A Proposal for a Health Insurance Plan:

How does it affect us?

Prepared by:
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Respectfully,

Syzana Baja
Program Coordinator
Solidar Suisse Kosovo

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LIST OF ABBREVIATIONS

CSO	Civil Society Organisations
ECLO	European Commission Liaison Office in Kosovo
FES	Friedrich Ebert Foundation
FMC	Family Medical Centres
FSSHK	Federation of Trade Unions in the Health Sector of Kosovo
HIF	The Health Insurance Fund
HIS	Health Information System
IMF	International Monetary Fund
MFMC	Main Family Medical Centres
MoH	Ministry of Health
MoF	Ministry of Finance
MoU	Memorandum of Understanding
NDI	National Democratic Institute
NIPH	National Institute of Public Health of Kosova
SDC	Swiss Development Cooperation
UCCK	University Clinical Centre of Kosova
UDCCK	University Dentistry Clinical Centre of Kosova
WB	The World Bank
WHO	World Health Organization
WTP	Willingness to Pay

EXECUTIVE SUMMARY

Since the dissolution of Yugoslavia, it has been particularly challenging for Kosovo to ensure a continuation of a social insurance system. Various circumstances such as ten years of parallel structures in the health and education sectors, followed immediately by a devastating war in 1998 and 1999 all have resulted in a complete detachment of health personnel from the social insurance system that existed in the former Yugoslavia. After the war in 1999 the UN administration took initial measures to resuscitate Kosovo's health care system in Kosovo, and after independence in 2008, the Kosovo government began exploring different approaches to developing a healthcare financing system.

Kosovo's citizens see the delays in healthcare system financing reform as yet another unfavourable element of the status quo in an overall health care system already tarnished with unsatisfactory performance. Moreover, this status is worsening each day. An inefficiently centralised regulation of the health system; non-existing contractual relations between purchaser and provider; uncontrolled and unregulated growth of the private sector; a malfunctioning public sector; a workforce that is trying to survive financially between two systems, private and public, all contribute to an untenable situation for the ultimate beneficiaries of health care system services: Kosovo's citizens.

In 2011, The Ministry of Health took the initiative to move reform in healthcare financing forward by introducing a health insurance plan. This has been the most concrete attempt to seriously address the malaise of health care in Kosovo to date. The proposed plan would collect funds from both government and individuals. A central authority independent from the Ministry of Health would manage the funds, and in due course, the funds would ensure a basic care package for the entire population.

Numerous stakeholders hold different opinions about the proposed health insurance scheme. Namely, two major stakeholders have publically articulated their positions. One stakeholder is the Federation of Trade Unions in the Health Sector (FSSHK), and the other is the Vetëvendosje (Self-Determination) Movement. Both are in favour of a social insurance system whereby the employers and employees pay for health insurance with money deducted from salaries. Other political parties, civil society entities, and relevant stakeholders have received media attention, and are known to sporadically support or oppose the draft law, yet clear positions on the initiative for a new law on health insurance from, remain scarce. Individuals believe that a health insurance scheme will improve care and relieve them of their financial burdens in the event of illness. Nonetheless, the public, generally speaking, has not been adequately informed of the government's plans and intentions for health insurance.

Impetus for this research emanates from the lack of involvement of private citizens in discussions about a health insurance scheme in Kosovo. Hence, Solidar Suisse Kosovo decided to conduct a study that reviews the proposed health insurance scheme and analyses its interaction with patients and other citizens. This paper has two objectives: 1) to examine the effec-

tiveness of the new health insurance scheme. That is, to provide answers to key questions about this scheme's effects on the quality and access to health services; the financial burden on the individual; as well as the effects on the different groups of patients, and 2) to present data on the Kosovo public's ability and willingness to pay for a mandatory health insurance as well as its preference for the various forms of insurance.

Analysis reveals that implementation of the proposed health insurance plan will affect different groups of Kosovo's population in different ways, in terms of finances, benefit entitlements, and other mechanisms of the health insurance scheme. In other words, the basic healthcare package that includes co-payments and premiums will affect household finances and the scope of benefits that citizens will receive from the health care system in the country. An additional concern in this process, for example, are the administrative problems stemming from earlier attempts to register individuals, families or entire communities, as well as the accompanying difficulties in issuing and procuring individual identification documents for particular minority groups will affect the efficiency of creating quality health services for all. Such challenges will need to be anticipated and addressed. As with any macro structure, management and administration has been known to change overtime and that can affect consistency in the quality of health services.

Most significantly, the survey of heads of households across the country revealed several interesting findings. Notably, ninety percent of respondents confirmed they would be willing to pay for health insurance for family members. The amount that heads of households would agree to pay varies across the survey sample. The average maximum WTP was 3.53 euros per family member per month. In this study, data demonstrate that the demand for health insurance increases in households with large numbers of educated family members, and when higher levels of education have been attained in the families. Additionally, the higher the income in a household, the higher the interest there is in paying for health insurance. An important part of analysis reflected the willingness of individuals to share the cost of care: 97.7 percent of household heads were willing to share the cost for health care services with a mean copayment level of about 10 percent of the total cost for services.

However, it was disturbing to discover that only 32.3 percent of those surveyed had heard about plans for reform. Nevertheless, further analysis confirmed that there was confidence that health insurance would have a positive influence on people's wellbeing. Household heads favour a public health insurance scheme with a publicly-run entity (fund) managing the health insurance system. Indeed, a large percentage of respondents believe that authorities can implement a public health insurance scheme.

To be sure, further discussion will be needed to ensure that patients' interests are fully addressed in this new health insurance system. The government has signalled an interest in civil society's participation in policy discussions related to a draft law on health insurance, and there are a number of citizen and patient advocacy groups with a good understanding of the needs of specific segments of population, a strong interest in representing these constituencies, and a certain level of organisational skills required to effectively accomplish these goals. All this, in turn, is an opportunity for a potentially effective participatory and democratic process that can result in informed decisions about health care reform, as well as positively contribute to implementing the reforms. But, fruitful citizen engagement with the governmental and private sectors of society is not going to happen on its own, and serious efforts must be made to ensure earnest reform in the healthcare sector.

01 INTRODUCTION

This research work has been motivated by the lack of involvement by the public in discussions about a health insurance scheme for Kosovo. Although there have been serious efforts in reforming the health financing system with the proposal of a new law on health insurance, involvement and communication with the public has been limited. Earlier analyses and studies have attempted to clarify the many details of the situation and to offer proposals and suggestions for the implementation of health system reform in Kosovo. The central theme of these studies and reports has focused on health financing and the details of different existing models.

Citizens' preferences and potential effects of such insurance schemes have not been a central focus of these reports. This is perhaps the core difference and added value of this study. Thus, based on ongoing consultations, the Solidar Suisse Kosovo programme decided to undertake this study in order to review the proposed health insurance scheme and to describe and analyse the interests and views of the public, and the interaction between the insurance scheme, and patients, families and other citizens.

This paper has two objectives. First, it aims to clarify the effects of the new health insurance scheme on Kosovo's public. That is, the first goal is to answer key questions connected with this scheme such as the effects on the quality and access to health services; the financial burden on patients and their families, and the effects on the different groups of patients. Second, the paper presents data on the willingness of Kosovo's population to pay for mandatory health insurance as well their as preference for insurance. In addition to these two primary objectives, this study makes the health insurance proposal more accessible to citizens and to patients' advocacy groups. In doing so, the study informs the population and creates a basis for a well-informed public discourse thereby contributing to the possibility for an improved and sound law on health insurance and its future implementation.

The first part of the paper introduces a description of the current context and circumstances that preceded the latest developments in Kosovo's health sector. In the paper's second part, the reader will find the Ministry of Health's simplified explanation of the proposed scheme for core health insurance concepts and structure. The third part of the paper presents a detailed analysis of the proposed scheme and potential effects of the health insurance system on the public, in general, and on patients, in particular. Here, too, special importance is given to service quality, people's financial burden as well as their access to services. The fourth section of the paper describes the positions of different stakeholders vis a vis the proposed health insurance scheme.

The culmination of the paper emphasises the need for debate and a proper engagement of citizens in the policy process.

To address these objectives, part of this study and its analysis is based on three elements: a critical review of the proposals of the law on health insurance; an assessmvent of the situation provided during workshops and focus group discussions with civil society organisations representing patients; and a country-wide survey with the heads of the households with a total sample size of 1107 respondents.

02 CURRENT HEALTH CARE SYSTEM

2.1. Organisation, financing and issues

Kosovo's circumstances differ from those of some countries of former Yugoslavia, such as Macedonia, Montenegro or Croatia, where a continuation of the social insurance system after the dissolution of Yugoslavia (WB 2007, FES 2009) was maintained. For these countries continuity was possible because the Yugoslav system that was inherited was preserved without an extended interruption between changes in the political system. Due to various circumstances in Kosovo, such continuity has been more difficult. Kosovo, not only endured a devastating war in 1998 and 1999, but immediately prior to that, a decade of medical structures, including the medical education system functioned in a parallel existence that left health personnel completely detached from the flow of the social insurance system that had existed in Yugoslavia.

Immediately after the war in 1999 the focus was on emergency assistance and basic organisation of the health care system. The process was led by WHO and resulted in a centralised health care system. In this system, the Ministry of Health manages the funds allotted for health care (Exhibit 2.1.1.). These funds are raised from taxes and then distributed among line Ministries. Since 1999, a much infrastructure development, technical assistance and training have taken place and the health sector has benefited. This has contributed to the improvement in human resources, better conditions for provision of services, and management of health care facilities.

Government health spending is

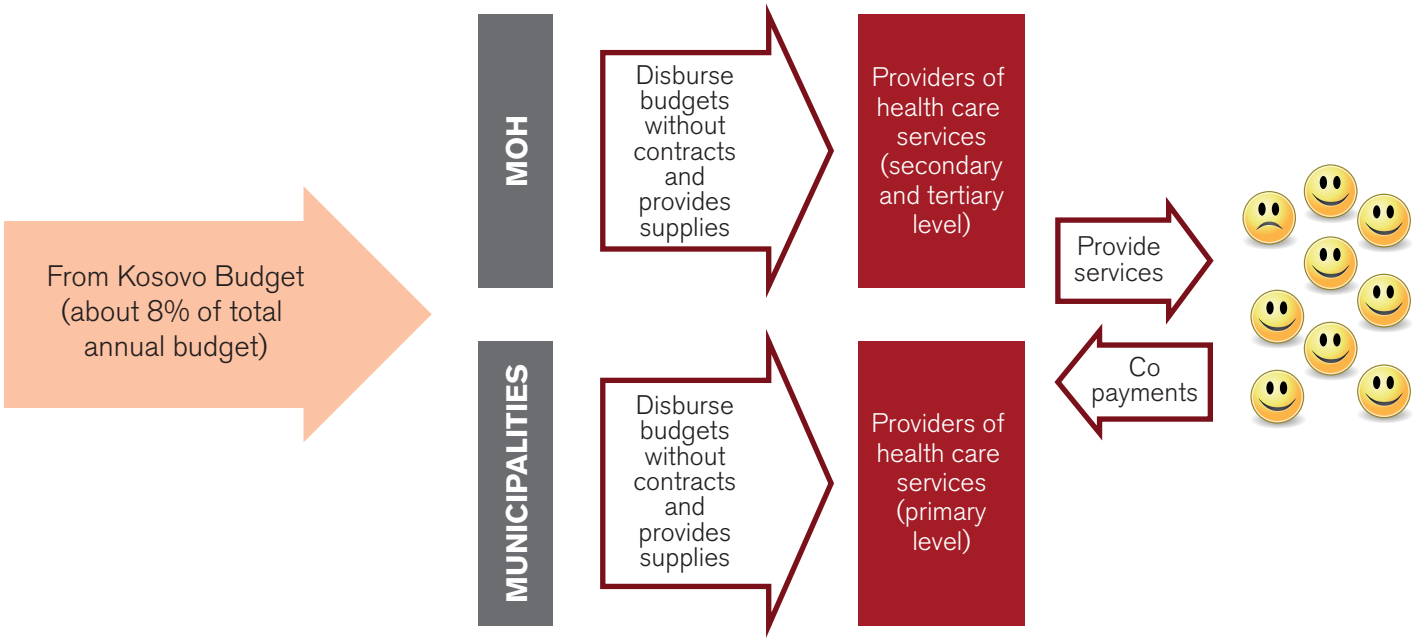


Exhibit 2.1.1 The current system of financing and organisation of health care

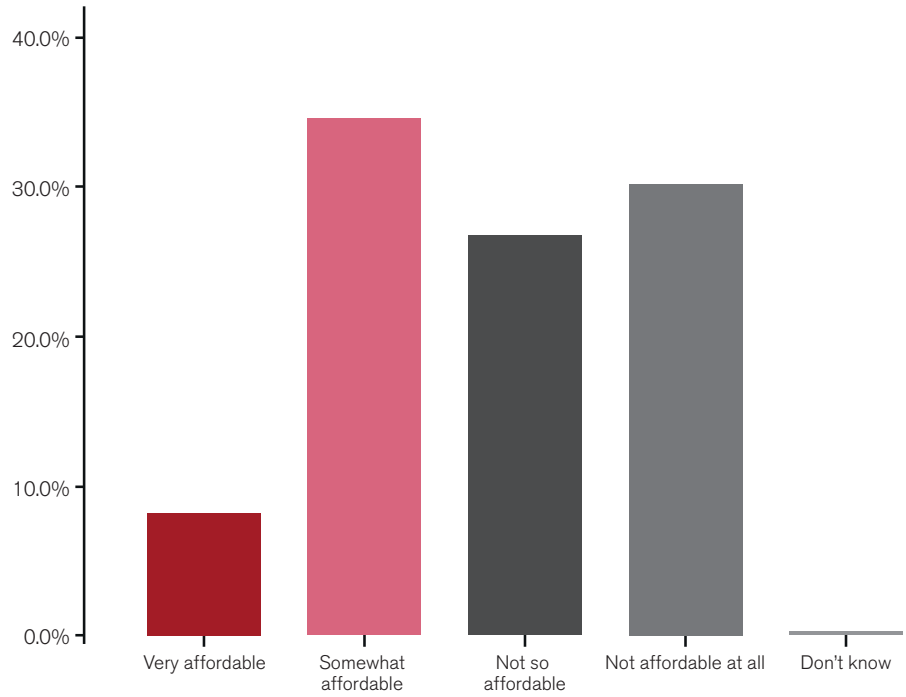
about three percent of the GDP and eight percent of general government expenditures (FES 2012). Only half of the overall health spending is covered by the government budget. The other half of the total health expenditure is covered by out-of-pocket payments at the point of service use by the patients. In 2004, it was estimated that each person paid an additional 81 Euros out-of-pocket beyond what the government spent on health, for the services they used (WB 2008). According to the survey, the average (six members) household expenditure was 716 Euros per year. Most of these additional services and expenditures have been taking place in the private sector and towards payment for medications.

The health care provision system in Kosovo is organised along three levels: primary, secondary and tertiary. The primary care system is the network of family medicine facilities. Secondary care represents regional hospitals where specialised care is provided. Tertiary care refers to research and teaching institutions that are also supposed to provide high-end diagnosis and treatment. In all, there are 426 primary care institutions of which 29 are MFMC, 163 are FMC, and another 234 are family medicine stations. Secondary care level comprises seven regional hospitals whilst the tertiary care level incorporates the UCCK, UDCCK, the National Transfusion Centre, six para-clinicical institutions, and the Institute for Work Medicine. There are a total of 11,484 employees in the state health care sector. The overall medical staff numbers 9464 (82.4 %) and another 2020 number

non-medical staff (17.6 %). Of the medical staff, there are 2141 (18.6 %) physicians, 330 (2.9 %) dentists, 6 (0.12 %) pharmacists, 6877 (59.9 %) nurses, 90 (0.8 %) professional associates, and 20 (0.2 %) physiotherapists (NIPH 2012).

Despite many post-war improvements, today's health sector is characterised by a low quality of health services, a lack of pharmaceuticals, related supplies, and consumable materials. In-patient treatment at public hospitals necessitates that patients' families bring their own supplies, such as drugs and their meals before undergoing surgical interventions. Low salaries and poor working conditions in the public sector leave staff highly discouraged. There is a rapidly growing private sector but considering the high level of poverty in Kosovo, it is not surprising that there are not many such patients in Kosovo who can afford to pay cash up-front, immediately following treatment.

The government of Kosovo has been exploring alternative ways to structure the health financing system. Both in public and behind closed doors, there has been much discussion and expressed intent to learn about other countries' experiences in health insurance (WB 2007, FES 2009, NDI 2011). In the past two years the issue of health insurance has become a key topic in health sector discussions among representatives from the government, civil society and the media. Aside from the passage of the Health Law by the parliament and the government, and the approval of the draft law on health insurance - all which set the stage for further developing a health insurance plan - no other concrete policy results have materialised.



In general, how affordable, for your household, is payment for medical bills?

Exhibit 2.2.1 Affordability of health care expenses

Kosovo's citizens see the delay in reforming health system financing as maintaining an unfavourable status quo in the health care system with unsatisfactory performance for the citizens of Kosovo. This status is worsening each day, more and more. One of the chain results of this situation is the increase in number of patients seeking help abroad. This means a continuous pouring of funds abroad and overutilisation of costly health services.

2.2. Citizens' perceptions of the current status

The survey revealed that many people have difficulty coping with the expenses of health care (Exhibit 2.2.1). Only 8.2 percent of the respondents find health care-related expenses affordable whereas 34.6 percent find it somewhat affordable. Most respondents have difficulties managing the cost of the care. For 26.7 percent, expenses are not very affordable, and for 30.2 percent of those surveyed, costs are not affordable at all.

When asked about usage of public health care services during the survey, only 6.9 percent responded that they use those services (Exhibit 2.2.2), and twenty-six percent responded that they use public services to a certain degree, whereas 50 percent of those surveyed said they do not rely on public health services at all. To a certain extent, these responses confirm that the public sector is losing grounds to the private health care sector as people rely on the latter.

Other interesting facts reveal that only 3.3 percent of the respondents confirmed that they have some kind of health insurance whereas 88.4 percent of population does not have any form of private or national insurance.

Yet, more than 45 percent of household heads have been insured at some point in their lives, 82 percent had social insurance that was available through the Yugoslav state system whereas, eight percent has had experience with private health insurance in the country and ten percent has had health insurance abroad. These percentages may somewhat reflect Kosovo's political and social transition over past 30 Years. This transition is, among other things, characteristic of changes in organisation of the health care system and the population's major migration patterns to, from, and within, Kosovo. These movements are reflected in the health system's utilisation and the experiences of the population.

	True		Somewhat True		Partially false		False		Don't know	
	n	%	n	%	n	%	n	%	n	%
Households using only free public services.	76	6.9%	288	26.0%	179	16.2%	560	50.6%	4	.4%
Households that are insured.	37	3.3%	56	5.1%	28	2.5%	979	88.4%	7	.6%
Households paying cash for services health services.	868	78.4%	102	9.2%	32	2.9%	99	8.9%	6	.5%
Heads of households understanding of the solidarity principle in health insurance	785	70.9%	180	16.3%	38	3.4%	68	6.1%	36	3.3%
Willing to share the costs of health care services - current status.	555	50.1%	335	30.3%	72	6.5%	132	11.9%	13	1.2%
Confidence that insurance will prevent household from financial difficulties in case of a severe illness - current status.	726	65.6%	211	19.1%	60	5.4%	95	8.6%	15	1.4%

Exhibit 2.2.2 Facts on service utilisation and other factors

03 DESCRIPTION OF THE PLANNED HEALTH INSURANCE SCHEME

3.1 The idea of health insurance

Simply put, a health insurance system is a financing system within the health sector and health services that is expected to meet the health needs of a population. There are two main components of a health financing system. First, the health insurance system determines the funding sources, collects, or pools, them, and manages them. Second, the collected funds are used to purchase services that meet the health needs of a population. This is a system that continuously requires adjustment and a sense of balance of the needs of the population, with funds that are available in order to purchase the services. That is to say, one should remember that health needs have no limits, whereas, financial sources are always limited. This indicates that a health insurance scheme can never be perfect. No matter what are the financial abilities there will always be limitations to what a health insurance scheme can cover. This applies to Kosovo and to the most developed countries in the world alike. The success of a health insurance system is in its ability to balance these two sides - needs and funds. Naturally, a balance between coverage of a wider population's needs with available funds is ideal.

One of the impediments to reaching this ideal balance is the effect that the conflicting interests of different participants have on a health insurance system. Some of the key parties are indivitduals; groups of patients and society at large; the health professionals and organisations representing them; Ministry of Health; the Health Insurance Fund; hospitals, and without a doubt, an overall sound health system will help address the needs and concerns of all parties involved in the quest for a balanced and efficient insurance programme. All parties will have certain interests that often will compete and even conflict with each other. To enhance the creation of an ideal balance, such a health system will need to regulate the behaviour of all participants in a health insurance scheme.

A health insurance system should define and develop a variety of mechanisms that regulate this balance between needs and available funds. Such mechanisms will strengthen a democratic approach to decision-making, thereby allowing citizens and shareholders to participate and to contribute to the regulation of the balance of these interests. Some of these mechanisms include the following: 1) definition of basic package of care, 2) a service pricelist, 3) a health insurance premium payment, 4) a determination of cost-sharing for services, and 5) contracts with relevant institutions. Basic package of care sets the list of health conditions and services that are covered by health insurance funds. The service price list defines the price for each of the services provided by health care institutions. Setting the

premium amount is an important process that determines how much money will be collected from citizens. After this is ascertained, it is known how much money will be available for the purchase of services for citizens. Determination of the cost-sharing amount can take several forms and will prevent over-utilisation of services that will save funds for better use by people who need the services. There are three key cost-sharing forms of that may be applied.

The deductible. This is an amount that must be paid out-of-pocket before insurance becomes active. For example, in Switzerland, one pays out-of-pocket until a certain limit after which the insurance, at an annual rate, assumes the remaining cost.

Co-payment. This is a flat amount that the insured patient must pay for each service used.

Co-insurance. This form represents a percentage of the total charges for a service that must be paid by the beneficiary.

The contracting of institutions by the service purchaser, i.e., the Health Insurance Fund, will not have much interaction with patients (or citizens, in general). This process has to do with regulating the behaviour of service providers, e.g. hospitals and other health institutions, by providing incentives and sanctions for service provision to patients. The mechanisms will put the system to work but they will also have an impact on the pockets of the patients as patients begin to assume a portion of the financial burden.

It takes time to establish and make functional health insurance mechanisms as both time and energy are required because such mechanisms are constantly refined and updated as demographics and other external conditions change. The cases that best illustrate this flux are the reforms in insurance systems in Macedonia and Croatia. With the disintegration of Yugoslavia and the subsequent creation of independent states it became necessary to re-build an insurance system. The process is still on-going. Health reform has been a long, arduous, and continuous process in developed countries. In the countries such as New Zealand, the United States, the United Kingdom, for example, this process has taken decades of reform and implementation and continues to be a source of much contentiousness and rancour to this day.

One of the main problems in the design and implementation of a health insurance system in Kosovo is the lack of knowledge about what system precisely could ensure that ideal balance, and how the participants', or stakeholders' behaviours might be regulated. This has delayed and derailed efforts towards a reform of the health system in Kosovo. Thus far, policy discussions among stakeholders remain at a wishful hypothetical level. That said, there have been some changes over the past two years. Most recently, the MoH has begun to signal its understanding of financial constraint. It has benefited from the technical assistance provided to building a health insurance system and is on the right path to designing a proper health system reform. For the first time, the MoH strategy has received support from the Ministry of Finance, and has received approval from the World Bank and IMF, both institutions with tremendous influence in decision-making about public expenditure because of the support agreements that Kosovo has with these institutions.

3.2. Proposal for health insurance scheme

According to the proposed model of financing, the Kosovo government will finance most health needs expenses (see Exhibit 3.2.1). To complete full financing of the scheme, beneficiaries will be asked to pay a premium for themselves, if they are the financial head of the household, as well as for each member of their family. The scheme is compulsory

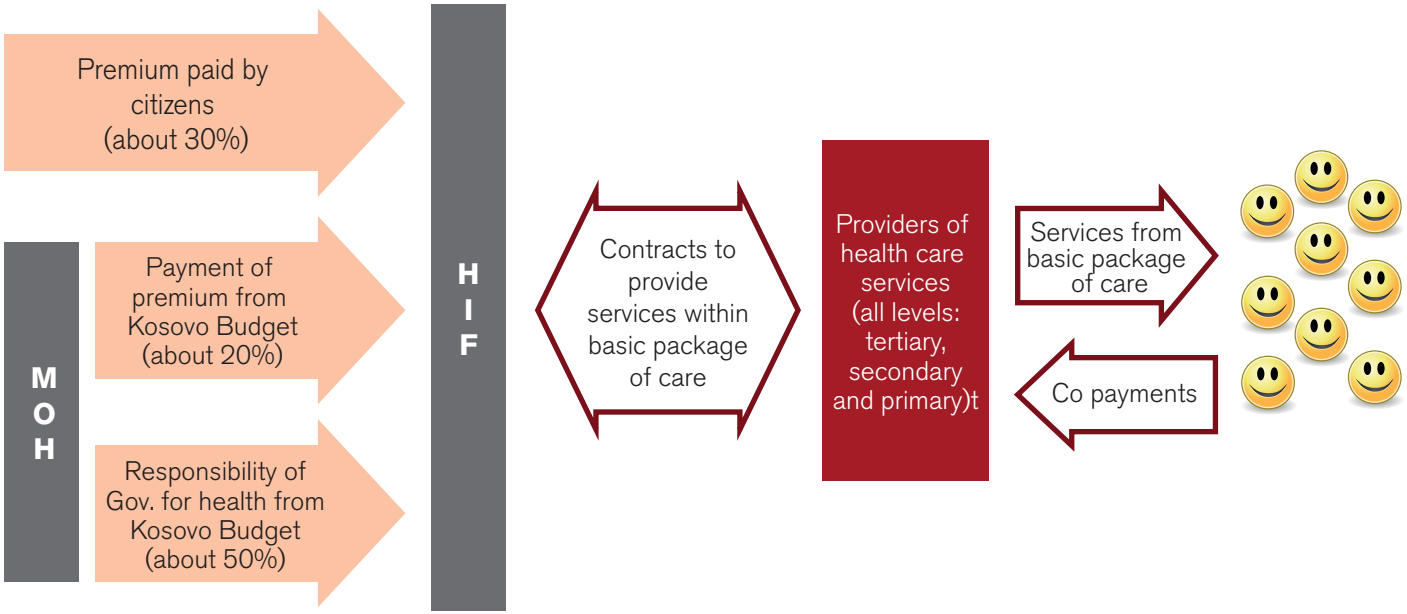


Exhibit 3.2.1 the structure of planned health insurance system

for all citizens with exception of pensioners (beginning at age 65), the unemployed, war invalids, families of war victims, and people living under social assistance. The government will provide complete coverage for these groups. The health insurance scheme is based on the principle of solidarity. That means, that those who can afford to pay do so for those who cannot do so as to ensure that everyone receives basic treatments when in real need.

The premium payments will cover the basic package of services that, in principle, would cover the diagnosis and treatment of all the diseases that the Kosovo population faces. The scheme will not cover all treatment and all diseases. It will cover basic treatment. Insurance holders wishing additional, and more inclusive services and insurance will need to pay additional premiums, or obtain private insurance. The insured will also be required to share the costs of services in order to reduce over-utilisation. In other words, a service provided at a health care facility that is covered by the insurance may require a small fee towards the total fee for service. The scheme will not cover plastic surgery, and court-ordered services, i.e. for legal purposes.

The Health Insurance Fund, a central authority, will manage the scheme. HIF will be a public organisation and its activities will be monitored by the government and the parliament, along with the participation of the patients' and health care workers' interest groups. Citizens will purchase health services from the HIF. It is hoped that this new arrangement will contribute to the improvement of the behaviour of health institutions and the quality of services.

The mandatory health insurance premium will ultimately be determined by the government and may be divided into categories depending

on the number of family members or other factors. HIF may propose that the government adjust the premium during the fiscal year in order to secure sufficient funds for next year's services.

Individuals not covered by mandatory health insurance shall pay full cost of the basic health care services pursuant to the price list adopted by the Ministry of Health, after due consideration of HIF's proposals. Supplementary health services not included in the list may be provided with the payment of a supplementary health insurance premium or through direct payment to the health institution. The voluntary supplementary health insurance is based on individual contracts between the voluntary insured person and the private health insurance company, in accordance with the draft law, and ultimately the final, ratified law.

The scheme will also define the levels of cost sharing that beneficiaries will pay, to which institution they will pay, and under which conditions services shall be accessed. The options for cost sharing are not defined at this stage.

Details such as exact amount of premium, amount of cost sharing, the prices for services, the list of services in the basic benefit package have not been defined at this stage. They will be determined in separately by way of administrative instructions, unlegislated acts, or other such decisions as foreseen by the law.

04 POSSIBLE IMPACT ON CITIZENS

The health insurance scheme will introduce changes to ways in which private citizens and the health system interact, as well as to the general quality of the health system operation. Conceptualising, developing, and implementing an entire insurance system means that changes and their effects will appear gradually. This section of the study outlines potential scenarios of the effects of the health financing system on the population. It is important to bear in mind that the scenarios are predicated on the assumption that the health insurance system will be implemented as described in this analysis. The first two parts of this section contain analyses based on information provided by the Ministry of Health and other institutional stakeholders whereas the analysis in the third part of the section is based on information gathered during focus groups with patient and citizens' groups.

Most part of the effects will be linked to the implementation mechanisms of the health insurance scheme, such as the basic delivery package, cost-sharing and premium payment. Another part may be related to the effects of the health system reform that comes with introduction of the new scheme. Certain other effects may be related to administrative issues.

4.1. General description of the main changes

Changes in the funding system will, themselves, influence changes in the management and leadership of the health care institutions. In the new legislative package, core changes in this direction are foreseen. To be sure, some of the main problems in the health sector are connected with mismanagement and ineffective leadership found in the institutions. It has been posited that change of the hospital management with the conclusion of the contractual relations between the insurance fund and health institutions may result in better performance and accountability of these institutions. Poor management of institutions is one of the main causes of poor health service quality in the country. Partial cause is due to the lack of obligatory relations between the payer of the services (Ministry of Health) and health institutions. Today, these relations are regulated by annual budgets that are approved and paid by the Ministry of Health without any conditions on performance. Hence, there are no incentives to encourage healthcare institutions to attain better results. With the inclusion of the health insurance scheme and application of contractual relations with health institutions, a new basis for the improvement of the health institutions management and, will hopefully result in an improvement of health service quality. The application of contracts and paragraphs that stimulate and sanction

different levels of health institutions' performance will inspire institutions to perform better.

This new scheme, in five to ten years, should improve the supply of pharmaceutical other medical supplies; improved maintenance; proper functioning of diagnostic equipment; access to services. Today's practice requires that the patient purchase most of his or her medical supplies before undergoing a surgical intervention. All these features are currently paid with patients' out-of-pocket money. Nepotism and other forms of corruption also affect a patient's access. To receive good care, one must know a healthcare giver who works at the desired healthcare institution, or perhaps bring a gift - often in a substantial monetary form. Otherwise, patients are denied that to which they are entitled: necessary health service. An overhaul in implementation of a complete health insurance scheme is expected to vastly improve as contractual relations between HIF and health care facilities themselves, improve. None of the hospitals wishes to be sanctioned financially for providing substandard quality services as this would lead to a reduction in funds received from health insurance.

The dissatisfaction found among medical staff is an important and continual challenge and has been reflected in the quality of services over the years. Because of low salaries, many medical personnel have found 'salvation' in the private sector and have used the public sector to recruit patients. The new scheme could have a positive effect on these negative developments that have thus far dominated the sector's environment. It is intended that the new scheme would stabilise the sector through improved working conditions, e.g. higher salaries in public sector, regulation of public and private sector engagement, for medical staff in both sectors. Succinctly said, satisfied staff performance will benefit their patients.

4.2. Who will pay premiums and co-payments and how much will be paid?

All citizens of Kosovo will be obliged to pay a premium. The law will allow for several exclusionary categories including pensioners, unemployed, disabled persons, war veterans and invalids, and persons under a social assistance scheme in compliance with applicable legislation. The government will pay for the premiums for people in these categories. Nevertheless, the payment level has yet to be determined as it passes through several necessary decision making levels. The logic of the premium payment is that it aims to extend the financial obligation across a longer period of time in order to cover the patient when in need of medical treatment. Additional point of reliance is the solidarity among the premium payers. That is, everyone pays when someone gets sick, even though the majority of individuals are healthy.

As a result of the premium payment, the new scheme will impose a financial burden on families in the short term. This burden will be in the form of an additional tax that family heads have thus far not paid. The burden will be more troublesome for large families. However, since there is a great likelihood that the determination of the premium payment may be based on family size (family economies) this financial burden may be somewhat easier for large size families. This would mean that families with more members would have a smaller rate of payment per family member, while families with fewer members will have a higher rate of premium payments per family member. One option under discussion is to establish three classifications of family size as well as the value of the premiums that would be paid each month to cover insurance. To reiterate, as mentioned in the previous paragraph, the government will cover

a large number of people who cannot afford to pay. This includes the groups as pensioners, registered unemployed people, and social assistance people as well as the persons who are the family members of martyrs and victims of the war.

In the long run, all citizens will be protected from paying out-of-pocket. According to the survey results this is more than 700 euros a year for household. Addressing the enormous out-of-pocket payments by the patients, particularly those with malignant diseases, will be one of the steps undertaken that could protect the people from financial collapse whilst at the same time provide health care for their overall, preventive health needs.

Cost-sharing poses similar challenges. In order to reduce inappropriate and unnecessary abuse of the health service, the government will need to determine the conditions and costs involved with cost-sharing. This is critical since the Fund will control spending that could otherwise be caused by over-utilisation.

4.3. Cases of potential impact on citizens

The health insurance scheme could potentially cover the costs of some groups of individuals in their entirety. It is understood that their coverage awaits a decision about whether it is to be included in the health care package. For example, patients with diabetes, malignant diseases, e.g. cancer, pregnant women, neonatal, and post-natal care would receive special dispensation. In some countries these services are guaranteed by the state. Patients diagnosed with diabetes in Kosovo are spending at least 100 euros per month to keep the disease under control. These costs are associated with regular monitoring of sugar levels (glucose) in the blood, insulin or anti-diabetic therapy as well as other medical tests and checkups that are necessary for proper disease management. In the event that full insurance for this category of patients becomes available, the annual financial burden of 1200 euros would be shifted from the patients to HIF. This amounts to one fourth of the average annual salary of per person in the country. When calculated, that a person pays approximately 60 euros per year for insurance, i.e., five euros per month, which provides considerable financial relief particularly for people with chronic diseases.

Positive effects towards facilitating the financial burden will be visible at time of birth and during care of newborns. Focus group discussions with patients reveal that the costs for delivery in the public system can be calculated from between 100 to 500 euros. These costs are connected with the payment of medical supplies needed for surgical interventions, medications as well as other costs related to food and maintenance of hygienic conditions during a hospital stay. Some such costs are associated with care for the newborn, e.g. food, clothing and hygiene. Where complications arise that require the patient to prolong their hospital stay or additional medical attention, these costs will rise. In the existing system, patients and their families cover the majority of these costs. With the new insurance scheme these costs could be covered entirely by funds collected when services in this category of patients are included in basic package.

The health insurance scheme should also cover diagnostics and the treatment of patients suffering from malignant diseases, e.g. cancer. The treatment of these diseases are some of the most costly for patients and their families. In most cases health services are required

abroad, which adds additional financial burdens. Guaranteeing these services with the new health insurance scheme will require time. Positive results can come from two directions. For one, hospitals will have an interest in developing health services to diagnose and treat malignant diseases because of contracts and an increased absorption of health insurance funds. The second benefit is that services previously sought abroad now will be available at home, creating revenue for hospitals in Kosovo. The guarantee of health care for malignant diseases would prevent families from financial collapse and provide better quality care to Kosovo's population. However, serious development in this direction will naturally require more time.

Another category that might benefit from this scheme includes children with various forms of autism. Care for this group of people is supposed to be provided by several sectors such as education, social welfare and health. A crucial component to dealing with this problem relates to diagnosis and care, and should be attended to by the healthcare system. According to focus groups of parents of child patients with autism, a family spends approximately 300 to 500 euros per month for the care of these children, often requiring one of the parents to remain at home in order to provide full-time care, meaning potentially one less salary for the family.

Some previously unresolved administrative issues could have negative effects on people's access to health services. The effects on the Roma, Ashkali and Egyptian communities are probably even more noticeable because of, among other things, lack of information about the health care opportunities. There are quite a number of citizens from the Roma, Ashkali and Egyptian communities still lacking proper identification documents and who are not registered in the civil registration system. The same applies to the Serbian community, especially in the north of Kosovo. For the use of health insurance system benefits people need to prove their Kosovo citizenship and that they have paid for their health insurance (or are exempt from payment). Otherwise, they will be obliged to pay full price for services. Measures taken to address this issue will vary among the different communities. As concerns the Roma, Ashkali and Egyptian communities, community-based information campaigns will be indispensible to provide information about the health insurance scheme as well as to collect the necessary demographic information about the individuals and families so as to improve cooperation between the communities and the various other stakeholders as all parties seek effective delivery of services. The state and municipal administrations should be engaged in this process and the procedures should take into consideration specific conditions of these communities. On the other hand, the issue with the Serbian community is dependent more on a political solution. Serbs in the northern regions of Kosovo remain under the influence of Serbia, and hence, reject documents issued by the Kosovo government. It is anticipated that recent negotiations between these two countries, endorsed and mediated by EU representatives, will clarify the position of this community in the north of the country which would vastly assist in the issuance of documents for citizens from the Serbian communities of Kosovo.

05 OPINIONS AND PERCEPTIONS OF THE PLANNED HEALTH INSURANCE

5.1. Opinion of different stakeholders

There have been two major stakeholders that have had a publically articulated position vis a vis proposed health insurance scheme. One is the Federation of Health Trade Union and the other one is the Vetëvendosje Movement. Other political parties, civil society actors and additional stakeholders have not held clear positions although they have been present in media and have alternately opposed and supported the initiative for a new law on health insurance. Generally speaking, though, the public has thus far not been sufficiently informed about the details of health care reform. This lack of awareness has been reflected in public opposition to the proposed law, e.g. declarations, interviews.

The Federation of Health Trade Union has been in favour of social insurance where payment for health insurance has two contributors: the employed and employee. They want employers to pay. This is not in line with their value system for a fair and just society. Their concerns have been voiced at every opportunity. Their concerns were not related to effects of the proposed scheme in the health care workforce.

Vetëvendosje Movement's position is similar to that of the Federation of Health Trade Union. They, too, are in favour of social insurance. They believe the current system is not in favour of citizens because they are assuming all the financial burdens. They argue that the government adopted this policy in order to create a more favourable environment for international investment. They claim this is a neo-liberal approach that will not be beneficial to Kosovo's citizens and its society.

There have been strong voices in favour of the social insurance system in parliament and in policy circles. A report on health insurance system sustainability (Bislimi, et al 2006) argued that the payment of seven euros divided equally by employer and employee would provide sufficient funds for the health system. It suggests that this arrangement can be implemented without negative effects on the country's economy. But the implementation of the labour law and maternity leave, as a part of this legal framework is an example of the effects on legal and economic decisions in the business sector. For example, it is widely known that employers balk at hiring young married women. The maternity leave reduction is the latest step to be reviewed under the Labour Law.

5.2. Opinion of citizens

In the survey, 91.7 percent of household heads confirmed that they are willing to pay for health insurance of their family members. Only 8.1 percent of household heads interviewed have no intention of pay-

	True		Somewhat True		Partially false		False		Don't know	
	n	%	n	%	n	%	n	%	n	%
Willing to share the costs of health care services - if scheme is implemented.	680	66.9%	264	26.0%	33	3.2%	31	3.0%	9	.9%
Confidence that insurance will prevent household from financial difficulties in case of a severe illness - if scheme is implemented.	680	66.9%	264	26.0%	26	2.6%	35	3.4%	12	1.2%
Confidence that this health insurance system will improve the health and wellbeing.	705	69.3%	244	24.0%	26	2.6%	31	3.0%	11	1.1%
Household heads in favor of public scheme for health insurance	822	74.3%	138	12.5%	51	4.6%	83	7.5%	13	1.2%
Households heads that are in favor of private scheme for health insurance.	296	26.7%	206	18.6%	87	7.9%	478	43.2%	40	3.6%
Trust that the authorities can implement such scheme.	428	42.1%	394	38.7%	75	7.4%	88	8.7%	32	3.1%

Exhibit 5.2.1 Perceptions about health insurance

ing for health insurance. Among the reasons for refusal of participation are those related to inability to pay; the belief that the financial burden should fall on government; potential for mismanagement of funds by authorities; belief that out-of-pocket payment is better.

The amount household heads agree to pay differs across the survey sample. Based on data, the average maximum WTP was 3.53 euros per family member per month (with a 95 percent confidence interval between the lower limit of 3.36 euros and an upper limit of 3.70 euros). The study has confirmed that the demand for a health insurance increases with a larger number of educated household members, higher educational levels, and, the more income generated by a household. A significant majority, 70.8 percent, of the respondents understand clearly the solidarity principle in health insurance.

An important part of analysis was the willingness of citizens to share the costs of care. A notable majority, 97.7 percent, of household heads were willing to share the cost for health care services. Only 2.3 percent of the respondents were not willing to share the costs for health care services. Data from the survey revealed that the mean copayment is 10.393 percent. The 95 percent confidence interval for the average copayment was created with a lower limit of 10.012 percent, and an upper limit of 10.774 percent. The maximal cost sharing level was 50 percent of the total price for health care services.

Only 32.3 percent of people had heard about the reform plans. An interesting fact was that they didn't hear about the plans from television, radio or printed media but from other sources of information. 67.7 percent have not heard about health insurance reform.

The study reveals interesting data concerning perceptions of household heads about health insurance. The willingness to share costs increased after the respondents obtained information about health insurance and government plans to introduce such a scheme, with 66.9

percent fully willing, and 26 percent somewhat willing to share costs. Not much changed, compared to the general initial perception in terms of confidence that health insurance would prevent household from financial difficulties in case of severe illness. Confidence that health insurance will have a positive effect on the wellbeing of citizens resulted in 69.3 percent of the respondents being certain about this fact, and 24 percent feeling somewhat certain.

Household heads are in favour of a public health insurance scheme where a publicly run entity (fund) would manage the health insurance system. Whereas 74.3 percent were certain about this, 12.5 percent were somewhat certain about this. The preference for a private health insurance was much lower with 26.7 percent in favour of a private health insurance scheme with multiple providers of health insurance. Comparatively, 43.2 percent of the respondents were not in favour of private health insurance scheme. A high percentage of respondents believe that authorities can implement a public health insurance scheme, 42.1 percent have trust that authorities can implement such a scheme, and 38.7 percent have partial trust that authorities will implement such a scheme.

06 THE NEED FOR DIALOGUE AND CO-DETERMINATION BY THE PEOPLE

The information on health care financing reform has been minimal. Close to 70 percent of the people have no clue regarding the newly proposed system. Since the discussion has primarily focused around stakeholders, most of real discussion and content of reform has not managed to reach the broader public. This last attempt to move the law on health insurance forward may well be one of most serious attempts to address the issue of health financing in Kosovo. But its success will depend on support of its citizens. They will be paying a large amount of the bill for health care in the future. Popular support for the law and the MoH's efforts will depend on the depth and breadth of intent to effectively convey all the necessary information and details about health insurance reform to the public.

The dialogue among the citizens and the government has to change its current quality and intensity. A continuous discussion is needed to

ensure that the needs of citizens will be fully addressed in the vision for a new health insurance system. The negotiation and the 'trading' between the government and the public over the details of the proposed scheme are an important aspect of the public debate and decision-making. A tripartite representation of employees, the government and employers on the governing board of the Fund has been foreseen in the draft law. However, this arrangement, is already being criticised for being overly concerned with financial issues and for not truly representing the interests of the citizens. Indeed, there is no substitution to good communication with citizens and the organisations representing them. Civil society organisations that represent citizens and patients should be invited to discuss, and to formally be included in the decision-making process. Such participation would enhance the citizen representation round the issue of health insurance coverage. An important part of communication with citizens should be done via public media and the government should have a clear strategy and means to do this. Finally, there seems to be an opportunity for MoH to use popular support to implement health insurance, which is acutely visible in this study. Such support could be more important and carry more weight than the support of some of stakeholders.

There will be moments when citizen participation will be essential. The periodic revision of the basic package of care; establishing cost share (copayment) levels, definition and revision of premium payment fees for health insurance are major examples. Citizens should be aware that there is a chance for a continuous debate (likely every year). This is the opportunity to discuss with authorities how much they will be obliged to pay, or which services might be covered in the basic heathcare package, and so on. The coverage and termination of services from the basic package will affect certain layers of the population. Imagine a patient with diabetes whose insulin is not covered by a health insurance scheme. On the other hand, as for any other benefit, one must pay a price to get a benefit. This is also no less applicable in the health sector. Therefore, if more health care is desired, more premiums might need to be paid for by the public. The balance of what is paid and what is provided must be achieved through discussions between the public and their representatives.

The CSO representing citizens and patients will have to define its positions before, and as they enter into dialogue with the government. It will not be enough merely to oppose anything the government is proposing. The CSOs should inform policy decisions and should create advocacy positions based on facts, information, and the needs of the people. There can be no improvisation in this process. This process will require long-term effort and commitment by organisations that represent citizens' interest. Ad hoc intervention will not bring desired effects and, hence, most likely fail to substantially affect the policy making process.

REFERENCES

Bislimi B, Muhaxheri E, Demukaj V, Bislimi F. 2006. Financial Sustainability of a Health Insurance Fund for Kosovo. Consultancy work on the "Strengthening capacity in the Ministry of Health, Kosovo" programme MoH - HLSP – RIINVEST Project.

Buwa D and Vuori H. 2006. Rebuilding a health care system: war, reconstruction and health care reforms in Kosovo. European Journal of Public Health. Oxford University Press.

Campbell J, Percival V and Zwi A. 2003. Ministerial Challenges: Post-conflict, Post-election issues in Kosovo's Health Sector. European Journal of Public Health 13: 177-181.

Donaldson C and Gerard K. 1993. Economics of Health Care Financing: The Visible Hand. London, The Macmillan Press Ltd.

Hoxha I. 2011. Health Insurance System in Kosovo: Are we being offered the right financing solution? FES.

Hoxha I, Shaipi K. 2009. Comparative Analysis of Health Insurance Schemes in SEE. FES.

Ministry of Health. 2011. Draft Law on health insurances.

Ministry of Health. 2012. Draft Law on health insurances.

Ministry of Health. 2011. Draft Law on health.

Ministry of Health. 2012. Draft Law on health.

Ministry of Health. 2012. Position paper on establishing health insurance fund in Kosovo.

Ministry of Health. 2011. Action plan for implementation of Health Sector Strategy 2010-2014.

Mossialos E, Dixon A, Figueras J, Kutzin J (ed). 2002. Funding Health Care: Options for Europe. Open University Press.

National Institute for Public Health. 2012. Analiza e Morbiditetit të popullatës së Kosovë për vitin 2011.

National Institute for Public Health. 2012. Analiza e gjendjes shëndetësore të popullatës në Kosovë për vitin 2010.

National Institute for Public Health. 2012. Analiza e gjendjes shëndetësore e nënës dhe fëmijëve për vitin 2010.

National Institute for Public Health. 2012. Health statistics yearbook: Human Resources in Public Health Institutions in Kosovo (situation 31.12.2011).

Schneider P, Langenbrunner J, Cho J, Kelmendi F, Tep S, Lebedeva V, Besimi F and Moll L. 2008. Kosovo Health Financing Reform Study. WB.

Valerie Percival and Egbert Sondorp. 2010. Case study of health sector reform in Kosovo. Conflict and Health 4:7. Accessed 12 August 2012 at http://www.conflictandhealth.com/content/pdf/1752-1505-4-7.pdf.

Qosaj FA and Berisha MK. 2010. Transition in Health and Health Care in Kosovo. Kosova School of Public Health.

Dobnikar B. 2010. Analysis of Health Sector Legal Framework Report. Sector Wide Approach in Health: Feasibility Study and Mapping - An EU funded project implemented by EPTISA.

FRIDOM. 2009. Vertical Functional Review of the Kosovo Ministry of Health. FRIDOM project.