Recommendations for Sustainability of Healthcare System Financing

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American Chamber of Commerce in Croatia Američka gospodarska komora u Hrvatskoj

Contents

Introduction

A quality and well-organized system of healthcare financing is a prerequisite for sustainable functioning of the healthcare system. The goal of each healthcare financing system is to ensure equal availability of quality healthcare services to users with the efficient, responsible and transparent use of available resources.

Although continuously increasing, healthcare expenditures per capita in the Republic of Croatia (RH) are among the lowest in the European Union (EU). At the same time, the share of public healthcare expenditures in total healthcare expenditures is among the highest in the EU, and healthcare coverage is universal with an exceptionally large scope of rights which are covered by funds from the compulsory health insurance.

Population health indicators such as the life expectancy at birth, which is more than three years shorter than the EU average, and the mortality rate related to diseases of the vascular system and malignant diseases, which is among the highest in the EU, point out not only the shortcomings in the way healthcare is provided but also the need for additional investments in the preservation of public health.

The possibility to increase funds for the healthcare system is limited by the existing legislative framework, i.e. the fiscal context and the way funds are collected in basic and voluntary health insurance funds.

Taking into account the population health indicators, the population's increasing needs for health care, primarily due to demographic changes, and the limitations of the current model of financing of the healthcare system in Croatia, it is necessary to consider new possibilities for financing the healthcare system as a prerequisite for financial stability and better efficiency and availability of quality healthcare for users.

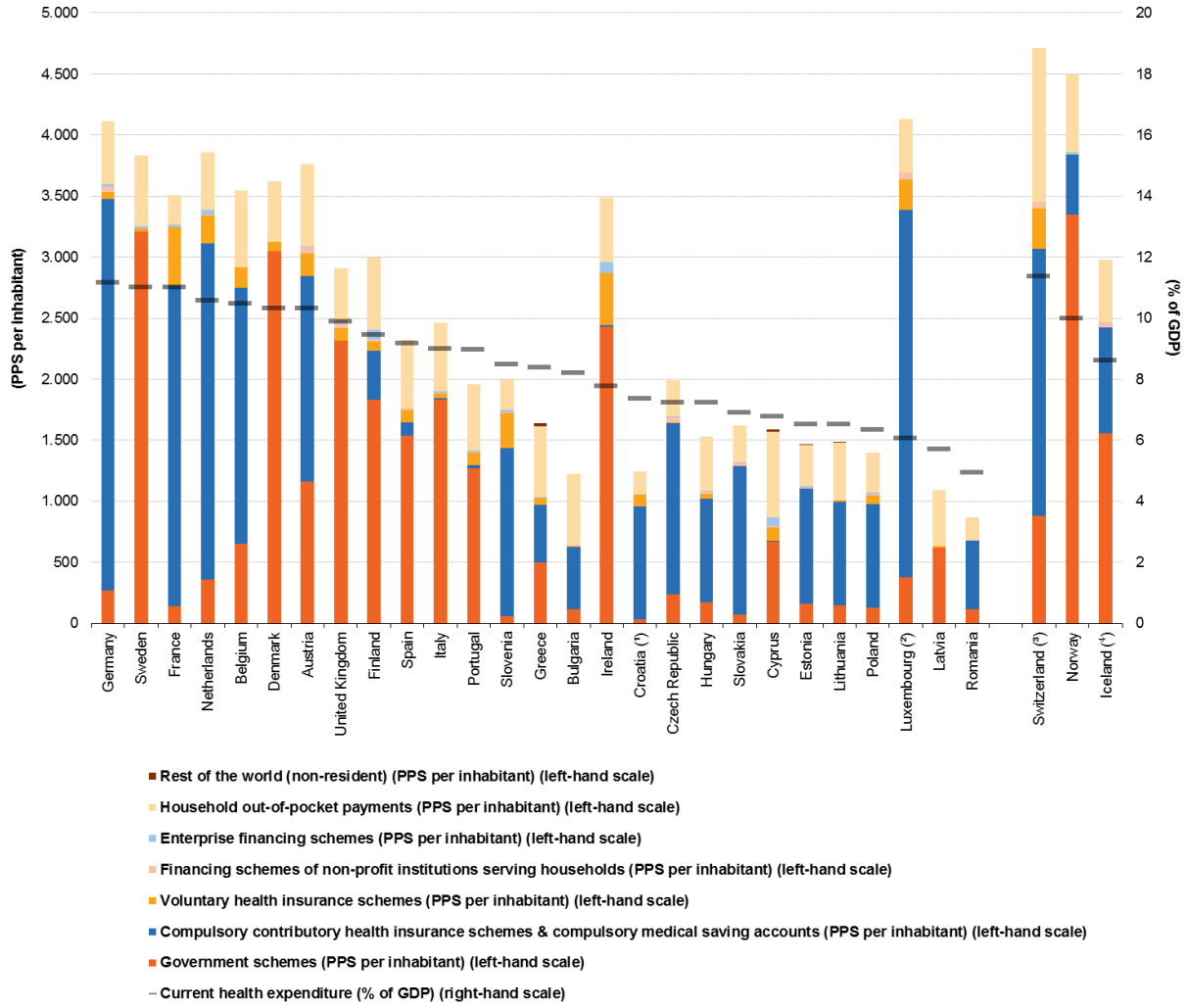
In this position paper AmCham wants to provide recommendations for improvements to the financing of the healthcare system in the Republic of Croatia.

Situation in Croatia

Healthcare expenditures

According to the latest data released by the Statistical Office of the European Union (Eurostat), Croatia's healthcare expenditure as a share of gross domestic product is less than the EU average (7.4% compared to 8.4%), and healthcare expenditures per capita adjusted to the purchasing power parity in Croatia are significantly lower than the EU average (€ 1,245 compared to € 2,431). [1]

Figure 1: Healthcare expenditure in Croatia compared to other EU states



Source: EUROSTAT

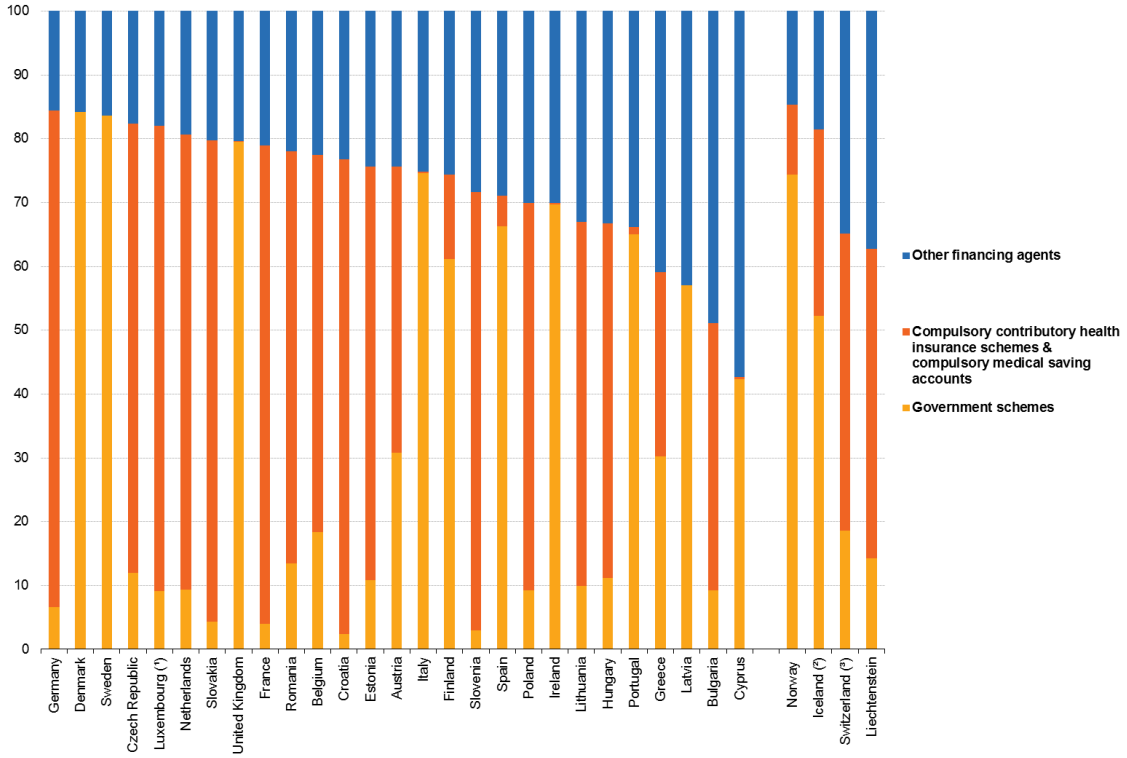
[1] EUROSTAT, *Healthcare expenditures statistics*. Available at: http://ec.europa.eu/eurostat/statistics-explained/index.php/Healthcare_expenditure_statistics

By applying the System of Health Accounts (*SHA*) methodology, healthcare expenditure data includes all expenditures for the healthcare of the population regardless of the source of funding (social security, voluntary insurance, household income). Since the Croatian Health Insurance Fund (HZZO), as the sole provider of basic health insurance services in the Republic of Croatia, in its annual reports on expenditures reports not only healthcare expenditures but also expenditures for various benefits, such as compensation for sick leave, disability benefits and maternity benefits, it is possible that reported data on Croatia's allocation for healthcare are unrealistically high. For example, reported HZZO expenditures for healthcare in 2017 amounted to 87.84% of total expenditures, while the benefits expenditures amounted to 10.46% of total expenditures of the HZZO. [2]

The sources of funding and financial flows

The share of public healthcare expenditure in the total healthcare expenditures in Croatia is about 78%, while the share of private expenditures is low and primarily related to direct payments of healthcare services from household income (paying "out of pocket").

Figure 2: Healthcare expenditure with regard to the source of funding



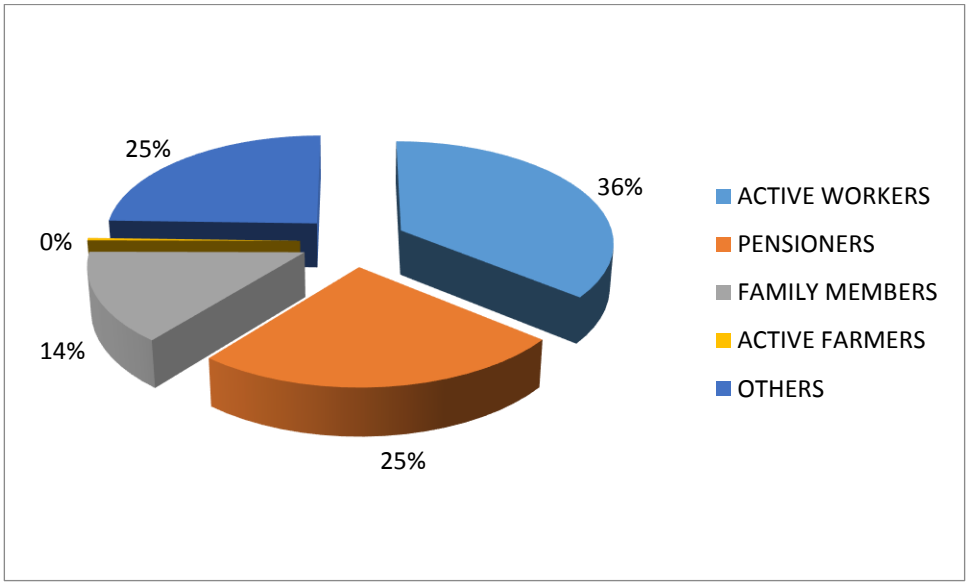
Source: EUROSTAT

[2] Croatian Health Insurance Fund (2018), *Croatian Health Insurance Fund Annual Report for 2017*. Zagreb: HZZO. Available at: http://www.hzzo.hr/wp-content/uploads/2018/04/Izvjesce_o_poslovanju_hzzo_01122017.pdf?b32def

The Republic of Croatia provides comprehensive healthcare to all citizens as part of compulsory health insurance (OZO) managed by the HZZO.

In 2017, a total of 4,244,232 persons were insured through the HZZO compulsory health insurance, of which there were 1,522,335 active (35.87%) and 2,721,897 other insured persons (64.13%).[3]

Figure 3: Participation of certain categories of insured persons in the total number of insured persons in Croatia for I - XII 2017



Source: HZZO

Sources of HZZO funding for compulsory health insurance predominately include:

- contributions for compulsory health insurance (86% of total revenue in 2017),
- revenue from state budget (9% of total revenue in 2017),
- revenue under special regulations (4% of total revenue in 2017).
- other revenue (1% of total revenue in 2017).

In 2017 the contribution rate for compulsory health insurance was 15% on gross salary, 0.50% for work injuries and occupational diseases, and 3% on pensions above 5,664 HRK.[4]

Revenues for financing compulsory health insurance from the state budget pursuant to Article 72 of the Compulsory Health Insurance Act consist of contributions for unemployed persons, revenue from special taxes on tobacco products (in the amount of 32% of the total revenue from the special tax on

[3] Croatian Health Insurance Fund (2018), *Croatian Health Insurance Fund Annual Report for 2017,* Zagreb: HZZO
[4] Ibid.

tobacco products), revenue from contributions for persons who have been deprived of their liberty by a decision of a competent court, additional contribution for pension insured persons under the pension insurance regulations and according to the Act on the Rights of Croatian Homeland War Veterans.[5]

Revenues in accordance with special regulations for financing compulsory health insurance include revenues from participation in the healthcare expenditures of the insured persons, or their insurers in the supplementary health insurance, revenues from compulsory motor vehicle liability insurance (in the amount of 4% of the paid functional premium of compulsory motor vehicle liability insurance), revenues from insurance for non-residents and other revenues.[6]

Voluntary health insurance is provided by insurance companies, including HZZO, which can contract *supplementary health insurance* (coverage of healthcare expenditures from compulsory health insurance which are not paid in full by HZZO), *additional health insurance* (coverage of healthcare expenditures of higher standard and greater scope of rights in relation to rights from the compulsory health insurance) or *private health insurance* which provides healthcare to individuals residing in Croatia who are not obliged to be insured pursuant to the Act on Compulsory Health Insurance and Health Insurance of Aliens in the Republic of Croatia.[7]

The share of voluntary health insurance in total healthcare expenditures amounts to approximately 8%.[8]

Direct payment of healthcare services from household income makes up the majority of total private healthcare expenditures. This includes the payment for healthcare services to private service providers and participation in healthcare expenditures for persons who do not have a supplementary health insurance policy (healthcare expenditures from the compulsory health insurance that HZZO does not pay in full to a maximum of HRK 2,000 per one issued invoice, primary healthcare examinations in the amount of HRK 10 and HRK 10 per prescription).

The share of expenditures related to direct payment of healthcare services from household income in total healthcare expenditures amounts to approximately 16%.[9]

[5] Official Gazette, *Compulsory Health Insurance Act* (OG No. 80/13, 137/13), Zagreb: Narodne novine d.d.
[6] Ibid.
[7] Ibid.
[8] EUROSTAT, *Healthcare expenditures statistics*. Available at: http://ec.europa.eu/eurostat/statistics-explained/index.php/Healthcare_expenditure_statistics
[9] Ibid.

Key challenges

Although continuously increasing, healthcare expenditures per capita in Croatia are among the lowest in the European Union.

In addition, the scope of healthcare rights covered from the compulsory health insurance funds is wide, without a clear definition of the type and amount of healthcare services that the insured persons have a legal right to.

Furthermore, there is a moral hazard problem, i.e. a situation when insured persons have an influence on increasing the cost of healthcare services by not avoiding the risks and by using compulsory health insurance services in the scope greater than objectively needed. This moral hazard problem arises primarily due to the fact that the majority of healthcare services covered by compulsory health insurance, especially in primary healthcare, are free of charge for the insured persons at the moment of use.

The Croatian healthcare system is predominately funded from the contributions for compulsory health insurance. In the context of demographic aging of the population and the ubiquitous emigration of the working population, this is expected to lead to a reduction in revenue from contributions for compulsory health insurance.

In the past few years, the Tax Administration of the Ministry of Finance responsible for organizing, monitoring and controlling the collection of contributions, has reported significant debts regarding payment of contributions for compulsory health insurance of a part of large employers in the Republic of Croatia.[10]

In addition, the transfers of funds from the state budget for certain categories of insured persons are not clearly agreed on between HZZO and the Ministry of Finance. For example, according to data and calculation of HZZO, the transfer of funds from the state budget to HZZO in 2016 should have amounted to HRK 4.2 billion, while the actual transfer of funds amounted to HRK 2.6 billion. At the same time, according to the State Audit Office's reports, the explanations of HZZO's financial plans are insufficient and do not include indicators used as the base for the calculation of the necessary funds to be transferred to HZZO for certain categories of insured persons, which would include a clear definition of rights from compulsory health insurance financed from the state budget for certain categories of insured persons, as well as the elements for calculating the funds that are to be allocated for each right to HZZO from the state budget.[11]

Due to the business losses of healthcare institutions and HZZO, during 2013 and 2014 a total of HRK 6.5 billion from the state budget was spent on rehabilitation of

[10]Republic of Croatia, State Audit Office (2018) *Report on conducted audit of the annual report on implementation of the state budget of the Republic of Croatia for 2017.* Zagreb. Available at: http://www.revizija.hr/hr/izvjesca/revizija-2018

[11] Ibid.

health institutions and HZZO. The aims of the rehabilitation were to meet the financial obligations within legal deadlines and to implement reorganization and rationalization measures in order to ensure business stability and prevent new losses. Although significant amounts of funds were spent on the rehabilitation, the planned aims were not achieved.[12]

[12] Ibid.

Examples of good practice from the EU

Netherlands

Healthcare expenditures

For more than 5 years the Dutch healthcare system has been rated the best healthcare system in Europe with regard to healthcare quality and availability (European Health Consumer Index, *EHCI*).[13]

According to the latest data released by Eurostat, Netherlands is among 5 EU states with the highest healthcare expenditure as a share of gross domestic product (10.6%), and the healthcare expenditures per capita adjusted to the purchasing power parity are significantly higher than the EU average (€ 3,857 compared to € 2,431).

The sources of funding and financial flows

Public healthcare in the Netherlands is provided through curative and long-term healthcare systems funded primarily from premiums paid by insurers, contributions paid by employers to employees and from the state budget.[14]

Compulsory payment by employer or employee is considered public healthcare and can be used with any service provider regardless of their ownership structure.

Public healthcare is compulsory and the insured person has no freedom of choice to direct the funds allocated on their behalf.

All Dutch citizens are covered by *compulsory health insurance* for a standard basic service package defined by the Health Insurance Act (*Zorgverzekeringswet, Zvw*). Compulsory health insurance is provided by private insurance companies. Citizens over the age of 18 are required to purchase a compulsory health insurance policy directly from the insurer, at premium price calculated on the basis of community risk (for example, in 2015 the average annual premium was € 1,211). For persons under the age of 18, the premium amount is covered by the state budget. In addition, employers are obliged to pay for each employee a contribution for compulsory health insurance to the tax administration in the amount depending on the amount of gross salary (for example, in 2015 the compulsory health insurance contribution was 6.95% of gross salary with the maximum contribution amount of €

[13] Health Consumer Powerhouse (2012–2017): *Euro Health Consumer Index Reports 2013, 2014, 2015, 2016, 2017.* Marseillan: Health Consumer Powerhouse

[14] Kroneman M. et all. (2016) Netherlands health system review. *Health Systems in Transition,* 18(2): 1 – 239. Available at: http://www.euro.who.int/__data/assets/pdf_file/0016/314404/HIT_Netherlands.pdf

3,573 per year). Collected funds are then awarded to insurance companies based on the population health risk profile that a particular insurer covers.[15]

For some categories of individuals and households the state provides a monthly healthcare allowance (in 2015 the maximum amount of allowance was € 78 for individuals, i.e. € 149 for households).[16]

All Dutch citizens are covered by *compulsory long-term care* in case of a need for 24-hour healthcare under the Long-Term Care Act (*Wet Langdurige Zorg, Wlz*). Long-term care is funded from the gross salary contributions paid by the employer to the tax administration (for example, in 2016 contributions for long-term care amounted to 9.65% of gross salary with the maximum contribution amount of € 3,241 per year).

In addition, funds from the state budget allocated to local communities are used to fund mental health of young people and preventive healthcare.[17]

Public healthcare expenditures account for about 82% of total healthcare expenditures.[18]

Direct payment of healthcare services from household income primarily refer to the compulsory participation of citizens over the age of 18 in basic healthcare expenditures by paying in advance the pre-established initial cost of basic healthcare "out of pocket" in each calendar year, after which additional costs are borne by the insurer (in 2016 mandatory initial participation in basic healthcare expenditures was € 385).[19]

Also, citizens are obliged to participate in the long-term care expenditures defined by complex schemes depending on the amount of their monthly income.

The share of expenditures related to direct payment of healthcare services from household income in the total healthcare expenditures amounts to approximately 13%.[20]

Voluntary health insurances provided by private insurance companies are mainly supplementary and include coverage of services that are not covered by the basic health insurance package.[21]

Voluntary health insurance as a share in total healthcare expenditures amounts to approximately 6%.[22]

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[15] Ibid.
[16] Ibid.
[17] Ibid.
[18] EUROSTAT, *Healthcare expenditures statistics*. Available at: http://ec.europa.eu/eurostat/statistics-explained/index.php/Healthcare_expenditure_statistics
[19] Kroneman M. et all. (2016) Netherlands health system review. *Health Systems in Transition,* 18(2): 1 – 239.
[20] EUROSTAT, *Healthcare expenditures statistics*. Available at: http://ec.europa.eu/eurostat/statistics-explained/index.php/Healthcare_expenditure_statistics
[21] Kroneman M. et all. (2016) Netherlands health system review. *Health Systems in Transition,* 18(2): 1 – 239.

Czech Republic

Healthcare expenditures

For more than 5 years the Czech healthcare system has been rated among the best healthcare system in the central and eastern Europe with regard to healthcare quality and availability (European Health Consumer Index, *EHCI*).[23]

According to recent Eurostat data, the Czech Republic is among the Central and Eastern European countries which allocate the highest share of gross domestic product to healthcare (7.2%) and whose per capita healthcare expenditures adjusted to the purchasing power parity are among the highest in the Central and Eastern Europe (€ 1,992).[24]

The sources of funding and financial flows

Public healthcare in the Czech Republic is secured through a compulsory health insurance system funded primarily by contributions on salaries and the state budget.[25]

Contribution for compulsory health insurance on gross salary is 13.5%, of which the employer pays 9% and the employee 4.5%. For certain categories of residents, the Ministry of Finance pays contributions from the state budget.[26]

Contributions for compulsory health insurance are paid to insurance companies which participate in the provision of compulsory health insurance. All insurance companies pass the paid funds to the General Health Insurance Fund (*Všeobecná zdravotní pojišťovna*, VZP), which redistributes funds to insurers based on the health risk profile of the population covered by an individual insurer.[27]

Healthcare coverage in the Czech Republic is universal with a large scope of healthcare rights covered from compulsory health insurance funds. Rationalization of public spending is carried out primarily through the restriction of services financed by compulsory health insurance funds, the establishment of lists of medicines and medical products, the annual negotiation of the conditions for the refund of services between insurers and healthcare providers and the participation of insured persons in healthcare expenditures.[28]

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[22] EUROSTAT, *Healthcare expenditures statistics*. Available at: http://ec.europa.eu/eurostat/statistics-explained/index.php/Healthcare_expenditure_statistics
[23] Health Consumer Powerhouse (2012-2017): *Euro Health Consumer Index Reports 2013, 2014, 2015, 2016, 2017.* Marseillan: Health Consumer Powerhouse
[24] EUROSTAT, *Healthcare expenditures statistics*. Available at: http://ec.europa.eu/eurostat/statistics-explained/index.php/Healthcare_expenditure_statistics
[25] Alexa J. et all. (2015) Czech Republic health system review. *Health Systems in Transition*, 17(1): 1 – 164. Available at: http://www.euro.who.int/__data/assets/pdf_file/0005/280706/Czech-HiT.pdf
[26] Ibid.
[27] Ibid.
[28] Ibid.

Public healthcare expenditures account for about 83% of total healthcare expenditures.[29]

Direct payment of healthcare services from household income mainly refers to direct payments for some services not covered by compulsory health insurance, the participation of insured persons in basic healthcare expenditures (user fee for medical examination, hospitalization, primary healthcare use outside working hours, medical prescription, co-payment to the full price for medicines whose price is covered by basic health insurance funds up to a reference price amount).

The share of expenditures related to direct payment of healthcare services from household income in the total healthcare expenditures amounts to approximately 15%.[30]

As a result of the universal coverage and broad scope of healthcare rights from compulsory health insurance, the market for voluntary health insurance is not very developed. Voluntary health insurance is mainly related to the coverage of healthcare expenditures when traveling abroad, the provision of better conditions for sick leave, health insurance for aliens who do not meet the insurance criteria through the compulsory health insurance system in the Czech Republic and the provision of certain services not covered by compulsory health insurance.

Voluntary health insurance as a share in total healthcare expenditures amounts to approximately 1%.[31]

[29] EUROSTAT, *Healthcare expenditures statistics*. Available at: http://ec.europa.eu/eurostat/statistics-explained/index.php/Healthcare_expenditure_statistics
[30] Ibid.
[31] Ibid.

Recommendations

Bearing in mind the indicators of the health status of the population, the increasing needs of the population for healthcare primarily due to demographic changes, limitations of the current model of healthcare financing in Croatia and the good practices of countries with the best healthcare systems in Europe, AmCham proposes that additional funding and rationalization of financing of the compulsory health insurance system should be ensured in the following ways:

Increasing compulsory health insurance revenues

1. Ensuring effective control of contribution payments for compulsory health insurance by the Tax Administration as the competent authority, provided that there are adequate sanctions for employers who violate the statutory obligations. This would ensure the payment of contributions for compulsory health insurance by employers in the prescribed manner.
2. Defining the rights deriving from the compulsory health insurance and the elements for the calculation of funds needed for securing these rights by the HZZO, in order to harmonize between the HZZO and the Ministry of Finance the amount of funds from the state budget that the Ministry of Finance is obliged to pay for certain categories of insured persons.
3. Increasing user participation in the cost of compulsory health insurance by introducing a predetermined initial amount of healthcare expenditures that the insured should paid directly in each calendar year, after which further costs should be borne by the insurer. Certain categories of insured persons, i.e. certain health conditions, are excluded from this model of participation in compulsory health insurance expenditures (for example, healthcare for children under 18, women's healthcare related to pregnancy and childbirth, healthcare in relation to infectious, psychiatric or malignant diseases, hemodialysis).
4. Increasing user participation in the cost of compulsory health insurance by increasing the maximum amount of participation in hospital healthcare expenditures (up to a maximum of 120.26% of the calculation base defined in the State Budget per single invoice instead of the current maximum of 60.13% of the calculation base).
5. Introducing the possibility of covering healthcare expenditures through grants, donations and charitable contributions by international or domestic legal persons.
6. Introducing the lowest monthly base for calculation of the contribution for compulsory health insurance based on the pension insurance system model:

the lowest monthly base amount for calculating the contribution for compulsory health insurance = average salary x 0.38

For example, in 2017 the lowest monthly base amount for calculating the contribution for compulsory health insurance would amount to HRK 3,047.60 (HRK 8,020.00 x 0.38), i.e. HRK 36,571.20 per year.

In this way, the number of persons who pay a mandatory contribution for compulsory health insurance based on the regulated status of insured persons whose status is currently not clearly regulated by Article 72 of the Compulsory Health Insurance Act would increase.

Rationalization of funding of compulsory health insurance

1. Defining the rights deriving from the compulsory health insurance by the HZZO, together with the revision of the scope of healthcare rights from compulsory health insurance, i.e. defining the "services package" covered by the compulsory health insurance funds.
2. Defining the obligations of insured persons regarding the compulsory health insurance (for example, arriving at a scheduled medical examination, timely cancellation of the scheduled appointment, going to preventive medical examinations).
3. Introducing a user fee for irresponsible behavior of the insured person (for example, not arriving at a scheduled medical examination without timely cancellation, failure to collect examination results, not going to preventive medical examinations).
4. Introducing the highest monthly base for the calculation of the contribution for compulsory health insurance based on the pension insurance system model:

   the highest monthly base amount for calculating the contribution for compulsory health insurance = average salary x 6

   For example, in 2017 the highest monthly base amount for calculating contribution for compulsory health insurance would amount to HRK 48,120.00 (HRK 8,020.00 x 6), i.e. HRK 577,440.00 per year.

These proposals would require minimal changes to the legal framework for financing the healthcare system and would result in an increase of available funds and more efficient spending of financial resources in the public healthcare system.

Long-term planning of the financing structure of the healthcare system in the context of encouraging Croatia's competitiveness

As a long-term measure of increasing the efficiency of financing of the healthcare system, we propose to also consider unburdening employers with regards to paying contributions for compulsory health insurance by reducing the contribution rate for compulsory health insurance they are obliged to pay and by introducing a contribution rate for compulsory health insurance that the employee would be obliged to pay.

In fact, the contribution rate for compulsory health insurance of 15% without the established maximum is high and significantly influences the increase in labor costs in Croatia. In addition, unlike other EU countries, payment of contributions for compulsory health insurance is an exclusive obligation of the employer while the employee has no obligation to participate in the cost of contributions for compulsory health insurance. The high contribution rate for compulsory health insurance which is entirely borne by the employer consequently makes the Croatian labor market less competitive.

Figure 4: Comparison of contribution rates for compulsory health insurance: Slovenia, Czech Republic, Netherlands and Croatia

EU state	**minimum gross salary (local currency)**	**maximum gross salary (€)**	**contribution for compulsory health insurance - employer rate**	**contribution for compulsory health insurance - employee rate**	**contribution - total rate**	**contribution for compulsory health insurance - employer (€)**	**contribution for compulsory health insurance - employee (€)**	**total contribution for compulsory health insurance (€)**
Slovenia	843.00	843.00	6.56%	6.36%	12.92%	55.30	53.61	108.92
Czech Republic	12,200.00	488.00	9.00%	4.50%	13.50%	43.92	21.96	65.88
Netherlands	1,578.00	1,578.00	6.95%	9.65%	16.60%	109.67	152.28	261.95
Croatia	3,430.00	446.00	15.00%	0%	15.00%	66.90	0.00	66.90

It is to be expected that this will result in a reduction in foreign direct investment in the Croatia and a more difficult retention of the labor force, especially those highly qualified.

The introduction of this change should be carried out with the revision of the overall salary tax policy in such a way that the introduction of the obligation to pay contributions for compulsory health insurance for the employee is accompanied by the change of the income tax rate so that ultimately the net salary of the employee remains unchanged.

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