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DOPUNSKO ZDRAVSTVENO OSIGURANJE U FUNKCIJI DOPRINOSA RAZVOJU ODRŽIVOG SISTEMA ZDRAVSTVENE ZAŠTITE U REPUBLICI SRBIJI

ORIGINALNI NAUČNI RAD

Apstrakt

Zakon o zdravstvenom osiguranju uređuje tri vrste dobrovoljnog zdravstvenog osiguranja: paralelno, dopunsko i privatno zdravstveno osiguranje. U pitanju su vrlo perspektivne usluge osiguranja, od kojih je autorka izdvojila dopunsko zdravstveno osiguranje. Kakav je potencijal tog tipa pokrića? Koji su uslovi za njegov razvoj? Da li su u našem zakonodavstvu ispunjene institucionalne pretpostavke za stvaranje održivog sistema zdravstvene zaštite? Nakon analize odnosa dopunskog i dobrovoljnog zdravstvenog osiguranja, autorka izdvaja zdravstveno opismenjavanje građana, potencijalnih korisnika osiguranja kao faktor koji nadmašuje sve ostale u važećem regulatornom okviru. Promovisanjem dopunskog zdravstvenog osiguranja kao usluge koja se direktno nadovezuje na obavezno zdravstveno osiguranje i dopunjuje ga u delu troškova participacije šalje se poruka građanima da zdravstveni troškovni rizik u jednom delu usluga obavezne zdravstvene zaštite može da se prevali na osiguravače dobrovoljnog zdravstvenog osiguranja. Autorka u zaključku dokazuje da se time podstiče uključivanje privatnih osiguravača u finansiranje troškova obavezne zdravstvene zaštite, čime se ostvaruje saradnja privatnog i državnog sektora radi održivog razvoja sistema zdravstvene zaštite.

Ključne reči: *Dobrovoljno zdravstveno osiguranje. – Dopunsko zdravstveno osiguranje. – Regulatorni okvir. – Perspektivne usluge osiguranja.*

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I. Uvodna razmatranja

Dobrovoljno zdravstveno osiguranje shvaćeno u širem smislu pruža finansijsku zaštitu od rizika bolesti i s njim povezanih posledica.[2] To osiguranje – koje se kreira prema željama i potrebama osiguranika – može da se koristi na različite načine: kao redovno osiguranje (koje u potpunosti zamenjuje obavezno zdravstveno osiguranje) ili kao dopuna postojećem sistemu zdravstvene zaštite.[3] Imamo li u vidu ambijent XXI veka koji karakterišu starenje stanovništva, finansijski pritisak na javne fondove zdravstvenog osiguranja i neslućene mogućnosti lečenja odnosno prevencije, jasno je da je jedan od primarnih zadataka svake države da *upotpuni paket zdravstvene zaštite*. Poslednjih decenija velika pažnja se posvećuje upravo dobrovoljnom zdravstvenom osiguranju iz tih razloga. Uočeno je da postojeći sistemi mogu opstati samo ako se osmisli kombinacija obaveznog i dobrovoljnog osiguranja, što će obezbediti i kombinovano korišćenje kapaciteta državnih i privatnih zdravstvenih ustanova. Preduslov za to je *zdravstveno opismenjavanje* najšireg kruga građana, uz istovremeno ukazivanje na potencijal dobrovoljnog zdravstvenog osiguranja u koje se pravovremeno investira. Građani, odnosno potencijalni pacijenti treba da budu osposobljeni da se postaraju za svoje zdravlje i da donose odluke kojima će ostvariti *upravljanje zdravstvenim rizikom* kao jednim od bazičnih i egzistencijalnih rizika.[4]

Dokle se u Srbiji stiglo sa zdravstvenim opismenjavanjem građana? I da li postoji *adekvatna zdravstvena strategija* koja uključuje i dobrovoljno zdravstveno

[2] H. Müller, „Private Krankenversicherung", u: Roland Michael Beckmann, Annemarie Matusche-Beckmann (hrsg.), *Versicherungsrechts-Handbuch*, Verlag C. H. Beck München 2009, str. 2697; J. Bigot, „Les assurances de personnes non-vie, Notions generals", u: Jean Bigot, Philippe Baillot, Jérôme Kullmann, Luc Mayaux (ed.), *Les assurances de personnes*, Tome 4, L.G.D.J, Paris, 2007, str. 503.

[3] „Dobrovoljno (privatno) zdravstveno osiguranje pokriva finansijske posledice ugovorom nabrojanih bolesti, uobičajeno je da pokriva farmaceutske troškove, troškove lečenja i hospitalizacije, a može da pokrije i posledice privremene nesposobnosti (invalidnosti) ili rizik od smrti nastao kao posledica bolesti." – N. Petrović Tomić, *Pravo osiguranja*, Sistem, Knjiga prva, Službeni glasnik, Beograd, 2019, str. 708. U.: I. Spasić, „Mesto dopunskog i privatnog zdravstvenog osiguranja u uporednom pravu i predlozi za reformu sistema zdravstvenog osiguranja u Srbiji", *Revija za pravo osiguranja*, br. 1/2, 2004, str. 1–13; J. Slavnić, „Ugovor o dobrovoljnom zdravstvenom osiguranju kao predmet zakonskog regulisanja – prilog raspravi o regulisanju ugovora o osiguranju u novom Građanskom zakoniku Srbije", *Evropske (EU) reforme u pravu osiguranja Srbije*, Palić 2010, str. 2.

[4] Upravljanje zdravstvenim rizikom podrazumeva niz mera, od kojih naročito izdvajamo zdravstvenu prevenciju. Preventivni sistematski pregledi su dragoceni u postupku ranog otkrivanja bolesti i stanja koja zahtevaju dugotrajno i skupo lečenje. Sistematski pregledi zaposlenih preventivnog karaktera su zakonita prestacija zdravstvenih ustanova. To proizlazi iz regulatornog okvira Republike Srbije, koji čini niz zakona, od kojih izdvajamo Zakon o zdravstvenoj zaštiti (*Službeni glasnik RS*, br. 25/2019 – dalje: ZZZ). Prema tom zakonu, zdravstvena zaštita obuhvata sprovođenje mera i aktivnosti za očuvanje i unapređenje zdravlja državljana Republike Srbije, sprečavanje, suzbijanje i rano otkrivanje bolesti, povreda i drugih poremećaja zdravlja i blagovremeno, delotvorno i efikasno lečenje, zdravstvenu negu i rehabilitaciju (čl. 2 st. 1). Po slovu tog zakona, zdravstvene ustanove u javnoj i privatnoj svojini, kao i privatna praksa, pružaoci su zdravstvene zaštite.

osiguranja? Kao što ćemo u daljem izlaganju pokazati, u Srbiji trenutno postoji niz problemskih situacija počev od terminoloških nedoumica do protekcionizma državnog fonda koji prete da uspore i/ili uruše napore za uspostavljanje javno-privatnog partnerstva države i osiguravača, kao jedinog održivog modela sprovođenja zdravstvene zaštite građana.

II. Regulatorni okvir dobrovoljnog zdravstvenog osiguranja u Srbiji

1. Istorijski osvrt – od Uredbe do Zakona

Regulatorni okvir za obavljanje privatnog zdravstvenog osiguranja u Srbiji već decenijama je izrazito podnormiran.[5] Naime, u ovom trenutku može se govoriti samo o statusnom delu regulatornog okvira, koji čine Zakon o osiguranju (dalje: ZO)[6] i Zakon o zdravstvenom osiguranju (dalje: ZZO).[7] Zakon o obligacionim odnosima (dalje: ZOO)[8] ne sadrži posebne odredbe o dobrovoljnom zdravstvenom osiguranju.[9] I pored usvajanja *lex specialis* propisa, ugovorni deo regulatornog okvira privatnog zdravstvenog osiguranja je neizgrađen, što već godinama ocenjujemo kao veliki nedostatak našeg zakonodavstva.[10] Za većinu materijalnopravnih pitanja vezanih za dobrovoljno zdravstveno osiguranje odgovor se mora tražiti u odeljku ZOO koji sadrži opšta pravila za osiguranje, dok je ZZO samo delimično i ovlaš dotakao ugovornu materiju. To će u mnogim situacijama dovesti do pravnih praznina, koje se moraju popunjavati shodnom primenom opštih ili posebnih pravila iz odeljka posvećenog osiguranju lica. Dakle, *nedostaje materijalnopravni deo regulatornog okvira* ugovora o privatnom zdravstvenom osiguranju. Problem može biti rešen samo donošenjem posebnog Zakona o ugovoru o osiguranju, koji bi sadržao odeljak posvećen dobrovoljnom zdravstvenom osiguranju.

[5] Termin privatni ovde koristimo u širem smislu kao opozit obaveznom zdravstvenom osiguranju, koje je javno i pod pokroviteljstvom države (nap. aut.).

[6] *Službeni glasnik RS,* br. 139/2014 i 144/2021.

[7] *Službeni glasnik RS,* br. 25/2019. Do usvajanja ZZO, materija dobrovoljnog zdravstvenog osiguranja bila je uređena podzakonskim aktom – Uredbom o dobrovoljnom zdravstvenom osiguranju (dalje: Uredba), *Službeni glasnik RS*, br. 108/2008, 49/09.

[8] *Službeni list SFRJ*, br. 29/78, 39/85, 45/89 – odluka USJ i 57/89, *Službeni list SRJ*, br. 31/93 i *Službeni list SCG*, br. 1/2003 – Ustavna povelja.

[9] Za ovo postoji jednostavno objašnjenje. Istorijski posmatrano, ovaj zakon je donet u vreme dominacije državnog sistema obavezne zdravstvene zaštite, te je logičan izostanak i samog pominjanja dobrovoljnog zdravstvenog sistema. Ni uporednopravno posmatrano, situacija nije bila drugačija.

[10] Poređenja radi, u uporednom pravu je uobičajeno da se donose zakoni koji regulišu samo dobrovoljno zdravstveno osiguranje, a ne i obavezno, kako je slučaj kod nas. Mi smo, zapravo, ushićeni što je konačno materija dobrovoljnog zdravstvenog osiguranja dobila zakonodavni rang, iako je to daleko od prakse referentnih evropskih i svetskih pravnih kultura.

Naglašavamo: pošto ZOO uopšte ne pominje dobrovoljno zdravstveno osiguranje, smatramo da se njegove opšte odredbe o osiguranju, kao i odeljak koji sadrži posebna pravila za osiguranje lica, moraju *mutatis mutandis* koristiti za odgovor na sva pitanja iz domena ugovornog prava, koja su ostala izvan ZZO. To svakako nije lak posao, budući da je i dobrovoljno zdravstveno osiguranje – kao i osiguranje od posledica nezgode – hibridna usluga i da prestacije osiguravača nije moguće posmatrati samo iz ugla osiguranja lica.[11] *In ultima linea*, takav zakonodavni okvir stvara plodno tlo za pojačani značaj uslova osiguranja. Osiguravači nastoje da zakonski vakuum popune detaljnim uređenjem svih pitanja uslovima osiguranja. Poželjno bi bilo usvojiti (bar) zajednička načela ugovora o dobrovoljnom zdravstvenom osiguranju. Uslovi naših osiguravači razlikuju se i po dopunskim i posebnim uslovima koje prilagođavaju konkretnim paketima zdravstvene zaštite. Ako znamo da je u pitanju prilično nova usluga osiguranja za naše prilike, to moramo računati sa još većom neukošću potrošača usluga osiguranja nego što je to slučaj kada se radi o ostalim ugovorima o osiguranju. Tipična potrošačka pozicija iz tih razloga natprosečno je tangirana odsustvom zakonskog minimuma uređenja osetljivih pitanja ugovornog odnosa dobrovoljnog zdravstvenog osiguranja. Stoga je jedan od razloga što godinama apelujemo na usvajanje ugovornog zakona o osiguranju upravo zakonsko normiranje podele na odštetna i svotna osiguranja, koja predstavlja *conditio sine qua non* pravilne kvalifikacije prestacija kod dobrovoljnog zdravstvenog osiguranja.[12]

Da napravimo kratak istorijski osvrt na naše zakonodavstvo. Kako ZOO ne sadrži odredbe posvećene dobrovoljnom zdravstvenom osiguranju, materijalnopravna regulativa ove vrste osiguranja donedavno se nalazila u podzakonskoj regulativi. Zapravo, kod nas takva zakonodavna zbrka postoji od 2008. godine. Usvajanjem Uredbe o dobrovoljnom zdravstvenom osiguranju napravljen je presedan u našem pravu, koji treba istaći kao negativnu paradigmu. Naime, njome su uređena brojna pitanja ugovornog prava osiguranja koja čine *domain reservé* zakonodavne materije: postupak zaključenja ugovora o dobrovoljnom zdravstvenom osiguranju, ograničenje slobode ugovaranja osiguravača – iako nije u pitanju obavezno osiguranje (sic!), uređenje obaveza osiguravača u pogledu kolektivnih ugovora itd. Kao takva, Uredba

[11] O tome smo već pisali: N. Petrović Tomić, „Hibridni proizvodi osiguranja – stanje i perspektive razvoja", u: Z. Petrović, V. Čolović, D. Obradović (ured.), *Prouzrokovanje štete, naknada štete i osiguranje*, XXIV međunarodni naučni skup, Beograd – Mionica 2021, str. 325–341.

[12] Po ugledu na uporedno pravo, u odeljak o dobrovoljnom zdravstvenom osiguranju trebalo bi uključiti minimum zaštite ne samo osiguranika, već i same ustanove osiguranja. Pod tim podrazumevamo ograničavanje slobode osiguravača da utvrđuju osnove tarifiranja premija osiguranja. Premija ne sme da bude obračunata samo na osnovu pristupne starosti i zdravstvenog stanja osiguranika, jer takav način obračuna favorizuje mlađe osiguranike, a može značiti odbijanje starijih osiguranika. Osiguravačima se ne sme ostaviti potpuna sloboda u pogledu uređenja karence; treba urediti bonus i malus na način kojim se osiguranik podstiče da smanji verovatnoću nastupanja rizika; franšize su uobičajene itd.

je bila protivna Ustavu Republike Srbije i ZOO.[13] Uredba, uz to, određuje i sadržaj polise dobrovoljnog zdravstvenog osiguranja (iako je to zakonska materija ZOO), nabraja pravila koje se odnose na dobrovoljno zdravstveno osiguranje (uključujući i opšte i posebne uslove) itd.

Polazeći od Ustava Srbije (čl. 68 st. 3), materija zdravstvenog osiguranja treba da bude uređena zakonom. Stoga pozdravljamo usvajanje posebnog zakona o zdravstvenom osiguranju, koji ima odeljak posvećen dobrovoljnom zdravstvenom osiguranju. Ali to bi moralo biti samo **prelazno rešenje.** Naime, u referentnim zakonodavstvima materija dobrovoljnog zdravstvenog osiguranja uveliko se uređuje *lex specialis* propisom, koji ne reguliše u istom paketu i obavezno zdravstveno osiguranje. Iznećemo nekoliko razloga zašto smatramo da je od esencijalnog značaja zakonsko uređenje ove vrste osiguranja, odnosno razdvajanje uređenja obaveznog i dobrovoljnog zdravstvenog osiguranja. Prvo, zbog *korisnosti* pomenute vrste osiguranja. Rizik od bolesti je jedan od onih rizika s kojim se svako lice suočava, koji je uz to potenciran u dvadeset i prvom veku koji karakteriše izraženo starenje stanovništva. U pitanju je *rizik egzistencijalnog karaktera*, čije pokriće nije moguće samo na osnovu obaveznog zdravstvenog osiguranja.[14] Na odluku jednog lica da investira u taj oblik pokrića odlučujuće utiče saznanje da je usled novih otkrića medicina toliko napredovala da mnoge bolesti više nisu neizlečive, kao i da lica i posle ozbiljnih nezgoda i povreda mogu računati na oporavak i nastavak života ako su u mogućnosti da sebi priušte savremene metode lečenja. Dakle, takvo korisno osiguranje treba da bude uređeno zakonskim izvorom, budući da se njime pokriva rizik koji nije u potpunoj dispoziciji lica na koje se odnosi, već pogađa javni interes. Država ima jasan interes da se stara o zdravlju stanovništva, što taj rizik izmešta iz polja slobodne dispozicije korisnika usluga. Drugo, iako u različitim državama postoje različiti modeli, generalno se može reći da dominira princip koegzistencije privatnog i javnog sektora u oblasti zdravstvene zaštite. Tako dobrovoljno osiguranje postoji **paralelno** sa obaveznim zdravstvenim osiguranjem i služi kao **dopuna** sistema obavezne zdravstvene zaštite. Zbog istovremenog smanjenja broja zaposlenih i izraženog starenja stanovništva u većini zemalja, sistem obaveznog zdravstvenog osiguranja se suočava s velikim ograničenjima. Ključno je da se lica koja su korisnici obavezne zdravstvene zaštite podstaknu da od najranijih dana izdvajaju sredstva na ime osiguranja, koje će svojim postojanjem smanjiti pritisak na fondove obavezne zdravstvene zaštite. Samo dobro osmišljeni paket dobrovoljnog zdravstvenog osiguranja može da nadomesti ograničene kapacitete obaveznog zdravstvenog osiguranja.

Treće, potreba zaštite osiguranika kao slabije strane ugovora o osiguranju još je više izražena kada je reč o novim vrstama osiguranja, s kojima su oni još manje

[13] Za detaljnu kritiku Uredbe: J. Slavnić, „Pogled na regulisanje ugovora o dobrovoljnom zdravstvenom osiguranju", *Pravni život*, br. 12/2009, str. 807–823.

[14] M. Wandt, *Versicherungsrecht*, 5. neu bearbeitete Auflage, Carl Heymanns Verlag, Köln 2010, str. 462.

familijarni nego sa ugovorima koje godinama unazad kupuju. Oni će biti bolje zaštićeni ako se zakonskim imperativnim ili poluimperativnim normama uredi najveći broj pitanja od značaja za ugovor o osiguranju. Time se sužava manevarski prostor za osiguravače. Zaštitna funkcija zakonskih normi utoliko je izraženija ukoliko se zna da u ovoj vrsti osiguranja postoji rizik od antiselekcije rizika. Zbog toga se osiguravač zakonom obavezuje da zaključi ugovor o osiguranju sa svakim licem koje uputi ponudu za zaključenje ugovora, a same okolnosti na osnovu kojih će biti ocenjen rizik i određena premija unapred se zakonom definišu.[15]

Četvrto, već smo ukazali na specifičnost ove vrste osiguranja i na različite prestacije koje osiguravač može preuzeti ugovorom.[16] Kod takvih usluga osiguranja u interesu je i osiguravača da se zakonom izvrše određena preciziranja. Peto, sudskoj praksi će biti neuporedivo lakše da rešava sporove iz te vrste osiguranja ako postoji jasan i moderan regulatorni okvir. Šesto, dobrovoljno zdravstveno osiguranje odlično se prodaje na razvijenim tržištima ne samo kao osnovni već i kao dopunski ugovor uz životno osiguranje ili osiguranje od posledica nezgode. Kada se pokriva rizik od smrti, budući da se može ostvariti i kao posledica nesrećnog slučaja ili bolesti, osiguravači nude povoljne pakete koji kombinuju životno i dobrovoljno zdravstveno osiguranje. Favorabilna regulativa tog osiguranja može, dakle, delovati podsticajno na razvoj drugih usluga osiguranja, sa kojima je po riziku srodno.

Sedmo, osiguranje lica (a najviše osiguranje od posledica nezgode i zdravstveno osiguranje) ima značajnu ulogu u poboljšanju sistema *socijalne zašite*. Bilo koja nezgoda ili ozbiljnija bolest lakše se prebrode ako je lice unapred investiralo u odgovarajući paket pokrića. Stoga se na razvijenim tržištima poslodavci takmiče u pogledu privlačenja kvalifikovane (ili deficitarne) radne snage dobrim paketima kombinovanog osiguranja od posledica nezgode i zdravstvenog osiguranja.[17] Imajući u vidu višestruke koristi od osiguranja lica, zakonodavci razvijenih država – koji planiraju da podstaknu ekspanziju proizvoda osiguranja – uvode *poreske olakšice* za osiguranja lica, pogotovo za osiguranje života. Porez na premije životnih osiguranja u mnogim državama ne postoji ili je takav da ne predstavlja dodatno fanansijsko opterećenje potrošača usluga osiguranja.

[15] U pitanju je ograničenje slobode ugovaranja uobičajeno u obaveznim vrstama osiguranja. Ali imajući u vidu socijalnu funkciju dobrovoljnog zdravstvenog osiguranja, zakonodavac nije mogao da prepusti osiguravačima da prilikom preuzimanja rizika primenjuju čisto tržišni pristup. Iz istih razloga, ugovorna sadržina je u velikoj meri uređena samim zakonom. Detaljnije o ograničenju principa slobode ugovaranja u pravu osiguranja: N. Petrović Tomić, „O ograničenoj i usmerenoj slobodi ugovaranja u ugovornom pravu osiguranja: fenomen 'pokoravanja' ugovora o osiguranju", u M. Karanikić Mirić, M. Đurđević (ured.), *Zbornik radova sa Druge regionalne konferencije* iz obligacionog prava održane 14. i 15. novembra 2019. godine na Pravnom fakultetu Univerziteta u Beogradu, Beograd 2020, str. 318–343.

[16] N. Petrović Tomić, „O pravnoj prirodi dobrovoljnog zdravstvenog osiguranja – Povodom predloga Zakona o zdravstvenom osiguranju", u: M. Orlić (ur.), *Aktuelna pitanja savremenog zakonodavstva*, Budva, 2019, str. 487–506.

[17] J. M. Binon, *Droit des assurances de personnes, Aspects civils, technique et sociaux,* Larcier, Bruxelles, 2007, str. 20.

2. Pogled na ZZO

U ZZO su sadržane identične odredbe onima koje sadrži Uredba. Po našem mišljenju, čl. 6 i 7 ZZO ne donose potreban napredak ovoj delatnosti. Naime, u čl. 7 stoji da se obavezno zdravstveno osiguranja organizuje i sprovodi u Republičkom zavodu, dok dobrovoljno zdravstveno osiguranje mogu da organizuju i sprovode i pravna lica koja obavljaju delatnost osiguranja (tj. društva za osiguranje), pored Republičkog zavoda, u skladu sa ZZO i zakonom kojim se uređuje osiguranje.[18] To potvrđuje čl. 10 st. 1 tač. 15. Po ZZO, društvo za osiguranje može da pruža sve vrste usluga dobrovoljnog zdravstvenog osiguranja, dok Republički zavod ne može da se bavi poslovima privatnog zdravstvenog osiguranja. ZZO izričito kaže da se na organizaciju i sprovođenje dobrovoljnog zdravstvenog osiguranja primenjuju odredbe zakona kojim se uređuje osiguranje. To otvara pitanje da li se odredbe ZO podjednako odnose i na Republički zavod kada se nađe u ulozi osiguravača dobrovoljnog zdravstvenog osiguranja. Pitanje nema samo teorijski značaj.

Na to se može odgovoriti sistematskim tumačenjem ZZO. Iako bi se samo na osnovu uvodnih odredaba moglo pomisliti kako svaki osiguravač dobrovoljnog zdravstvenog osiguranja – uključujući i Republički zavod – treba da ispunjava uslove iz ZO, takav zaključak ne proizlazi iz onoga što piše u trećem delu posvećenom dobrovoljnom zdravstvenom osiguranju. U čl. 177, koji nosi naslov Uslovi za organizovanje i sprovođenje dobrovoljnog zdravstvenog osiguranja, izričito se pravi razlika između uslova koje treba da ispuni osiguravač i onih koje treba da ispuni Republički zavod. Dok Republički zavod donosi odluku o organizovanju i sprovođenju dobrovoljnog zdravstvenog osiguranja (podvukla N. P. T.); za privatne osiguravače važi sistem dvostruke dozvole. Oni, naime, pored mišljenja ministarstva za poslove zdravlja o ispunjenosti uslova za organizovanje i sprovođenje dobrovoljnog zdravstvenog osiguranja, treba da pribave i dozvolu NBS. Dok se mišljenje resornog ministarstva daje na osnovu ZZO, dozvola NBS dobija se na osnovu ZO.

Ono po čemu će se razlikovati poslovanje društava koja se osnivaju za poslove dobrovoljnog zdravstvenog osiguranja jeste kumuliranje dozvola. Naime, resorno ministarstvo izdaje mišljenje o ispunjenosti uslova za organizovanje i sprovođenje dobrovoljnog zdravstvenog osiguranja. Ali uz zahtev za izdavanje tog mišljenja u slučaju privatnih osiguravača dostavlja se i kopija dozvole za rad NBS o obavljanju poslova osiguranja u skladu sa zakonom o osiguranju. Budući da je dobrovoljno zdravstveno osiguranje podvrsta neživotnog osiguranja, tim poslovima bave se kompozitna društva za osiguranje, kao i ona što imaju dozvolu za obavljanje poslova neživotnog osiguranja. Izuzetno, poslovima dobrovoljnog zdravstvenog osiguranja mogu se baviti i društva koja obavljaju poslove životnog osiguranja u delu koji pokriva troškove lečenja, pod uslovom da se to osiguranje odnosi na lice s kojim je

[18] Obavezno zdravstveno osiguranje rezervisano je za Republički zavod, koji osigurava osnovni paket pokrića.

zaključen neki od ugovora o životnom osiguranju.[19] Dopunska klauzula zahteva da se o tim ugovorima vodi posebna evidencija.

Ispada da je specijalnim zakonom samo prepisana Uredba! To je slaba tačka statusnopravnog dela regulatornog okvira dobrovoljnog zdravstvenog osiguranja. Osim toga, pomenuto rešenje Uredbe protivno je odredbama važećeg ZO (i naravno direktivama EU o neživotnom osiguranju). Time je napravljen dvostruki izuzetak u domenu dobrovoljnog zdravstvenog osiguranja. Prvo, Republičkom zavodu, koji je *ex lege* ekskluzivni osiguravač u domenu obaveznog zdravstvenog osiguranja, priznato je pravo da se bavi i nekim poslovima dobrovoljnog zdravstvenog osiguranja. I to bez prethodnog odobrenja nadzornog tela za poslove osiguranja. Time je napravljen presedan ne samo iz ugla našeg prava, već i generalno. U sektoru osiguranja sistem dozvola može se nazvati tekovinom. Drugo, time što Republički zavod ne primenjuje ZO čini se još opasnije odstupanje od pravnog režima koji – po dobroj evropskoj praksi – treba da važi za sve pružaoce usluga osiguranja. To doslovno omogućava Republičkom zavodu da ne formira potrebne rezerve, a NBS onemogućava da vrši nadzor nad delom poslovanja koji se odnosi na dobrovoljno zdravstveno osiguranje. Jedino što je u ZZO rečeno jeste to da i Republički fond vodi sredstva dobrovoljnog zdravstvenog osiguranja odvojeno od sredstava i računa obaveznog zdravstvenog osiguranja, i to po vrstama dobrovoljnog zdravstvenog osiguranja koje sprovodi na posebnim računima (čl. 193 st. 2). Osim što nije u interesu potrošača usluga osiguranja, situacija koju ponavlja ZZO, a koja već postoji na osnovu Uredbe, krajnje je nepodsticajna po privatne osiguravače, koji su u nepovoljnijem položaju od Republičkog zavoda.[20]

Sigurno je da je regulatorni okvir pružanja zdravstvenog osiguranja u Srbiji vrlo limitiran, te da se osiguravači koji pokušavaju da razviju ovu vrstu osiguranja suočavaju s brojnim ograničenjima. Nije obezbeđena jednakost dobrovoljnih (premijskih) osiguravača i fondova obaveznog zdravstvenog osiguranja, niti sigurnost poslovanja. Po onome što piše u ZZO, to neće biti slučaj ni ubuduće. Favorizovanje Republičkog zavoda za zdravstveno osiguranje u odnosu na privatne osiguravače utoliko je problematičnije ukoliko znamo da on nema razvijenu prodajnu mrežu, što je, po nama, jedan od dugogodišnjih uzroka što dobrovoljno zdravstveno osiguranje nije uhvatilo korena. Sve i da naprasno izgradi prodajnu mrežu, pitanje je da li će nju činiti samo lica koja imaju licencu za prodaju usluga osiguranja? Ili je RFZO i u tom pogledu iznad i izvan ZO? Osim toga, zakon stvara sukob interesa, budući da se o pravima koja proizlaze iz obaveznog osiguranja i pravima koja proizlaze iz dobrovoljnog osiguranja (koje se plaća!) odlučuje na istom mestu!!

[19] ZO, čl. 22 st. 1.

[20] N. Botica Jukić, „Usklađenost Zakona o dobrovoljnom zdravstvenom osiguranju s pravnom stečevinom Europske unije", *Osiguranje*, br. 1/2015, str. 30–33.

Uzor kako treba regulisati privatno zdravstveno osiguranje je nemačko pravo.[21] U zakonu o nadzoru osiguranja stoji da se zdravstvenim osiguranjem ne može baviti osiguravač koji se bavi poslovima osiguranja imovine ili životnog osiguranja.[22] Zakon o ugovoru o osiguranju sadrži materijalnopravne odredbe. Taj zakon dopušta da se dobrovoljno zdravstveno osiguranje ugovori kao imovinsko ili kao osiguranje lica, u zavisnosti od toga o kojoj vrsti zdravstvenog osiguranja je reč. Primena zakona o ugovoru o osiguranju u svakom slučaju je ograničena (primera radi, ne primenjuju se norme o povećanju rizika, ali se primenjuje subrogacija osiguravača i kod zdravstvenog osiguranja koje je zaključeno kao osiguranje lica). Osim toga, u nemačkom pravu postoje i model-uslovi za pojedine vrste zdravstvenog osiguranja koje je donelo udruženje osiguravača i koje pojedinačni osiguravači prihvataju i na osnovu njih pružaju ovu vrstu usluga osiguranja.

III. Vrste dobrovoljnog zdravstvenog osiguranja u Srbiji – da li je zakonodavac pobrkao lončiće?

ZZO sadrži poseban odeljak koji uređuje dobrovoljno zdravstveno osiguranje. Zapravo, predmet tog zakona su dve vrste zdravstvenog osiguranja: obavezno i dobrovoljno osiguranje. Sama činjenica da je materija dobrovoljnog zdravstvenog osiguranja prvi put kod nas dobila zakonodavni rang zaslužuje da se istakne kao korak napred u razvoju ovog tipa osiguranja, koji u razvijenim državama uveliko doživljava ekspanziju. Ali da li zbog nedovoljne familijarnosti ili iz namere da izbegne zamke zakonskih definicija, zakonopisac koristi *generični pojam dobrovoljno zdravstveno osiguranje* kako bi njime uredio tri vrste pokrića. Stoga je zadatak teorije da najpre razgraniči srodne modalitete pokrića obuhvaćene istim zakonskim pojmom.

ZZO pominje sledeće vrste dobrovoljnog zdravstvenog osiguranja: 1) **dopunsko** zdravstveno osiguranje – osiguranje kojim se pokrivaju troškovi zdravstvene zaštite koji nastaju kada osigurano lice dopunjuje prava iz obaveznog zdravstvenog osiguranja u pogledu sadržaja, obima i standarda; 2) **dodatno** zdravstveno osiguranje – osiguranje kojim se pokriva učešće u troškovima zdravstvene zaštite, to jest troškove zdravstvenih usluga, lekova, medicinskih sredstava, odnosno novčanih naknada koji nisu obuhvaćeni pravima iz obaveznog zdravstvenog osiguranja; 3) **privatno** zdravstveno osiguranje – osiguranje lica koja nisu obuhvaćena obaveznim zdravstvenim osiguranjem, za pokrivanje troškova za vrstu, sadržaj, obim i standard prava koja se ugovaraju sa osiguravačem.[23]

[21] R. Müller-Stein, „Krankenversicherung", u: H. W. Van Bühren, *Handbuch Versicherungsrecht,* 4. Auflage, Deutscher AnwaltVerlag, Bonn, 2009, str. 2119–2182.
[22] Time je obezbeđen najveći mogući stepen finansijske zaštite osiguranika zdravstvenog osiguranja.
[23] ZZO, čl. 6 st. 2 tač. 1 do 3 u vezi sa čl. 174.

Generalno posmatrano, dobrovoljno zdravstveno osiguranje omogućava viši nivo zdravstvenih usluga korisnicima, kao i obezbeđenje onih usluga koje sistem obaveznog zdravstvenog osiguranja nema u ponudi.[24] Uobičajeno je da se prvi modalitet privatnog (dobrovoljnog) zdravstvenog osiguranja označava kao paralelno (engl.: *complementary voluntary health insurance*),[25] a drugi kao dopunsko zdravstveno osiguranje (engl.: *supplementary voluntary health insurance*),[26] dok je za treću vrstu rezervisan naziv privatno zdravstveno osiguranje (engl.: *private voluntary health insurance*).[27] To je slučaj u uporednom pravu, dok se kod nas termini dopunsko, odnosno dodatno zdravstveno osiguranje koriste u pogrešnom kontekstu. Stvar je u tome da je zakonopisac pobrkao lončiće i upotrebio pogrešne nazive za vrste dobrovoljnog zdravstvenog osiguranja koje reguliše, pri čemu i u uporednim pravu ima primera preklapanja pokrića dodatnog, odnosno dopunskog zdravstvenog osiguranja.[28] Imajući u vidu stepen neupoznatosti potrošača s tim uslugama osiguranja kao faktor koji utiče na njihovo interesovanje, smatramo da je propust zakonopisca utoliko veći. U sklopu *zdravstvenog opismenjavanja stanovništva*, element o kome treba voditi računa jeste i dobrovoljno zdravstveno osiguranje.[29] Korisnicima zdravstvene zaštite treba približiti potencijal dobrovoljnog zdravstvenog osiguranja, što se čini kao nemoguća misija ako je greška napravljena već u nazivu usluge.

[24] Pružanjem mogućnosti izbora korisnicima, dobrovoljno zdravstveno osiguranje utiče na smanjenje prekomernog korišćenja usluga obavezne zdravstvene zaštite, smanjenje korupcije, investiranje u zdravstvo, itd. V.: T. Rakonjac Antić, *Penzijsko i zdravstveno osiguranje*, Ekonomski fakultet u Beogradu, Beograd, 2018.

[25] Primera radi, u hrvatskom Zakonu o dobrovoljnom zdravstvenom osiguranju stoji da se dodatnim zdravstvenim osiguranjem osigurava viši standard zdravstvene zaštite u odnosu na standard zdravstvene zaštite iz obveznoga zdravstvenog osiguranja, te veći opseg prava u odnosu na prava iz obaveznog zdravstvenog osiguranja (čl. 6).

[26] Dopunsko zdravstveno osiguranje jest osiguranje kojim se osigurava pokriće troškova zdravstvene zaštite iz obveznoga zdravstvenog osiguranja iz članka 16 stavka 3 i 4 i članka 17 stavka 5 Zakona o obveznom zdravstvenom osiguranju (Hrvatski Zakon o dobrovoljnom zdravstvenom osiguranju, čl. 5).

[27] Za pravo EU: E. Mossialos, S. Thomson, *Voluntary Health Insurance in the European Union,* European Opservatory on Health Systems and Polisies, Brussels, 2004, str. 51–67.

[28] Neki autori preferiraju termin *voluntary additional healt insurance* kojim obuhvataju sva dobrovoljna zdravstvena osiguranja, osim privatnog, koje ima potpuno drugačiju funkciju. V.: P. Calcoen, W. P. M. M. van de Ven, „Voluntary Additional Health Insurance in the European Union: Free Market or Regulation", *European Journal of Health Law*, Vol. 24 /2017, str. 2.

[29] Zdravstvena pismenost stanovništva je od krucijalnog značaja za održivost zdravstvenog osiguranja. *Svetska zdravstvena organizacija definiše zdravstvenu pismenost kao znanje pojedinca i sposobnost da razume i primeni informacije o zdravlju kako bi mogao da donosi odluke vezane za zdravlje i time uticati na održavanje i/ili poboljšanje zdravlja tokom života*. V.: H. D. C. Roscam Abbing, „Health, human rights and health law: The move towards internationalizam, with special emphasis on Europe", *International Digest of Health Legislation*, Vol. 49, No. 1, 1998, str. 101–112.

IV. Dopunsko versus dodatno zdravstveno osiguranje: dva stuba privatne zdravstvene zaštite

Prema uporednom pravu i praksi, prva asocijacija na dobrovoljno zdravstveno osiguranje je dodatno, to jest *paralelno zdravstveno osiguranje.* To je osiguranje kojim se pokrivaju troškovi zdravstvene zaštite što nastaju kada osigurano lice unapređuje paket zdravstvene zaštite u pogledu sadržaja, obima i standarda. Već na prvi pogled, jasno je da je to prilično nejasno osiguranje, oko čijeg se opsega mogu javiti nedoumice. U pitanju je osiguranje koje stupa na scenu kada osiguranik ostvaruje zdravstvenu zaštitu koja je obuhvaćena obaveznim zdravstvenim osiguranjem na način i po postupku koji su drugačiji od načina i postupka ostvarivanja prava iz obaveznog zdravstvenog osiguranja propisanog zakonom kojim se uređuje zdravstveno osiguranje i propisima donetim za sprovođenje tog zakona. Paralelno zdravstveno osiguranje, kao što naziv sugeriše, zamišljeno je kao dopuna postojećem sistemu obaveznog zdravstvenog osiguranja. Ono bespogovorno po vokaciji zakona pruža širi obim prava od obaveznog zdravstvenog osiguranja, iako može biti razlike između zakonodavstava u pogledu onoga šta se pod tim tačno podrazumeva.[30] Odgovor na to pitanje može se dobiti samo na osnovu uvida u uslove osiguranja.

Da bismo razgraničili polje primene paralelnog dobrovoljnog zdravstvenog osiguranja, uporedićemo ga s dopunskim zdravstvenim osiguranjem. Iako ZZO za tu vrstu osiguravajuće zaštite koristi pogrešan naziv, definisana je na način koji se inače sreće u uporednom zakonodavstvu. Dopunsko zdravstveno osiguranje pokriva troškove zdravstvene zaštite, odnosno zdravstvenih usluga, lekova, medicinskih sredstava,[31] rehabilitacije i novčanih naknada, koje nije obuhvaćeno obaveznim zdravstvenim osiguranjem. *Dopunsko zdravstveno osiguranje,* zapravo, dopunjuje paket obaveznog zdravstvenog osiguranja u delu zdravstvenih usluga poznatih pod nazivom troškovi participacije.[32] *A contrario*, ako neko želi širi obim dodatnog pokrića, a ne samo da pokrije troškove participacije, opredeliće se za dodatno, a ne za dopunsko zdravstveno osiguranje.

Suštinski posmatrano, dve vrste sličnog pokrića mogu se pribaviti dobrovoljnim zdravstvenim osiguranjem. Sličnost se ogleda u tome što se u većoj ili manjoj meri oslanjaju na obavezno zdravstveno osiguranje, takoreći bez njega nije moguće odrediti njihov opseg pokrića, dok je treći modalitet (privatno zdravstveno osiguranje) potpuno samostalno.[33] Uostalom, osiguranik je fizičko lice koje je zaključilo ugovor

[30] E. Mossialos, S. Thomson, str. 66–67.

[31] U Uredbi je stajalo medicinsko-tehničkih pomagala i implantata, što je sada izostavljeno. Verujemo da će to ograničiti širinu pokrića, odnosno umanjiti stepen zdravstvene zaštite stanovništva.

[32] E. Mossialos, S. Thomson, str. 67.

[33] B. Nikolić, „Slovenian Complementary Health Insurance as a Service of General Economic Interest", *International Public Administration Review,* Vol. 13 (1), 2015, str. 49–67.

o dobrovoljnom zdravstvenom osiguranju ili za koga je ugovor zaključen, i koji koristi prava predviđena ugovorom, kao i član njegove porodice. ZZO je postavljeno ograničenje u pogledu svojstva osiguranika paralelnog i dodatnog zdravstvenog osiguranja. U paralelnom i dodatnom osiguranju osiguranik može biti samo lice koje ima svojstvo osiguranika obaveznog zdravstvenog osiguranja. Dakle, lice koje nije obuhvaćeno obaveznim zdravstvenim osiguranjem ne može u Srbiji kupiti ni paralelno ni dodatno dobrovoljno zdravstveno osiguranje. Takođe, ZZO propisuje da lice koje izgubi položaj osiguranika u obaveznom osiguranju gubi isti položaj i u paralelnom i u dodatnom zdravstvenom osiguranju. Time je jasno ukazano na vezu između pomenutih vrsta dobrovoljnog zdravstvenog osiguranja i obaveznog zdravstvenog osiguranja.[34]

Da najpre krenemo od pokrića koje se odnosi na onaj deo troškova zdravstvene zaštite koji po pravilima obaveznog zdravstvenog osiguranja snosi sam osiguranik (tzv. troškovi participacije).[35] Iako ga zakon pominje kao drugi tip dobrovoljnog zdravstvenog osiguranja, njegova sadržina se lakše može odrediti. Dok u pogledu troškova participacije i nema problema,[36] drugi oblik pokrića – koje donosi „veći sadržaj, obim i standard prava" u odnosu na prava iz obaveznog zdravstvenog osiguranja –prilično je neodređen. Zakon nije definisao šta se smatra pod navedenim višim standardom zaštite i većim obimom prava. Za njegovo određenje bitno je poznavanje propisa koji uređuju obavezno zdravstveno osiguranje. Generalno posmatrano, *veći strandard zdravstvene zaštite obično se odnosi na lekarske preglede i dijagnostičke postupke bez listā* čekanja, viši standard bolničkog smeštaja, mogućnost izbora specijaliste ili hirurga, proširenu lista lekova čiju kupovinu finansira osiguravač.[37] Takođe, iz uslova osiguranja proizlazi da *dodatno zdravstveno osiguranje može da obuhvata i: troškove godišnjeg sistematskog pregleda, troškove različitih specijalističkih pregleda, troškove dodatnih laboratorijskih analiza* itd.[38] Ono što je izvesno, bar stručno posmatrano,

[34] Osim toga, u opštim uslovima osiguranja postoji klauzula supsidijariteta dobrovoljnog zdravstvenog osiguranja. Prema toj klauzuli, osiguranik ima pravo na pokriće troškova lečenja na osnovu dobrovoljnog zdravstvenog osiguranja samo ako nema pravo na naknadu tih troškova po osnovu obaveznog zdravstvenog osiguranja. Samo privatno zdravstveno osiguranje uživa autonomiju u odnosu na obavezno zdravstveno osiguranje. Paralelno i dodatno zdravstveno osiguranje posmatraju se u sadejstvu sa obaveznim zdravstvenim osiguranjem. To je jako korisno pri tumačenju nejasnih pitanja, poput domašaja paralelnog osiguranja i njegovog razgraničenja od dodatnog zdravstvenog osiguranja.

[35] Detaljnije o tome na šta se odnose troškovi participacije: L. Belanić, „Ugovor o dobrovoljnom zdravstvenom osiguranju u hrvatskom pravu s osvrtom na njemačko pravo", Palić 2017, str. 117.

[36] Uvođenje troškova participacije nastalo je kao posledica smanjenja troškova u sistemu obaveznog zdravstvenog osiguranja. Prebacivanjem dela troškova zdravstvenih usluga na teret građana nastoji se obezbediti racionalizacija troškova.

[37] V. Bradić, „Privatno zdravstveno osiguranje", *Osiguranje,* br. 3/2002, str. 51–52.

[38] Ali troškovi stomatoloških tretmana, presađivanja organa, estetskih zahvata, dijalize, promene pola, veštačke oplodnje, prekida trudnoće koji nije medicinski indikovan itd. isključeni su iz pokrića. U: L. Belanić, str. 124.

jeste to da se oba tipa pokrića mogu nazvati dopunskim ili dodatnim u širem smislu, budući da se njima kompletira zdravstvena zaštita koja proizlazi iz državnog sistema zdravstvene zaštite. Ali jezička distinkcija nije nebitna, tako da je u praksi uobičajeno da se za pokriće koje obuhvata troškove participacije koristi termin dopunsko zdravstveno osiguranje.

Zvuči neozbiljno to što je naš zakonopisac našao za shodno da koristi drugačiju terminologiju od one koja je široko odomaćena u uporednom pravu i praksi. Pitanje je kolike će probleme izazvati takav pristup, budući da terminološka odrednica predstavlja ličnu kartu svake usluge osiguranja. Ako se već prilikom prevoda jave nedoumice (u ovom slučaju potpuno opravdane), može se očekivati da strani poslovni partneri (ulagači u delatnost osiguranja) pokažu određenu dozu nepoverenja. Poslednje što treba da uradi ozbiljan zakonodavac jeste da prilikom uređenja nedovoljno poznatih vrsta osiguranja pribegava nekakvoj originalnosti, koja ga može skupo koštati. Terminološki aparat je azbuka regulative svakog instituta, a ovo utoliko više važi u uslovima globalizacije i širenja stranih investicija.

Privatno zdravstveno osiguranje zamišljeno je kao rešenje za ona lica koja nisu obuhvaćena obaveznim zdravstvenim osiguranjem ili se nisu uključila u obavezno zdravstveno osiguranje.[39] Na osnovu privatnog zdravstvenog osiguranja, ona mogu pribaviti uži ili širi paket pokrića, već prema visini premije osiguranja. Tako se privatnim osiguranjem mogu obuhvatiti samo lekarski troškovi ili i troškovi boravka u bolnici, različite vrste naknada itd. Pritom se ugovorom određuje s kojim zdravstvenim ustanovama osiguravač ima ugovor, tako da je usluga zdravstvene zaštite obuhvaćena pokrićem samo u tim ustanovama. To je jedini modalitet dobrovoljnog zdravstvenog osiguranja koji pružaju samo društva za osiguranje, ne i Republički zavod. Ujedno, to je jedino dobrovoljno zdravstveno osiguranje koje pretenduje da bude *zamena za obavezno zdravstveno osiguranje* i čiji sadržaj nije zakonom ograničen.[40]

V. Pravna priroda dobrovoljnog zdravstvenog osiguranja

U ZZO stoji da je dobrovoljno zdravstveno osiguranje *vrsta neživotnog osiguranja*.[41] To nije ništa novo. ZO je to već rekao, a mi smo izneli dovoljno argumenata iz kojih proizlazi da ta odredba nije dovoljna za kvalifikaciju dobrovoljnog zdravstvenog osiguranja kao hibridne usluge.[42] ZZO samo potvrđuje naše uverenje da je

[39] Što se tiče naziva privatno zdravstveno osiguranje, on je u neku ruku neprecizan, jer su i paralelno i dodatno osiguranje vrste privatnog osiguranja. Ali s druge strane, jedino privatno osiguranje egzistira samostalno i nezavisno od obaveznog zdravstvenog osiguranje, te je u tom smislu naziv odgovarajući.

[40] Slično iz ugla hrvatskog prava: L. Belanić, str. 118.

[41] ZZO, čl. 6 st. 1.

[42] N. Petrović Tomić, „O pravnoj prirodi dobrovoljnog zdravstvenog osiguranja – Povodom predloga Zakona o zdravstvenom osiguranju", u: M. Orlić (ur.), *Aktuelna pitanja savremenog zakonodavstva*, Budva, 2019, str. 487–506.

neophodno ugovornim zakonom o osiguranju uvesti podelu prema vrsti prestacije osiguravača. Naime, u čl. 6 st. 5 ZZO izričito stoji da se na odnose između ugovornih strana u dobrovoljnom zdravstvenom osiguranju primenjuju odredbe zakona kojim se uređuju obligacioni odnosi. Taj oblik *renvoi* na opšti ugovorni propis je potencijalno najslabija tačka zakonske regulative dobrovoljnog zdravstvenog osiguranja. ZZO upućuje na ZOO, u kome ovo osiguranje nije ni pomenuto! I zbog čije podnormiranosti je, uostalom, i usvojena najpre Uredba, kasnije i ZZO. S druge strane, takav pristup samo potvrđuje da je neophodno u što kraćem roku usvojiti novi ugovorni zakon o osiguranju. Dobar ugovorni zakon – koji će sadržati norme koje omogućavaju da se prestacija osiguravača kod osiguranja lica ugovori kao svotna ili odštetna – stvoriće temelj razvoja modernog sistema dobrovoljnog zdravstvenog osiguranja.

Da ukratko ukažemo na pravnu prirodu dodatnog i dopunskog dobrovoljnog zdravstvenog osiguranja.

1. Neživotno osiguranje

Da bismo što više ušli u suštinu dobrovoljnog zdravstvenog osiguranja, potrebno je da ukažemo, najpre, na njegovu kategorizaciju polazeći od odredaba ZO. Taj zakon uvodi podelu na životna i neživotna osiguranja, koja uglavnom ima administrativni značaj.[43] U odredbi o vrstama neživotnih osiguranja ZO pominje dobrovoljno zdravstveno osiguranje koje pokriva: 1) ugovorenu novčanu naknadu za slučaj bolesti; 2) naknadu ugovorenih troškova lečenja i 3) kombinaciju isplata po prethodna dva osnova.[44]

Naglašavamo da uvođenje podele na životna i neživotna osiguranja ne znači napuštanje podele na osiguranje imovine i osiguranje lica. Ta podela ostaje u ugovornom izvoru (ZOO). Ono što je na prvi pogled jasno jeste da ZO omogućava da se i u srpskom pravu ugovore različite prestacije osiguravača koji nude dobrovoljno zdravstveno osiguranje. ZO najpre pominje *ugovorenu novčanu naknadu za slučaj*

[43] *Direktivom 73/239 o usaglašavanju zakonskih, podzakonskih i administrativnih akata koji se odnose na otpočinjanje i obavljanje delatnosti direktnog osiguranja, osim osiguranja života (Prva neživotna direktiva)* po prvi put je izvršena *kategorizacija rizika*, što je uticalo na uobličavanje prava osiguranja u formi koju danas poznajemo. Naime, Aneksom A Prve neživotne direktive nabrojani su ugovori o osiguranju kod kojih se obaveza osiguravača sastoji u naknadi štete. To su ugovori o osiguranju koji pokrivaju sledeće rizike: nesrećni slučaj (uključujući i nezgodu na radu i profesionalno oboljenje), bolest, odgovornost za kopnena vozila, železnička vozila, vazduhoplove, brodove, gubitak ili oštećenje stvari u saobraćaju, odgovornost za požar i druge prirodne sile, odgovornost za ostalu štetu u imovini, odgovornost za upravljanje motornim vozilom, odgovornost za upravljanje avionom (uključujući i odgovornost prevozioca), odgovornost za upravljanje brodovima (uključujući i odgovornost prevozioca), opšta odgovornost, odgovornost za vraćanje kredita i kad nastupi stečaj, odgovornost u vezi sa jemstvom, finansijski gubici i rizik pri zapošljavanju i osiguranje od pravnih troškova. Kao što se može primetiti, bolest je već tada kategorisana kao neživotni rizik.

[44] ZO, čl. 9 st. 2.

bolesti. Ugovorom o dobrovoljnom zdravstvenom osiguranju mogu se, dakle, pokriti ugovorene (dnevne) naknade. Iako koristi termin naknada, u pitanju su svotne prestacije, što se dâ zaključiti iz formulacije ugovorena novčana naknada. U oblasti imovinskih osiguranja naknade se ne mogu unapred ugovarati, već se odmeravaju prema određenim pravilima, uz uvažavanje principa obeštećenja.[45] *U ovom osiguranju čak i kada se upotrebi termin naknada, ako je ona ugovorena tj. unapred određena, to nije naknada, već suma koju osiguravač treba da isplati*. ZO pominje te naknade, ali bez preciziranja na koju vrstu naknada se misli. To je učinjeno u ZZO. U ZZO je precizirан pojam novčane naknade. One obuhvataju: *ugovorene troškove lečenja, gubitak zarade odnosno plate i drugih prihoda zbog privremene sprečenosti za rad, troškove prevoza u vezi s lečenjem i druge vrste novčanih naknada u vezi sa ostvarivanjem prava iz dobrovoljnog zdravstvenog osiguranja.*[46] Opštim uslovima osiguranja propisuje se da je osiguravač u obavezi da isplati ugovorene novčane naknade u slučaju gubitka zarade, odnosno plate i drugih primanja, zbog privremene sprečenosti za rad, kao i druge vrste novčanih naknada u vezi sa ostvarenjem prava iz dobrovoljnog zdravstvenog osiguranja koje su definisane ugovorom o osiguranju.[47]

Pođe li se od nemačkog prava kao referentnog, dve vrste naknada mogu biti obuhvaćene pojmom *ugovorene novčane naknade za slučaj bolesti*.[48] Prvo, naknade koje se isplaćuju prema unapred ugovorenom iznosu, koji bi trebalo da kompenziraju gubitak zarade tokom perioda privremene nesposobnosti za rad nastale kao posledica ugovorom obuhvaćenih bolesti (nem.: *Krankentagegeldversicherung*). Sama činjenica da su utvrđene u fiksnom iznosu, odnosno da zavise samo od sprečenosti za rad, a ne od konkretne štete koju osiguranik trpi usled toga, daje prestaciji osiguravača svotni karakter.[49] Prema preovlađujućem mišljenju u nemačkoj teoriji, u pitanju je svotno osiguranje koje treba da nadomesti gubitak redovnih primanja izazvan određenom bolešću. Drugo, dnevne naknade za vreme boravka u bolnici (nem.: *Krankenhaustagegeldversicherung*). I ta prestacija osiguravača je fiksna, tj. ne mora da odgovara materijalnim izdacima koje je osiguranik imao za vreme boravka u bolnici. U pitanju je iznos koji se unapred ugovara i koji ne zavisi od konkretne štete. Kao što ćemo u daljem izlaganju videti, obaveza osiguravača u slučaju isplate dnevnih naknada bilo zbog boravka u bolnici bilo zbog privremene sprečenosti za rad suštinski se razlikuje od njegove obaveze u slučaju pokrića troškova lečenja. Troškovi se pokrivaju prema stvarnom iznosu tj. obaveza osiguravača je usmerena ka saniranju konkretne štete.

[45] J. Bigot, „Le règlement du sinistre", u: Jean Bigot (ed.), *Traité de droit des assurance, Le contrat d'assurance,* Tome 3, 2 édition, L. G. D. J., 2014, str. 942.

[46] ZZO, čl. 10 st. 1 tač. 20.

[47] Čl. 2 st. 12 Opštih uslova za dobrovoljno zdravstveno osiguranje, „Generali osiguranje Srbija".

[48] H. Tschersich, „Krankentagegeld-und Krankenhaustagegeldversicherung", u: Roland Michael Beckmann, Annemarie Matusche-Beckmann (hrsg.), *VersicherungsrechtsHandbuch*, 2. Auflage, Verlag C. H. Bech, München 2009, str. 2757–2758.

[49] M. Wandt, str. 459-460.

U pitanju su vrlo korisne prestacije osiguravača, kojima se licu koje je zadesila neka bolest i koje je suočeno s prolaznom nesposobnošću za rad omogućava da lakše prebrodi taj period. Dnevne naknade zbog privremene sprečenosti za rad donose potrebnu finansijsku sigurnost. Isti je slučaj i sa naknadama za dane boravka u bolnici, koje znatno olakšavaju svakodnevni život osiguranika koji je usled bolesti hospitalizovan ili primoran na svakodnevno ambulantno lečenje. Time osiguranik obezbeđuje unapred određenu sumu novca koju može koristiti za bilo koju svrhu, a koja mu se isplaćuje u slučaju bolesti.

Drugo, dobrovoljno zdravstveno osiguranje može da pokriva *ugovorene troškove lečenja*. Tokom razvoja dobrovoljnog zdravstvenog osiguranja došlo je do toga da obaveza osiguravača može biti usmerena i ka naknadi troškova lečenja. Tada su nastali uslovi da se to osiguranje kvalifikuje kao mešovita usluga. Naravno, sama obaveza osiguravača koja se odnosi na naknadu ugovorenih troškova lečenja nije precizirana odredbama statusnog zakona (što je očekivano!), tako da osiguravači to čine uslovima osiguranja. Njihova namera je da precizno propišu na pokriće kojih medicinskih tretmana i zahvata ima pravo njihov osiguranik. Osiguravači tako definišu troškove lečenja da se njihova obaveza odnosi samo na one troškove koji su bili *medicinski neophodni u postupku lečenja* dijagnostikovanih bolesti i stanja osiguranika.[50] To bi trebalo da piše i u zakonu koji uređuje materijalnopravna pitanja. Da bi se sprečile zloupotrebe tog osiguranja, nemački Zakon o ugovoru o osiguranju *explicite* propisuje da osiguravač neće biti obavezan da naknadi troškove u onim slučajevima kada postoji značajna nesrazmera između nastalih troškova i pružene medicinske usluge.[51]

Najzad, ZO dozvoljava mogućnost kombinacije ugovorene novčane naknade za slučaj bolesti i ugovorenih troškova lečenja. I u našem pravu od osiguranika zavisi kakav će paket dobrovoljnog zdravstvenog osiguranja izabrati.

Ako se u obzir uzmu odredbe ZOO, ZO i ZZO, zaključujemo da je dobrovoljno zdravstveno osiguranje neživotno osiguranje lica. Šta to u stvari znači? Naročito iz ugla prakse. Po čemu se ono razlikuje od osiguranja života? Ili od ostalih neživotnih osiguranja? Posmatrano iz ugla uporednog prava, osiguranje od posledica nesrećnog slučaja i dobrovoljno zdravstveno osiguranje kasnije su se pojavila u odnosu na životno osiguranje, koje je po svim karakteristikama tipično osiguranje lica. Stoga ih je trebalo i jezički razgraničiti od životnog osiguranja s kojim dele pripadnost istoj vrsti osiguranja lica polazeći od predmeta osiguranja, u ovom slučaju ličnog dobra na kome se realizuje osigurani rizik. Sam naziv neživotna osiguranja lica koji potiče iz francuskog prava (fran.: *les assurances de personnes non-vie*) nastao je kako bi se ukazalo na *razlike u pravnom i tehničkom režimu* osiguranja od posledica nezgode i dobrovoljnog zdravstvenog osiguranja u odnosu na životno

[50] To je slučaj i u uporednom pravu: H. Müller, str. 2722–2724.
[51] Par. 192 Abs. 2 nemačkog VVG.

osiguranje.[52] Nažalost, o neizgrađenosti našeg regulatornog okvira osiguranja svedoči podatak da ZOO sadrži odeljak posvećen osiguranju lica i u njemu čitav set pravila s intencijom primene i na osiguranje života i na osiguranje od posledica nezgode. Reč je o sledećim pravilima: o osiguranoj sumi, o formi ugovora, nemogućnosti prinudne naplate premije osiguranja,[53] osiguranju za slučaj smrti maloletnika i lica lišenih poslovne sposobnosti, osiguranju za slučaj smrti trećeg lica, kumulaciji osigurane sume i naknade štete, namernom ubistvu osiguranika, isključenju ratnih rizika i pravu osiguravača da ugovorom isključi određene rizike.[54] Na današnjem stupnju razvoja prava osiguranja, savršeno je jasno da je takav pristup neodrživ. Potrebno je zakonodavstvom uvažiti razlike između životnih i neživotnih osiguranja lica i urediti ih posebnim pravilima. Zapravo, po našem mišljenju, najbolje je da se ugovornim zakonom najpre definišu pojedine vrste osiguranja lica, kao i da svakoj od njih bude posvećen poseban odeljak u zakonu.

Iako ne negiramo da je odredbama ZO i ZZO učinjen prvi korak ka rasvetljavanju pravne prirode dobrovoljnog zdravstvenog osiguranja, smatramo da bi ono postalo lakše razumljivo prosečnom pravniku ako se u naše pravo uvede podela osiguranja prema prirodi prestacije osiguravača.

2. Osiguranje lica

Podnormiranost srpskog prava u pogledu dobrovoljnog zdravstvenog osiguranja utoliko je ozbiljniji problem ukoliko znamo da dobrovoljno zdravstveno osiguranje nije tipična usluga osiguranja lica. Da bismo skrenuli pažnju na njegovu osobenu pravnu prirodu i potrebu zakonskog uređenja, najpre ćemo pokušati da ga svrstamo u okviru postojećih podela.

Iz ugla našeg ugovornog prava osiguranja, najstarija je podela na osiguranje imovine i osiguranje lica. Pođemo li od podele na kojoj počiva ZOO, dobrovoljno zdravstveno osiguranje pripada porodici osiguranja lica, iako ga ZOO izričito ne pominje. Zašto? Zato što je bazični rizik koji se osigurava u ovom tipu osiguranja, bolest, primer rizika koji se ostvaruje na ličnim dobrima osiguranika.[55] Taj rizik se ostvaruje na zdravlju kao tipičnom ličnom dobru osiguranika. Iako najčešće dovodi

[52] J. Bigot, P. Baillot, J. Kullmannn, L. Mayaux, *Traité de Droit des Assurances, Les assurances de Personnes,* Tome 4, I. G. D. J., Paris 2007, str. 499–503.

[53] Izuzetak o nemogućnosti prinudne naplate premije osiguranja uređen je u opštem odeljku. I izričito se odnosi samo na osiguranje života. U teoriji, a i sudskoj praksi, stoga se postavilo pitanje da li se odnosi i na osiguranje od posledica nesrećnog slučaja. U sudskoj praksi je u nekoliko navrata ispravno primećeno da zbog razlika između pomenutih osiguranja nema mesta primeni čl. 945 na osiguranje od posledica nezgode.

[54] P. Šulejić, „Osiguranje lica u svetlu donošenja Građanskog zakonika Srbije", *Pravni život*, br. 12/2009, str. 801.

[55] Dobrovoljno zdravstveno osiguranje se i u uporednom pravu navodi kao primer osiguranja lica. U nemačkom pravu, gde postoji podela na lična (nem.: *Personenversicherung*) i nelična (nem.: *Nichtpersonenversicherung*) osiguranja, ovo osiguranje se pominje kao lično osiguranje. V.: E. Lorenz, „Allgemeiner

do materijalnih posledica (tj. izdataka ili gubitka zarade), krucijalna za kvalifikaciju ovog osiguranja kao ličnog jeste činjenica da rizik pogađa ličnu, a ne imovinsku sferu osiguranika.[56] U tom smislu ono je uporedivo sa životnim osiguranjem (rizik se odnosi na smrt ili doživljenje) ili osiguranjem od posledica nesrećnog slučaja (rizik se odnosi na život, telesni integritet ili radnu sposobnost). Dobrovoljno (privatno) zdravstveno osiguranje, naime, pokriva finansijske posledice ugovorom nabrojanih bolesti, uobičajeno je da pokriva farmaceutske troškove, troškove lečenja i hospitalizacije,[57] a može da pokrije i posledice privremene nesposobnosti (invalidnosti) ili rizik od smrti nastao kao posledica bolesti.[58] U osnovi ovog osiguranja je *saniranje ekonomskih posledica ugovorom definisanih bolesti i stanja* (trudnoće, porođaja itd).[59] Iz tog razloga je neophodno prilagoditi prestaciju osiguravača vrsti posledica koje se pokrivaju konkretnim tipom zdravstvenog osiguranja.

Ako bi se pošlo od toga da je dobrovoljno zdravstveno osiguranje vrsta osiguranja lica (iako to u ugovornom zakonu ne piše *explicite*), očekivalo bi se da i u pogledu njega važi načelno pravilo iz odeljka o osiguranju lica. ZOO već u prvom članu odeljka koji nosi naslov osiguranje lica kaže da se visina osigurane svote, koju je osiguravač dužan isplatiti kad nastupi osigurani slučaj, utvrđuje u polisi prema sporazumu ugovornih strana.[60] Iako naslov iznad člana ne ukazuje izričito na to, time je zakonodavac opredelio svrhu osiguranja lica. Iz toga se dâ zaključiti da su *osiguranja lica po zakonskoj percepciji svotna osiguranja*. U našem pravu, dakle, postoji implicitna pretpostavka da su osiguranja lica svotnog karaktera. Iako ZOO *explicite* pominje samo osiguranje života i osiguranje od nesrećnog slučaja, ta odredba morala bi da se odnosi i na dobrovoljno zdravstveno osiguranje. Ono je, dakle, po pretpostavci svotno osiguranje.

Međutim, u praksi prestacija osiguravača neće biti u svakom slučaju čisto svotna, već će po načinu utvrđivanja mnogo puta biti sličnija prestacijama kod imovinskih osiguranja (kao što je to slučaj kod troškova lečenja). Iz tog razloga u inostranoj teoriji je uobičajeno da se dobrovoljno zdravstveno osiguranje kvalifikuje kao mešovita usluga osiguranja, tačnije kao lično osiguranje koje spaja osobine i svotnih i odštetnih osiguranja. Najbolji primer je pokriće troškova lečenja koji na-

Teil. Das Privatversicherungsrecht", u: Roland Michael Beckmann, Annemarie Matusche-Beckmann (hrsg.) *Versicherungsrechts-Handbuch*, Verlag C. H. Bech, München 2009, 21; M. Wandt, str. 459.

[56] J. Bonnard, *Droit des assurances,* 4 édition, LexisNexis, Paris 2012, str. 16.

[57] Ovo osiguranje kreirano je sa vokacijom pokrića svih zdravstvenih troškova. Kako pokriće medicinskih troškova zahteva da se dokaže koliko oni iznose, do izražaja dolazi odštetni karakter prestacije osiguravača.

[58] H. Müller, 2697; J. Bigot, „Les assurances de personnes non-vie, Notions générales", u: Jean Bigot, Philippe Baillot, Jérôme Kullmann, Luc Mayaux (ed.), *Les assurances de personnes,* Tome 4, L.G.D.J, Paris, 2007, str. 503.

[59] H. Tscherisch, „Krankentagegeld- und Krankenhaustagegeldversicherung", u: Roland Michael Beckmann, Anemarie Matusche-Beckmann (hrsg.), *Versicherungsrechts-Handbuch*, München 2015, str. 3060.

[60] ZOO, čl. 942.

staju usled ugovorom obuhvaćenih bolesti i koji se pokrivaju u stvarnom iznosu.[61] Zapravo, najtačnije je reći da je to osiguranje *hibrid, tj. da ima mešovit karakter* i da za njega treba da važi sličan pravni režim kao za osiguranje od posledica nezgode.[62] Tu dolazimo do najvećeg ograničenja našeg regulatornog okvira osiguranja. Pošto dobrovoljno zdravstveno osiguranje uopšte nije pomenuto u odeljku ZOO koji uređuje osiguranje lica, njegova kvalifikacija vrši se samo na osnovu onoga što stoji u uslovima osiguranja.

Suočeni sa tim problemom i svesni činjenice da ZOO nigde direktno ne pominje dobrovoljno zdravstveno osiguranje, domaći osiguravači su problem rešili unošenjem u opšte uslove osiguranja klauzula iz kojih proizlazi da je ovo odštetno osiguranje, bez obzira na to kakva prestacija je *in concreto* ugovorena.[63] Umesto dovitljivosti domaćih osiguravača, zalažemo se za uređenje dobrovoljnog zdravstvenog osiguranja u posebnom zakonu.[64] Ključno je da se ono definiše na jasan način, kao i da se precizno odredi koja pravila iz odeljka o osiguranju lica imaju primenu i na ovo osiguranje, odnosno koja pravila koja inače važe za imovinska osiguranja dolaze u obzir ako priroda prestacije to nalaže.

3. Zaključno o pravnoj prirodi dobrovoljnog zdravstvenog osiguranja – osiguranje lica odštetnog karaktera

Naše je mišljenje da je dobrovoljno zdravstveno osiguranje po svojoj prirodi hibridna usluga osiguranja. I da kao takvo neće biti razvijeno u našem pravu dok se ne izgradi odgovarajuća pravna infrastruktura. Pod tim prvenstveno mislimo na usvajanje sektorskog propisa tj. Zakona o ugovoru o osiguranju, koji bi trebalo da implementira podelu na svotna i odštetna osiguranja. Reč je o podeli prema vrsti prestacije osiguravača, koju uporedno pravo uveliko poznaje, direktno ili indirektno.[65] Za održivi razvoj dobrovoljnog zdravstvenog osiguranja (i uopšte perspektivnih usluga osiguranja) u srpskom pravu bitno je stvoriti uslove da se prestacije

[61] J. Bonnard, str. 316.

[62] Ipak, između ova dva tipa pokrića postoji jedna značajna razlika: osiguranju od posledica nezgode se osporava odštetni, dok se dobrovoljnom zdravstvenom osiguranju osporava svotni karakter. Istina je naravno na sredini. Oba osiguranja mogu podrazumevati različita pokrića, te prema onome što je ugovoreno treba odgovoriti kakav je karakter prestacije osiguravača.

[63] U nekim opštim uslovima sadržana je odredba o regresu koja potvrđuje odštetni karakter ovog tipa osiguranja. Ispravnije bi bilo reći da dolazi do subrogacije osiguravača u prava osiguranika. Tako stoji da se „prava osiguranika, odnosno osiguranog lica prema trećem licu koje je odgovorno za štetu, prenose na osiguravača u visini naknade isplaćene od strane osiguravača, bez pribavljanja posebne saglasnosti osiguranika". Takođe, u uslovima osiguranja se pominje pravo osiguravača da iznos naknade koji je platio štetnik odbije od iznosa naknade koju treba da plati osiguraniku na osnovu nastalog osiguranog slučaja.

[64] M. Ćurković, *Ugovor o osiguranju osoba, život-nezgoda-zdravstveno,* Inženjerski biro, Zagreb, 2006, str. 209.

[65] N. Petrović Tomić, „O podeli na svotna i odštetna osiguranja – Pravo osiguranja na prekretnici", u: V. Radović, *Usklađivanje poslovnog prava Srbije sa pravom Evropske unije*, Beograd 2019, str. 415–436.

osiguravača kvalifikuju prema onome što u ugovoru piše. Time se uvažava *princip slobode ugovaranja u pogledu vrste ugovorenih prestacija, čime se ne dovodi u pitanje ograničenje te iste slobode uvođenjem imperativnih normi u pogledu same sadržine ugovora*. Naglašavamo: sama podela prema vrsti prestacije osiguravača ne mora biti zakonom predviđena *expressis verbis*. Uporedno pravo nas uči da je dovoljno da iz svih odredaba koje se odnose na određeni odeljak (npr.: na osiguranje lica) proizlazi da određeni tip osiguranja može da se ugovori kao odštetno ili svotno pokriće. To u kojoj meri pravni poredak izlazi u susret očekivanjima osiguranika najbolje se može proceniti ako se pođe od toga da li je ugovornim stranama dopušteno da odrede hoće li prestacija imati svotni ili odštetni karakter.[66]

Dakle, ključno kod regulative ugovora o dobrovoljnom zdravstvenom osiguranju u novim propisima jeste to da se izbegne usvajanje rešenja kojima se praksa onemogućava da dalje razvija ovu uslugu budućnosti. Pod tim prvenstveno mislimo na dispozitivne norme kojima bi bilo propisano da se dobrovoljno zdravstveno osiguranje može zaključiti kao osiguranje od štete, kao osiguranje određene osigurane sume ili kao kombinacija navedenih osiguranja. Pritom, ako je osiguranje zaključeno kao osiguranje od štete, regulatorni okvir treba da sadrži normu koja osiguravaču daje pravo da se subrogira u prava osiguranika prema licu odgovornom za nastupanje osiguranog slučaja. Time bi se priznao hibridni karakter ovog osiguranja, što bi osiguravačima omogućilo da razvijaju različite pakete dobrovoljnog zdravstvenog osiguranja. Najzad, da kompletira priču, zakonodavac bi *pro futuro* trebalo da usvoji *lex specialis* o dobrovoljnom zdravstvenom osiguranju. Time se stvaraju uslovi za najviši stepen razvoja te vrste osiguranja.

VI. Atraktivnost dopunskog zdravstvenog osiguranja

1. Dopunsko osiguranje – dopuna obaveznog zdravstvenog osiguranja

Po opšteprihvaćenoj definiciji u uporednom pravu, dopunsko zdravstveno osiguranje obezbeđuje pokriće troškova zdravstvene zaštite iz obaveznog zdravstvenog osiguranja u delu *troškova participacije*, tj. u delu usluga zdravstvene zaštite u kome su osigurane osobe dužne da učestvuju u troškovima zdravstvene zaštite, odnosno u ceni lekova.[67] Ono pokriva troškove do pune cene zdravstvene zaštite iz obaveznog zdravstvenog osiguranja u slučajevima kada RFZO ne osigurava plaćanje zdravstvenih

[66] H. Tschersich, str. 2757–2758.

[67] Zdravstvene usluge koje stvaraju obavezu participacije u troškovima razlikuju se od države do države. Na ovom mestu izdvajamo kao referentne: troškove specijalističkih pregleda, različitih pretraga, biotehnologije, alternativne medicine, medicinskih tehničko-tehnoloških pomagala (različitih proteza), zatim okvira za naočare itd.

usluga u celosti.[68] Dopunsko zdravstveno osiguranje se nadovezuje na obavezno zdravstveno osiguranje, koje je na našim prostorima još uvek osnovno zdravstveno osiguranje.[69] Dakle, zdravstvena zaštita je zasnovana na modelu pozajmljenom iz socijalističkog perioda. Ali zbog izraženog starenja stanovništva i finansijskog pritiska koji prati sistem obaveznog osiguranja, u pogledu dela usluga zdravstvene zaštite postoji obaveza osiguranika da učestvuju u troškovima.

Smanjenje troškova obaveznog zdravstvenog osiguranja jedan je od načina rešavanja problema koji se u istom ili sličnom obliku javlja u većini država, što je dovelo do smanjenja obima zdravstvenih usluga koje pokriva ovaj vid socijalne zaštite i prevaljivanja dela usluga na teret samih osiguranika.[70] Kako je danas u mnogim državama izuzetno izraženo starenje stanovništva i kako rizik od bolesti raste s godinama, ne čudi što se danas sve više pažnje posvećuje oblicima privatnog (dobrovoljnog) zdravstvenog osiguranja.[71] Lica koja žele blagovremeno da investiraju u uslugu koja će im omogućiti pokriće troškova lečenja i uopšte medicinskih tretmana, kao i izgubljene zarade, u dobrovoljnom zdravstvenom osiguranju pronalaze željeni ugovor. Na odluku jednog lica odlučujuće deluju najnovija saznanja u medicini, otkrića novih lekova, postupaka lečenja itd. Zahvaljujući današnjoj dinamici razvoja medicine, mnoge bolesti više nisu neizlečive, i posle strašnih saobraćajnih nesreća i uopšte nezgoda oštećeni uspevaju ne samo da prežive, već i da se izleče. U opisanim okolnostima, zdravstveno opismenjeno lice nastoji da se pobrine za svoju budućnost, te se pravovremeno opredeljuje za dobrovoljno zdravstveno osiguranje.

Tu na scenu stupa dopunsko zdravstveno osiguranje. Pokriće koje se njime pribavlja je funkcionalno povezano s osnovnim zdravstvenim osiguranjem, koje je kod nas još uvek obavezno i čini deo paketa socijalne zaštite.[72] Dopunsko privatno osiguranje u tom smislu je zaista *finansijska dopuna obaveznom osiguranju* i direktno zavisi od onoga što je predviđeno regulatornim okvirom. Drugim rečima, definisanjem prava iz zdravstvenog osiguranja koja se mogu koristiti uz odgovarajuće troškove participacije, zakonodavac ostavlja mogućnost da se u tom segmentu zdravstvene zaštite pozicioniraju privatni osiguravači. I da na taj način obezbede ulazak svežeg kapitala. Ali ono po čemu se taj tip dobrovoljnog zdravstvenog osiguranja razlikuje od paralelnog osiguranja jeste njegov *akcesorni karakter*. Njegova egzistencija pretpostavlja kakav-takav sistem bazičnog zdravstvenog osiguranja (obično državnog!), koji u pogledu dela usluga zdravstvene zaštite zahteva učešće osiguranika

[68] L. Belanić, str. 117.

[69] R. Roemer, „Health Legislation as a Tool for Public Health and Health Policy", *International Digest of Health Legislation*, Vol. 49, br. 1, 1998, str. 95–96.

[70] N. Petrović Tomić, *Pravo osiguranja, Sistem,* str. 708.

[71] G. Pinet, „Health Challenges of 21st Century: a legislative approach to health determinants", *International Digest of Health Legislation,* Vol. 49, No. 1, 1998, str. 131–178.

[72] V. Gotovec, *Zdravstveno osiguranje – socijalni aspekti*, doktorska disertacija, Pravni fakultet Sveučilišta u Zagrebu, Zagreb, 2010, str. 211–212.

u troškovima. Budući da dopunjuje obavezno osiguranje u samo jednom segmentu, mogućnosti razvoja tog tipa pokrića skučene su i usmerene samo ka onom krugu korisnika obaveznog zdravstvenog osiguranja koji ima interes da upravlja rizikom troškova participacije. Iz toga nedvosmisleno proizlazi da je krug lica koja mogu biti zainteresovana za taj tip dobrovoljnog zdravstvenog osiguranja određen time da je reč o licima koja nisu oslobođena plaćanja troškova participacije.[73] To ovo osiguranje čini delom socijalne zaštite, pod uslovom da se koncipira na adekvatan način.

U državama koje se suočavaju s naglim odlivom mlađe populacije i istovremenom ekonomskom krizom, obavezno zdravstveno osiguranje opstaje najviše zahvaljujući dopuni koju obezbeđuje dobrovoljno zdravstveno osiguranje po modalitetu dopunskog. Kako troškovi participacije najteže padaju osobama s nižim primanjima (što obuhvata i lica nakon završetka radnog veka), to se dopunskim osiguranjem njima omogućava da plaćanje iz sopstvenog džepa u trenutku kada se ostvari zdravstveni rizik zamene plaćanjem premija dopunskog osiguranja.[74] Premija dopunskog zdravstvenog osiguranja u svakom slučaju je niža od troškovnog rizika koji snosi pojedinac suočen s iznosom participacije, koji varira u zavisnosti od vrste zdravstvene usluge.[75] Da nema te opcije, moglo bi se desiti da lica s natprosečno niskim primanjima u trenutku ostvarenja zdravstvenog rizika moraju da biraju između osiromašenja i nekorišćenja zdravstvene zaštite, što je protivno ciljevima zdravstvene

[73] Po našem pravu, zdravstvena zaštita u punom iznosu iz sredstava obaveznog zdravstvenog osiguranja bez plaćanja participacije obezbeđuje se:
1) ratnim vojnim invalidima, mirnodopskim vojnim invalidima i civilnim invalidima rata;
2) slepim licima i trajno nepokretnim licima, kao i licima koja ostvaruju novčanu naknadu za pomoć i negu drugog lica, u skladu sa zakonom;
3) dobrovoljnim davaocima krvi koji su krv dali deset i više puta, osim za lekove sa Liste lekova, kao i za medicinska sredstva;
4) dobrovoljnim davaocima krvi koji su krv dali manje od deset puta, osim za lekove sa Liste lekova, kao i za medicinska sredstva, u roku od 12 meseci posle svakog davanja krvi;
5) živim davaocima organa, osim za lekove sa Liste lekova, kao i za medicinska sredstva;
6) davaocima ćelija i tkiva, osim za lekove sa Liste lekova, kao i za medicinska sredstva;
7) osiguranicima iz člana 16 st. 1 i 3 ovog zakona;
8) članovima uže porodice osiguranika iz člana 16 stav 1 tač. 7)-9) i 11) i stav 3 ovog zakona.

[74] Iako dopunsko zdravstveno osiguranje nije obavezno, za lica koja najteže pogađa rizik od troškova participacije, ovo osiguranje je u određenoj meri prinudno, budući da je to jedini način upravljanja troškovima participacije. Upravo takva situacija utiče na zakonodavca da ograniči slobodu ugovaranja i na strani osiguravača, kako bi se dopunsko zdravstveno osiguranje izuzelo od primene čisto tržišnih uslova. Ograničenje se ogleda, primera radi, u obavezi osiguravača da zaključi ugovor sa svakim osiguranikom obaveznog zdravstvenog osiguranja prema uslovima koji nisu isključivo rezultat individualne procene rizika, već se primenjuje odgovarajuća optimizacija rizika u okviru zajednice rizika.

[75] Ovo zato što osiguranje počiva na zajednici rizika i što je jedno od bazičnih pravila da je teret koji pogađa pojedinca u vidu premije osiguranja manji što je veća zajednica rizika.. Korisnicima zdravstvene zaštite je, dakle, povoljnije da investiraju u taj vid zdravstvene sigurnosti nego da zadrže rizik od troškova participacije.

zaštite i javnom interesu u oblasti zdravlja.[76] U tom smislu je iz aspekta stvaranja uslova za *održivi sistem zdravstvene zaštite* neophodno promovisati dopunsko zdravstveno osiguranje. Njime se ostvaruje bitna socijalna funkcija zaštite osiguranika obaveznog zdravstvenog osiguranja s nižim primanjima, kojima je povoljnije da investiraju u dopunsko zdravstveno osiguranje nego da snose rizik nesrazmerno velikih troškova participacije. Smanjenje visine troškova iz džepa građana za potrebe zdravstvene zaštite treba smatrati ciljem od opšteg interesa. Održivi razvoj u oblasti zdravstvene zaštite iziskuje *sveobuhvatnu reformu*, koja će na adekvatan način *implementirati različite modalitete dobrovoljnog zdravstvenog osiguranja*.[77]

2. Širina pokrića

Šta je, dakle, predmet dopunskog zdravstvenog osiguranja? Osiguranje dopunskog pokrića zdravstvene zaštite, koje omogućava pokriće razlike, odnosno učešća u troškovima zdravstvene zaštite koji padaju na teret osiguranika u pogledu određenih usluga zdravstvene zaštite.[78] Lice koje ugovori dopunsko zdravstveno osiguranje pokriva finansijske gubitke uzrokovane zdravstvenim troškovima nastalim usled učešća u troškovima participacije.[79] Reč je o **pokriću delimično pokrivene zdravstvene zaštite** koja se pruža u okviru sistema obavezne zdravstvene zaštite.[80] Ugovaranjem dopunskog zdravstvenog osiguranja delimično pokrivene zdravstvene usluge se obuhvataju u celosti ili do iznosa koji definitivno prevazilazi onaj obuhvaćen delovanjem obaveznog osiguranja.[81] To učešće u troškovima, poznatije kao troškovi participacije, može biti u fiksnom iznosu (nešto poput administrativne takse) ili procentualni udeo u troškovima zdravstvene zaštite, a u nekim sistemima se koristi i mehanizam odbitne franšize, tako da osiguranik sudeluje u troškovima zdravstvene zaštite do određenog iznosa. Teorijski posmatrano, svi osiguranici obaveznog osiguranja imaju interes da zaključe dopunsko zdravstveno osiguranje, ali je taj interes

[76] V. Gotovac, članak, str. 49.

[77] Kada je reč o dopunskom zdravstvenom osiguranju, sve i da se promoviše i postane popularno, nije realno očekivati veće finansijske učinke. Njegova svrha i nije da prikupi dobit, već da finansijski okrepi javni zdravstveni sistem, kao i da omogući investicije u njega.

[78] J. C. Langenbrunner, „Supplemental Health Insurance: Did Croatia Miss an Opportunity?", *Croatian Medical Journal*, Vol. 43, br. 4, 2002, str. 404.

[79] Reč je o riziku od plaćanja učešća u troškovima zdravstvene zaštite.

[80] Ovo osiguranje je uvedeno u Sloveniji još 1993. godine za pokrivanje participacije za obavezno zdravstveno osiguranje i procena je da je tokom tri decenije ostvaren sledeći rezultat: kupuje ga oko 73 posto stanovništva i ono pokriva oko polovine privatnih troškova. V.: P. Calcoen, W. P. Van de Ven, „Voluntary Additional Health Insurance in the European Union: Free Market or Regulation?", *European Journal of Health Law*, Vol. 25 (4), 2017, str. 591–613.

[81] S. Thomson, A. Sagan, E. Mossialos, „Why Private Health Insurance?", S. Thomson et all (ed.), *Private Health Insurance – History, Politics and Performance*, Cambridge University Press, Cambridge, 2020, str. 3.

najizraženiji kod lica sa skromnijim ili osrednjim prihodima.[82] Njima to osiguranje omogućava da *upravljaju rizikom troškova participacije*, koji mogu poprimiti i veće razmere, već prema tome koji je tip zdravstvene usluge u pitanju. Osim koristi za pojedince, dopunsko zdravstveno osiguranja omogućava *preusmeravanje troškova zdravstvenih usluga na privatni sektor*.[83]

Podvlačimo: dopunsko zdravstveno osiguranje je *komplementarno* obaveznom zdravstvenom osiguranju. Ono pruža pokriće koje se odnosi na zdravstvene usluge koje se i dalje pružaju u okviru javnog sistema zdravstvene zaštite. Samim tim, osigurani rizici i osigurani slučajevi se podudaraju. U pitanju je usluga privatnog osiguranja koja svoju egzistenciju duguje prazninama i ograničenjima socijalnog osiguranja. To znači da je neophodno poznavanje pravnog okvira obaveznog zdravstvenog osiguranja da bi se mogao osmisliti *nacionalni tip dopunskog zdravstvenog osiguranja*. Manjkavosti javne zdravstvene zaštite su takve da osiguranici ne uživaju zaštitu za određene zdravstvene usluge ili je uživaju uz obavezu da snose deo troškova zdravstvene zaštite. U prvom slučaju ima mesta za razvoj dobrovoljnog, a u drugom dopunskog zdravstvenog osiguranja.

ZZO u čl. 131 definiše u kojim slučajevima i do kog iznosa se naplaćuju troškovi participacije. Osiguranim licima obezbeđuju se zdravstvene usluge:

1) U celosti na teret sredstava obaveznog zdravstvenog osiguranja: (1) mere prevencije i ranog otkrivanja bolesti, (2) pregledi i lečenje u vezi s planiranjem porodice, trudnoćom, porođajem i u postporođajnom periodu, uključujući prekid trudnoće iz medicinskih razloga, (3) pregledi, lečenje i medicinska rehabilitacija u slučaju bolesti i povreda dece, učenika i studenata do kraja propisanog školovanja, a najkasnije do navršenih 26 godina života, odnosno starijih lica koja su teško telesno ili duševno ometena u razvoju, (4) pregledi i lečenje bolesti usta i zuba kod lica iz člana 63 tač. 1), 10) i 11) ovog zakona, kao i pregledi i lečenje bolesti usta i zuba u vezi sa trudnoćom i 12 meseci posle porođaja, (5) pregledi i lečenje u vezi sa zaraznim bolestima za koje je zakonom predviđeno sprovođenje mera za sprečavanje njihovog širenja, (6) pregledi i lečenje od malignih bolesti, šećerne bolesti, psihoze, epilepsije, multipleks skleroze, progresivnih neuromišićnih bolesti, cerebralne paralize, paraplegije, tetraplegije, trajne hronične bubrežne insuficijencije kod koje je indikovana dijaliza ili transplantacija bubrega, sistemskih autoimunih bolesti, reumatske bolesti i njenih komplikacija i retkih bolesti, (7) palijativno zbrinjavanje, (8) pregledi i lečenje u vezi sa uzimanjem, davanjem i razmenom organa, ćelija i tkiva za presađivanje od osiguranih i drugih lica za obezbeđivanje zdravstvene zaštite osiguranih lica, (9) pregledi, lečenje i rehabilitacija zbog profesionalnih bolesti i povreda na radu, (10)

[82] P. Martin, M. Del Sol, „The Uncertain and Differentiated Impact of EU Law on National (Private) Health Insurance Regulations", C. Benoït et all (ed.), *Private Health Insurance and European Union*, Palgrave Macmillan, Cham, 2021, str. 118.

[83] T. Alberth, M. Kuhar, V. P. Rupel, „Complementary health insurance in Slovenia", *Health Insurance*, str. 2022.

pružanje hitne medicinske i stomatološke pomoći, kao i hitan sanitetski prevoz, (11) medicinska sredstva u vezi sa lečenjem bolesti i povreda iz ove tačke;

2) u visini od najmanje 95% od cene zdravstvene usluge iz sredstava obaveznog zdravstvenog osiguranja za: (1) intenzivnu negu u stacionarnoj zdravstvenoj ustanovi, (2) operativne zahvate koji se izvode u operacionoj sali, uključujući i implantate za najsloženije i najskuplje zdravstvene usluge, (3) najsloženije laboratorijske, rendgenske i druge dijagnostičke i terapijske procedure (magnetna rezonanca, skener, nuklearna medicina i dr.);

3) u visini od najmanje 80% od cene zdravstvene usluge iz sredstava obaveznog zdravstvenog osiguranja za: (1) preglede i lečenje od strane izabranog lekara i lekara specijaliste, (2) laboratorijske, rendgen i druge dijagnostičke i terapijske procedure koje nisu obuhvaćene stavom 1 tačka 2) podtačka (3) ovog člana, (3) kućno lečenje, (4) stomatološke preglede i lečenje u vezi s povredom zubā i kostiju lica, kao i stomatološke preglede i lečenje zubā pre operacije srca i presađivanja organa, ćelija i tkiva, (5) lečenje komplikacija karijesa kod dece, učenika i studenata do kraja propisanog školovanja, a najkasnije do navršenih 26 godina života, ekstrakcija zuba kao posledice karijesa, kao i izrada pokretnih ortodontskih aparata, (6) stacionarno lečenje, kao i rehabilitaciju u stacionarnoj zdravstvenoj ustanovi, (7) preglede i lečenje u dnevnoj bolnici, uključujući i hirurške zahvate van operacione sale, (8) medicinsku rehabilitaciju u ambulantnim uslovima, (9) medicinska sredstva koja nisu obuhvaćena stavom 1 tačka 1) podtačka (11) ovog člana;

4) u visini od najmanje 65% od cene zdravstvene usluge iz sredstava obaveznog zdravstvenog osiguranja za: (1) izradu akrilatne totalne i suptotalne proteze kod lica starijih od 65 godina života, (2) očna i slušna pomagala za odrasle, (3) promenu pola iz medicinskih razloga, (4) sanitetski prevoz koji nije hitan, (5) lečenje bolesti čije je rano otkrivanje predmet ciljanog preventivnog pregleda, odnosno skrininga, prema odgovarajućim nacionalnim programima, ukoliko se osigurano lice nije odazvalo ni na jedan poziv u okviru jednog ciklusa pozivanja, niti je svoj izostanak opravdalo, a ta bolest je dijagnostikovana u periodu do narednog ciklusa pozivanja.

Za zdravstvene usluge koje se obezbeđuju kao pravo iz obaveznog zdravstvenog osiguranja u skladu sa stavom 1 ovog člana, a za koje Republički fond ne vrši plaćanje na osnovu cene zdravstvene usluge, već troškove obračunava i plaća na drugačiji način (po poseti osiguranog lica zdravstvenom radniku, dijagnostički srodnih grupa zdravstvenih usluga, programima, bolesničkom danu i dr.), osiguranim licima obezbeđuje se pravo na zdravstvenu zaštitu na teret sredstava obaveznog zdravstvenog osiguranja u procentima propisanim u stavu 1 ovog člana.

Izuzetno od stava 1 tačka 1) podtačka (4) ovog zakona, za ostvarivanje prava na stomatološku zdravstvenu zaštitu iz obaveznog zdravstvenog osiguranja, opštim aktom iz člana 133 ovog zakona može se utvrditi plaćanje participacije ako se osigurano lice ne odazove pozivu izabranog lekara na preventivni pregled,

odnosno ako ne ostvaruje pravo na preventivne stomatološke usluge u skladu s ovim zakonom, odnosno republičkim programom stomatološke zdravstvene zaštite koji donosi Vlada u skladu sa zakonom.

Zdravstvene usluge koje se plaćaju po dijagnostički srodnim grupama obezbeđuju se osiguranim licima na teret sredstava obaveznog zdravstvenog osiguranja u visini od najmanje 95% od cene dijagnostički srodne grupe, u skladu sa propisom iz člana 133 ovog zakona.

Ministar, na predlog Republičkog fonda, za svaku kalendarsku godinu uređuje sadržaj i obim prava na zdravstvenu zaštitu iz obaveznog zdravstvenog osiguranja iz člana 131 ovog zakona za pojedine vrste zdravstvenih usluga i pojedine vrste bolesti i povreda, procenat plaćanja cene zdravstvene usluge, odnosno cene dijagnostički srodne grupe iz sredstava obaveznog zdravstvenog osiguranja, kao i procenat plaćanja osiguranog lica do punog iznosa cene zdravstvene usluge, odnosno cene dijagnostički srodne grupe.

U propisu iz stava 1 ovog člana, ministar utvrđuje i najviši godišnji iznos, odnosno najviši iznos po određenoj vrsti zdravstvene usluge, odnosno dijagnostički srodne grupe koji osigurano lice plaća iz svojih sredstava, vodeći računa da takav iznos ne sprečava osigurano lice da koristi zdravstvenu zaštitu, odnosno da onemogućava osiguranom licu uspešno korišćenje zdravstvene zaštite.

Novčani iznos do punog iznosa iz člana 131 stav 1 tač. 2)-4) i stav 2 ovog zakona, kao i novčani iznos iz člana 132 ovog zakona (dalje u tekstu: participacija), plaća osigurano lice koje koristi tu zdravstvenu uslugu, odnosno lek, ako ovim zakonom nije drukčije određeno, odnosno plaća pravno lice koje osiguranom licu obezbeđuje dobrovoljno zdravstveno osiguranje.

Propisom iz člana 133 ovog zakona može se utvrditi da se participacija plaća u fiksnom iznosu, s tim da fiksni iznos ne sme biti veći od procentualnog iznosa određenog u skladu s ovim zakonom.

Propisom iz člana 133 ovog zakona uređuju se način i uslovi za naplaćivanje participacije, kao i povraćaj sredstava uplaćenih iznad najvišeg godišnjeg iznosa, odnosno najvišeg iznosa participacije po određenoj vrsti zdravstvene usluge.

Zabranjeno je da davalac zdravstvene usluge naplati drukčije iznose participacije za pružene zdravstvene usluge koje su obuhvaćene obaveznim zdravstvenim osiguranjem od propisanih u skladu sa čl. 131–133 ovog zakona, kao i da naplati participaciju osiguranom licu koje je platilo najviši godišnji iznos participacije ili najviši iznos participacije po određenoj vrsti zdravstvene usluge.

Osigurano lice može iz svojih sredstava, odnosno iz sredstava dobrovoljnog zdravstvenog osiguranja da ostvari pravo na veći sadržaj, obim i standard usluga iz člana 131 ovog zakona, koje se obezbeđuju iz sredstava obaveznog zdravstvenog osiguranja u skladu s ovim zakonom i propisima donetim za sprovođenje ovog zakona, na taj način što plaća razliku od cene utvrđene u skladu s ovim zakonom

i propisima donetim za sprovođenje ovog zakona i cene zdravstvene usluge koja se pruža osiguranom licu, a koja je utvrđena cenovnikom davaoca zdravstvene usluge.

Bliži uslovi i način ostvarivanja doplate iz stava 5 ovog člana uređuju se propisom iz člana 124 ovog zakona.

Davalac zdravstvene usluge dužan je da osiguranom licu izda račun o naplaćenoj participaciji.

Obrazac računa iz stava 1 ovog člana uređuje ministar propisom iz člana 133 ovog zakona.

Osigurano lice dužno je da čuva sve račune o naplaćenoj participaciji u toku jedne kalendarske godine, koji služe kao dokaz u postupku utvrđivanja prava na povraćaj sredstava uplaćenih iznad najvišeg godišnjeg iznosa, odnosno najvišeg iznosa participacije po određenoj vrsti zdravstvene usluge, kao i druge račune za naplaćene zdravstvene usluge radi ostvarivanja prava iz dobrovoljnog zdravstvenog osiguranja.

3. Prognoza pravaca razvoja dopunskog zdravstvenog osiguranja u Republici Srbiji

Kada se razmatraju mogući pravci razvoja dopunskog zdravstvenog osiguranja u Srbiji, akcenat treba staviti na *održivi razvoj u domenu zdravstvene zaštite*. Kad se kao target postavi održivi razvoj u domenu zdravstva, jasno je da je rešenje u kombinovanom *javno-privatnom partnerstvu države i osiguravača*. Drugim rečima, neophodno je uspostaviti saradnju obaveznog i privatnog zdravstvenog osiguranja, povezivanje državnih i privatnih zdravstvenih ustanova, povećanje zdravstvene pismenosti stanovništva, kao i promociju različitih paketa usluga dobrovoljnog zdravstvenog osiguranja.[84]

Dobrovoljno zdravstveno osiguranje u mnogim državama jedan je od modaliteta finansiranja zdravstvenog sistema. Pružanjem zaštite od visokih troškova lečenja naročito se licima s nižim prihodima omogućava korišćenje zdravstvene zaštite u situacijama kada bi alternativa bila odustanak od nje zbog visokih troškova. Time se doprinosi ostvarenju prava na zdravstvenu zaštitu kao jednog od elementarnih prava. Da bismo došli do željenog učešća dobrovoljnog, a naročito dopunskog zdravstvenog osiguranja u portfelju domaćeg tržišta osiguranja, ključno je da se sprovede akcija u cilju povećanja zdravstvene pismenosti stanovništva. *Zdravstvena pismenost stanovništva je od krucijalnog značaja za održivost zdravstvenog osiguranja.* Svetska zdravstvena organizacija definiše zdravstvenu pismenost kao znanje pojedinca i sposobnost da razume i primeni informacije o zdravlju kako bi mogao da donosi odluke

[84] J. Kočović, T. Rakonjac Antić, V. Rajić, „Dobrovoljno zdravstveno osiguranje kao dopuna obaveznom zdravstvenom osiguranju u Srbiji", *Ekonomske teme,* Vol. 51(3), 2013, str. 541–560.

vezane za zdravlje i time utiče na održavanje i/ili poboljšanje zdravlja tokom života. Veća je verovatnoća da će lica koja su zdravstveno opismenjena uvideti prednosti dobrovoljnog zdravstvenog osiguranja. To pod pretpostavkom da je kampanja u vezi sa ovim osiguranjem fundirano sprovedena.

VII. Zaključno o perspektivama usluga dobrovoljnog zdravstvenog osiguranja u Srbiji

Pravo na zdravstvenu zaštitu, koje predstavlja jedno od elementarnih ljudskih prava, u većini država ostvaruje se posredstvom etatističkog, javnog sistema zdravstvene zaštite. Tokom XX veka, a u XXI još više, države se suočavaju s ogromnim pritiskom koji prati državni fond zdravstvene zaštite, zbog čega se razvija ideja privatnog, premijskog zdravstvenog osiguranja. Dobrovoljno zdravstveno osiguranje igra značajnu ulogu u omogućavanju prilagođavanja sistema obaveznog zdravstvenog osiguranja pravilima igre koje karakteriše starenje stanovništva, odliv mlađe populacije i uticaj inflacije i uopšte faktora obezvređivanja novca. Ono treba da omogući širem krugu lica da koriste usluge zdravstvene zaštite u privatnim zdravstvenim ustanovama, čime bi se značajno rasteretio državni fond zdravstvenog osiguranja. Time bi se stekli uslovi za ravnomerno opterećenje državnog i privatnog zdravstvenog sistema, što je *conditio sine qua non* održive zdravstvene zaštite.

Dobrovoljno zdravstveno osiguranje u srpskom pravu decenijama je podnormirano. Takva situacija ima za posledicu da se, s jedne strane, nedostatan regulatorni okvir dopunjuje uslovima osiguranja, dok se, s druge strane, potrošačima ne garantuje isti nivo zaštite kao u drugim vrstama osiguranja. Osiguravači, naime, koriste zakonski vakuum kako bi uslovima osiguranja uredili sva pitanja ugovornog odnosa ovog osiguranja. To neretko dovodi do unošenja klauzula kojima se prejudicira karakter obaveze osiguravača, bez obzira na to šta je u konkretnom slučaju obuhvaćeno pokrićem i kako je to ugovoreno. Za razumevanje pravne prirode dobrovoljnog zdravstvenog osiguranja ključno je da predstavlja hibridnu vrstu osiguranja. Kakva će biti obaveza osiguravača, trebalo bi da zavisi isključivo od onoga što je ugovoreno.

Stoga je neophodno što pre modernizovati naš regulatorni okvir i učiniti ga kompatibilnim s modernim pravnim sistemima osiguranja. Tome će doprineti usvajanje Zakona o ugovoru o osiguranju, kojim bi se – *explicite* ili *implicite* – uvela podela na odštetna i svotna osiguranja. Ono što trenutno imamo – ZZO – samo je u izvesnoj meri korak napred u smislu regulative dobrovoljnog zdravstvenog osiguranja. Pozdravljamo samo usvajanje zakona kojim je materija zdravstvenog osiguranja uređena na zakonodavnom nivou. Ali po mnogim rešenjima, pomenuti zakon je za uzor imao Uredbu, što ne možemo oceniti kao dobru polaznu osnovu. Ostaje, dakle, da se u budućnosti radi na poslednjoj fazi u razvoju dobrovoljnog zdravstvenog

osiguranja, a to je usvajanje *lex specialis* propisa, kojim bi se dobrovoljno zdravstveno osiguranje i zakonski emancipovalo od obaveznog zdravstvenog osiguranja.

Dobrovoljno i dopunsko zdravstveno osiguranje – ako se kreira favorabilan regulatorni okvir – nose potencijal kompletiranja sistema obaveznog zdravstvenog osiguranja. Sistem socijalne zaštite u pogledu zdravstvene zaštite može i mora da počiva na principu održivosti. Održiva zdravstvena zaštita nije moguća u XXI veku ako se u priču ne uključe privatni osiguravači. Njima treba prepustiti deo kolača, a zadatak zakonodavca je da ne uvodi neracionalna ograničenja u pogledu širine pokrića. Kao naročito značajnu ocenjujemo ulogu dopunskog zdravstvenog osiguranja, iz ugla korisnika zdravstvene zaštite kojima je rizik od troškova participacije neprihvatljiv i od koga se korisnik štiti zaključenjem ovog osiguranja. Ono vrši značajnu socijalnu funkciju, budući da zahvaljujući tom osiguranju osiguranici obaveznog zdravstvenog osiguranja ostvaruju zdravstvenu zaštitu u situaciji kada bi je troškovi participacije mogli učiniti nedostupnom licima s niskim primanjima.

Smatramo da privatni osiguravači imaju značajnu ulogu u unapređenju zdravstvene zaštite, što proizlazi i iz Zakona o zdravstvenoj zaštiti kao obaveza svih privrednih društava. Osiguravači su u poziciji koja im dopušta da ostvare doprinos u ovom pogledu, bilo da su partner ili konkurencija RFZO. To će, zapravo, zavisiti od vrste usluga koje nude. Ponudom preventivnih usluga iz domena primarne zdravstvene zaštite (godišnji sistematski pregledi, doplate za veći obim i standard usluga odabranog lekara itd) osiguravači stupaju u partnerstvo sa RFZO, što *in ultima linea* čini plodno tlo za ulaganja u sekundarni i tercijarni segment zdravstvene zaštite. *A contrario*, ponudom osiguranja lica koja nisu uključena u obavezno zdravstveno osiguranje, osiguravači postaju konkurencija RFZO.[85]

Održivi razvoj sistema zdravstvene zaštite i uopšte socijalnih davanja zahteva sveobuhvatnu reformu, čiji je nezaobilazni segment dobrovoljno zdravstveno osiguranje. Dok smo o dodatnom zdravstvenom osiguranju više puta pisali, u ovom radu fokus je na dopunskom zdravstvenom osiguranju, koje ocenjujemo kao uslugu koja je u našim prilikama prilično neiskorišćena. Etatistički sistem zdravstvene zaštite forsira obavezno zdravstveno osiguranje, dok dobrovoljno prvi put zakonski uređuje tek 2019. godine. Dok je dobrovoljno zdravstveno osiguranje još i uhvatilo korena, dopunsko tek treba da se promoviše. Njegov potencijal je utoliko veći ukoliko znamo da troškovi participacije rastu dok je pod uticajem ekonomske krize veći broj lica suočen s osiromašenjem. Održivi razvoj u oblasti zdravstva zahtevaće promociju dopunskog zdravstvenog osiguranja kako bi se premije prikupljene po osnovu ovog osiguranja koristile za pokriće rashoda državnog osiguravača, a u budućnosti i za investiranje u njega.

[85] U stranoj praksi se sreće osnivanja klinika od strane osiguravajućih društava, pri čemu te klinike pružaju usluge licima s kojima je zaključeno privatno zdravstveno osiguranje. Takva praksa je krajnje rizična za osiguravače.

Da zaključimo: dopunsko dobrovoljno zdravstveno osiguranje predstavlja najbolji način da se pomogne građanima da smanje izdatke/troškove koji nastaju pri korišćenju usluga zdravstvene zaštite koje uključuju troškove participacije. Umesto da plaćaju iz sopstvenog džepa, korisnici usluga mogu da investiraju u paket osiguranja koji će olakšati ostvarenje prava na zdravstvenu zaštitu.

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SUPPLEMENTARY HEALTH INSURANCE AS A CONTRIBUTION TO DEVELOPMENT OF A SUSTAINABLE HEALTHCARE SYSTEM IN THE REPUBLIC OF SERBIA

SCIENTIFIC PAPER

Abstract

Law on Health Insurance regulates three types of voluntary health insurance – complementary, supplementary and private health insurance. These are promising insurance products and the author selected supplementary health insurance. What is the potential of this type of cover? What are conditions for its development? Are the institutuional prerequisites for creating a sustainable healthcare system fulfilled in our legislation? After analyzing the relationship between supplementary and voluntary health insurance, the author singles out the health literacy of citizens, potential service users as a prevailing factor in the current regulatory framework. By promoting supplementary health insurance as a product directly linked to compulsory health insurance a message is being sent that the healthcare cost risk in one part of compulsory healthcare can be transferred to insurers offering voluntary health insurance. Author proves that this encourages the inclusion of private insurers in financing the costs of compulsory healthcare, thus achieving cooperation between the private and state sectors with the aim of sustainable development of the healthcare system.

Keywords: voluntary health insurance, supplementary health insurance, regulatory framework, perspective insurance services

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I. Introduction

Voluntary health insurance in a broader sense provides financial protection against the risk of an illness and its consequences.[2] This insurance, which is created according to wishes and needs of the insured – can be used in different ways as a regular insurance (completely replaces compulsory health insurance) or as a supplement to the existing healthcare system.[3] Having in mind that the 21st century is characterized by the ageing of the population, financial pressure on public health insurance funds and unsuspected options of treatment and prevention, it is clear that one of the primary tasks of every state is *to complete the healthcare package*. Therefore, in recent decades, much attention was paid to voluntary health insurance. It was observed that the existing systems can survive only if compulsory and voluntary insurance are combined, which will ensure combined use of the state and private health institutions. A prerequisite for this is the *health literacy* of the citizens, and simultaneous pointing out the potential of timely investments in voluntary health insurance. Citizens, that is, potential patients, should be able to take care of their health and make decisions that will achieve *health risk management* as one of the main and existential risks.[4]

What is the status of the health literacy of citizens in Serbia? Is there an *adequate healthcare strategy* including voluntary health insurance? There are currently numerous problems in Serbia, starting from terminological doubts to the

[2] H. Müller, „Private Krankenversicherung", u: Roland Michael Beckmann, Annemarie Matusche-Beckmann (hrsg.), *Versicherungsrechts-Handbuch*, Verlag C. H. Beck München 2009, p. 2697; J. Bigot, „Les assurances de personnes non-vie, Notions generals", u: Jean Bigot, Philippe Baillot, Jérôme Kullmann, Luc Mayaux (ed.), *Les assurances de personnes*, Tome 4, L.G.D.J, Paris, 2007, p. 503.

[3] „Dobrovoljno (privatno) zdravstveno osiguranje pokriva finansijske posledice ugovorom nabrojanih bolesti, uobičajeno je da pokriva farmaceutske troškove, troškove lečenja i hospitalizacije, a može da pokrije i posledice privremene nesposobnosti (invalidnosti) ili rizik od smrti nastao kao posledica bolesti." – N. Petrović Tomić, *Pravo osiguranja*, Sistem, Knjiga prva, Službeni glasnik, Beograd, 2019, p. 708. U.: I. Spasić, „Mesto dopunskog i privatnog zdravstvenog osiguranja u uporednom pravu i predlozi za reformu sistema zdravstvenog osiguranja u Srbiji", *Revija za pravo osiguranja*, br. 1/2, 2004, pp. 1–13; J. Slavnić, „Ugovor o dobrovoljnom zdravstvenom osiguranju kao predmet zakonskog regulisanja – prilog raspravi o regulisanju ugovora o osiguranju u novom Građanskom zakoniku Srbije", *Evropske (EU) reforme u pravu osiguranja Srbije*, Palić 2010, p. 2.

[4] Health risk management involves several measures, of which we particularly highlight healthcare prevention. Preventive medical examinations are valuable in the process of early detection of illnesses and conditions that require long-term and expensive treatment. Preventive medical examinations of employees are a legal duty of healthcare institutions. This results from the regulatory framework of the Republic of Serbia that consists of a series of laws, of which we single out the Law on Healthcare (*Official Gazette of the RS*, no. 25/2019 – hereinafter the LHC). Pursuant to this law, healthcare includes implementation of measures for preservation and improvement of the health of citizens of the RS, prevention, control, and early detection of illnesses, injuries, and other health disorders and timely and efficient treatment, healthcare and rehabilitation (Article 2 Para 1). According to the law, healthcare institutions in public and private ownership, as well as private practices, are healthcare providers.

protectionism of the state fund, which threaten to slow down and/or collapse the efforts to establish a public-private partnership between the state and insurers, as the only sustainable model for the implementation of citizens' healthcare.

II. Regulatory Framework of Voluntary Health Insurance in Serbia

1. Historical Overview – from Regulation to the Law

Regulatory framework for private health insurance in Serbia has been unprecisely defined for decades.[5] Namely, at this moment we can only talk about the status part of the regulatory framework, which consists of the Insurance Law (hereinafter the IL)[6] and the Law on Healthcare.[7] The Law of Contract and Torts (hereinafter the LCT)[8] does not contain any special provisions regarding voluntary health insurance.[9] Despite the adoption of *lex specialis* regulations, the contractual part of the regulatory framework of private health insurance has not been developed, which we assess as a major shortcoming of our legislation for years.[10] For most substantive legal issues related to voluntary health insurance, the answer must be sought in the section of the LCT, which contains general rules for insurance, while the LHC only partially and superficially dealt with it. This will lead to legal gaps in many situations, which must be filled by adequate application of general or special rules from the section related to personal insurance. Therefore, *the substantive legal part of the regulatory framework* of private health insurance contracts is missing. The issue can be solved only by adopting a special law on insurance contracts that would contain a section related to voluntary health insurance.

Since the LCT does not mention voluntary health insurance at all, we believe that its general provisions on insurance, and the section with special rules for

[5] We use the term *private* here in a broader sense as opposed to compulsory health insurance which is public and under the auspices of the state (author's note).

[6] *Official Gazette of the RS,* no. 139/2014 and 144/2021.

[7] *Official Gazette of the RS, no*. 25/2019. Until the adoption of the LHI, voluntary health insurance was regulated by a bylaw - the Regulation on Voluntary Health Insurance (Regulation), *Official Gazette of the RS*, nos. 108/2008, 49/09.

[8] *Official Gazette of the RS,* no. 29/78, 39/85, 45/89 – decision of the Constitutional Court of Yugoslavia and 57/89, *Official Gazette of the FRY*, no. 31/93 and *Official Gazette of the SMG,* no. 1/2003 – the Constitutional Charter.

[9] There is a simple explanation for this. From a historical point of view, this law was adopted during the dominance of the state compulsory healthcare system, so it is logical that there is no mention of the voluntary healthcare system. The situation was not different in terms of comparative law.

[10] In comparative law it is common to adopt laws that regulate only voluntary health insurance, and not compulsory, as in our country. We are, in fact, delighted that finally the voluntary health insurance entered legislation, although it is far from the practice of European and world legal cultures.

personal insurance, must be used *mutatis mutandis* to answer all questions from the contract law, which remained outside the LHC. It is certainly not an easy job, since voluntary health insurance - as well as accident insurance - is a hybrid service and the insurer's obligations cannot be viewed only from the perspective of personal insurance.[11] *In ultima linea*, such legislative framework creates fertile ground for increased importance of insurance conditions. Insurers try to fill the legal vacuum by detailing all issues of insurance conditions. It would be desirable to adopt (at least) common principles of voluntary health insurance contracts. Conditions of our insurers differ in terms of additional and special conditions that they adapt to specific healthcare packages. If we know that it is a new insurance product in our country, we have to consider that insurance service users know even less about it than about other insurance products. Therefore, the typical consumer position is highly affected by the absence of a legal minimum regulation of sensitive issues of the contractual relationship of voluntary health insurance. So, one of the reasons that for years we have been requesting adoption of the insurance contract law is precisely the legal standardisation of the division into indemnity insurance and fixed-sum insurance, which presents *conditio sine qua non* of a precise qualification of obligations in voluntary health insurance.[12]

Let's make a brief historical overview of our legislation. Since the LCT does not contain provisions about voluntary health insurance, the substantive legal regulation of this type of insurance was until recently contained in the by-laws. In fact, we have had such legislative confusion since 2008. By adopting the Regulation on voluntary health insurance, a precedent was set in our law, which should be highlighted as a negative paradigm. Namely, it regulates numerous issues of insurance contract law that constitute *domain reservé* of legislative matter – the procedure for concluding a voluntary health insurance contract, the limitation of the insurer's freedom to contract – although it is not a compulsory insurance (sic!), regulation of insurers' obligations in terms of collective agreements, etc. As such, the Regulation was against the Constitution of the Republic of Serbia and the LCT.[13] In addition, the Regulation defines the content of the voluntary health insurance policy (although

[11] We wrote about it: N. Petrović Tomić, „Hibridni proizvodi osiguranja – stanje i perspektive razvoja", in: Z. Petrović, V. Čolović, D. Obradović (ured.), *Prouzrokovanje štete, naknada štete i osiguranje*, XXIV međunarodni naučni skup, Beograd – Mionica 2021, pp. 325–341.

[12] According to comparative law, the section on voluntary health insurance should include the minimum protection not only of the insured, but also of the insurance company itself. That means restricting insurers to determine the basis of pricing insurance premiums. The premium must not be calculated only based on the access age and health status of the insured, because such calculation method favours younger insureds, and may mean rejection of older insureds. Insurers must not be given complete freedom in terms of regulating the waiting period; bonus and malus should be defined as to encourage the insured to reduce the probability of risk occurrence; deductibles are common etc.

[13] For a detailed criticism of the Regulation: J. Slavnić, „Pogled na regulisanje ugovora o dobrovoljnom zdravstvenom osiguranju", *Pravni život*, No. 12/2009, pp. 807-823.

it is a legal matter of the LCT), lists the rules related to voluntary health insurance (including general and special conditions), etc.

According to the Constitution of Serbia (Article 68, Paragraph 3), health insurance should be regulated by the law. We therefore welcome the adoption of a special law on health insurance which has a section dedicated to voluntary health insurance. However, that would have to be **a temporary solution**. Namely, in relevant legislations voluntary health insurance is regulated by the *lex specialis* regulation, which does not include compulsory health insurance in the same package. We will present several reasons why we believe that the legal regulation of this insurance type is essential, that is, the separation of compulsory and voluntary health insurance. First, because of the *usefulness* of the said insurance type. Risk of an illness is one of those risks that every person is faced with, which is also stressed in the 21st century – a century characterized by a pronounced aging of the population. It is a *risk of an existential nature* whose coverage is not possible only on the basis of compulsory health insurance.[14] A person's decision to invest in this cover is decisively influenced by the knowledge that, due to new discoveries, medicine has advanced so much that many illnesses are no longer incurable, and that even after severe accidents and injuries, people can count on recovery and continuation of life if they are able to afford modern treatment methods. Therefore, such useful insurance should be regulated by the law since it covers a risk that affects the public interest as well as an individual. The state has a clear interest in taking care of the population's health, which displaces that risk from the free disposition of service users. Second, although models differ among countries, in general it can be said that the principle of coexistence of the private and the public sector in the healthcare is dominant. Thus, voluntary insurance exists **in parallel** with compulsory health insurance and serves as a **supplement** to the compulsory healthcare system. Due to simultaneous reduction in the number of employees and the aging of the population in most countries, compulsory health insurance system is faced with major limitations. It is crucial that persons who are beneficiaries of compulsory healthcare are encouraged to allocate funds for insurance from the earliest days, which will reduce the pressure on the compulsory healthcare funds. Only a well-designed voluntary health insurance package can replace limited capacities of compulsory health insurance.

Third, the need to protect the insured as a weaker side of the insurance contract is even more stressed with new insurance types, with which they are even less familiar than with the contracts they have been buying for years. They will be better protected if the majority of issues relevant to the insurance contract are regulated by legal imperative or semi-imperative norms. This narrows the maneuvering space for insurers. Protective function of legal norms is more expressed if it is known that

[14] M. Wandt, *Versicherungsrecht*, 5. neu bearbeitete Auflage, Carl Heymanns Verlag, Köln 2010, p. 462.

in this insurance type there is a risk of anti-selection of risks. Therefore, the insurer is obliged by law to conclude an insurance contract with each person who sends an offer to conclude the contract, and the circumstances upon which the risk will be assessed and the premium will be determined are defined in advance by the law.[15]

Fourth, we have already pointed out the specificity of this insurance type and various obligations the insurer can assume under the contract.[16] With such insurance services, it is in the insurer's interest that certain obligations are defined by law. Fifth, it will be incomparably easier for case law to resolve disputes arising from this insurance type if there is a clear and modern regulatory framework. Sixth, voluntary health insurance recorded excellent sale in developed markets not only as a basic contract but also as a supplementary contract to life or accident insurance. When the death risk is included, since it can also occur as a result of an accident or an illness, insurers offer favourable packages that combine life and voluntary health insurance. Favourable regulation of that insurance can, stimulate development of other insurance services with similar risk.

Seventh, personal insurance (especially accident insurance and health insurance) has a significant role in improving the *social welfare* system. Any accident or more severe illness is easier to overcome if a person has invested in an adequate insurance package in advance. Therefore, in developed markets, employers compete to attract skilled (or scarce) labour with good packages of combined accident and health insurance.[17] Having in mind multiple benefits of personal insurance, the legislators of developed countries – that plan to encourage the expansion of insurance products – introduce *tax incentives* for personal insurance, especially for life insurance. In many countries, the life insurance premium tax does not exist or is such that it does not present an additional financial burden on insurance service users.

2. Overview of the LHC

The LHC contains provisions identical to those contained in the Regulation. In our opinion, Articles 6 and 7 of the LHC do not bring the necessary progress to this

[15] This is about the limitation of freedom of contracting that is common with compulsory insurance types. However, taking into account the social function of voluntary health insurance, the legislator could not let the insurers to apply a purely market approach when assuming risks. For the same reasons, the contractual content is largely regulated by the law itself. More details on the limitation of the principle of freedom of contracting in insurance law: N. Petrović Tomić, „O ograničenoj i usmerenoj slobodi ugovaranja u ugovornom pravu osiguranja: fenomen 'pokoravanja' ugovora o osiguranju", u M. Karanikić Mirić, M. Đurđević (ured.), Zbornik radova sa Druge regionalne konferencije iz obligacionog prava održane 14. i 15. novembra 2019. godine na Pravnom fakultetu Univerziteta u Beogradu, Beograd 2020, pp. 318-343.

[16] N. Petrović Tomić, „O pravnoj prirodi dobrovoljnog zdravstvenog osiguranja – Povodom predloga Zakona o zdravstvenom osiguranju", u: M. Orlić (ur.), *Aktuelna pitanja savremenog zakonodavstva*, Budva, 2019, pp. 487–506.

[17] J. M. Binon, *Droit des assurances de personnes, Aspects civils, technique et sociaux,* Larcier, Bruxelles, 2007, p. 20.

sector. Namely, Article 7 stipulates that compulsory health insurance is organized and implemented by the Republic Fund of Health Insurance (RFHI), while voluntary health insurance can be organized and implemented by legal entities dealing with insurance activities (insurance companies), in addition to the RFHI, in accordance with the LHC and the law regulating insurance.[18] This is confirmed by Article 10 Paragraph 1 Point 15. According to the LHC, an insurance company can provide all types of voluntary health insurance, while the RFHI cannot provide private health insurance. The LHC expressly stipulates that the provisions of the law regulating insurance are applied to the organization and implementation of voluntary health insurance. This raises the question of whether the provisions of the IL apply equally to the RFHI when the Fund itself is the insurer of voluntary health insurance. The question is not only of theoretical importance.

This can be answered by a systematic interpretation of the LHC. Although based only on introductory provisions, one could think that every insurer of voluntary health insurance – including the RFHI – should meet the requirements of the IL, such conclusion does not result from what is written in the third part dedicated to voluntary health insurance. Article 177, entitled Conditions of voluntary health insurance, expressly states the difference between the conditions to be met by the insurer and those to be met by the RFHI. While the RFHI makes a decision on the organization and implementation of voluntary health insurance (underlined by N.P.T.) – a double licence system applies for private insurers. Namely, in addition to the opinion of the Ministry of Health on the fulfilment of the conditions for organizing and implementing voluntary health insurance, they should also obtain a licence from the National Bank of Serbia. The opinion of the relevant ministry is given on the basis of the LHC, and the NBS licence is obtained on the basis of the IL.

What will differentiate the operations of companies established for voluntary health insurance is obtaining of licences. Namely, the relevant ministry issues an opinion on the fulfilment of the conditions for organizing and implementing voluntary health insurance. However, private insurers have to submit a copy of the NBS licence for performing insurance activities in accordance with the insurance law along with the request for the issuance of that opinion. Since voluntary health insurance is a subtype of non-life insurance, it is handled by composite insurance companies, as well as those with a licence to perform non-life insurance business. Exceptionally, voluntary health insurance can also be carried out by companies dealing with life insurance in the part that covers medical expenses, provided that this insurance refers to the person with whom a life insurance contract was concluded.[19] Additional clause requires special record-keeping of these contracts.

[18] Compulsory health insurance is done by the Republic Fund of Health Insurance, which provides a basic package of coverage.

[19] IL, Article 22 paragraph 1.

It turns out that the special law only copied the Regulation! It is a weak point of the statutory part of the regulatory framework of voluntary health insurance. In addition, the said solution of the Regulation is contrary to the provisions of the current IL (and of course the EU directives on non-life insurance). This created a double exception in voluntary health insurance. First, the RFHI, which is *ex lege* the exclusive insurer for compulsory health insurance, was granted the right to deal with some voluntary health insurance – without the prior approval of the supervisory body for insurance sector. This set a precedent not only from the point of view of our law, but also in general. In the insurance sector, the licence system can be called an achievement. Second, since the RFHI does not apply the IL, it seems to be an even more dangerous deviation from the legal system, which – according to good European practice – should be applicable to all insurance service providers. This literally enables the RFHI not to form the necessary reserves, and prevents the NBS from supervising the voluntary health insurance. The only thing stipulated by the LHC is that the RFHI manages voluntary health insurance funds separately from compulsory health insurance funds and accounts, according to the voluntary health insurance types which have separate accounts (Article 193, Paragraph 2). Apart from not being in the interest of insurance service users, the situation repeated by the LHC, which already exists based on the Regulation, is extremely unincentive for private insurers that are in a less favourable position than the RFHI.[20]

It is certain that the regulatory framework for health insurance in Serbia is limited, and that insurers who try to develop this type of insurance face numerous restrictions. The equality of voluntary (premium) insurers and compulsory health insurance funds is not ensured, nor is business security. According to the LHC, this will not happen in the future either. Favouring the RFHI in relation to private insurers is more problematic when we know that it does not have a developed sales network, which, in our opinion, is one of the long-term reasons why voluntary health insurance has not taken roots. Even if a sales network is hastily built, the question is whether it will consist only of entities with a licence to sell insurance products? Is the RFHI above and beyond the IL in this regard? In addition, the law creates a conflict of interest, since the rights from compulsory insurance and the rights from voluntary insurance (which is paid!) are decided in the same place!!

Private health insurance should be modelled according to the German law.[21] The Law on Insurance Supervision stipulates that health insurance cannot be provided by an insurer dealing with property or life insurance.[22] The Law on Insurance

[20] N. Botica Jukić, „Usklađenost Zakona o dobrovoljnom zdravstvenom osiguranju s pravnom stečevinom Europske unije", *Osiguranje*, No. 1/2015, pp. 30–33.

[21] R. Müller-Stein, „Krankenversicherung", u: H. W. Van Bühren, *Handbuch Versicherungsrecht,* 4. Auflage, Deutscher AnwaltVerlag, Bonn, 2009, pp. 2119–2182.

[22] This provides the highest degree of financial protection of the insured with health insurance.

Contracts contains substantive legal provisions. That law enables voluntary health insurance to be contracted as property or personal insurance, depending on the type of health insurance. Implementation of the law on insurance contracts is in any case limited (e.g. norms on increased risk do not apply, but the insurer's subrogation applies even if health insurance is concluded as personal insurance). In addition, in German law there are also model conditions for certain types of health insurance, which were adopted by the association of insurers and which individual insurers accept and accordingly provide this type of insurance.

III. Voluntary Health Insurance Types in Serbia – Did the Legislator Mixed Things up?

The LHC contains a special section about voluntary health insurance. Actually, the subject of that law make two types of health insurance – compulsory and voluntary insurance. The fact that the voluntary health insurance was regulated for the first time in our country deserves to be highlighted as a step forward in the development of this type of insurance, which in developed countries is experiencing a large expansion. However, whether due to insufficient knowledge or intention to avoid the pitfalls of legal definitions, the legislator uses the *generic term voluntary health insurance* in order to use it to regulate three types of covers. Therefore, the task of the theory is to first divide related modalities of covers encompassed by the same legal term.

The LHC recognises the following types of voluntary health insurance 1) **supplementary** health insurance – insurance covering the healthcare costs arising when the insured person supplements the rights from compulsory health insurance in terms of content, scope and standards; 2) **complementary** health insurance – insurance covering the share in the healthcare costs, that is, healthcare service costs, medicines, medical devices, i.e. money that is not covered by rights from compulsory health insurance; 3) **private** health insurance – insurance of persons not covered by compulsory health insurance, to cover costs for the type, content, scope and standard of rights that are contracted with the insurer.[23]

Generally speaking, voluntary health insurance enables a higher level of healthcare services for users, and the provision of services not included in the compulsory health insurance system.[24] It is common to refer to the first modality of private (voluntary) health insurance as complementary voluntary health insurance,[25]

[23] LHC, Article 6 Paragraph 2 Points 1 to 3 regarding Article 174.

[24] By providing users with choice, voluntary health insurance affects the reduction of excessive use of compulsory healthcare services, reduction of corruption, investment in healthcare, etc. V.: T. Rakonjac Antić, *Penzijsko i zdravstveno osiguranje*, Ekonomski fakultet u Beogradu, Belgrade, 2018.

[25] For example, the Croatian Law on Voluntary Health Insurance states that complementary health insurance ensures a higher standard of healthcare compared to the standard of healthcare from compulsory health insurance, and a greater scope of rights compared to rights from compulsory health insurance (Article 6).

and the second one as supplementary voluntary health insurance,[26] while the third one is called private voluntary health insurance.[27] This is the case in comparative law, while in our country the terms complementary or supplementary health insurance are used in the wrong context. The point is that the legislator mixed-up titles of voluntary health insurance types, while the comparative law recognises examples of overlapping of covers of complementary and supplementary health insurance.[28] Having in mind that users do not know much about these insurance products, which affects their interest, we believe that the legislator's omission is even greater. As part of the *health literacy of the population*, an element that should be taken into account is voluntary health insurance.[29] Healthcare users should be explained the potential of voluntary health insurance, which seems like an impossible mission if an error was made already in the product's name.

IV. Supplementary versus Complementary Health Insurance – Two Pillars of Private Healthcare

According to comparative law and practice, the first association with voluntary health insurance is *complementary health insurance*. This insurance covers healthcare costs arising when the insured person extends the healthcare package in terms of content, scope and standards. At first glance, it is clear that it is a rather vague insurance whose scope may cause doubts. This insurance emerges when the insured uses healthcare covered by compulsory health insurance in a way and according to a procedure that are different from the way and procedure of exercising rights from compulsory health insurance prescribed by the law regulating health insurance and the regulations adopted for implementation of the law. Complementary health insurance, as the name suggests, is designed as a complement to the existing system of compulsory health insurance. It unquestionably provides a wider scope of rights than compulsory health insurance, although there may be

[26] Supplementary health insurance is insurance intended to cover healthcare costs provided under mandatory health insurance referred to in article 16 paragraphs 3 and 4 and article 17 paragraph 5 of Mandatory Health Insurance Act (Croatian Voulntary Health Insurance Act, article 5).

[27] The EU law: E. Mossialos, S. Thomson, *Voluntary Health Insurance in the European Union,* European Opservatory on Health Systems and Polisies, Brussels, 2004, pp. 51–67.

[28] Some authors prefer the term *voluntary additional health insurance* that includes all voluntary health insurance tyoes, except for private health insurance that has a completely different function. V.: P. Calcoen, W. P. M. M. van de Ven, „Voluntary Additional Health Insurance in the European Union: Free Market or Regulation", *European Journal of Health Law*, Vol. 24 /2017, p. 2.

[29] Health literacy of the population is crucial for sustainability of health innsurance. *The WHO defines health literacy as the ability of individuals to understand and use information on health in order to make decisions in ways which promote and/or maintain good health for themselves.* V.: H. D. C. Roscam Abbing, „Health, human rights and health law: The move towards internationalizam, with special emphasis on Europe", *International Digest of Health Legislation*, Vol. 49, No. 1, 1998, pp. 101–112.

differences between legislations as to what exactly is meant by this.[30] The answer to that question can only be obtained based on the insurance terms and conditions.

In order to divide application of complementary voluntary health insurance, we will compare it with supplementary health insurance. Although the LHC uses the wrong name for this insurance type, it is defined in a way that is usually found in comparative law. Supplementary health insurance covers the healthcare costs, i.e. healthcare services, medicines, medical devices,[31] rehabilitation and monetary compensations, which are not covered by compulsory health insurance. *Complementary health insurance*, in fact, complements the compulsory health insurance in the part of healthcare services known as out-of-pocket costs.[32] On the contrary, if someone wants to extend the scope of additional cover, and not only to cover out-of-pocket costs, they will opt for complementary and not supplementary health insurance.

Essentially, two types of similar covers can be obtained through voluntary health insurance. Similarity is reflected in the fact that they rely to a greater or lesser extent on compulsory health insurance, so without it it is not possible to determine their scope of cover, while the third modality (private health insurance) is completely independent.[33] After all, the insured person is a natural person who concluded a voluntary health insurance contract or for whom the contract was concluded, and who exercises the rights provided in the contract, as well as a member of his family. The LHC set a limit regarding the capacity of insureds of complementary and supplementary health insurance. In complementary and supplementary insurance the insured can only be a person who has the compulsory health insurance. Therefore, a person who is not covered by compulsory health insurance cannot buy complementary or supplementary voluntary health insurance in Serbia. In addition, the LHC prescribes that a person who loses the status of the insured in the compulsory insurance loses the same status in both complementary and supplementary health insurance. This clearly indicates the connection between the said types of voluntary health insurance and compulsory health insurance.[34]

Let's start with the cover referring to that part of healthcare costs that, according to the rules of compulsory health insurance, is borne by the insured himself

[30] E. Mossialos, S. Thomson, pp. 66-67.

[31] Medical and technical aids and implants were mentioned in the Regulation, which is now omitted. We believe that this will limit the scope of cover, that is, reduce the level of healthcare of the population.

[32] E. Mossialos, S. Thomson, p. 67.

[33] B. Nikolić, „Slovenian Complementary Health Insurance as a Service of General Economic Interest", *International Public Administration Review,* Vol. 13 (1), 2015, 49–67.

[34] In addition, there is a subsidiarity clause in general terms and conditions of voluntary health insurance. According to that clause, the insured is entitled to a cover of treatment costs based on voluntary health insurance only if he is not entitled to reimbursement of those costs on the basis of compulsory health insurance. Only private health insurance has autonomy from compulsory health insurance. Complementary and supplementary health insurance are considered in interaction with compulsory health insurance. This is useful when interpreting unclear issues, such as the scope of complementary insurance and its distinction from supplementary health insurance.

(the so-called out-of-pocket costs).[35] Although the law mentions it as another type of voluntary health insurance, its content can be determined more easily. Regarding out-of-pocket costs there is no problem,[36] but the second type of cover – which brings "greater content, scope and standard of rights" compared to rights from compulsory health insurance – is rather vague. The law did not define the higher standard of protection and a greater scope of rights. In order to define it, it is important to know the regulations governing compulsory health insurance. Generally speaking, *a higher healthcare standard usually refers to medical examinations and diagnostic procedures without waiting lists, a higher standard of hospital accommodation, a possibility of choosing a specialist or a surgeon, an expanded list of medicines whose purchase is financed by the insurer*.[37] In addition, the insurance terms and conditions state that *complementary health insurance can also include the costs of an annual medical examination, the costs of various specialist examinations, the costs of additional laboratory analyses,* etc.[38] What is certain, at least from a professional point of view, is that both types of cover can be called complementary or supplementary in a broader sense since they complete the healthcare provided by the state healthcare system. However, the linguistic distinction is not insignificant, so in practice it is common to use the term supplementary health insurance for cover that includes out-of-pocket costs.

It sounds frivolous that our legislator decided to use a different terminology than that widely adopted in comparative law and practice. The question is how many problems such approach will cause since the terminological definition is the identity card of each insurance product. If doubts arise during the translation (in this case completely justified), it can be expected that foreign business partners (investors in insurance sector) will show a certain amount of mistrust. The last thing a serious legislator should do is to resort to some kind of originality when arranging insufficiently known types of insurance, which can cost him dearly. Terminological apparatus is the alphabet of the regulations of each company, and this is truer in globalization and expansion of foreign investments.

Private health insurance is designed as a solution for persons who are not covered by compulsory health insurance or have not joined compulsory health insurance.[39]

[35] Details on out-of-pocket costs: L. Belanić, „Ugovor o dobrovoljnom zdravstvenom osiguranju u hrvatskom pravu s osvrtom na njemačko pravo", Palić 2017, p. 117.

[36] Introduction of out-of-pocket costs resulted from the reduction of costs in the compulsory health insurance system. By transferring a part of the healthcare costs to the burden of citizens, efforts are being made to ensure the rationalization of costs.

[37] V. Bradić, „Privatno zdravstveno osiguranje", *Osiguranje,* No. 3/2002, pp. 51–52.

[38] However, costs of dental treatments, organ transplants, cosmetic procedures, dialysis, gender reassignment, IVF, termination of pregnancy that is not medically indicated, etc. are excluded from cover. U: L. Belanić, 124.

[39] As for the name private health insurance, it is somewhat imprecise, because both complementary and supplementary insurance are private insurance types. However, only private insurance exists independently of compulsory health insurance, and in that sense the name is appropriate.

On the basis of private health insurance, they can obtain a narrower or wider cover package, depending on the insurance premium. Thus, private insurance can cover only medical expenses or hospital stays, various types of compensations, etc. Healthcare service is provided only in those institutions with which the insurer had concluded a contract. It is the only modality of voluntary health insurance provided only by insurance companies, not by the RFHI. At the same time, it is the only voluntary health insurance aiming to be a *substitute for compulsory health insurance* and whose content is not limited by the law.[40]

V. Legal Nature of Voluntary Health Insurance

The LHC defines the voluntary health insurance as a *type of non-life insurance*.[41] It's nothing new. The IL has already stated that and we presented sufficient arguments that this provision is not sufficient for the qualification of voluntary health insurance as a hybrid service.[42] The LHC only confirms our belief that it is necessary to introduce a division according to the type of the insurers' obligation in the insurance contract law. Namely, Article 6 Paragraph 5 of the LHC expressly states that the provisions of the law regulating the obligations are applied to the relations between the contracting parties in voluntary health insurance. That form *renvoi* to the general contractual regulation is potentially the weakest point of the legal regulation of voluntary health insurance. The LHC refers to the LCT where this insurance is not even mentioned! The Regulation was first adopted, and later the LHC due to its unprecise definition. On the other hand, such approach only confirms that it is necessary to adopt a new insurance law as soon as possible. A good law – which will contain norms that allow the insurers' obligations in personal insurance to be contracted as a fixed-sum or an indemnity insurance – will create the foundation for development of a modern system of voluntary health insurance.

Let us briefly point out the legal nature of complementary and supplementary voluntary health insurance.

1. Non-life Insurance

In order to explain the essence of voluntary health insurance, we need to point out, first of all, its categorization based on the provisions of the IL. That law introduces the division into life and non-life insurance, which mainly has administrative

[40] Similar in the Croatian law: L. Belanić, p. 118.

[41] LHC, Article 6 Paragraph 1.

[42] N. Petrović Tomić, „O pravnoj prirodi dobrovoljnog zdravstvenog osiguranja – Povodom predloga Zakona o zdravstvenom osiguranju", u: M. Orlić (ur.), *Aktuelna pitanja savremenog zakonodavstva*, Budva, 2019, pp. 487–506.

significance.[43] In the provision on non-life insurance types, the IL mentions voluntary health insurance that covers 1) contracted monetary compensation in case of an illness; 2) reimbursement of contracted treatment costs and 3) a combination of payments according to the previous two bases.[44]

We emphasize that introducing the division into life and non-life insurance does not mean abandoning the division into property insurance and personal insurance. That division remains in the LCT. What is clear at first glance is that the IL enables to contract different obligations of insurers that offer voluntary health insurance. The IL first mentions the *agreed monetary compensation in case of an illness*. The voluntary health insurance can therefore cover the contracted (daily) compensations. Although the term compensation is used, it is an obligation from fixed-sum insurance, which can be concluded from the wording of the agreed monetary compensation. In the property insurance, compensations cannot be agreed in advance, but are determined according to certain rules, observing the indemnity principle.[45] *In this insurance, even when the term compensation is used, if contracted, it is not a compensation, but an amount that the insurer should to pay*. The IL mentions these compensations, but without any specific details. This was done in the LHC. The concept of monetary compensation is specified in the LHC. They include *contracted medical costs, loss of earnings or salary and other income due to temporary incapacity for work, transportation costs related to treatment and other types of monetary compensations related to exercising rights from voluntary health insurance.*[46] General insurance terms and conditions stipulate that the insurer is obliged to pay the agreed monetary compensations in case of loss of earnings or salary and other income, due to temporary incapacity for work, as well as other types of monetary compensations related to exercising rights from voluntary health insurance that are defined by an insurance contract.[47]

[43] *Directive 73/239 on the coordination of laws, regulations and administrative provisions relating to the taking-up and pursuit of the business of direct insurance other than life assurance (the first non-life directive),* for the first time, categorised the risk, which influenced the formation of insurance rights in the form we know today. Namely, Annex A of the First Non-Life Directive lists insurance contracts where the insurers' obligation consists of compensation for damages. These are insurance contracts covering the following risks – accident (including industrial injury and occupational diseases), illness, land vehicles, railway rolling stock, aircraft, ships, damage to or loss of items in traffic, fire and natural forces, other damage to property, motor vehicle liability, aircraft liability (including carrier's liability), liability for ships (including carrier's liability), general liability, credit - insolvency liability, suretyship, financial loss and employment risks and legal expenses. As you can see, the illness was even then categorized as a non-life risk.

[44] IL, Article 9 Paragraph 2.

[45] J. Bigot, „Le règlement du sinistre", u: Jean Bigot (ed.), *Traité de droit des assurance, Le contrat d'assurance,* Tome 3, 2 édition, L. G. D. J., 2014, p. 942.

[46] LHC, Article 10 Paragraph 1 Item 20.

[47] Article 2 paragraph 12 of the General Voluntary Health Insurance Terms and Conditions, Generali osiguranje Srbija.

German law recognizes two types of compensations in the concept of *contracted monetary compensations in case of an illness*.[48] First, the compensations paid according to the amount agreed in advance, which should compensate for the loss of earnings during the period of temporary incapacity for work as a result of ilnesses covered by the contract (*Krankentagegeldversicherung*). The fact that they are determined as a fixed amount, i.e. that they depend only on the incapacity for work and not on the specific damage sustained by the insured, makes the insurer's obligation as the fixed-sum insurance.[49] According to the prevailing opinion in German theory, it is a fixed-sum insurance that should compensate for the loss of regular income caused by an illness. Second, daily compensations during hospital stay (*Krankenhaustagegeldversicherung*). That insurer's obligation is fixed, i.e. it does not have to correspond to the expenses incurred by the insured during his stay in the hospital. It is an amount agreed in advance that does not depend on a specific damage. As we will see, the insurer's obligation in case of payment of daily compensations either due to a hospital stay or a temporary incapacity for work is fundamentally different from its obligation in case of covering the treatment costs. Costs are covered according to the actual amount, i.e. the insurer's obligation is aimed at remediating a specific damage.

These are useful insurer's obligations which enable a person who has suffered an illness and who is faced with temporary incapacity for work to get through that period more easily. Daily compensations due to temporary incapacity for work bring necessary financial security. It is the same with compensations for hospital stays, which greatly facilitate the daily life of the insured who is hospitalized or forced to undergo daily outpatient treatment due to an illness. In this way, the insured provides a predetermined amount of money that he can use for any purpose, which is paid to him in case of an illness.

Second, voluntary health insurance can cover *contracted medical expenses*. During development of voluntary health insurance, it came to the point that the insurer's obligation can be aimed at reimbursement of medical costs. At that moment, conditions enabled that insurance to be qualified as a mixed service. Of course, the insurer's obligation to reimburse contracted medical costs was not specified by the provisions of the law (which was expected!), so insurers defined it in the insurance terms and conditions. Their intention was to prescribe precisely which medical treatments and procedures are included in the cover their insured is entitled to. Insurers define medical costs so that their obligation refers only to those costs that were *medically required during treatment* of the insured's diagnosed illnesses and

[48] H. Tschersich, „Krankentagegeld-und Krankenhaustagegeldversicherung", u: Roland Michael Beckmann, Annemarie Matusche-Beckmann (hrsg.), *VersicherungsrechtsHandbuch*, 2. Auflage, Verlag C. H. Bech, München 2009, pp. 2757–2758.

[49] M. Wandt, pp. 459-460.

conditions.[50] This should also be written in the law governing substantive legal issues. In order to prevent abuses of this insurance, the German Insurance Contract Act explicitly stipulates that the insurer shall not be liable to reimburse costs in cases where there is a significant disproportion between the costs incurred and the medical service provided.[51]

Finally, the IL enables the option of combining the contracted monetary compensation in case of an illness and contracted treatment costs. In our law, the insured chooses a type of voluntary health insurance package.

If the provisions of the LCT, the IL and the LHC are taken into account, we conclude that voluntary health insurance is a non-life personal insurance. What does that actually mean? Particularly regarding practice. How is it different from life insurance? Or other non-life insurances? In terms of comparative law, accident insurance and voluntary health insurance emerged later in relation to life insurance, which is a typical personal insurance by all its characteristics. Therefore, they should linguistically differ from life insurance, since they are in the same group of personal insurance, in this case the personal rights that sustained the insured risk. The name non-life personal insurance, which originated from the French law (*les assurances de personnes non-vie*), was created to indicate the *differences in the legal and technical scheme* of accident insurance and voluntary health insurance in relation to life insurance.[52] Unfortunately, the incompleteness of our insurance regulatory framework is evidenced by the fact that the LCT contains a section dedicated to personal insurance and in it a whole set of rules intended to apply to both life assurance and accident insurance. It is about the following rules – the sum insured, the form of the contract, the impossibility of compulsory collection of the insurance premium,[53] insurance in case of death of minors and persons deprived of business capacity, insurance in case of death of a third party, cumulation of the sum insured and damage indemnity, intentional killing of the insured, exclusion of war risks and the insurer's right to exclude certain risks by contract.[54] At today's level of development of insurance law, it is perfectly clear that such approach is not sustainable. Legislation needs to recognize the differences between life and non-life insurance and regulate them with special rules. In our opinion, it is best that the contract law first defines certain

[50] That is the case in the comparative law: H. Müller, pp. 2722–2724.

[51] Par. 192 Abs. 2 VVG.

[52] J. Bigot, P. Baillot, J. Kullmannn, L. Mayaux, *Traité de Droit des Assurances, Les assurances de Personnes,* Tome 4, l. G. D. J., Paris 2007, pp. 499-503.

[53] The exception on the impossibility of compulsory collection of the insurance premium is defined in the general section. It specifically refers only to life insurance. Theory and case law question whether it also referred to accident insurance. In case law it was correctly observed on several occasions that due to the differences between the said insurances, there is no place to apply Article 945 for accident insurance.

[54] P. Šulejić, „Osiguranje lica u svetlu donošenja Građanskog zakonika Srbije", *Pravni život*, No. 12/2009, p. 801.

types of personal insurance, and that each type of personal insurance is defined in a separate section.

Although we do not deny that the provisions of the IL and the LHC are the first steps towards clarifying the legal nature of voluntary health insurance, we believe that it would be more understandable to an average lawyer if the division of insurance according to the nature of the insurers' obligations is introduced into our law.

2. Personal Insurance

Non-specific definition of voluntary health insurance in Serbian law is a more serious problem when we know that voluntary health insurance is not a typical personal insurance. In order to emphasize its special legal nature and the need for legal regulation, we will first try to classify it within the existing divisions.

From the point of view of our insurance contract law, the oldest division is into property insurance and personal insurance. According to the division in the LCT voluntary health insurance belongs to personal insurance, although the LCT does not explicitly mention it. Why? Because the basic risk insured in this insurance type, an illness, is an example of a risk realised on the insured's personal rights.[55] That risk is realised on health as a typical personal right of the insured. Although it most often leads to material consequences (i.e. expenses or loss of earnings), the fact that the risk affects the insured's personal and not property sphere is crucial for the qualification of this insurance as personal.[56] In this sense, it is comparable to life insurance (the risk is related to death or survival) or accident insurance (the risk is related to life, physical integrity or work capacity). Voluntary (private) health insurance, namely, covers the financial consequences of illnesses listed in the contract, and it usually covers pharmaceutical costs, medical and hospitalization costs,[57] and it can also cover the consequences of temporary incapacity (disability) or the risk of death as a result of the illness.[58] The basis of this insurance is the *remediation of the economic consequences of contractually defined illnesses and conditions* (pregnancy, childbirth, etc.).[59] For this

[55] Voluntary health insurance is cited in comparative law as an example of personal insurance. In the German law there is division into personal (*Personenversicherung*) and non-personal insurances (*Nichtpersonenversicherung*), this insurance is stated as personal insurance. V.: E. Lorenz, „Allgemeiner Teil. Das Privatversicherungsrecht", u: Roland Michael Beckmann, Annemarie Matusche-Beckmann (hrsg.) *Versicherungsrechts-Handbuch*, Verlag C. H. Bech, München 2009, p. 21; M. Wandt, p. 459.

[56] J. Bonnard, *Droit des assurances,* 4 édition, LexisNexis, Paris 2012, p. 16.

[57] This insurance was created with the purpose of covering all medical expenses. As the cover of medical expenses requires proving their exact amount, the compensatory nature of the insurer's obligation is expressed.

[58] H. Müller, 2697; J. Bigot, „Les assurances de personnes non-vie, Notions générales", u: Jean Bigot, Philippe Baillot, Jérôme Kullmann, Luc Mayaux (ed.), *Les assurances de personnes,* Tome 4, L.G.D.J, Paris, 2007, p. 503.

[59] H. Tscherisch, „Krankentagegeld- und Krankenhaustagegeldversicherung", u: Roland Michael Beckmann, Anemarie Matusche-Beckmann (hrsg.), *Versicherungsrechts-Handbuch*, München 2015, p. 3060.

reason, it is necessary to adjust the insurer's obligation to the type of consequences covered by the specific type of health insurance.

If it were assumed that voluntary health insurance is a type of personal insurance (although this is not explicitly stated in the law), it would be expected that the general rule from the section on personal insurance would also apply to it. The first article of the LCT, titled personal insurance, states that the sum insured, which the insurer is obliged to pay in case of occurrence, is determined in the policy according to the agreement of the contracting parties.[60] Although the title above the article does not explicitly indicate this, the legislator determined the purpose of personal insurance. Accordingly, it can be concluded *that personal insurances are fixed-sum insurances*. In our law, it is implied that personal insurances are fixed-sum insurances. Although the LCT explicitly mentions only life insurance and accident insurance, that provision should also apply to voluntary health insurance. It is, therefore, by assumption a fixed-sum insurance.

However, in practice, the insurer's obligation will not always be purely fixed-sum, but according to the determination method it will often be more similar to property insurance obligations (as with medical expenses). For this reason, foreign theory regularly classified voluntary health insurance as a mixed insurance, more precisely as a personal insurance that combines features of both fixed-sum insurance and indemnity insurance. The best example is the cover of treatment expenses arising from illnesses stated in the contract which are covered at the actual amount.[61] In fact, it is most accurate to say that this insurance is a *hybrid, i.e. that it has a mixed character* and that it should be subject to a similar legal regulation as the accident insurance.[62] Here we come to the biggest limitation of our insurance regulatory framework. Since voluntary health insurance is not mentioned at all in the section of the LCT regulating personal insurance, it is qualified based on the insurance terms and conditions.

Faced with this problem and aware of the fact that the LCT does not directly mention voluntary health insurance anywhere, domestic insurers solved the problem by introducing clauses in the general insurance terms and conditions which state that this is indemnity insurance, regardless of what obligation was actually contracted.[63]

[60] LCT, Article 942.

[61] J. Bonnard, 316.

[62] However, there is one significant difference between these two types of cover – accident insurance is contested as indemnity insurance, while voluntary health insurance is contested as fixed-sum insurance. The truth is in the middle. Both insurances can include different covers, and what is contracted defines the nature of the insurer's obligation.

[63] Certain general terms and conditions contain a recourse provision that confirms the nature of this type of insurance. It would be correct to say that there is a subrogation of the insurer to the insured's rights. Thus, it is stated that "the insured's rights against a third party that is responsible for the damage are transferred to the insurer at the amount of compensation paid by the insurer, without obtaining

Instead of the ingenuity of domestic insurers, we are advocating for the regulation of voluntary health insurance in a separate law.[64] It is crucial that it is defined in a clear way, as well as to determine precisely the rules from the personal insurance section that apply to this insurance, i.e. rules that normally apply to property insurance.

3. Conclusion on the Legal Nature of Voluntary Health Insurance – Personal Indemnity Insurance

In our opinion voluntary health insurance is a hybrid insurance by its nature, and as such it will not be developed in our law until the appropriate legal infrastructure is built. We primarily mean the adoption of insurance regulations, i.e. the Law on Insurance Contracts, which should implement the division into fixed-sum insurance and indemnity insurance. It is a division according to the type of the insurer's obligation, which comparative law is aware of, directly or indirectly.[65] For a sustainable development of voluntary health insurance (and perspective insurance products in general) it is important to create in the Serbian law the conditions for the insurer's obligations to be qualified according to the wording of the contract. Thus, *the principle of freedom of contracting with regard to the type of contracted obligations is accepted, which does not question the limitation of that freedom by introducing imperative norms regarding the content of the contract itself.* We emphasize – the division according to the type of insurer's obligation does not have to be explicitly stipulated by the law. Comparative law teaches us that it is sufficient that all the provisions relating to a certain section (e.g. personal insurance) show that a certain insurance type can be contracted as an indemnity insurance or a fixed-sum insurance. The extent to which the legal system meets the expectations of the insured can best be assessed by starting with whether the contracting parties are enabled to determine whether the obligation will be within a fixed-sum insurance or an indemnity insurance.[66]

Therefore, it is crucial to avoid adopting solutions that prevent further development of this service in the regulation of voluntary health insurance contracts. We primarily mean the dispositive norms that would prescribe that voluntary health insurance can be concluded as an indemnity insurance, as a fixed-sum insurance or as a combination of the aforementioned insurances. At the same time, if the insurance is concluded as an indemnity insurance, the regulatory framework should contain

the insured's special consent". In addition, the insurance terms and conditions state the insurer's right to deduct the amount of compensation paid by the tortfeasor from the amount of compensation to be paid to the insured based on occurrence.

[64] M. Ćurković, *Ugovor o osiguranju osoba, život-nezgoda-zdravstveno,* Inženjerski biro, Zagreb, 2006, p. 209.

[65] N. Petrović Tomić, „O podeli na svotna i odštetna osiguranja – Pravo osiguranja na prekretnici", u: V. Radović, *Usklađivanje poslovnog prava Srbije sa pravom Evropske unije*, Belgrade 2019, pp. 415–436.

[66] H. Tschersich, pp. 2757–2758.

a norm that gives the right to the insurer to subrogate the insured's rights against the person responsible for the occurrence. Thus, the hybrid nature of this insurance would be recognized, which would enable insurers to develop different packages of voluntary health insurance. Finally, to complete the story, the legislator should *pro futuro* adopt the *lex specialis* on voluntary health insurance. This would create the conditions for the highest level of development of this type of insurance.

VI. Attractiveness of Supplementary Health Insurance

1. Supplementary Health Insurance – Supplement to Compulsory Health Insurance

According to the generally accepted definition in comparative law, supplementary health insurance provides cover of healthcare costs from compulsory health insurance in the part of the *out-of-pocket costs*, i.e. in the part of healthcare services where insured persons are obliged to participate in the healthcare costs, i.e. in the price of medicines.[67] It covers costs up to the full cost of healthcare from the compulsory health insurance in cases where the RFHI does not ensure payment of healthcare services in full.[68] Supplementary health insurance is added to compulsory health insurance, which is still the main health insurance in our region.[69] Therefore, healthcare is based on a model borrowed from the socialist period. However, due to a prominent aging of the population and the financial pressure on the compulsory insurance system, with regard to a part of the healthcare services, there is an insured's obligation to participate in the costs.

Reducing the costs of compulsory health insurance was one of the ways to solve problems occurring in the same or similar form in most countries, which led to a reduction in the scope of healthcare services covered by this type of social protection and the transfer of a part of the services to the insureds themselves.[70] Since the aging of the population is extremely pronounced in many countries today and the risk of illnesses increases with age, it is not surprising that more and more attention is being paid to private (voluntary) health insurance.[71] Persons who wish to invest in a timely manner in a product that will enable them to cover medical costs

[67] Healthcare services creating out-of-pocket costs vary from state to state. Here we will single out as reference – costs of specialist examinations, various tests, biotechnology, alternative medicine, medical technical-technological aids (various prostheses), eyeglass frames, etc.

[68] L. Belanić, p. 117.

[69] R. Roemer, „Health Legislation as a Tool for Public Health and Health Policy", *International Digest of Health Legislation*, Vol. 49, No. 1, 1998, pp. 95-96.

[70] N. Petrović Tomić, *Pravo osiguranja, Sistem, p.* 708.

[71] G. Pinet, „Health Challenges of 21st Century: a legislative approach to health determinants", *International Digest of Health Legislation,* Vol. 49, No. 1, 1998, pp. 131–178.

and medical treatments in general, as well as lost earnings, will buy voluntary health insurance. The latest findings in medicine, discoveries of new drugs, treatment procedures, etc. have a crucial effect on a person's decision. Owing to today's dynamics of medical development, many illnesses are no longer incurable, and after terrible traffic accidents and accidents in general, the injured manage not only to survive, but also to be cured. In described circumstances, a health-literate person tries to take care of own future and opts for voluntary health insurance in a timely manner.

This is where supplementary health insurance becomes an importnant factor. The cover it provides is functionally linked to the main health insurance, which is still compulsory in our country and is the part of the social protection package.[72] Supplementary private insurance in this sense is really a *financial supplement to compulsory insurance* and directly depends on what is stipulated by the regulatory framework. In other words, by defining rights from health insurance that can be used with adequate out-of-pocket costs, the legislator leaves the option for private insurers to position themselves in that segment of healthcare. Thus, they ensure the entry of fresh capital. This type of voluntary health insurance differs from complementary insurance in its *accessory character*. Its existence assumes some kind of the main health insurance system (usually the state!), which in terms of a part of the healthcare services requires the insured's participation in costs. Since it complements compulsory insurance in only one segment, the possibilities of developing this type of cover are limited and directed only to the group of compulsory health insurance users who have an interest in managing the risk of out-of-pocket costs. It unequivocally means that the group of persons who may be interested in this type of voluntary health insurance is determined by the fact that they are not exempted from paying out-of-pocket costs.[73] This makes this insurance a part of social protection, provided that it is designed adequately.

[72] V. Gotovec, *Zdravstveno osiguranje – socijalni aspekti*, doktorska disertacija, Pravni fakultet Sveučilišta u Zagrebu, Zagreb, 2010, pp. 211–212.

[73] According to our law, healthcare in the full amount from the compulsory health insurance funds without any out-of-pocket costs is provided to:

1) disabled war veterans, disabled military persons in peacetime and war-disabled civilians;
2) the blind and permanently disabled persons as well as persons receiving pecuniary benefits for assistance and care by other person, in accordance with the law;
3) volunary blood donors who gave blood ten or more times, except for medicines from the List of medicines as well as for medical-technical devices and implants;
4) voluntary blood donors who gave blood less that ten times, within 12 months after each blood donation, except for medicines from the List of medicines, as well as for medical-technical devices and implants.
5) living donors, except for medicines from the List of medicines, as well as for medical-technical devices and implants;
6) tissue and cell donors, except for medicines from the List of medicines, as well as for medical-technical devices and implants;
7) insureds under Article 16 Paragraph 1 and 3 of this law;

In countries facing a sudden outflow of younger population and a simultaneous economic crisis, compulsory health insurance survives mostly owing to the supplement provided by voluntary health insurance. Since out-of-pocket costs fall hardest on people with lower income (including people after the end of working life) the supplementary insurance enables them to replace out-of-pocket costs when a health risk occurs by paying the supplementary insurance premium.[74] Supplementary health insurance premium is in any case lower than out-of-pocket costs borne by an individual, which vary depending on the type of health service.[75] Without that option, it could happen that persons with above-average low income at the occurrence of a health risk have to choose between poverty and not using healthcare, which is against the goals of healthcare and the public interest in the healthcare.[76] In this sense, in order to create conditions for a *sustainable healthcare system*, it is necessary to promote supplementary health insurance. It achieves the important social function of protecting compulsory health insurance policyholders with lower income, for whom it is more favourable to invest in supplementary health insurance than to bear the risk of disproportionately large out-of-pocket costs. Reducing the amount of out-of-pocket healthcare costs should be considered a goal of general interest. Sustainable development in the healthcare requires a *comprehensive reform* that will adequately *implement various modalities of voluntary health insurance*.[77]

2. Scope of Coverage

What is the subject of supplementary health insurance? Supplementary health insurance enables cover of the difference, i.e. out-of-pocket healthcare costs

8) members of the insured's nuclear family under Article 16 Paragraph 1 Item 7)-9) and 11) and Paragraph 3 of this law.

[74] Although supplementary health insurance is not compulsory, for persons most affected by out-of-pocket costs, this insurance is to some extent compulsory, since it is the only way to manage out-of-pocket costs. It is precisely this situation that influences the legislator to limit the insurer's freedom of contracting in order to exempt supplementary health insurance from the application of purely market conditions. The limitation is reflected, for example, in the insurer's obligation to conclude a contract with each compulsory health insurance policyholder according to conditions that are not solely the result of an individual risk assessment, but an appropriate risk optimization is applied within the risk community.

[75] Insurance is based on the community of risks and one of the basic rules is that the burden affecting the individual in the form of an insurance premium is lesser if the community of risks is greater. It is therefore more favourable for healthcare users to invest in this type of health security than to retain the risk of out-of-pocket costs.

[76] V. Gotovac, article, 49.

[77] Even if supplementary health insurance is promoted and becomes popular, it is not realistic to expect greater financial effects. Its purpose is not to collect profit, but to financially strengthen the public healthcare system, as well as to enable investments in it.

borne by the insured regarding certain healthcare services.[78] A person who contracts supplementary health insurance covers financial losses caused by healthcare costs incurred as a result of out-of-pocket costs.[79] It is a **cover of partially covered healthcare** provided within the system of compulsory healthcare.[80] By contracting a supplementary health insurance, partially covered healthcare services are included in their entirety or up to the amount that definitely exceeds the one covered by compulsory insurance.[81] These out-of-pocket costs can be a fixed amount (something like an administrative fee) or a percentage share in healthcare costs, and in some systems a deductible is also used, so that the insured participates in healthcare costs up to a certain amount. Theoretically, all insured persons of compulsory insurance have an interest in concluding supplementary health insurance, but this interest is most pronounced among persons with modest or moderate incomes.[82] This insurance enables them to *manage the risk of out-of-pocket costs*, which can take on even greater proportions, depending on the type of healthcare service. In addition to the benefits for individuals, supplementary health insurance allows the *redirection of healthcare costs to the private sector*.[83]

We emphasize – supplementary health insurance is *complementary* to compulsory health insurance. It provides cover for healthcare services that continue to be provided within the public healthcare system. Therefore, insured risks and insured events match. It is a private insurance that owes its existence to gaps and limitations of social insurance. This means that knowledge of the legal framework of compulsory health insurance is necessary in order to design a *national type of supplementary health insurance*. The shortcomings of public healthcare are such that insured persons do not have protection for certain healthcare services or have it with the obligation to bear a part of the healthcare costs. In the first case, there is room for the development of voluntary, and in the second case, supplementary health insurance.

Article 131 of the LHC specifies situations and maximum amount out-of-pocket costs that are charged. Insured persons are provided with healthcare services:

[78] J. C. Langenbrunner, „Supplemental Health Insurance: Did Croatia Miss an Opportunity?", *Croatian Medical Journal*, Vol. 43, No. 4, 2002, p. 404.

[79] It is the risk of out-of-pocket healthcare costs.

[80] This insurance was introduced in Slovenia in 1993 to cover out-of-pocket costs for compulsory health insurance and it is estimated that over three decades the following result was achieved: it is bought by about 73 percent of the population and it covers about half of private expenses. V.: P. Calcoen, W. P. Van de Ven, „Voluntary Additional Health Insurance in the European Union: Free Market or Regulation?", *European Journal of Health Law*, Vol. 25 (4), 2017, pp. 591-613.

[81] S. Thomson, A. Sagan, E. Mossialos, „Why Private Health Insurance?", S. Thomson et all (ed.), *Private Health Insurance – History, Politics and Performance*, Cambridge University Press, Cambridge, 2020, p. 3.

[82] P. Martin, M. Del Sol, „The Uncertain and Differentiated Impact of EU Law on National (Private) Health Insurance Regulations", C. Benoït et all (ed.), *Private Health Insurance and European Union*, Palgrave Macmillan, Cham, 2021, p. 118.

[83] T. Alberth, M. Kuhar, V. P. Rupel, „Complementary health insurance in Slovenia", *Health Insurance*, p. 2022.

1) **Entirely at the expense of compulsory health insurance funds** – (1) prevention and early detection of diseases, (2) medical examinations and treatment related to family planning, pregnancy, childbirth and the postpartum period, including termination of pregnancy for medical reasons, (3) medical examinations, treatment and medical rehabilitation in case of illnesses and injuries of children, pupils and students until the end of the prescribed education, and at the latest until the age of 26, i.e. elderly persons who are severely physically or mentally disabled, (4) medical examinations and treatment of diseases of the mouth and teeth in persons referred to in Article 63 Item 1), 10) and 11) of this law, as well as examinations and treatment diseases of the mouth and teeth related to pregnancy and 12 months after a childbirth, (5) medical examinations and treatment related to infectious diseases for which the law provides measures to prevent their spreading, (6) medical examinations and treatment for malignant diseases, diabetes, psychosis, epilepsy, multiple sclerosis, progressive neuromuscular diseases, cerebral palsy, paraplegia, tetraplegia, permanent chronic renal insufficiency in which dialysis or kidney transplantation is indicated, systemic autoimmune diseases, rheumatic diseases and their complications and rare diseases, (7) palliative care, (8) medical examinations and treatment in connection with the taking, giving and exchange of organs, cells and tissues for transplantation from insured persons and other persons to provide the healthcare of insured persons, (9) medical examinations, treatment and rehabilitation due to occupational diseases and injuries at work, (10) emergency medical and dental aid, as well as emergency medical transport, (11) medical means related to the treatment of diseases and injuries from this point;

2) at the amount of at least 95% of the price of the healthcare service from the compulsory health insurance funds for (1) intensive care in a stationary healthcare institution, (2) surgical procedures performed in the operating room, including implants for the most complex and the most expensive healthcare services, (3) the most complex laboratory, X-ray and other diagnostic and therapeutic procedures (MRI, scanner, nuclear medicine, etc.);

3) at the amount of at least 80% of the price of the healthcare service from the compulsory health insurance funds for (1) medical examinations and treatment by a selected physician and a specialist physician, (2) laboratory, X-ray and other diagnostic and therapeutic procedures not included under paragraph 1 item 2) sub-item (3) of this article, (3) home care, (4) dental examinations and treatment related to injury to teeth and facial bones, as well as dental examinations and dental treatment before heart surgery and organ, cell and tissue transplantations, (5) treatment of caries complications in children, pupils and students until the end of the prescribed education, and at the latest until the age of 26, dental extraction as a result of caries, as well as manufacture of mobile orthodontic apparatuses, (6) inpatient treatment and rehabilitation in an inpatient healthcare facility, (7) medical

examinations and treatment in a day hospital, including surgical procedures outside the operating room, (8) medical rehabilitation in outpatient facilities, (9) medical means not included under paragraph 1 item 1) sub-item (11) of this article;

4) at the amount of at least 65% of the price of the healthcare service from the compulsory health insurance funds for (1) total and partial acrylic prosthesis for persons over the age of 65; (2) eye and hearing aids for adults, (3) gender changing for medical reasons, (4) non-emergency medical transport, (5) treatment of an illness whose early detection is the subject of a targeted preventive examination, i.e. screening, according to appropriate national programmes, if the insured person did not respond to a single call within one call cycle, nor did he/she justify his/her absence, and the illness was diagnosed in the period until the next call cycle.

Healthcare services provided as a right from compulsory health insurance in accordance with paragraph 1 of this article, and for which the RFHI does not make payment based on the price of the healthcare service, but calculates and pays the costs in a different way (after the visit of the insured person to a healthcare worker, diagnostically related groups of healthcare services, programmes, sick days, etc.), insured persons are guaranteed the right to healthcare at the expense of compulsory health insurance funds in the percentages prescribed in paragraph 1 of this article.

As an exception to paragraph 1 item 1) sub-item (4) of this law, in order to exercise the rights to dental healthcare from compulsory health insurance, a general act from Article 133 of this law can determine the payment of out-of-pocket costs if the insured person does not respond to the call of the selected physician for a preventive examination, that is, if he/she does not exercise the right to preventive dental services in accordance with this law, that is, with the republic programme of dental healthcare adopted by the Government in accordance with the law.

Healthcare services paid by diagnostically related groups are provided to insured persons at the expense of compulsory health insurance funds at the amount of at least 95% of the price of a diagnostically related group, in accordance with the regulation from Article 133 of this law.

The Minister, upon the proposal of the RFHI, for each calendar year regulates the content and scope of rights to healthcare from the compulsory health insurance under Article 131 of this law for certain types of healthcare services and certain types of illnesses and injuries, the percentage of the price of the healthcare service, i.e. the price of diagnostically related group from the compulsory health insurance funds, as well as the percentage of the insured person's payment up to the full amount of the price of the healthcare service, i.e. the price of a diagnostically related group.

In the regulation from paragraph 1 of this article, the minister determines the highest annual amount, i.e. the highest amount for a specific type of healthcare service, i.e. diagnostically related group that the insured person pays from own funds,

taking into account that such amount does not prevent the insured person from using healthcare, that is, it prevents the insured person to successfully use healthcare.

Monetary amount up to the full amount from Article 131 paragraph 1 item 2)-4) and paragraph 2 of this law, as well as the monetary amount from Article 132 of this law (hereinafter out-of-pocket costs), is paid by the insured person who used that healthcare service, i.e. medicine, unless otherwise specified by this law, i.e. legal entity providing voluntary health insurance to an insured person is in charge of paying.

The regulation from Article 133 of this law can determine that out-of-pocket costs are paid in a fixed amount, provided that the fixed amount must not be higher than the percentage amount determined in accordance with this law.

The regulation from Article 133 of this law defines the manner and conditions for charging out-of-pocket costs, as well as the return of funds paid above the highest annual amount, that is, the highest out-of-pocket costs for a certain type of healthcare service.

It is prohibited for the healthcare provider to charge different out-of-pocket costs for the provided healthcare services included in compulsory health insurance than those prescribed in accordance with Articles 131-133 of this law, as well as to charge out-of-pocket costs to the insured person who paid the highest annual out-of-pocket costs or the highest out-of-pocket costs for a certain type of healthcare service.

The insured person can use own funds or voluntary health insurance funds to exercise the right to a greater content, scope and standard of services from Article 131 of this law, which are provided from compulsory health insurance funds in accordance with this law and regulations adopted for the implementation of this law, by paying the difference between the price determined in accordance with this law and regulations adopted for the implementation of this law and the price of the healthcare service provided to the insured person, which is determined by the pricelist of the healthcare service provider.

Detailed conditions and method of obtaining the additional payment from paragraph 5 of this article are prescribed by the regulation from article 124 of this law.

Healthcare service provider is obliged to issue an invoice for charged out-of-pocket costs to the insured person.

The invoice form referred to in paragraph 1 of this article shall be regulated by the minister with the regulation referred to in article 133 of this law.

The insured person is obliged to keep all out-of-pocket costs' invoices charged in one calendar year, which serve as evidence in the procedure for determining the right to refund of funds paid above the highest annual amount, i.e. the highest out-of-pocket costs for a certain type of healthcare service, as well as other invoices for healthcare services in order to exercise rights from voluntary health insurance.

3. Forecast of the Direction of Development of Supplementary Health Insurance in the Republic of Serbia

When considering possible directions for development of supplementary health insurance in Serbia, the emphasis should be on a *sustainable development of healthcare*. When sustainable development of healthcare is set as a target, it is clear that the solution lies in a combined *public-private partnership between the state and insurers*. In other words, it is necessary to establish a cooperation between compulsory and private health insurance, linking state and private healthcare institutions, increasing health literacy of the population, and promoting various voluntary health insurance packages.[84]

Voluntary health insurance in many countries is one of the modalities of financing the healthcare system. By providing protection against high treatment costs, especially people with lower income are enabled to use healthcare when the alternative would be to give it up due to high costs. This contributes to the exercise of the right to healthcare as one of the elementary rights. In order to reach the desired share of voluntary, and especially supplementary health insurance in the portfolio of the domestic insurance market, it is crucial to conduct a campaign aimed at increasing the health literacy of the population. *Health literacy of the population is crucial for the sustainability of health insurance*. The World Health Organization defines health literacy as an individual's knowledge and ability to understand and apply health information in order to make health-related decisions and thereby influence the maintenance and/or improvement of health throughout life. People who are health literate are more likely to acknowledge the benefits of voluntary health insurance. Assuming that the campaign related to this insurance was soundly implemented.

VII. Conclusion on Perspectives of Voluntary Health Insurance in Serbia

The right to healthcare, which is one of the elementary human rights, is exercised in most countries through the state, public healthcare system. During the 20th century, and even more in the 21st, states faced enormous pressure on the state healthcare fund, which is why the idea of a private, premium health insurance was developed. Voluntary health insurance has a significant role in enabling adaptation of the compulsory health insurance system to the rules of the game, which is characterized by the ageing of the population, the outflow of younger population, and the impact of inflation and the devaluation of money in general. It should enable

[84] J. Kočović, T. Rakonjac Antić, V. Rajić, „Dobrovoljno zdravstveno osiguranje kao dopuna obaveznom zdravstvenom osiguranju u Srbiji", *Ekonomske teme,* Vol. 51(3), 2013, pp. 541–560.

a wider range of people to use healthcare services in private healthcare institutions, which would significantly relieve the state health insurance fund. This would create conditions for an equal load on the state and private healthcare systems, which is a *conditio sine qua non* of a sustainable healthcare.

Voluntary health insurance in the Serbian law has not been precisely regulated for decades. Such situation resulted in, on one hand, insufficient regulatory framework that is supplemented by insurance terms and conditions, while, on the other hand, consumers are not guaranteed the same level of protection as in other insurance types. Insurers use the legal vacuum in order to regulate all contractual relations of this insurance. This often leads to introduction of clauses that presume the nature of the insurer's obligation, regardless of what is included in the cover in the specific case and how it was contracted. To understand the legal nature of voluntary health insurance, it is crucial that it is a hybrid type of insurance. The insurer's obligation should depend solely on what is contracted.

Therefore, it is necessary to modernize our regulatory framework as soon as possible and make it compatible with modern legal insurance systems. Adoption of the Law on Insurance Contracts will contribute to this, which would – explicitly or implicitly – introduce the division into an indemnity and a fixed-sum insurance. What we currently have – the LHC – is only to an extent a step forward in terms of regulation of voluntary health insurance. We only welcome the adoption of the law regulating the matter of health insurance. However, according to many solutions, the said law was modelled after the Regulation, which we cannot consider a good starting point. Therefore, it remains to work on the last stage in development of voluntary health insurance in the future, which is the adoption of *lex specialis* regulations, which would legally separate voluntary health insurance from compulsory health insurance.

Voluntary and supplementary health insurance – if a favourable regulatory framework is created – have the potential to complete the compulsory health insurance system. The social protection system in terms of healthcare can and must be based on the principle of sustainability. Sustainable healthcare is not possible in the 21st century if private insurers are not included. They should be given a share, and the legislator's task is not to introduce irrational limitations regarding the scope of cover. We consider the role of supplementary health insurance to be particularly significant, from the point of view of healthcare users for whom the risk of out-of-pocket costs is unacceptable and from whom the user is protected by concluding this insurance. It has an important social function, since owing to this insurance, compulsory health insurance policyholders obtain healthcare when out-of-pocket costs could make it unaffordable for people with low income.

We believe that private insurers have a significant role in the improvement of healthcare, which also results from the Law on Healthcare as an obligation of all

companies. Insurers are in a position that allows them to make a contribution in this regard, whether they are partners or competitors of the RFHI. It will actually depend on the type of services they offer. By offering preventive services from the primary healthcare (annual medical examinations, additional payments for a larger scope and standard of services of the selected doctor, etc.), insurers enter into a partnership with the RFHI, which ultimately creates a fertile ground for investments in the secondary and tertiary segments of healthcare. On the contrary, by offering insurance to persons who are not included in compulsory health insurance, insurers become competitors of the RFHI.[85]

Sustainable development of the healthcare system and social benefits in general requires a comprehensive reform, with voluntary health insurance as an indispensable segment. We have written about complementary health insurance several times, but in this paper the focus is on supplementary health insurance which we assess as a service that is quite unused in our circumstances. The state healthcare system imposes compulsory health insurance, while voluntary health insurance is legally regulated for the first time in 2019. While voluntary health insurance has been accepted, supplementary health insurance has yet to be promoted. Its potential is greater if we know that out-of-pocket costs are increasing, while under the influence of the economic crisis a greater number of people are facing poverty. Sustainable development in the healthcare system will require promotion of supplementary health insurance so that insurance premiums are used to cover the expenses of the state insurer, and in future also to invest in it.

We concluded that supplementary voluntary health insurance was the best way to help citizens reduce expenses/costs incurred when using healthcare services that include out-of-pocket costs. Instead of paying out of pocket, service users can invest in an insurance package that will facilitate exercise of the right to healthcare.

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[85] In foreign practice, clinics are established by insurance companies, and these clinics provide services to persons with whom private health insurance has been concluded. Such practice is extremely risky for insurers.

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