IMPLEMENTATION OF THE CONSTITUTIONAL RIGHT TO HEALTH INSURANCE IN THE ALBANIAN LEGISLATION

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ABSTRACT: *The right to health insurance is a constitutional right. The right to health insurance is included into the group of economic and social rights. The implementation of these rights is conditioned to a special law which has to establish the rules and their application procedure. Starting from March 2013, Albania has started to implement a new law, Law no. 10383 dated 24.2.2011 "on mandatory insurance of health care in the Republic of Albania."*

In this article, we intend to analyze the concrete way of fulfilling this constitutional obligation in the Albanian legislation. Law defines the main principles on which the health insurance is established in Albania. Albanian health insurance is based on Bismarck system and is financed mostly by the contributions of the insured people. Law confirms the application of the solidarity and universal coverage of the population regarding health insurance and it introduces a new approach on relation between public and private sector in health care.

KEYWORDS: *Constitution, health, insurance, law, right*
JEL CLASSIFICATION: *K 20, K22, K32*

The right to health insurance is a constitutional right. The Constitution of the Republic of Albania provides for it in Article 55: "Citizens enjoy equally the right to health care from the state. Everyone has the right to health insurance in accordance with the procedure established by law." The right to health insurance is part of the social and economic rights group in the constitution. Based on the classification of human rights according to theoretical perspective of constitutional law, it is not difficult to conclude that even this right is a positive right, just like most of the rights that are part of this group. This fact is confirmed by constitutional provision references, where it is underlined that the implementation of this right is conditioned by a special law which has to establish rules and application procedure.

It is also understood that the existence of this right is based not only on human nature, but it is associated with the interaction of the state and its obligation to create special conditions so that this right can be realized. Considering the importance of health care,

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and fulfilment of the constitutional obligation[1] and constitutional objective[2] as well, the state takes on the responsibility of enabling and creating the conditions for the implementation of this right. In this way this commitment comes from the framework of the good and the right of individuals and it is raised in a broader plan regarding the public service. In this way this right is a public right, which creates an obligation for the state, as well as for the specially created institutions of the state that aims to fulfil the constitutional obligation.

Albanian social protection schemes defined by the law include health services, health insurance services, social assistance and social security services. This scheme is established with respect to fundamental human rights provided by the Albanian Constitution in Articles 52, 54, 55, 57, and constitutional and social objectives, as provided in Article 59 of the Constitution. In particular, Article 55 of the Constitution provides for the right to health care and Article 59 of the Constitution states that the State within its constitutional powers and potential resources intends to achieve the highest available standard of physical and mental health.

Article 55 of the Constitution provides the right to health care as a fundamental right with socio-economic character. This article clearly states the State's duty to guarantee health care for its citizens and the right to health insurance for all in accordance with the law. This article also restates that citizens should not be discriminated and should be treated equally. This is evident in two cases: when it is mentioned that "citizens enjoy equally the right of health care by the state," as well as the right to health insurance is referred to as a right of all. The Constitution provides that health insurance procedures are regulated by law.

It is further noted that the Law no. 10 383, dated 24.02.2011 "On Compulsory health care in the Republic of Albania", correctly interprets the Constitution when it specifies that "the scheme of compulsory health insurance is intended to cover the population in order to benefit from health care services, financed by public and private sector, according to this law[3]."

By using the term "population coverage" law, the use of words “nationals”, or “foreign nationals “ and furthermore foreign nationals working in Albania are avoided. These words were included in the 1994 year law under which, compulsory insurance covers all citizens of the Republic of Albania residing permanently in Albania, as well as the foreigners employed and insured in Albania[4]. The previous definition narrows the scope of protection in relation to the constitutional norm, because stateless persons and foreigners living but not working in Albania were excluded from this right. Concerning the term coverage of the population, current law provides a precise reference to Article 55 of the Constitution, the second paragraph of which reads: "Everyone has the right to health insurance under the procedure established by law".

Pursuant to the Constitution, Law no. 10 383, dated 24.02.2011 "On Compulsory health care in the Republic of Albania", has set up a non for profit mandatory national system. Compulsory Health Care Insurance Fund is the administrative body charged with

[1]Article 55, The Constitution of the Republic of Albania
[2]Article 59, The Constitution of the Republic of Albania
[3]Article 4,paragraph 2 of Law no. 10 383 dated 24.02.2011 "On Compulsory health care in the Republic of Albania
[4]Article 4 of Law no. 7870 dated 13.10.1994 "On health insurance in the Republic of Albania", as amended.

implementing the scheme. In accordance with the health insurance scheme provided for by law, in return of the insurance contributions, health care service packages are covered by the scheme of the compulsory insurance. Those packages include visits, examinations and treatments in primary health care centres and in hospitals, private or public ones, drugs from the drugs reimbursement list and medical products. All these aspects are regulated with bylaws, most of them by the decisions of the Council of Ministers.

Given the above regulation, some problems must be analyzed in order to verify the implementation of constitutional law, related to the relationship between citizens and the Fund. Here are some of the issues that may cause debate:

- How will the citizen's right to a fair hearing be respected?

The Constitution guarantees the general tools, but the problem arises because the Fund does not provide health services by themselves, but enters into contracts with providers for this service. In these cases, problems arise not only regarding the determination of the parties to the conflict, but also the implementation of judicial decisions. We are of the opinion that the solution in this case should be sought in the wording of the contracts concluded by Fund.

- Potential concern remains the case when any individual remains a debtor to the Fund due to insufficient income. *Would they be deprived from the right to benefit of equal health care from the state without paying contributions?*

Such a situation can be avoided by possibly distributing the social and economic risk between the various institutions of the system.

*New law on health insurance***.** The legal framework regulating the right to health insurance in the Republic of Albania is relatively broad and complex. The most important among them is Law no. 10 383, dated 24.02.2011 "On Compulsory health care in the Republic of Albania".

The law that observes the constitutional obligation to determine the procedure by which everyone will have the right to health insurance is Law no. 10 383, dated 24.02.2011 "On Compulsory health care in the Republic of Albania". The law provides that health insurance in the Republic of Albania is a mandatory provision. Such a formulation raises the issue: Are we dealing with a right to health insurance or with the obligation to be insured to health?

On the other hand, such a formulation goes toward confirmation of the principle of universality. The thesis that compulsory schemes aimed at covering the entire population in a given country, is defined in the second paragraph of Article 4 of the law concerning the coverage of the population, as well as in the listing of categories of persons subject to compulsory health insurance. According to the law, beneficiaries are divided into two groups: economic active persons (employees, self-employed, unpaid family workers, other economic active persons) and economic inactive persons (persons benefiting from the Institute of Social Security, people receiving social assistance or disability payments, in accordance with relevant legislation, persons registered as unemployed jobseekers in the National Employment Service, foreigners seeking asylum in Albania, children under the age of 18, pupils and students under the age of 25 years, upon condition that they do not receive incomes from economic activities, categories of persons defined by special laws.[5]

[5] Article 5 of the Law no. 10 383 dated 24.02.2011 "On Compulsory health care in the Republic of Albania.

*Covered Groups***.** In theory, all population groups have been covered by health insurance. However, the law has provided for the opportunity to protect any isolated individual who is not included in the categories provided by law. Voluntary insurance will help in avoiding such cases[6]. This approach is a further development and protection of the constitutional right to health insurance. Some ideas that circumstances mentioned above do not present the features of an obligation, but the right of the individual to freely choose joining of the scheme are already expressed. However, we think that this choice is again indirectly binding, because the uninsured person, who needs medical care, can get this service by paying its full cost. So, it goes without saying that those who do not comply with the procedure established by law shall not be treated equally from the financial standpoint. On the other hand, when someone joins the voluntary insurance scheme, he/she shall have the right to equally benefit from the same amount just like the rest of the obligatory insured population[7]. As explained above, the universal principle of health insurance is applied not only to Albanian citizens but also to foreign nationals and stateless persons to whom the Constitutional provisions refer as "anyone".

Every person participating in the scheme is called the insured. Participation in the scheme is based on the payment of contributions. Contributions are paid from the income of economic active persons and the state budget, which pays for economic inactive persons. We have to do in this way with the ideology of another important principle of health insurance schemes - the principle of solidarity.

*Financial Resources***.** Under this law, the Fund provides coverage of health care services packages that are included in the scheme, through these resources:

- compulsory contributions to health insurance, which are obtained from the contributions of economic active persons according to the categories defined in Article 5, paragraph 1 of Law, which means employees, self employed, unpaid family workers etc.
- the contribution of compulsory health insurance from State Budget for economic inactive persons, according to paragraph 2 of Article 5 of the law, which means contributions for persons benefiting from the Institute of Social Security, people receiving social assistance or payment for persons with limited abilities, in accordance with relevant legislation, persons registered as unemployed jobseekers in the National Employment Service, foreigners seeking asylum in Albania, children under the age of 18, etc.
- voluntary health insurance contributions, according to paragraph 3 of Article 5 of the law which are foreseen for that part of the population that, for specific reasons, are not included in the categories of compulsory insurance.
- transfers from the Ministry of Health to subsidize a portion of direct payments. These transfers come as the financial support of various social policies that the government can undertake to facilitate various social categories in need.
- transfers from the Ministry of Health for the services required, beyond those budgeted or contracted by the Fund, targeting financial guarantee to cover the predefined service packages.

[6] Article 5/3 of the Law no. 10 383 dated 24.02.2011 "On Compulsory health care in the Republic of Albania
[7] Stefan Grezd ,*Regulated competition in social health insurance*, International Social Security Review, Vol.59/2006

- transfers approved in the state budget to balance the budget of the Fund or for compensation of unrealized contributions due to implementation of the budget process, which does not allow de facto the bankruptcy of the Fund.

There are other financial resources that come from other alternative sources such as donations and grants from national and international sources.

The law provides for rules on the Fund's financial resources, financial structure and rules of accounting and auditing. Meanwhile it underlines that the Fund manages its activities within the available financial resources, it is not included in debt, does not cover health care services outside the compulsory insurance package and observes the relevant contracts.

The contribution rate. The rate of contributions to health insurance is 3.4 percent of the basis for calculating contributions. In this way, the new law introduces the unification of contribution rate for all the insured. This represents a change compared to the previous law under which employees (including foreigners) paid a fixed contribution of 3.4% of gross salary. For the self-employed and unpaid family workers the contribution was 7% and for the self-employed and unpaid family workers working in the countryside the contribution was 5% on the field areas and 3% on hilly and mountainous areas. For the category of self-employed workers and for voluntary insured people, the unified percentage will be not calculated based on the minimum wage, but on the average between minimal and maximal wage due to contributions calculation.

*Collection of contributions***.** The procedure on the practical implementation of the process of realization of the constitutional right to health insurance is set out in the Law No. 9136, dated 11.9.2003 "The collection of mandatory social and health insurance contributions in the Republic of Albania".

The law regulates the collection of compulsory contributions to health insurance and decisions issued pursuant thereto. The Fund is not directly responsible for the collection of contributions. The Ministry of Finance collects these contributions through the Directorate General of Taxation, which operates through local offices in the districts since they are responsible for the collection of contributions and taxes and their distribution to the respective institutions. According to this Law and other relevant bylaws, and taking into account that a part of the Fund budget is included in the state budget, arrears in the payment of taxes or penalties imposed on entities for not registering, or paying health insurance contribution in time do not pass in favour of Fund, something that negatively affects the fund of this institution.

*Benefits from mandatory schemes, services packages***.** One of the innovations that this law introduces is that the Fund shall exercise its functions through development and purchase of health services packages by health care providers. In this way, the Fund achieves an active function.

Another specific aspect is that the law creates flexibility in the process of drafting packages associated with the respective prices, taking into consideration the solvency of the Fund's budget. This implies that not all types of services can be included in the package financed by the Fund. On the other hand, the law sets out the medical, economic and social criteria on the basis of which packages of services will be drafted, such as to what extent the service impacts expectancy, effectiveness, the cost of service, the solvency of the population.

The drafting of services packages is made by technical committees, the experts of which equally represent medical, economic and social criteria. Members of the Technical Committees are appointed by the Fund's Administrative Council according to the rules set out in the Fund's Statute. The Administrative Council of the Fund approves the draft packages proposed by the technical committees and sends them to the Minister of Health for processing by the Council of Ministers. The proposed package is accompanied by a financial report of the Fund's General Director, on financial coverage options of the packages proposed by the Fund.

The compulsory insurance packages services contain:

a) visits, medical examinations and treatment in public primary health care centres and public hospitals;

b) visits, medical examinations and treatments in private primary medical care and private hospitals.

c) drugs, medical products and treatments by contracted providers of health services

*Co-payment***.** The law specifically addresses the problem of co-payment confirming the principle of participation on covering the price of services provided to the insured persons. Co-payment mechanism in a health insurance scheme aims to achieve several goals: primarily, it reminds consumers about the cost of health services; secondly it helps to manage the scheme by formalizing informal payments, and thirdly it is a means to prevent or limit abusive requests for access to the insurance scheme. However, in the framework of further extending the principle of solidarity, the law also provides the exemptions from co-payment of some categories of persons because of social or health characteristics, determined by CMD. These categories are pensioners, children up to one year old, war invalids, the sick people with some diagnoses as Ca, AIDS and TB, etc.

The Fund of compulsory health insurance does not finance health care services to persons who are not insured in accordance with the provisions of this law except of cases of medical emergency. Excluding cases of emergency, persons that want to benefit from health insurance must follow the procedures and rules established by law in order to certify which category of health insurance they belong to.

Contracts with service providers and the private sector. The Fund pays health care providers only for services provided to insured persons and based on the terms and conditions of the respective contracts and their annexes. The Administrative Council shall adopt the procedures and criteria for making contracts and payments, aiming to stimulate access to services, cost effectiveness and increase the quality of services provided to the community by public and private providers.

The Fund may make contracts with private health care providers, licensed by the competent authority. The contract provides for that health service that has to be covered by the Fund. Contracts are made for a certain period of time and can be renewed.

The law creates the possibility for the Fund to select those institutions that will be health service providers and with which they will make contract to purchase the services package. The selection process is done through the implementation of transparent criteria and procedures, taking into account the health needs of the population and their right to have access to the health services package that covers compulsory healthcare. In this law a distinction is made between private service providers, in the contracting process. By placing these institutions at the same level, it is aimed to create a real market and competition between service providers.

The Fund terminates the contract with a service provider when performance analysis shows that the provider does not meet the criteria foreseen by law. Previous to the contract termination, the Fund should inform the Ministry of Health and has to leave to the service provider a deadline for meeting the criteria.

Administrative Council sets out the various forms of payments for providers of health care services and health care institutions.

The Fund reimburses the insured persons, who receive services from health care providers within the country and who do not have contract with the Fund, only in the absence of contracted providers of health services, after the relevant verification by the Fund. The Administrative Council shall specify the cases of providing reimbursement to persons and reimbursement rules and procedures.

The law pays a special attention to issues related to information by providing the obligation of a number of public institutions to exchange information with the Fund. Thus, the Fund receives information from the Ministry of Finance, the Ministry of Health, the Directorate General of Taxation and the other institutions.

Health care providers are required to submit to the Ministry of Health and the Fund, periodic information concerning their activities, according to reporting obligations stipulated in contracts with the Fund. The Fund will manage confidential information in accordance with the health care legislation, legislation on data protection and other legislation.