REVIEW ARTICLE
PREGLEDNI RAD

https://doi.org/10.2298/SGS2302095G
UDC: 614.2:336(497.11)"2004/2020"

Overview of changes in the health sector and its financing in the Republic of Serbia in the period 2004–2020

Milena Gajić-Stevanović, Ivan Stevanović

NGO Health Monitor, Belgrade, Serbia

SUMMARY

Introduction In the period from 2004 to 2020, many reforms were implemented in the health sector of the Republic of Serbia and it's financing. The aim of this work was to provide an insight into foundations on which healthcare was based in the Republic of Serbia in the period from 2004 to 2020 and review the reform changes in the healthcare sector and it's financing.

Material and method A retrospective analysis of data from the National Health Account of the Institute of Public Health of Serbia, the regulations of the Republic Health Insurance Fund, reports of the Ministry of Health as well as laws and regulations related to the health sector was performed.

Results The results of the analysis showed that the State health sector represented the foundation of the health system in the Republic of Serbia in the observed period. Of the total health financing, it was estimated that about sixty percent were public financing schemes, and about forty percent belonged to private schemes, with a large part of private schemes being out-of-pocket payments.

Conclusion The general conclusion of the analysis is that in the observed period, within the framework of the reform changes, Serbia had a good system of exemption from participation, but that out-of-pocket payments for certain health services and corrupt payments represented a barrier to health care.

Keywords: Health sector reform; health care financing; basic benefit package

INTRODUCTION

The health care system of the Republic of Serbia is based on the principles of mandatory health insurance. The Republic Health Insurance Fund (RHIF) is a national organization through which citizens exercise their right to health insurance and finance health care. RHIF finances the functioning of health care at all levels, contracts the provision of services with public and private health institutions, controls the implementation of the obligations assumed when contracting with them, defines the basic package of health services.

Due to the lack of an adequate network of private health insurance, private health financing is mainly based on out-of-pocket payments, supplemented by the participation of a small number of large companies. The mentioned companies have (and finance) their own health institutions that specialize in the treatment of occupational diseases, and also provide all services in the domain of primary health care.

The aim of this work was to provide an insight into the foundations on which healthcare was based in the Republic of Serbia in the period from 2004 to 2020 and review the reform changes in the healthcare sector and it's financing.

MATERIAL AND METHOD

A retrospective analysis of data from the National Health Account of the Institute of Public Health of Serbia, the regulations of the Republic Health Insurance Fund, reports of the Ministry of Health as well as laws and regulations related to the health sector was performed.

RESULTS

In the period from 2004 to 2020, of the total health financing, it was estimated that about sixty percent were public financing schemes, and that about forty percent belonged to private schemes, with a large part of private schemes consisting of out-of-pocket payments [1]. About 1.5% of the 60% of public funding schemes were directed at funding private healthcare providers, and the rest at public providers. Of the 40% of private funding schemes, it was estimated that 35% were directed towards private healthcare providers and 5% towards public providers.

Within the public sector of health care financiers in the Republic of Serbia, the predominant financier was the Republic Health Insurance Fund (RHIF) with a share of around 94% [1]. RHIF was financed from the contributions of employees and employers in the amount of 67%, 22% from the PIO Fund, 4% from the contributions of the self-employed, and 7% from state transfers on behalf of special vulnerable groups of the population [1].

Public health care was provided directly through the network of health institutions defined by the Regulation on the Plan of the Network of Health Institutions [2]. According to the network plan in 2020, there were 313 health institutions (without institutions from Kosovo and Metohija) at the primary, secondary and tertiary levels.

Address for correspondence: Milena GAJIĆ-STEVANOVIĆ, Cvijićeva 72, Belgrade, Serbia; *mima_gajic@yahoo.com*

In the observed period, the Ministry of Health owns the majority of health institutions and directly finances them mainly through capital investments. The Ministry of Finance transfers funds to the RHIF for providing health care for vulnerable uninsured groups: the long-term unemployed, uninsured elderly and very young people, as well as migrants, refugees and internally displaced persons.

Donations from foreign countries and international organizations are also transferred to RHIF. Local government contributes to health financing, mainly for investment purposes.

Payment model for primary and secondary health care

The health reform between 2004 and 2020 transformed the health service and focused on primary health care and prevention over curative care, in order to reduce the rate of curable diseases and reduce health expenditure.

Capitation was chosen as the payment model for primary health care (application of the capitation formula began in November 2012 in primary health care institutions) and the model of diagnostically related groups (DSG) for payments in secondary health care.

There were key changes in the capitation formula in 2020 established by the Regulation on the corrective coefficient in the capitation formula [3].

In addition to corrective factors such as the age of the patient, a corrective factor for population density, specific quality indicators for each specialty, the aforementioned Regulation also introduced corrective factors of efficiency and diagnostic-therapeutic procedure (DTP) as corrective factors for all specialties.

For diagnostically related groups, changes are taking place in the way of hospital reporting and budget modeling. It is gradually moving from the retrospective method of paying for health services, which was based on the historical budget, to a prospective payment system based on diagnostically related groups.

Laws regulating health care

The provision of health care in the Republic of Serbia is regulated by: the Law on Health Care, the Law on Health Insurance and the Law on Public Health. The Constitution of the Republic of Serbia defines the Republic of Serbia as the state of the Serbian people and all its citizens, establishes the rule of law and social justice, the principles of civil democracy, human and minority rights and freedoms, as well as belonging to European principles and values [4]. According to the Article 68 of the Constitution, everyone has the right to the protection of their physical and mental health according to the principle of solidarity in financing and the principle of equality in access to health care.

Compulsory health insurance is organized on the principle of: obligation, solidarity and reciprocity, protection of the rights of the insured and protection of public interest, continuous improvement of the quality of compulsory health insurance and economy as well as efficiency of compulsory health insurance [5]. The principle of compulsory insurance refers to the obligation to pay contributions for compulsory health insurance based on 12.3% until 2014 and from then until today 10.3% deduction from salary [6]. Regardless of the amount of available funds and fluctuations in health care costs, in the observed period, the Law on Health Care and the Law on Health Insurance define the basic package of health services. Under these laws, compulsory health insurance covers (A) non-work-related illnesses and injuries and (B) work-related injuries and illnesses [3].

In addition, mandatory health insurance funds cover the costs of rehabilitation, procurement of medical-technical equipment, prescription drugs, sick leave (longer than a month), transportation costs related to the use of health care, etc. Sick leave up to 30 days are covered by the employer and there is no regularly collected data on them by the state. Social care for health is achieved by providing health care to groups of the population with an increased risk of disease, health care of persons in connection with the prevention, control, early detection and treatment of diseases and conditions of greater public health importance, as well as health care of the socially vulnerable population, under equal rights on the territory of the Republic of Serbia [7].

The basic package of health services represents the services that are provided from the funds of mandatory health insurance, according to the Article 52 of the law on health insurance, the nomenclature (name and description) of health services and the price list of health services from mandatory health insurance. The basic package consisted of:

1. measures for prevention and early detection of diseases;
2. examinations and treatment related to family planning, during pregnancy, childbirth and up to 12 months after childbirth;
3. examinations and treatment in case of illness and injury;
4. examinations and treatment of diseases of the mouth and teeth;
5. medical rehabilitation in case of illness and injury;
6. medicines;
7. medical means [5].

According to the Law on Health Insurance, insured persons are fully covered without any co-payment for: preventive measures and early detection of diseases, screening and treatment for family planning, pregnancy, childbirth and postpartum care, including termination of pregnancy for medical reasons, examinations, treatment and medical rehabilitation in case of illness and injury of children, pupils and students until the end of the prescribed schooling, and at the latest until the age of 26, i.e. elderly persons with severe physical or mental disorders, examinations and treatment of mouth and dental diseases related to pregnancy and 12 months after childbirth, examinations and treatment of infectious diseases that are legally required to implement measures to prevent

their spread, examinations and treatment of malignancy, diabetes, psychosis, epilepsy, multiple sclerosis, progressive neuromuscular diseases, cerebral palsy, paraplegia, tetraplegia, permanent chronic renal insufficiency that indicates dialysis or kidney transplantation, systemic autoimmune diseases, rheumatic diseases and their complications, rare diseases, palliative care, examinations and treatment in connection with the collection, application and exchange of organs, cells and tissues for transplantation, examinations, treatment and rehabilitation from occupational diseases and injuries at work, provision of emergency medical and dental assistance, as well as emergency medical transport [5].

If the content and scope of the right to health care from the mandatory health insurance cannot be realized due to insufficient funds, the Government passes an act that determines the priorities in the provision and implementation of health care. Also, the Government every year, on the proposal of the Minister of Health, passes an act that determines the priorities in the treatment of patients with certain types of rare diseases, for which funds are provided in the budget of the Republic of Serbia.

The percentage of co-payment coverage varies depending on the type of health service:

- In the amount of at least 95% of the price of health services from the mandatory health insurance funds for: intensive care in a stationary health facility, surgical procedures performed in the operating room, including the installation of implants for the most complex and expensive health services, the most complex laboratory, X-ray and other diagnostic and therapeutic procedures (magnetic resonance imaging, scanner, nuclear medicine, etc.);
- In the amount of at least 80% of the price of health services from the funds of the mandatory health insurance for: examinations and treatment at the selected doctor and specialist, laboratory, X-ray and other diagnostic and therapeutic procedures, home treatment, dental examinations and treatment related to injuries to teeth and bones faces, as well as dental examinations and dental treatments before heart surgery and transplantation of organs, cells and tissues.
- Also, for the treatment of caries complications in children, students and students until the end of the prescribed period of schooling, and at the latest until the age of 26, tooth extraction as a result of caries, as well as the development of mobile orthodontic appliances, inpatient treatment and rehabilitation in an inpatient health facility, examinations and treatment in a day hospital, including surgery outside the operating room, outpatient medical rehabilitation, some medical devices.
- In the amount of at least 65% of the price of health services from the mandatory health insurance funds for: fabrication of acrylate total and subtotal dentures for persons over 65 years of age, eye and hearing aids for adults, gender change for medical reasons, non-emergency medical transport, treatment of diseases, early detection of which is subject to targeted preventive screening, i.e. screening, in accordance with the relevant national programs, if the insured person did not respond to a single call within one call cycle, or justified his absence, and was diagnosed with a disease by the next call cycle.

Health services that are not described in the Basic package of services are services that the insured person pays from his own funds, at prices determined by the health care provider.

The negative list of health services is a list of interventions, services and products that are generally paid out of pocket in public or private health institutions, and are not included in the list of the basic package of services.

The new Health Insurance Law that came into force in 2019, provided more rights to use health services such as medical gender reassignment and artificial insemination for women [5], compared to the 2005 law.

Costs of health care users for medicines and health aids

In its contracts with public institutions, the Republican Health Insurance Fund approximates in advance the participation that each institution realizes. The approximate amount is deducted from the funds transferred to the institutions. The amount of the approximate participation is 1-3% of the total income of health institutions.

The State of Serbia adopts by-laws and regulations that regulate the scope of the right to health care from the mandatory health insurance, which also includes the right to medicines. The population's costs for medicines and auxiliary means make up about sixty percent of their total direct costs for health care, although RHIF also invests significant financial resources [1].

According to the RHIF rulebook [8] in the list of drugs that are prescribed and issued on the basis of mandatory health insurance, all drugs are divided into 5 basic groups.

1) A. Prescription drugs (List A, drugs that are issued with a fixed co-payment - 50 dinars per prescription);
2) A1. Medicines that are prescribed and issued in the form of a doctor's prescription, which have a therapeutic parallel (therapeutic alternative) to drugs from List A (List A1 drugs are issued with a 10 to 90% co-payment per package);
3) B. Medicines used during outpatient or hospital treatment in health institutions (List B, medicines dispensed without co-payment);
4) C. Medicines with a special regime (List C, medicines that are issued without co-payment);
5) drugs that do not have a license to be placed on the market in the Republic of Serbia, but are necessary for diagnosis and therapy - unregistered drugs, and exceptionally drugs are registered in the Republic of Serbia with the same generic name (IGN) as the drug that is placed on the list of drugs, and which is not available on the market of the Republic of Serbia in quantities necessary to provide health care to insured persons, i.e. which has been withdrawn from the market (List D, drugs issued without co-payment).

The entire process of placing a medicine or deleting it from the list of medicines must be in accordance with the Rulebook on the conditions, criteria, method and procedure for placing a medicine on the List of Medicines, amendments and additions to the List of Medicines, that is, for deleting a medicine from the List of Medicines [9].

The key information required by the current regulations is evidence of safety and efficacy, together with a cost-based pharmaco-economic analysis according to the defined daily dose and a budget impact analysis. However, a cost-effectiveness analysis is required, which is not yet a routine part of the evaluation carried out by RHIF.

Due to the limitation of financial resources, there are several rules that should be followed: first-class drugs representing new mechanisms of action must demonstrate superior efficacy/safety and must not cost more than the lowest published wholesale price in the reference countries.

New drugs within an existing therapeutic class can be added to the List if the assessment shows no impact on the existing budget. Generics, depending on the order of entry, reduce the price (10 to 30 percent) of already mentioned drugs with the same inter-republic unprotected name (IGN). This way, the expansion of the list of medicines, provided that there is no impact on the budget, has been limited mainly to generic medicines for years, which has seriously affected access to innovative medicines (given that 22 innovative medicines entered the List thanks to managed entry agreements in 2016, only several of them were added in the next three years) [5].

However, due to the given rights, even drugs that are not on the list of drugs, but are necessary for treatment, under the conditions prescribed by the RHIF Law (Articles 15, 16 and 17 of the Rulebook on the Content and Scope of Rights) up to health care from compulsory health insurance and participation are provided to the insured person [10]. It refers to drugs that are not on the list of drugs, but are proven to be effective for certain indications in a specific patient when all other treatment options have already been applied without a positive result, it also refers to rare diseases under similar conditions of proven effectiveness, and the third case when the drug must ensure her status after transplantation abroad.

In a situation of slow progress towards the introduction of innovative medicines on the Medicines List, these three additional options significantly improve access to essential medicines.

The role of voluntary health insurance (VHI)

The Republic Health Insurance Fund (RHIF) implements voluntary health insurance with the aim of enabling citizens, under the most favorable conditions, to secure rights that are not covered by mandatory health insurance.

Regulation on health care Article 10 explains the process of obtaining a license from the National Bank for the performance of voluntary health insurance [11].

According to Article 30 of the aforementioned regulations, the following types of voluntary health insurance exist in Serbia:

- **Parallel health insurance** is insurance to cover health care costs incurred when the insured person obtains health care covered by mandatory health insurance in a manner and procedure different from the manner and procedure prescribed by law and regulations adopted for the implementation of the law on insurance.

This insurance is most often used for the purpose of using the insured's health care during their stay abroad. The National Bank provides data on consumption in Serbia for these purposes;

- **Supplementary health insurance** is insurance that covers costs that are not covered by rights from mandatory health insurance, and refer to health services, medicines, medical and technical aids, implants, coverage of greater content, scope and standards of rights;
- **Private health insurance** as insurance for persons who are not covered by mandatory health insurance or were not included in mandatory health insurance, to cover costs for the type, content, scope and standard of rights contracted with the insurance provider.

- Informal payments

Informal payment of health services in public institutions of Serbia is prohibited by law for both providers and recipients of such payments. However, informal payments for health services, especially in hospitals, are increasing [1]. Exceptions are the expression of gratitude as a gift of lesser value or advertising material and samples, which are not expressed in money.

Expressing gratitude in the form of a gift whose value does not exceed 5%, and the total value does not exceed the amount of one average monthly salary in the Republic of Serbia without taxes and contributions, is not considered corruption, conflict of interest, or private interest in accordance with the Law on Health Care [6].

DISCUSSION

The main gaps in the financial coverage of healthcare in the observed period, according to data from the National Health Account, refer to:

– Cancer therapy, orthopedic and heart surgeries, which are often paid for out of pocket by those who could not wait on waiting lists and could afford it.

Also, medicines, dental, laboratory and diagnostic services are obtained mostly from one's own pocket;

– Limited health care provided by Voluntary Health Insurance leads people to spend unplanned on health services;
– Informal payments for inpatient care are frequent, which makes a difference in the status of those who can afford it and those who are unable to pay for the service;
– There is a problem with waiting lists that are legally overcome by personal financing for a better position on the list, a greater financial burden for the poor without the possibility to provide a better place on the list with personal finances.

Concerns about financial protection in healthcare remained throughout the reform period of the healthcare system. Over the years, households have been exposed to a growing burden of out-of-pocket payments, so they have increasingly avoided using health services.

In particular, cancer patients are at high risk of impoverishment, as financial barriers to paying for prescribed diagnostic services, treatments, and medications have increased. The population with cancer often decided to sell their property to pay for expensive treatments and operations.

CONCLUSION

An overview of the reforms that took place in the period from 2004 to 2020 in the health sector of the Republic of Serbia and its financing forms an important basis for planning the functioning of health care and the implementation of subsequent reforms.

The general conclusion of the analysis is that in the observed period, Serbia had a good system of exemption from co-payments, but that out-of-pocket payments for certain health services and corrupt payments represented a barrier to health care.

RECOMMENDATION

It is necessary to make more efforts during the health care reform and its financing, in order to overcome the observed problems in the observed period from 2004 to 2020 and to remove financial barriers to the use of health care.

REFERENCES

1. National health account Institute for Public Health of Serbia. Available at: http://www.batut.org.rs/index.php?category_id=50
2. National Assembly. Regulation on the plan of the network of health institutions ("Official Gazette of RS", numbers 42/06, 119/07, 84/08, 71/09, 85/09, 24/10, 6/12, 37/12, 8/14, 92/15, 111/17, 114/17, 13/2018, 15/2018, 5/2020, 11/2020, 52/2020 and 88/2020). Available at: https://www.paragraf.rs/propisi/uredba_o_planu_mreze_zdravstvenih_ustanova.html
3. REGULATION on the corrective coefficient in the capital Sl, no. 13/2020.
4. Republic Assembly. Constitutional law, 2006 ("Official Gazette of RS", number 98/2006)
5. Republic Assembly. Law on Health Insurance, Official Gazette, number 25/2019. Available at: https://www.paragraf.rs/propisi/zakon_o_zdravstvenom_osiguranju.html
6. Assembly of the Republic of Serbia. Law on Contributions for Mandatory Social Security, "Official Gazette", number 86/2019. Available at: https://www.paragraf.rs/propisi/zakon-o-doprinosima-za-obavezno-socijalno-osiguranje.html
7. Parliament of the Republic of Serbia. Law on Health Care, Official Gazette, no. 25/2019. Available at: https://www.paragraf.rs/propisi/zakon_o_zdravstvenoj_zastiti.html
8. Republic Health Insurance Fund. Rulebook on the list of medicines prescribed and issued at the expense of compulsory health insurance funds, "Official Gazette of the RS", numbers 43/19, 55/19, 56/19, 73/19 and 87/19.
9. Republic Health Insurance Fund. Rulebook on conditions, criteria, method and procedure for placing a medicine on the list of medicines, changing the list of medicines, i.e. for deleting a medicine from the list of medicines "Official Gazette of RS", numbers 41/14, 125/14, 48/15 and 14/18).
10. Republic Health Insurance Fund. Rulebook on the content and scope of health care rights to health insurance and participation for 2019, "Official Gazette of RS", number 7/2019)
11. Republic Health Insurance Fund. Available at: https://www.paragraf.rs/propisi/uredba_o_planu_mreze_zdravstvenih_ustanova.html
12. Republic Assembly. Law on Health Care, Official Gazette, numbers 107/2005, 72/2009, 88/2010, 99/2010, 57/2011, 119/2012, 45/2013, 93/2014)
13. Law on Public Health. Available at: https://www.paragraf.rs/propisi/uredba_o_planu_mreze_zdravstvenih_ustanova.html
14. Public health strategy in the Republic of Serbia 2018–2026 http://ipc.rs/download/strategija.pdf

Received: 9.3.2023 • Accepted: 30.5.2023

Pregled promena u zdravstvenom sektoru i njegovom finansiranju u Republici Srbiji u periodu od 2004. do 2020. godine

Milena Gajić-Stevanović, Ivan Stevanović

NVO Zdravstveni monitor, Beograd, Srbija

KRATAK SADRŽAJ

Uvod U periodu od 2004. do 2020. godine u zdravstvenom sektoru Republike Srbije i njegovom finansiranju sprovedene su mnoge reforme.

Cilj ovog rada je bio da se izvrši uvid u osnove na kojima se baziralo zdravstvo u Republici Srbiji u periodu od 2004. do 2020. godine i pregledaju izvršene reformske promene u zdravstvenom sektoru i njegovom finansiranju.

Materijal i metode Urađena je retrospektivna analiza podataka iz Nacionalnog zdravstvenog računa Instituta za javno zdravlje Srbije, pravilnika Republičkog fonda za zdravstveno osiguranje, izveštaja Ministarstva zdravlja, kao i zakona i uredbi vezanih za zdravstveni sektor.

Rezultati Rezultati analize su pokazali da je državni zdravstveni sektor predstavljao temelj zdravstvenog sistema u Republici Srbiji u posmatranom periodu. Od ukupnog finansiranja zdravstva, procenjeno je da su oko šezdeset posto činile šeme javnog finansiranja, a da je oko četrdeset posto pripadalo privatnim šemama, pri čemu je veliki deo privatnih šema činilo plaćanje iz džepa.

Zaključak Opšti zaključak analize je da je u posmatranom periodu Srbija u okviru reformskih promena imala dobar sistem oslobađanja od participacije, ali da su plaćanja iz džepa za određene zdravstvene usluge i koruptivna plaćanja predstavljala barijeru ka zdravstvenoj zaštiti.

Ključne reči: reforma u zdravstvenom sektoru; finansiranje zdravstvene zaštite; bazični paket zdravstvenih usluga

UVOD

Sistem zdravstvene zaštite Republike Srbije zasniva se na principima obaveznog zdravstvenog osiguranja. Republički fond za zdravstveno osiguranje (RFZO) predstavlja nacionalnu organizaciju kojom građani ostvaruju pravo na zdravstveno osiguranje i finansiraju zdravstvenu zaštitu.

RFZO finansira funkcionisanje zdravstvene zaštite na svim nivoima, ugovara pružanje usluga sa javnim i privatnim zdravstvenim ustanovama, kontroliše sprovođenje obaveza preuzetih prilikom ugovaranja sa njima, definiše osnovni paket zdravstvenih usluga.

Zbog nepostojanja adekvatne mreže privatnog zdravstvenog osiguranja, privatno finansiranje zdravstva je uglavnom zasnovano na plaćanju iz džepa, a dopunjeno je učešćem malog broja velikih kompanija.

Pomenute kompanije imaju (i finansiraju) svoje zdravstvene ustanove koje su specijalizovane za lečenje profesionalnih oboljenja, a pružaju i sve usluge iz domena primarne zdravstvene zaštite.

Cilj ovog rada je bio da se izvrši uvid u osnove na kojima se baziralo zdravstvo u Republici Srbiji u periodu od 2004. do 2020. godine i pregledaju izvršene reformske promene u zdravstvenom sektoru i njegovom finansiranju.

METODOLOGIJA I MATERIJAL

Urađena je retrospektivna analiza podataka iz Nacionalnog zdravstvenog računa Instituta za javno zdravlje Srbije, pravilnika Republičkog fonda za zdravstveno osiguranje, izveštaja Ministarstva zdravlja, kao i zakona i uredbi vezanih za zdravstveni sektor.

REZULTATI

U periodu od 2004. do 2020. godine, od ukupnog finansiranja zdravstva, procenjeno je da su oko šezdeset posto činile šeme javnog finansiranja, a da je oko četrdeset posto pripadalo privatnim šemama, pri čemu je veliki deo privatnih šema činilo plaćanje iz džepa [1]. Oko 1,5% od 60% šema javnog finansiranja se usmeravalo na finansiranje privatnih pružalaca zdravstvenih usluga, a ostatak na javne pružaoce usluga. Od 40% privatnih finansijskih šema, procenjeno je da se 35% usmeravalo ka privatnim pružaocima zdravstvenih usluga, a 5% ka javnim pružaocima usluga.

U okviru javnog sektora finansijera zdravstvene zaštite u Republici Srbiji predominantni finansijer je bio Republički fond za zdravstveno osiguranje (RFZO) sa učešćem oko 94% [1]. RFZO se finansirao iz doprinosa zaposlenih i poslodavaca u visini od 67%, 22% iz Fonda PIO, 4% iz doprinosa samozaposlenih, a 7% iz državnih transfera na ime posebnih ugroženih grupa stanovništva [1].

Javna zdravstvena zaštita se direktno pružala preko mreže zdravstvenih ustanova definisanih Uredbom o Planu mreže zdravstvenih ustanova [2]. Po planu mreže u 2020. godini bilo je 313 zdravstvenih ustanova (bez ustanova sa Kosova i Metohije) na primarnom, sekundarnom i tercijarnom nivou.

U posmatranom periodu Ministarstvo zdravlja poseduje većinu zdravstvenih ustanova i direktno ih finansira uglavnom kroz kapitalna ulaganja. Ministarstvo finansija prenosi sredstva RFZO-u za obezbeđenje zdravstvene zaštite ugroženih neosiguranih grupa: dugotrajno nezaposlenih, neosiguranih starijih i veoma mladih ljudi, kao i migranata, izbeglica i interno raseljenih lica.

Donacije stranih zemalja i međunarodnih organizacija se takođe transferišu u RFZO. Lokalna uprava doprinosi finansiranju zdravstva, uglavnom u investicione svrhe.

Model plaćanja za primarnu i sekundarnu zdravstvenu zaštitu

Zdravstvena reforma između 2004. i 2020. godine reformisala je zdravstvenu službu i fokusirala se na primarnu zdravstvenu zaštitu i prevenciju u odnosu na kurativnu zaštitu, kako bi se smanjila stopa izlečivih bolesti i zdravstveni izdaci.

Kao model plaćanja za primarnu zdravstvenu zaštitu izabrana je kapitacija (primena formule kapitacije počela je u novembru 2012. godine u ustanovama primarne zdravstvene zaštite) i model dijagnostički srodnih grupa (DSG) za plaćanja u sekundarnoj zdravstvenoj zaštiti.

Došlo je do ključnih promena u kapitacionoj formuli u 2020. godini utvrđenoj Uredbom o korektivnom koeficijentu u kapitacionoj formuli [3]. Pomenutom Uredbom su pored korektivnih faktora kao što je starost pacijenta, korektivnog faktora za gustinu naseljenosti, specifičnih indikatora kvaliteta za svaku specijalnost, uvedeni i korektivni faktori efikasnosti i dijagnostičko-terapijski postupak (DTP) kao korektivni faktori za sve specijalnosti.

Kod dijagnostički srodnih grupa promene se dešavaju u načinu bolničkog izveštavanja i u modeliranju budžeta. Postepeno se prelazi sa retrospektivnog načina plaćanja zdravstvenih usluga, koji je bio zasnovan na istorijskom budžetu, na prospektivni sistem plaćanja zasnovan na dijagnostički srodnim grupama.

Zakoni koji regulišu zdravstvenu zaštitu

Pružanje zdravstvene zaštite u Republici Srbiji uređuje se: Zakonom o zdravstvenoj zaštiti, Zakonom o zdravstvenom osiguranju i Zakonom o javnom zdravlju.

Ustav Republike Srbije definiše Republiku Srbiju kao državu srpskog naroda i svih njenih građana, utvrđuje vladavinu prava i socijalne pravde, principe građanske demokratije, ljudska i manjinska prava i slobode, kao i pripadnost evropskim principima i vrednostima [4].

Prema članu 68 Ustava svako ima pravo na zaštitu svog fizičkog i psihičkog zdravlja po principu solidarnosti u finansiranju i principu jednakosti u pristupu zdravstvenoj zaštiti.

Obavezno zdravstveno osiguranje je organizovano na principu: obaveznosti, solidarnosti i reciprociteta, zaštite prava osiguranika i zaštite javnog interesa, kontinuiranog unapređenja kvaliteta obaveznog zdravstvenog osiguranja i ekonomičnosti, kao i efikasnosti obaveznog zdravstvenog osiguranja [5].

Načelo obaveznog osiguranja odnosi se na obavezu plaćanja doprinosa za obavezno zdravstveno osiguranje po osnovu 12,3% do 2014. godine i od tada do danas 10,3% odbitka od plate [6].

Bez obzira na visinu raspoloživih sredstava i fluktuiranja troškova zdravstvene zaštite u posmatranom periodu, Zakon o zdravstvenoj zaštiti i Zakon o zdravstvenom osiguranju definišu osnovni paket zdravstvenih usluga. Prema ovim zakonima, obavezno zdravstveno osiguranje [3] pokriva (A) bolesti i povrede koje nisu povezane sa radom i (B) povrede i bolesti u vezi sa radom.

Pored toga, sredstvima obaveznog zdravstvenog osiguranja pokrivaju se troškovi rehabilitacije, nabavke medicinsko-tehničkih sredstava, lekova na recept, bolovanja (duže od mesec dana), troškovi prevoza u vezi sa korišćenjem zdravstvene zaštite i dr. Bolovanje do 30 dana pokriva poslodavac i o njima nema redovno prikupljanih podataka od strane države.

Društvena briga o zdravlju ostvarena je pružanjem zdravstvene zaštite grupama stanovništva sa povećanim rizikom od oboljenja, zdravstvenom zaštitom lica u vezi sa prevencijom, kontrolom, ranim otkrivanjem i lečenjem bolesti i stanja od većeg javnozdravstvenog značaja, kao i zdravstvenom zaštitom socijalno ugroženog stanovništva, pod jednakim pravima na teritoriji Republike Srbije [7].

Bazični paket zdravstvenih usluga predstavlja usluge koje se obezbeđuju iz sredstava obaveznog zdravstvenog osiguranja, prema članu 52 Zakona o zdravstvenom osiguranju, nomenklaturi (naziv i opis) zdravstvenih usluga i cenovniku zdravstvenih usluga iz obaveznog zdravstvenog osiguranja. Bazični paket su činili [5]:

1. mere za prevenciju i rano otkrivanje bolesti;
2. pregledi i lečenje u vezi sa planiranjem porodice, tokom trudnoće, porođaja i do 12 meseci nakon porođaja;
3. pregledi i lečenje u slučaju bolesti i povrede;
4. pregledi i lečenje bolesti usta i zuba;
5. medicinska rehabilitacija u slučaju bolesti i povrede;
6. lekovi;
7. medicinska sredstva.

Prema Zakonu o zdravstvenom osiguranju [5] osiguranici su u potpunosti pokriveni bez ikakve participacije za: mere prevencije i ranog otkrivanja bolesti, skrining i lečenje za planiranje porodice, trudnoću, porođaj i postporođajnu negu, uključujući prekid trudnoće iz medicinskih razloga, preglede, lečenje i medicinsku rehabilitaciju u slučaju bolesti i povreda dece, učenika i učenika do završetka propisanog školovanja, a najkasnije do 26. godine, odnosno starijih lica sa teškim fizičkim ili psihičkim smetnjama, preglede i lečenje usta i bolesti zuba u vezi sa trudnoćom i 12 meseci nakon porođaja, preglede i lečenje zaraznih bolesti koje su po zakonu obavezne za sprovođenje mera za sprečavanje njihovog širenja, preglede i lečenje maligniteta, dijabetesa, psihoza, epilepsije, multiple skleroze, progresivnih neuro-mišićnih oboljenja, cerebralne paralize, paraplegije, tetraplegije, trajne hronične bubrežne insuficijencije koja ukazuje na dijalizu ili transplantaciju bubrega, sistemskih autoimunih bolesti, reumatskih bolesti i njihovih komplikacija, retkih bolesti, palijativno zbrinjavanje, preglede i lečenje u vezi sa uzimanjem, primenom i razmenom organa, ćelija i tkiva za transplantaciju, za pružanje zdravstvene zaštite osiguranim licima, preglede, lečenje i rehabilitaciju od profesionalnih oboljenja i povreda na radu, pružanje hitne medicinske i stomatološke pomoći, kao i hitan medicinski prevoz.

Ako se ovako utvrđen sadržaj i obim prava na zdravstvenu zaštitu iz obaveznog zdravstvenog osiguranja ne može ostvariti zbog nedovoljnih sredstava, Vlada donosi akt kojim se utvrđuju prioriteti u pružanju i sprovođenju zdravstvene zaštite.

Takođe, Vlada svake godine, na predlog ministra zdravlja, donosi akt kojim se utvrđuju prioriteti u lečenju pacijenata sa određenim vrstama retkih bolesti, za šta su obezbeđena sredstva u budžetu Republike Srbije.

Pokrivenost uz participaciju se procentualno razlikuje zavisno od vrste zdravstvene usluge:

– U iznosu od najmanje 95% cene zdravstvene usluge iz fondova obaveznog zdravstvenog osiguranja za: intenzivnu negu u stacionarnoj zdravstvenoj ustanovi, hirurški zahvat

koji se obavlja u operacionoj sali, uključujući ugradnju implantata za najsloženije i najskuplje zdravstvene usluge, najsloženije laboratorijske, rendgenske i druge dijagnostičke i terapijske procedure (magnetna rezonanca, skener, nuklearna medicina i dr.);
- U iznosu od najmanje 80% cene zdravstvene usluge iz sredstava obaveznog zdravstvenog osiguranja za: preglede i lečenje kod izabranog lekara i lekara specijaliste, laboratorijske, rendgenske i druge dijagnostičke i terapijske procedure, kućno lečenje, stomatološke preglede i lečenje u vezi sa povredama zuba i kostiju lica, kao i stomatološke preglede i stomatološke tretmane pre operacije srca i transplantacije organa, ćelija i tkiva. Takođe za lečenje komplikacija karijesa kod dece, studenata i studenata do isteka propisanog roka školovanja, a najkasnije do 26. godine, vađenje zuba kao posledicu karijesa, kao i razvoj mobilnih ortodontskih aparata, stacionarno lečenje, kao i rehabilitaciju u stacionarnoj zdravstvenoj ustanovi, preglede i lečenje u dnevnoj bolnici, uključujući hirurgiju van operacione sale, ambulantnu medicinsku rehabilitaciju, neka medicinska sredstva.
- U iznosu od najmanje 65% cene zdravstvene usluge iz fondova obaveznog zdravstvenog osiguranja za: izradu akrilatnih totalnih i subtotalnih proteza kod lica starijih od 65 godina, očna i slušna pomagala za odrasle, promenu pola iz medicinskih razloga, medicinski transport koji nije hitan, lečenje bolesti čije rano otkrivanje podleže ciljanom preventivnom skriningu, odnosno skriningu u skladu sa relevantnim nacionalnim programima, ako se osigurano lice nije odazvalo ni na jedan poziv u okviru jednog ciklusa poziva, ili opravdalo izostanak, a dijagnostikovano mu je oboljenje do sledećeg ciklusa poziva.

Zdravstvene usluge koje nisu opisane u bazičnom paketu usluga čine usluge koje osigurano lice plaća iz sopstvenih sredstava, po cenama koje odredi davalac zdravstvene zaštite.

Negativna lista zdravstvenih usluga predstavlja listu intervencija, usluga i proizvoda koji se uglavnom plaćaju iz džepa u javnim ili privatnim zdravstvenim ustanovama, a ne nalaze se na listi bazičnog paketa usluga.

Novi Zakon o zdravstvenom osiguranju koji je stupio na snagu 2019. godine omogućio je više prava za korišćenje zdravstvenih usluga, poput promene pola iz medicinskih razloga i veštačke oplodnje za žene [5], u poređenju sa Zakonom iz 2005. godine.

Troškovi korisnika zdravstvene zaštite za lekove i pomoćna sredstva

Republički fond za zdravstveno osiguranje u svojim ugovorima sa javnim ustanovama unapred aproksimira participaciju koju svaka ustanova ostvaruje. Aproksimirana suma se umanjuje od transferisanih sredstava u ustanove. Visina aproksimirane participacije iznosi 1–3% od ukupnog prihoda zdravstvenih ustanova.

Država Srbija donosi podzakonske akte i propise kojima se uređuje obim prava na zdravstvenu zaštitu iz obaveznog zdravstvenog osiguranja, a u okviru kojih je obuhvaćeno i pravo na lekove. Troškovi stanovništva za lekove i pomoćna sredstva čine oko šezdeset posto [1] njihovih ukupnih direktnih troškova za zdravstvenu zaštitu, iako i RFZO ulaže značajna finansijska sredstva.

Prema pravilniku RFZO [8], na listi lekova koji se propisuju i izdaju po osnovu obaveznog zdravstvenog osiguranja, svi lekovi su podeljeni u pet osnovnih grupa:
1) A. Lekovi koji se propisuju i izdaju na recept (Lista A, lekovi koji se izdaju uz fiksnu participaciju – 50 dinara po receptu);
2) A1. Lekovi koji se propisuju i izdaju u obliku lekarskog recepta, koji imaju terapijsku paralelu (terapeutsku alternativu) lekovima sa Liste A (Lista A1, lekovi se izdaju uz 10 do 90% participacije po pakovanju);
3) B. Lekovi koji se koriste tokom ambulantnog ili bolničkog lečenja u zdravstvenim ustanovama (Lista B, lekovi koji se izdaju bez participacije);
4) C. Lekovi sa posebnim režimom (Lista C, lekovi koji se izdaju bez participacije);
5) lekovi koji nemaju dozvolu za stavljanje u promet u Republici Srbiji, ali su neophodni u dijagnostici i terapiji – neregistrovani lekovi, a izuzetno lekovi su registrovani u Republici Srbiji sa istim generičkim nazivom (IGN) kao lek koji se stavlja na listu lekova, a koja nije dostupna na tržištu Republike Srbije u količinama neophodnim za pružanje zdravstvene zaštite osiguranim licima, odnosno koja je povučena sa tržišta (Lista D, lekovi izdati bez participacije).

Ceo proces stavljanja leka ili njegovog brisanja sa liste lekova mora biti u skladu sa Pravilnikom o uslovima, kriterijumima, načinu i postupku za stavljanje leka na Listu lekova, izmenama i dopunama Liste lekova, odnosno za brisanje leka sa Liste lekova [9].

Ključne informacije koje zahtevaju tadašnji propisi su o dokazima o bezbednosti i efikasnosti, zajedno sa farmako-ekonomskom analizom zasnovanom na troškovima prema definisanoj dnevnoj dozi i analizom uticaja na budžet. Međutim, potrebna je analiza isplativosti koja još uvek nije rutinski deo procene koju vrši RFZO.

Zbog ograničenja finansijskih resursa, postoji nekoliko pravila koja bi trebalo da se poštuju: prvoklasni lekovi koji predstavljaju nove mehanizme delovanja moraju da pokažu superiornu efikasnost/bezbednost i ne smeju da imaju višu cenu od najniže objavljene veleprodajne cene u referentnim zemljama.

Novi lekovi u okviru postojeće terapijske klase mogu se dodati na Listu ako procena ne pokaže uticaj na postojeći budžet. Generici, u zavisnosti od redosleda unosa, snižavaju cenu (10 do 30 odsto) već navedenih lekova sa istim međurepubličkim nezaštićenim nazivom (IGN). Na taj način proširenje liste lekova, pod uslovom da nema uticaja na budžet, godinama je ograničeno uglavnom na generičke lekove, što je ozbiljno uticalo na pristup inovativnim lekovima (s obzirom na to da su 22 inovativna leka ušla na Listu zahvaljujući ugovorima o upravljanom ulasku u 2016, samo nekoliko njih [5] dodato je u naredne tri godine). Međutim, zbog datih prava, čak i lekovi koji nisu na listi lekova ali su neophodni za lečenje, pod uslovima propisanim Zakonom RFZO (čl. 15, 16. i 17. Pravilnika o sadržini i obimu prava) do zdravstvene zaštite od obaveznog zdravstvenog osiguranja i participacije (10)) obezbeđuju se osiguranom licu. Odnosi se na lekove koji nisu na Listi lekova, ali su dokazano delotvorni za određene indikacije kod određenog pacijenta kada su sve druge opcije lečenja već primenjene bez pozitivnog rezultata, odnosi se i na retke bolesti pod sličnim uslovima dokazane efikasnosti,

a treći slučaj kada se lek mora obezbediti je status nakon transplantacije u inostranstvu.

U situaciji usporenog kretanja ka uvođenju inovativnih lekova na Listu lekova, ove tri dodatne opcije značajno poboljšavaju pristup neophodnim lekovima.

Uloga dobrovoljnog zdravstvenog osiguranja (DZO)

RFZO sprovodi dobrovoljno zdravstveno osiguranje sa ciljem da građanima omogući da, pod najpovoljnijim uslovima, obezbede prava koja nisu obuhvaćena obaveznim zdravstvenim osiguranjem.

Uredba o zdravstvenoj zaštiti [11], član 10, objašnjava proces dobijanja dozvole od Narodne banke za obavljanje poslova dobrovoljnog zdravstvenog osiguranja.

Prema članu 30 navedenih propisa, u Srbiji postoje sledeće vrste dobrovoljnog zdravstvenog osiguranja:

– **Paralelno zdravstveno osiguranje** je osiguranje za pokrivanje troškova zdravstvene zaštite nastalih kada osigurano lice ostvari zdravstvenu zaštitu obuhvaćenu obaveznim zdravstvenim osiguranjem na način i postupak drugačiji od načina i postupka propisanog zakonom i propisima donetim za sprovođenje zakona o osiguranju.

Ovo osiguranje se najčešće koristi u svrhu korišćenja zdravstvene zaštite osiguranika tokom boravka u inostranstvu. Narodna banka daje podatke o potrošnji u Srbiji za te namene.

– **Dopunsko zdravstveno osiguranje** je osiguranje koje pokriva troškove koji nisu obuhvaćeni pravima iz obaveznog zdravstvenog osiguranja, a odnose se na zdravstvene usluge, lekove, medicinska i tehnička pomagala, implantate, pokriće većeg sadržaja, obima i standarda prava.
– **Privatno zdravstveno osiguranje** je osiguranje lica koja nisu obuhvaćena obaveznim zdravstvenim osiguranjem ili nisu bila uključena u obavezno zdravstveno osiguranje. Pokriva troškove za vrstu, sadržaj, obim i standard prava ugovorenih sa davaocem osiguranja.

Neformalna plaćanja

Neformalno plaćanje zdravstvenih usluga u javnim ustanovama Srbije je zakonom zabranjeno i za pružaoce i za primaoce takvih plaćanja. Međutim, neformalna plaćanja za zdravstvene usluge, posebno u bolnicama, rastu [1]. Izuzeti su iskazivanje zahvalnosti kao poklon manje vrednosti ili reklamnog materijala i uzoraka, koji nisu izraženi u novcu.

Iskazivanje zahvalnosti u vidu poklona čija vrednost ne prelazi 5%, a ukupna vrednost ne prelazi iznos jedne prosečne mesečne plate u Republici Srbiji bez poreza i doprinosa, ne smatra se korupcijom, sukobom interesa, odnosno privatnim interesom u skladu sa Zakonom o zdravstvenoj zaštiti [6].

DISKUSIJA

Glavne praznine u finansijskoj pokrivenosti zdravstva u posmatranom periodu, prema podacima iz Nacionalnog zdravstvenog računa, odnose se na sledeće:

– Terapija raka, ortopedske i srčane operacije često se plaćaju iz džepa onih koji nisu mogli da čekaju na listama čekanja, a mogli su da to sebi priušte. Takođe, lekovi, stomatološke, laboratorijske i dijagnostičke usluge dobijaju se uglavnom iz sopstvenog džepa.
– Ograničena zdravstvena zaštita koju pruža Dobrovoljno zdravstveno osiguranje dovodi ljude u situaciju da troše neplanski na zdravstvene usluge.
– Česta su neformalna plaćanja za stacionarnu negu, što pravi razliku u statusu onih koji to mogu sebi da priušte i onih koji nisu u mogućnosti da plate uslugu.
– Postoji problem sa listama čekanja koje se zakonski prevazilaze ličnim finansiranjem za bolju poziciju na listi. Veće je finansijsko opterećenje za siromašnije, bez mogućnosti da ličnim finansijama obezbede bolje mesto na listi.

Zabrinutost oko finansijske zaštite u zdravstvu ostala je tokom čitavog reformskog perioda zdravstvenog sistema. Tokom godina domaćinstva su bila izložena rastućem teretu plaćanja iz džepa, tako da su sve više izbegavala korišćenje zdravstvenih usluga.

Stanovništvo se često odlučuivalo na prodaju imovine da bi platili skupa lečenja i operacije. Konkretno, pacijenti sa kancerom su u visokom riziku od osiromašenja, jer su se povećale finansijske prepreke za plaćanje propisanih dijagnostičkih usluga, tretmana i lekova.

ZAKLJUČAK

Pregled reformi koje su se dogodile u periodu od 2004. do 2020. godine u u zdravstvenom sektoru Republike Srbije i njegovom finansiranju čini značajnu osnovu za planiranje funkcionisanja zdravstvene zaštite i sprovođenje narednih reformi.

Opšti zaključak analize je da je u posmatranom periodu Srbija imala dobar sistem oslobađanja od participacije, ali da su plaćanja iz džepa za određene zdravstvene usluge i koruptivna plaćanja predstavljala barijeru ka zdravstvenoj zaštiti.

PREPORUKA

Potrebno je uložiti više napora tokom reforme zdravstvene zaštite i njenog finansiranja, kako bi se uočeni problemi u posmatranom periodu od 2004. do 2020. godine prevazišli i kako bi nestale finansijske barijere kod korišćenja zdravstvene zaštite.