- Besides some other basic resources and contributions for health financing, co-payments for health care expenses by users were introduced in 1993.
- Health financing and reform of the health insurance system at that point were of high importance within the ongoing health care reform in the Republic of Macedonia. It was expected that the new Law on health insurance will strengthen the mechanisms for collecting revenues and introduce new methods of co-payment and risk-adjusted reallocation of the funds related to age structure and health status of the population.

Mandatory Insurance

- One of the highest contributions in the region (currently 7.5% of gross earned wages)
- The amount of insurance is related to the income of the insured and in some way to education, and does not depend on age, gender, or family size
- Avoiding high contributions by reporting employees on lower monthly incomes
- Dissatisfaction and inequality among the insured

Health Insurance Fund

- The Health Insurance Fund of Macedonia was established by the Law on Health Insurance ("Official Gazette of RM" no. 25/2000, 34/2000 and 96/2000) for the implementation of compulsory health insurance, as an institution that performs activity of public interest and public powers established by law.
- The Law on Health Insurance regulates the health insurance of the citizens, the rights and obligations from the health insurance, as well as the manner of implementation of the health insurance. Based on the authorizations given in the Law and the scope of work, the Fund is managed by a Board of Directors, and the work of the Fund is managed by the Director of the Fund.

Voluntary Health Insurance since 2012

- A new system of voluntary health insurance is introduced, which gives a legal opportunity to insurance companies to offer insurance policies for certain health services and to determine the conditions and the manner of implementation of this system.

АГЕНЦИЈА ЗА СУПЕРВИЗИЈА НА ОСИГУРУВАЊЕ

Voluntary Health Insurance according to statistics (Insurance Supervision Agency)

	2012	2013	2014	2015	2016	2017	2018	2019	2020
Part of GWP	0.03	0.03	0.03	0.08	0.52	0.65	1.27	1,78%	2,72%
Number of contracts	87	0	269	368	Around 1200	1752	4144	7895	10706

Voluntary health insurance

Voluntary and long-term insurance that may be agreed for minimum one year from the date of commencement of insurance, unless otherwise regulated by Law.

Voluntary health insurance is not life insurance or additionally life insurance in accordance with the Law on Supervision of insurance.

The rights and obligations arising from voluntary health insurance can NOT be transmitted or inherited.

Types of voluntary insurance

Supplementary voluntary

- Supplementary health insurance covers the costs of participating in personal funds when using health services from the mandatory health insurance, in accordance with the regulations of the compulsory health insurance and health care.

Private

- Costs for health services that are not covered by compulsory health insurance
- Higher standard of health services
- Using health services in health institutions outside the network of health institutions in which the health activity is performed
- Services of legal entities that perform production, issuance and servicing of orthopedic or similar aids

Supplementary health insurance

- established by agreement on additional health insurance concluded between the insured and the insurance company.
- This health insurance can also be established by agreement on additional health insurance concluded between the insurance company and the employer for its employees and their family members, associations for its members or another legal entity that has an interest in insuring a certain group of people.
- The contract for this health insurance especially determines the content, the manner and the conditions for using the rights from the additional health care insurance.

Connection mandatory-voluntary health insurance

- Insured persons in supplementary health insurance can be only the persons with status of insured persons in the system of compulsory health care insurance, in accordance with the regulations of the compulsory health insurance.
- The insured persons that losses of the status of insured persons in the system of compulsory health insurance, will also lose the status of insured persons in the supplementary health insurance

Included services

The subject of this insurance are only costs for health services realized in health institutions that have a work permit issued by the Ministry of Health and legal entities that perform production, issuance and servicing of orthopedic and other devices.

Included/excluded citizens

In 2015, an amendment is introduced for foreign citizens who are not covered by the compulsory health insurance system

They can be insured with private voluntary health insurance

COVID 19 IMPACT ON HEALTH INSURANCE

- The risk of COVID-19 and all its consequences was new risk that didn't existed before, and it was not subject to cover or exclusion in insurance terms and conditions. From theoretical and practical point of view this created and still creates dilemmas regarding the insurance coverage provided to the insured.
- The comparative examples show that insurance supervisors have made statements or provided guidance on the types of COVID-19 related losses that various (or specific) types of insurance policies might cover. There are also examples of insurance supervisors that have required or encouraged insurers to provide information to policyholders on coverage and exclusions related to COVID-19 losses, across all relevant lines of business, as well as examples of insurance associations that have also published guidance on coverage and exclusions. But has Macedonian regulatory authority followed any of these examples? The insurers as well as their regulatory authorities needed to respond quickly to all the open questions. Some of the dilemmas were cleared by adopting new terms, but other remain confusing for the insured as well as for theory and practice

The case of in North Macedonia

- In North Macedonia this respond was clear in some cases, like the voluntary health insurance, where a quick reaction was noted as the insurers adopted new term**s that exclude the liability of the insurer in case of epidemic or pandemic risks**. On the other hand, few insurers introduced new health insurance related products to the market i.e., products tailored to the challenges that have arisen in the context of COVID-19.
- The health insurance in 2020 marked 10, 706 concluded health insurance contracts which compared to 2019 represents an increase of 35,60% of the number of concluded contracts, i.e. 44,88% of the total GWP. Thus, the question that remains for us are the reasons why voluntary health insurance marked increased in this period of pandemics? Another question refers to life insurance policies and how death claims are treated in case of death due to COVID-19? Are special terms and conditions applicable in case of death due to COVID-19 or Macedonian life insurance sector follows the examples of treating death due to COVID-19 as any other death case.

Implications on the health care system

Having in mind that North Macedonia does not rely on private insurance markets to provide for health care expenses, there was no gap in insurance coverage for COVID-19 related expenses because these costs were covered in general through a state – mandated social security coverage.