Reform of Health Insurance in the Federation of Bosnia and Herzegovina

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The aim of this report is to provide an overview of the reform of health insurance in the Federation of Bosnia and Herzegovina (FBH). Health financing and resource allocation policies in the FBH are also summarized. Health financing should be ensured through three types of health insurance: compulsory, supplementary, and voluntary. The revenues for the compulsory health insurance will be earmarked through payroll taxation. Facing the scarcity of resources, the Federation authorities have decided to raise the proportion of the payroll contribution as compared to the pre-war level and engage in various arrangements of cost-sharing and priority setting in health care. The resource allocation policy underlines two key parts of the health care reform: contracting mechanisms and payment systems. We also discuss the optimal correlation between solidarity and competition in the course of the ongoing reform of the health insurance in the Federation. The social function of a competent health system, where the well-being of the population is viewed as a sociological category of the overall society's concern, requires considerable subsidization. Incentive-based market mechanisms may be introduced into some of the segments of health care system but only under government-led control of the effects of such measures.

Key words: Bosnia and Herzegovina; health care; health expenditures; health insurance; health plan implementation; hospital costs; insurance, health; planning, health and welfare; resource allocation reform

The Federation of Bosnia and Herzegovina (FBH) was established as an entity within Bosnia and Herzegovina in 1994, covering the area controlled by the Army of Bosnia and Herzegovina (BH) and the Croatian Defense Council at the time. FBH is a complex state of two constituting nations, consisting of ten federal units or cantons with a considerable autonomy. According to the 1991 census, the population of the BH stood at 4,377,033. The population residing in the area corresponding to the Federation today is 2,759,961 or 63% of the overall population in BH. The war had severe implications for the demographic structure and trends. According to the data of the Federal Institute for Statistics, in mid 1996 the population in the Federation stood at 2,253,606, which is a decline of 18.3% compared to 1991 (1).

The organization of health care in the Federation is based on two constitutions: the BH Constitution (commonly called "the Dayton Constitution") and the Federal Constitution. The BH Constitution defines health care as the domain under the full authority of the entities. Not a single portion of this domain is under the full authority of the BH government. However, there are functions that would seem rational to perform jointly, whereas institutionalizing of these functions is not judged unattainable. The spirit of this intermediary option from the Constitution has been translated into the two major laws concerning health care: Law on Health Care and Law on Health Insurance (2,3).

The four years of war, as well as prominent social, economic, and demographic changes in BH affect the pace of the health care reform. Demographic changes (refugees and displaced persons), a large...
number of the wounded and disabled, newly emerging environment factors affecting health (housing, water supply, nutrition, etc), significant changes in the health status of the population, devastation of health facilities and medical equipment during the war, outflow of medical professionals, all still affect and will be affecting the development of the health care reform in the Federation. The preceding health care system in BH was grounded on anarchic planning and financing from the revenues levied by the health insurance company. The health system provided full health care coverage to its consumers in the pre-war economic and social environment. However, the present situation is utterly different and therefore it is necessary that a system be ensured through the health care reform in the Federation, with rationalized structure and function and controlled expenditures, while new attitudes and fashion of the problem resolving must be adopted. The main objectives of the health financing reform in FBH are: (a) to control the expenditures on the macro level; (b) to improve the institutional efficiency; (c) to promote the principles of solidarity; (d) to develop instruments for the implementation of the health policy objectives through the contracting process; (e) to develop a sustainable health financing system by means of establishing three types of health insurance and also by mobilizing all available resources in the community for health care; and (f) to establish a uniform health care system in the Federation, which will be based on the cantonal organization as opposed to the ethnical organization.

It is essential to review the financial resources in the health sector available during the pre-war and post-war period, as well as projections for the future (Table 1). In 1990, the overall health expenditures were 8.2% of the gross domestic product (GDP). Health care resources were collected through compulsory contributions from gross salaries, with the average contribution rate of 12%. At the same time, overall health expenditures per capita were DM364 (1).

Table 1. Available resources in the health sector of the Federation of Bosnia and Herzegovina in the 1990-2000 period

During the war, the contribution rate for health care was 25% of net salaries within the provisional administrative arrangement of the Croat Community (for some time Republic) of Herzeg-Bosnia (HR H-B, administrative self-organizationm of the Croat community in BH during the 1992-1885 war). Health sector was financed by Health Insurance Fund of HR H-B, and other domains were financed from humanitarian assistance. Average per capita resources were DM115 in the period 1995-1997, and DM133 in 1998. During the war, contributions to health sector remarkably declined on the territories controlled by the BH Army (DM10-40 per capita annually in the 1992-1995 period). However, in the post-war period a trend of rapid increase (DM95 in 1996 and DM130 in 1997) has been noted. In 1998, per capita contributions to health insurance within both former administrative arrangements in the Federation have been approximately the same. Projections for 2000 state that per capita contribution will be around DM150. In accordance with the decision of the BH Presidency during the war, applicable on the territories controlled by BH Army, the Health Insurance Fund stopped operating as an institution. Health care was financed directly by the Ministry of Health. Although the contribution rate was increased from 12% to 19%, the available resources in the compulsory health insurance were sufficient to cover only a smaller proportion of health care needs (10-20%). The most important domain was financed from the state budget, as well as from humanitarian assistance.

Health Financing Policy in the Federation of Bosnia and Herzegovina

The Federal Ministry of Health is responsible for sustainable ensuring of sufficient funds for health care in compliance with the socially approached health care concept. Such efforts must be invested while considering two principles of major importance:

1. Since many consumers and regions in the country do not posses a sufficient amount of money for financing their health needs, it is necessary to introduce the solidarity scheme.
2. Health financing must be clearly regulated so that the health insurance funds may be organized to deal with the funds in a socially responsible and, at the same time, autonomous way.

Our orientation to the health financing system that is based on health insurance is a continuation of the activities which had already been realized in BH in the decades before the war. Namely, the payroll contributions levied for health insurance had never been a part of the governmental budget but had been directly paid into the health insurance funds. The new legislation is in line with the political orientation of the Government of the FBH asserting that the major portion of health care expenditures should be covered from the cantonal health insurance funds, and not from the federal budget.

The Law on Health Insurance (3) brings in that the financing of health care should be provided through three types of health insurance: (a) compulsory health insurance – which will cover the basic
package of health services; b) supplementary health insurance – which may be introduced by the cantonal parliaments for their citizens as a compulsory financing of extended rights; and (c) voluntary health insurance – where the entitlements and obligations of the insurer and subscribers are defined by their mutual agreement.

Facing the scarcity of resources, Federation authorities have decided to raise the proportion of the payroll contribution as compared to the pre-war level (from 12% up to 18%) and engage in various arrangements of cost-sharing (co-payment) and priority setting in health care (the basic package of health services). The Law conceives the potential for merging two or more cantonal health insurance funds into a single one if stipulated by the necessity of a broader solidarity or reduction of administrative costs of the funds’ operations.

The revenues for the compulsory health insurance will be levied through payroll taxation and not through health insurance premiums or general taxation. The rate of contributions is expected to reduce with the increase of the GDP rate. The aim of introducing cost-sharing in the Federation is to raise additional funds needed for regular operations of the health care system. Broadly-based exemptions from cost-sharing will alleviate inequalities in financing for people with the low level of income and inequalities in health services to the elderly, children, and chronic patients.

Setting the priorities in health care to be covered by the compulsory health insurance will be comprehended in the basic package of health services before December 1998. The basic package of health services will guarantee the same rights to all citizens of the Federation and also respect the principles of solidarity and equity. In view of the social approach to the health care concept, the services which are not included in the basic package can be left to the individual responsibility of the citizens. It is expected that additional funds may be raised by establishing private health insurance companies. The private companies will be allowed to cover extra risks on the voluntary basis, but may not cover the services already encompassed by the scheme of compulsory health insurance. Since the competition between health insurers tends to erode solidarity in health care financing inasmuch as health insurers seek to select good risks, strategies for regulating the operations of these private companies are currently being discussed.

Resource Allocation Policy in Health Services
The Ministry of Health of the Federation considers resource allocation in health care to be the quintessential area of the health system reform since resource allocation determines the ways of distribution of the funds raised both in geographic regions and at some of the health care levels. There are two main areas for a more effective resource allocation aimed at ensuring cost control at the macro level and improving institutional efficiency: contracting mechanisms (including purchasing mechanisms for pharmaceuticals) and payment systems for health professionals and institutions.

The federal budget will cover the operations of the federal public health institutes, as well as the tertiary level of health care in hospitals and clinical centers. Contracting between health insurance funds and health institutions is viewed as an instrument to implement health policy objectives. It is a coordinating mechanism that offers an alternative to the traditional command-and-control model of health care management. The essential element of contracting is introducing a market-oriented form of institutional resource allocation based on separating the financier from health services providers. The contracting mechanisms oblige both parties explicitly and generate economic incentives so that these obligations may be executed. The main reasons for the future promotion of the contracting mechanisms in health care are: (a) to encourage decentralization of management; (b) to improve the performance of providers; (c) to improve planning of health care development; and (d) to improve management of care.

Contracts can support equity if, through needs assessment, they take explicit account of vulnerable and disadvantaged groups, as well as underserved communities. From this perspective, purchasers represent the interests of their populations, allocating resources and purchasing services in accordance with their needs. However, contracting also carries dangers that can undermine equity. For example, services that are less profitable, which does not imply less efficient, may be underemphasized or phased out. Contracting may often be restricted by insufficient information systems. Minimal information prerequisites for effective contracting encompass a database on the flow of patients, costs, and consumption of services of various specialties or diagnostic groups, as well as a database on demographic groups and groups at risk.

Community participation in contracting can lead to a process of democratization in health services, increase of the accountability of the government and the medical profession, and make health policy more relevant to the needs and priorities in society. The process of contracting can be divided into three stages: pre-contracting, the actual contract or written agreement, and post-contracting. Community participation can take place in all three of these stages.

One of the central principles that should be respected in the process of contracting is that health care
expenditures must keep level with the resources available in the health insurance funds. Exiguous funds must be spent rationally and according to the health care priorities set in the community, so that the invested money produces maximum effects on health improvement. The efforts invested in strengthening primary health care will not be fruitful unless the funding proportion of this health care level is increased as compared to the proportion of hospital health care. The Federal Ministry of Health is well aware of the fact that the overall expenditures on health care are to a great extent affected by health services payment systems. There is ample evidence that physicians use their discretionary power to increase the quantity and alter the mix of services, thereby maintaining their target income. It is generally maintained that mixed payment systems "with a large prospective component" may result in a variety of incentives, may improve the desired performance or penalize improper delivery of health services, which leads to a more successful combining of macro and micro efficiency objectives.

Family Medicine

Family medicine physicians in primary health care will be paid through capitation scheme for each patient registered with a health services provider, and this payment will be a basic level of their income but only up to the maximum number of patients. The income paid in this way may vary depending on the area where the physicians perform (urban or rural). Incentive payments are foreseen as well for various achievements (i.e., immunization of children or conspicuous results of health promotion). Fee-for-service can be introduced in the practice of outpatient departments, but only as a minor portion of the total income. The proposed payment system tends to give physicians incentives to practice preventive medicine and control expenditures, but may also lead to a better geographical distribution. However, payment systems are only one among several determinants of professional behavior, such as professional standards, access to education and professional expectations.

Hospitals

The reform of hospital payment mechanisms affects the control of expenditure, quality of services and accessibility of services to the community. The hospitals that are a part of the health institutions network will be paid prospectively via global budgets provided to the hospital for a given period of time. The budget may be calculated according to actual costs, historical patterns of expenditure, provisions of beds, population covered, or volume of services to be provided. In light of the prevailing economic situation in the country and absence of control of the overall health expenditures, fee-for-service cannot be accepted as the basic method of payment within public sector in the Federation.

Pharmaceuticals

The allocation of resources for pharmaceuticals is a delicate issue given the increasingly central importance of this field in the performance of health institutions, as well as the high proportion of pharmaceutical expenditures in the overall health care expenditures. A broad specter of measures aimed at the control of expenditures and the increase of the quality of drug prescribing is foreseen, these measures being the measures on the supply side, measures on the demand side and market-oriented measures.

Role of the Market and Privatization of Health Services

The new Law on Health Care (2) supports a social approach to health care issues in the Federation as opposed to purely market-oriented approach. Health of the population is of major sociological interest for the society as a whole and therefore cannot be entirely left to the simplified demand-and-supply market rules. Therefore the state, as a representative of the community, must possess the instruments to control the health care system. These instruments must correspond to the substantive global economic and social changes in the countries in the process of transition. Decisions to introduce more market-based incentives into one or more sub-sectors of the health system require somewhat altered activities of the government which, in any case, are not to be reduced. The government of the Federation will have to show more competence in the course of monitoring the contracting between the health insurance funds and health care providers, as well as the control of market arrangements than when directly commanding the system. Incentive-based market mechanisms may be introduced into some of the segments of the health care system, but only under government-led control of the effects of such measures.

One among the reform objectives is privatization as the ultimate form of decentralization. The health care privatization strategy will be developed by the working group nominated by the Ministry of Health of the Federation. The process of privatization must not be chaotic or entangle all sub-sectors of the health system simultaneously. There is a political commitment to restrict privatization to family medicine offices at the primary health care level. Such approach will serve a strong incentive to family medicine physicians. It is important to underline that the payment of health care services in the private
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Solidarity in health care financing, because health insurers seek to select good risks, two groups of income solidarity, while risk solidarity will be limited. It is to be expected that solidarity will be additionally eroded with the higher level of private health insurance, which functions parallel to or mixed with public financing. Considering that competition between health insurers tends to erode solidarity in health care financing, because health insurers seek to select good risks, two groups of strategies for regulating the operations of private insurers are being considered: mandatory open enrolment and the introduction of either individual or collective risk adjustment schemes that redistribute the health insurance system’s revenue among competing health insurers. Solidarity will be significantly reduced by limiting the health entitlements contained in the basic package of health services. Nevertheless, our health care system will manage to achieve an ethically acceptable level of solidarity, because it will be able to implement a fairer distribution among age groups, social classes, individuals and families and among good and bad health risks. Broadly based exemptions from cost-sharing will alleviate inequalities in financing for people with low income and inequalities in health services delivery to the elderly, children and chronic patients.

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for the following reasons: (a) the rate of contribution represents the same percentage of salaries or income; (b) there is no taxation ceiling; and (c) there are no possibilities of dropping out of the compulsory health insurance.

Ongoing Activities in the Process of Health Financing Reform
The international community has assisted the health financing reform in the Federation with significant financial resources. Two major projects on this issue have been financed by the Government of the Great Britain (through the Know How Fund) and European Commission (the PHARE Program). The World Bank and World Health Organization have also expressed their interest in these reforms. What the international community wants to witness is that the Government of the Federation has a clearly conceived concept of the reform of this sector. One of the prerequisites for future investments in health care system in the Federation is to ensure that our system proves sustainable.

References

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