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Original article

# EUROPEAN UNION HEALTH SYSTEMS AND RESPONSES TO THE ECONOMIC CRISIS

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## Abstract

There is no doubt that the overall health of the population is the area of a special social concern of a state, hence, this concern is most often expressed through complex systems of healthcare insurance. Having in mind the fundamental social significance of the healthcare system, debates pertaining to its functioning and efficiency have been ubiquitously present all around the globe. The importance of scientific and practical research in the healthcare area are becoming particularly important in the unfavorable economic conditions as have been present in the most of the World's countries during and after the 2007 economic crisis. Considering the severity of the crisis, many of the countries have been facing the need for a revision of their health systems in order to assure sustainability of their healthcare in newly arisen, adverse and uncertain financial reality. Additionally, although the healthcare systems can be grouped and attributed to a certain model, we must not neglect the fact that healthcare systems are different from state to state and that they are under a strong influence of history, tradition, political system, economy and national values of every state. Because of this, it has not been possible to offer a single set of universally efficient measures for tackling the crisis' repercussions on healthcare systems. In this paper we analyze the responses implemented by European Union countries in the light of the most recent economic crisis, deemed unprecedented in the Union since its establishment.

**Key words:** healthcare systems, healthcare consumption, economic crisis

# 1. HEALTHCARE SYSTEMS

The definition of a healthcare system mostly includes an organized approach to providing health services which requires the existence of a system or a program through which the population is given the access to healthcare and which is financed by the state, private subjects or by public and private subjects in combination. According to the definition of the World Health Organization, a healthcare system enhances "all activities the primary purpose of which is to improve, renew and take care of health" (Todaro, 2006). In other words, a healthcare system consists of all organizations, people and activities whose primary intention is to promote, regain and maintain health (WHO, 2000). The previously mentioned includes activities that directly improve a health condition, as well as all other endeavors aimed at raising health determiners. Despite the fact that some authors tend to narrow the definition of healthcare system thus reducing it to the obvious elements – organizations, institutions and resources that directly provide healthcare to their users (Mills and Ranson, 2012), the complexity of healthcare systems requires a broader approach that enhances more than the obvious pyramid of public institutions that are direct providers of health services to their users.

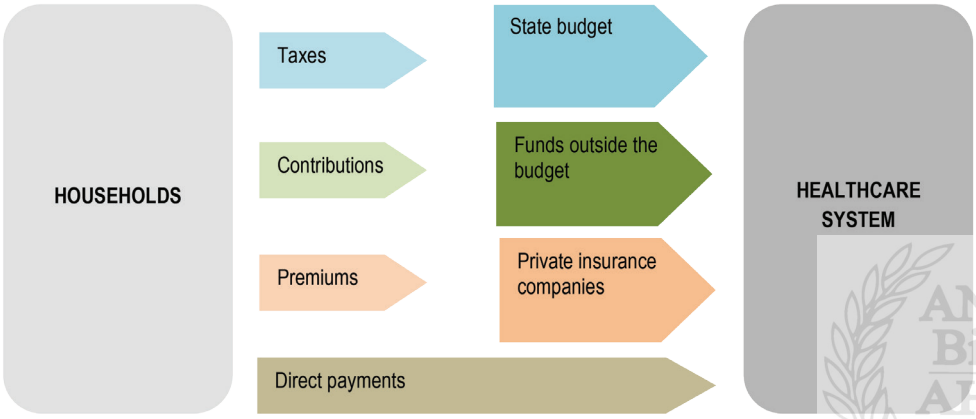
Following the conclusions of World Health Report 2000, the primary aim of a healthcare system refers to improving health and health equity in ways that are responsive, financially fair and that secure the best, that is, the most efficient usage of available resources. In the same report, a basic medium-term aim is also stated and that is to direct the transformation of health inputs according to the final health output in a way that will secure a broader enhancement and a better availability of efficient health interventions to users, without compromising the quality level and the security of the provided service.

Global development of the healthcare system through time has been defined by numerous and various factors, among which some are especially important: historical and cultural context, political system and ideology, geographic-climatic factors, and the level and direction of socio-economic development of a state. Certain form of the healthcare system has been present as long as is the natural tendency of the people to take care of their health and to treat diseases, but organized health systems, as political and social institutions of today, have only been present in the last hundred years, even in industrially developed countries. The establishment of primary healthcare as the elementary interest of mankind can be seen as the first attempt of creating

a unified approach to the issue of health, that is, forming a unique frame for health policies, for it has as such been articulated in the international declaration Alma Ata in 1978. Although the Declaration defines governments as responsible for the health of their people and states that primary healthcare is key to achieving this aim, within a socially just development, only ten years later, unfavorable economic tendencies in most of the World's countries have forced upon the need for a revision of the modus of providing health services, partly discarding the imperative of social justice and equality. Globally endangered financial prosperity of the 80s, which was marked by high prices of petrol, low tax income and economic adjustment to the newly established conditions, has introduced two difficult ways for basic healthcare financing – directing public consumption exclusively on interventions that are cost-efficient and improvement of financing through charging for the provided services. Although most countries introduced increased fees for health services, which as a consequence had poor categories distanced from a good healthcare service, the other choice – spending exclusively on essential interventions – was politically and practically impossible to implement. Expanding the crisis in the 90s directed creators of healthcare system policies toward market based reforms of European public services shaped within the common phrase – do more at lower expense. International Community took a serious approach to revising the sources of financing needed for a functional and overall healthcare system only at the beginning of the 21st century, when it was faced with the fact that the operability of the healthcare system with per capita allocations which are limited primarily by cost efficiency is not a sustainable solution as well as with the growing problem of HIV/AIDS pandemia. This lead to signing the declaration in Jakarta in 1997 and Millennium Declaration of the United Nations in 2000, where 189 countries from around the world became obliged to fulfill eight common goals, four of which referred to health issues.

Theories of organizational sociology and industrial organization assume that the activities which are implemented within the public healthcare system are primarily determined by available resources, the way those resources are organized and the defining attributes of the community, that is, the market that is provided by the health system. (Mays et al., 2006). When we talk about basic resources available to the public health system, it is primarily about financial means and human resources. Naturally, the available financing is the basic determiner of the number of human, technological and other resources that could be engaged in the process of implementation of public health

activities. Thus, although systems of healthcare can be classified according to different criteria, it is evident that the financial aspect, that is, way of collecting means, as well as the way of paying services, is the main criterion. When we talk about the basic ways of collecting means of financing healthcare sector, the following things are singled out: taxes, income, participation, paying full price in healthcare system, as well as voluntary monetary contributions and gifts from institutions, groups and individuals (Cučić, 2000). From economic aspect, it can be said that money coming from households is the primary source of financing in all healthcare systems. *(Scheme 1).*




*Scheme 1:* **Healthcare financing**
*Source: the authors' image*

Yet, regardless of this fact, all individual types of health systems have specific attributes, having in mind that using the above mentioned methods of securing financial means as well as ways of paying service providers create the system of healthcare which is directly defined by the position of the user, that is, citizen who has the approach to and uses the health service. Institutional frame of a health system can be seen as a system of economic regulations and mutual interactions within healthcare which enhances the owner's structure, organization of the flow of financial and material resources as well as the rules that regulate the approach to the means and services that are exchanged in health markets. (Lyszczarz, 2014). It is exactly on the basis of the methods of securing financial resources and the modus of paying the service provider that the most often used and most famous division of the healthcare system is made, according to which systems of healthcare are separated into three basic models: Beveridge, Bismarck and Market model of Health Insurance.

### 1.1. The Beveridge Model

The model was named after Sir William Beveridge who was a social reformer, a principal of London School of Economics and a co-author of the Report made by a committee in charge of social insurance and allied services, better known as The Beveridge Report *(The Report of the Inter-Departmental Committee on Social Insurance and Allied Services; Beveridge Report)*. A unique significance of this report is seen in the fact that on the basis of its recommendations in 1948, the National Health Service (NHS) of Great Britain was established, although the report itself „says very little of medical care and literally nothing of diseases." (Musgrove, 2000). The focus of the Report, despite a logical assumption, is not directed toward health interventions but treats them as „joined services" included in the all-enhancing scheme the basic intention of which is the upkeeping of national employment and revenues. This was in line with the time in which Beveridge lived and which was marked by the consequences of the Depression and the fear from an economic collapse due to war once the economic stimulus was gone. Beveridge's primary endeavor was to protect, that is, renew the ability of the population to work, and thus the real accent was put on post-medical care and rehabilitation. Today NHS, which was established on the Beveridge Model, is considered to be the pioneer of the universal government financed health insurance and is in charge of organizing and financing the health sector as well as of making agreements with providers of health services, so that prices and ways of payment could be defined. When NHS was established in 1948, it had a budget of 437 million pounds (around 15 billion according to today's value), while, according to the publicly available data for the year 2015/2016, the budget of HNS amounted to 116,4 billion pounds (source: www.nhs.uk). NHS has more than 1,5 million employees (which places this service among five biggest employers in the world) and it provides services to the population of 54,3 million users.

According to the model created by Beveridge, healthcare system is financed by the government, from the budget, while actual sources of financial means are general taxes. The model is based on principles of solidarity and equality and services are free and equal for all which means that they include the whole population and that bills are not issued to patients. It is evident that the model offers a high level of fairness when it comes to system financing, as well as availability and quality of service provision. Most hospitals and clinics are owned and governed by the state, while service providers, such as

doctors and pharmacists, mostly have the status of civil servants (the system also recognizes private doctors who receive financial means from the government). The advantage of this kind of healthcare financing is primarily seen in a rather simple way of governing and the possibility of direct cost control. In the systems based on the Beveridge Model, the primary focus is set on keeping expense per an individual as low as possible, because the Government solely controls what service providers can do and which services they have the right to charge (Pijalović, 2015).

In systems which follow the principles of the Beveridge Model, defining the amount of financial means allocated for healthcare is a process that happens usually once a year, when budget structure is decided upon. Having in mind that healthcare is only one of the numerous elements that are financed from the budget, it is very often the case that the necessary means for the adequate and good health care are underestimated, and this is also the main downside of the Beveridge Model, together with the fact that a significant number of countries face the problem of budget deficit. Practice shows that this system has proved to be good only in those countries that have stable and strong government budgets, such as Scandinavian countries: Sweden, Denmark, Norway, Finland. Apart from them, this model has been applied in the already mentioned Great Britain, Ireland, Iceland, Australia and New Zealand, and in Greece, Italy, Portugal, Spain and South Korea that made transition from the Bismarck to the Beveridge Model in the 1970s and 1980s.

### 1.2. The Bismarck Model

Named after the first Chancellor of the New German Empire, Otto von Bismarck, who set the new basis for the establishment of an overall system of social and health insurance by introducing a statutory health insurance in 1883. Bismarck's primary goal was to face social unrests and to repress the growing popularity of socialist ideas, as well as to economically weaken the voluntary social insurance of the Trade Union and working associations which were governed by the Church. (Franke, 2004) Basic characteristics of the systems based on the Bismarck Model include the following: (a) insured individuals are persons who are employed, that is, persons who are paid for their work; (b) financing is secured through taxes that are ranked on the basis of income and (c) taxes are paid on the basis of the amount of salary or wage, which means that every individual in the system contributes according to his/her possibilities.

Bismarck's system is the system that uses insurance, that is, funds of health insurance that are independent and non-profitable and that can be public or private, and that are strictly defined by special laws and regulations. Funds are mutually financed by both employers and employees through taxes on and from salaries, or taxes on the overall income for agriculturists and independent entrepreneurs, according to the defined corresponding rate on obligatory regular basis. The system is regulated so that the funds are those that manage the collected means, make arrangements with health service providers and make payments, and in this way they provide health services to all the insured individuals.

It is possible to make arguments for the assertion that the system of salaries tax is more fair than the Beveridge Model, the downside of which is reflected in the lack of insight into variations of outlays given for the healthcare sector. A person who is employed can insure children and family members by paying salaries tax. Healthcare expenses for other categories, such as the unemployed, pensioners, invalids and others, are covered by social care funds (funds for the unemployed, pension, invalid and other funds), while those who are socially unattended for, who have no assets or income, that is those who social care funds are not obliged to cover expenses for, they are given special compensations from the budget, mainly on municipality level. On the other hand, individuals who cannot exercise their right to health insurance on any basis, have the right to health care only in cases of emergency. Also, the government is obligated to allocate financial means from the budget for capital investments, cover expenses for epidemiological controls and research in the field of healthcare (Pijalović, 2015).

It is important to emphasize that the Bismarck Model of healthcare offers the possibility of a voluntary additional insurance, as well as additional and replacement insurance. Replacement insurance is possible in cases when, for example, the income of the user is above a certain limit, which was not seen as the best practice in public healthcare, because it violated the principles of fairness and equality, and it carried a greater healthcare expense and a more difficult cost control. In that case, the required redistributory role of financing nor the concept of mutual risk among different categories are fulfilled. Voluntary insurance is defined by special regulations and can vary from country to country.

Although this is a model for more than one insured individual, (often described as decentralized), a tight regulation of health services and fees provides the government with the possibility of cost control similar to the Beveridge Model of one insured individual (centralized model). It is important

to emphasize that the Bismarck Model, as well as the Beveridge Model, is based on the principles of solidarity and equality, which means that it guarantees for an undiscriminatory approach to providing services to all, regardless of financial possibilities of the insured.

The key significant problems of this model are related to the notion of „moral hazard". A „moral hazard" appears when the population, that is, the insured individuals, having in mind that they do not directly pay for healthcare services, start considering them to be free and use them in an overly and unnecessary way, thus increasing the cost.

In recent years, the trend of private medicinal practices and hospitals is present, especially in the countries which apply the Bismarck Model, for example, Japan has more private hospitals than USA. Applying this model results in a mix of private and public service providers, which makes cost control in public healthcare easier and more efficient.

Countries that apply this model or its variations are: Germany, Austria, France, Japan, Luxemburg, Belgium, the Netherlands, Switzerland, Czech Republic, Slovenia, Croatia, Serbia and Bosnia and Herzegovina.

### 1.3. Market models of private insurance

In the model of private insurance, healthcare is conceived on voluntary basis while financing is based on premiums that are defined according to health state, age, salary and such. It is justified to claim that this models represents a certain form of discrimination and a classic example of violation of solidarity principles. Premiums are paid to private insurance companies that are profitable, and in its pure form this model actually exists only in USA. Anyway, it is important to point up that American healthcare is fragmented, as it offers various kinds of care and covers different categories of population. When it comes to treatment of veterans and the military, the USA applies the Beveridge Model. For those Americans who are work capable and employed, and who get their right to insurance at work, the USA applies the Bismarck Model and the employees pay, entirely or partly, the insurance for their employees and for members of their families who are not insured. For Americans above 65 years of age and for the poor as well as for beneficiaries of public monetary compensations, that is, for those who have the right to Medicare and Medicaid programs, the USA applies the model of National Health Insurance, the same as in Canada. For those who do not enter in the previously mentioned groups, that is, for the population that does not exercise the right to health insurance,

to live in the USA is the same as to live in the Third World countries, with health care services provided only in cases when the seeker of medical help is able to pay the bill during the period of treatment directly „out of pocket“ or when his/her health is endangered seriously enough for him/her to be admitted to the emergency center of a public hospital.

The Law on Healthcare Insurance Reform in the USA (*The Patient Protection and Affordable Care Act),* better known as Obamacare, which was passed in both Houses and was signed by the President in 2010, and also verified on the Supreme Court, had the aim to establish a common universal health insurance coverage, which would solve the problem of 44 million of Americans who were, before the Reform, uninsured (healthcare reform in the USA in more details on http://obamacarefacts.com/obamacare-facts.php). Yet, current American administration won the elections in 2017 with the program that, among other things, promised to abolish and replace Obamacare Law that was presented as a „huge economic burden“ for the Unite States. Despite numerous attempts, Obamacare hasn't been completely abolished and it has been the subject of a continuous conflict between the two opposing parties.

## 2. HEALTHCARE COSTS

Costs and financial resources which countries direct towards healthcare sector are determined by a great number of socio-economic factors as well as the financial and organizational structures of the healthcare system of a specific country. Great majority of countries has been continuously facing the problems related to financing of the healthcare system, which places this sector at the very top of important economic and political issues in developed countries. On the other hand, in countries with low and middle income and in European countries in transition, health sector has since the 90s been one of the central issues when it comes to economic reforms.

Most of the world costs in the health sector refer to the countries with high income, while the expansion of diseases is reverse proportional to the amount of invested means. (Gottret and Schieber, 2006). Based on this, there is no doubt that countries with low or middle income per capita are facing more difficult problems related to securing the means necessary for treatments of illnesses. World Health Organization has recognized this problem and has, as one of its main goals, set the establishment of a financing system for healthcare that would secure the availability of health services to all members of population, without them being exposed to financial risks. However, according to the latest report of World Health Organization, direct or out-of-pocket

payments for health services made, in 2015, 32% of the overall world healthcare costs (in 2012, the percentage amounted to 17,6%), which is proven to create catastrophic consequences in terms of population impoverishment. In Bosnia and Herzegovina, out-of-pocket payments made almost a third (28,64%) of overall costs for health services, that is, 123,48 USD per capita.

On the other hand, in those countries in which governments took the responsibility for healthcare, the costs of healthcare have become one of the main and continuously growing components of the public finance. Because of this, in the conditions of recession and increased fiscal pressures, the growth of health costs becomes an especially important problem.

In the countries of OECD, the overall public and individual costs for healthcare has been increased for 3,4% on average in 2016, which is the highest rate since 2009. The USA spent more in 2016 than any other OECD member, spending the equivalent of 9982 USD per capita. This amount of costs for health services surpasses almost a triple average of thirty-five OECD countries (an average cost in 2016 was 4003 USD).

According to the World Bank data from 2015, on the world level, 7,2 trillion USD or 10% of the overall world GDP was spent. On the other hand, financial means directed by the state toward the healthcare sector compared to overall costs on all other goods and services in economy are a good indicator of the position of the health sector as well as of the overall performances of the overall economy. According to the assessments of OECD in 2016, healthcare costs made an average of 9.0% of GDP in OECD countries.

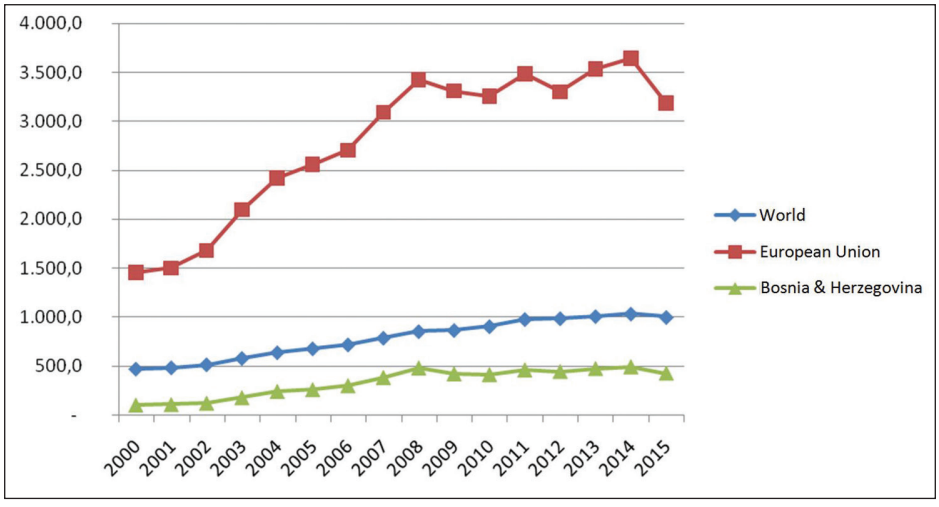
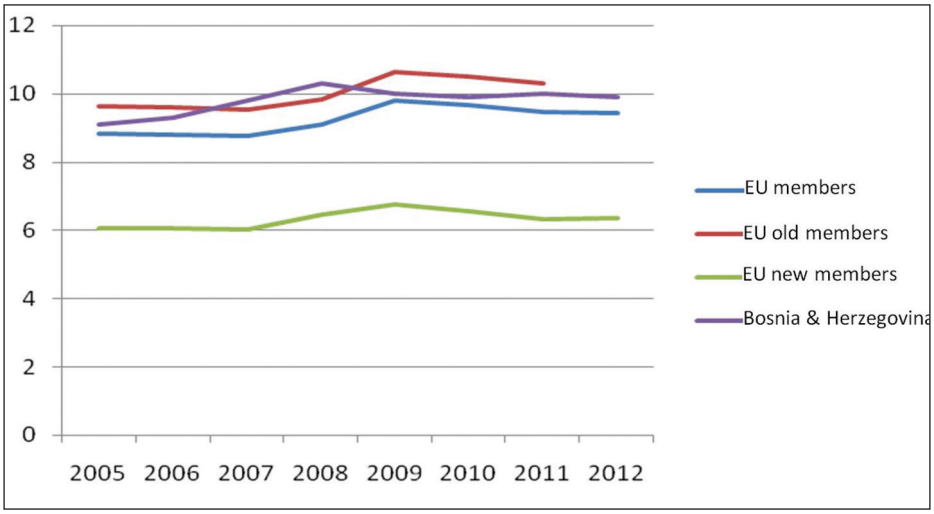



*Chart 1: Healthcare cost per capita, (World, EU and B&H)*
*Source: WHO, Regional Office for Europe, 2018*



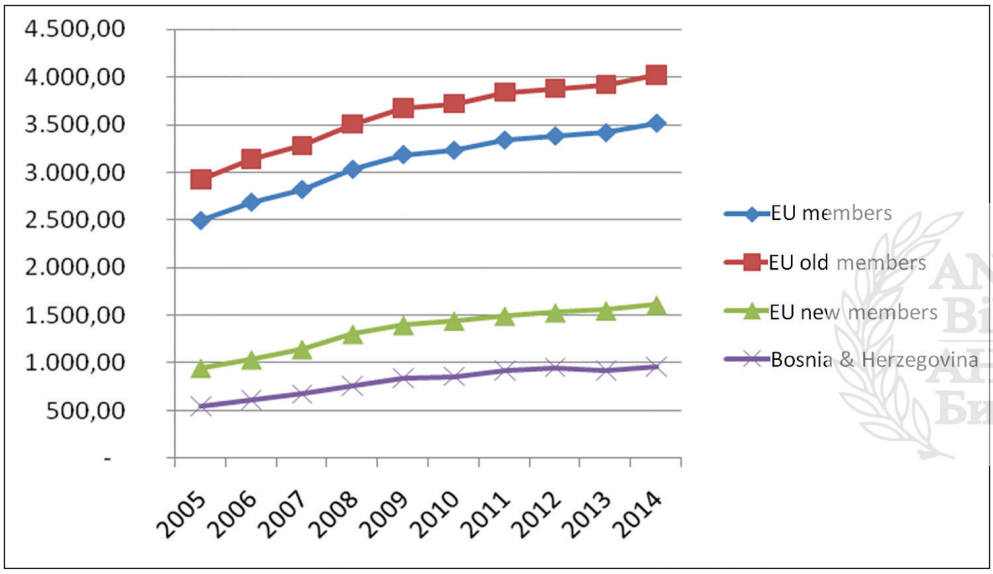

| | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 |
|---|---|---|---|---|---|---|---|---|
| % Share of overall costs in GDP EU members | 8.85 | 8.82 | 8.78 | 9.12 | 9.79 | 9.65 | 9.45 | 9.43 |
| % Share of overall costs in GDP EU old members | 9.63 | 9.59 | 9.54 | 9.85 | 10.62 | 10.49 | 10.29 | |
| % Share of overall costs in GDP EU new members | 6.06 | 6.07 | 6.02 | 6.48 | 6.77 | 6.56 | 6.32 | 6.37 |
| % Share of overall costs in GDP B&H | 9.1 | 9.3 | 9.8 | 10.3 | 10 | 9.9 | 10 | 9.9 |

*Chart 2: Healthcare costs as GDP percentage (EU and B&H)*
*Source: WHO, Regional Office for Europe, 2018*

By analyzing the data showed in Chart 2, we can conclude that in 2012, the last year for which official data are available, healthcare costs in Bosnia and Herzegovina was 9.9% of GDP, which is a little more than an average cost made by all the countries that are members of European Union and much more than the cost of new members (members that jointed the EU in 2004: Bulgaria, Cyprus, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Romania, Slovakia, and Slovenia – Croatia was not included in the given data because it became an EU member in 2013.) For old members of EU, known as the EU15 (members of EU before 2004: France, Germany, Italy, Belgium, the Netherlands, Luxemburg, Great Britain, Denmark, Ireland, Greece, Spain, Portugal, Finland, Austria and Sweden), the data for the year 2012 are not available, but it is evident that in the previous year, 2011, overall healthcare costs in these countries made 10, 29% of GDP, which is a little

more in comparison to the costs in Bosnia and Herzegovina (10,00%) and to the average of all countries in the European Union (9,45%).

Precisely because of the fact that Bosnia and Herzegovina has a high share of healthcare costs in GDP that is practically on the same level as the costs of the EU, it has often been said that a cost of healthcare sector in Bosnia and Herzegovina is too big, and that this is the reason why a reform of the healthcare sector is indispensable. Yet, if we look into the data showing the health care costs per capita, we come to a significantly different conclusion. Also, it should be noted that consequences of 1992-1995 war on health of B&H population are still present and therefor imply higher healthcare costs on a state level.




| | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 |
|---|---|---|---|---|---|---|---|---|---|---|
| % Overall healthcare costs per capita (PPP) EU members | 2,494.3 | 2,688.1 | 2,820.9 | 3,033.2 | 3,188.4 | 3,234.5 | 3,341.4 | 3,384.6 | 3,418.4 | 3,518.8 |
| % Overall healthcare costs per capita (PPP) EU old members | 2,927.7 | 3,146.9 | 3,282.9 | 3,506.3 | 3,676.1 | 3,719.3 | 3,839.4 | 3,880.1 | 3,921.3 | 4,021.8 |
| % Overall healthcare costs per capita (PPP) EU new members | 941.7 | 1,029.7 | 1,139.8 | 1,301.8 | 1,396.1 | 1,441.6 | 1,491.6 | 1,527.9 | 1,549.0 | 1,608.9 |
| % Overall healthcare costs per capita (PPP) B&H | 544.8 | 607.6 | 671.8 | 754.9 | 837.7 | 855.8 | 915.1 | 947.9 | 919.2 | 957.4 |

*Chart 3: Healthcare costs per capita (EU and B&H)*
*Source: WHO, Regional Office for Europe, 2018*

The overall healthcare cost per capita in B&H in 2014 was 957,4$, which is considerably below the EU average, which was 3518,8$ per capita. Healthcare costs per capita in the given year were 4021,8$ in old EU members, and new members had a lower per capita cost (1608,9$), but we have to bear in mind that public expense is higher in these countries than in Bosnia and Herzegovina.

When it comes to the human resources engaged in the health sector, it is evident that Bosnia and Herzegovina significantly lags behind the EU15 average in terms of number of doctors, dentists, nurses and particularly pharmacists. For example, Bosnia and Herzegovina has more than three times fewer dentists and almost twelve times less pharmacists per 100.000 inhabitants when compared with the EU15 average. Also, if look into the material resources used by the health sector the most prominent difference is noticable in the number of hospitals. While Bosnia and Herzegovina counts 1,02 hospitals per 100.000 inhabitants, EU15 countries have almost three times more (2,94).

*Table 1: Health sector resources: EU15, EU12 and B&H*

| Indicator | 2012 | | | 2011 | | |
|---|---|---|---|---|---|---|
| | B&H | EU15 | EU12 | B&H | EU15 | EU12 |
| **Human resources (per 100.000 inhabitants)** | | | | | | |
| Doctors | 24,74 | 35,35 | 9,63 | 25,08 | 35,99 | 9,61 |
| Dentists | 22,81 | 68,45 | 55,77 | 21,04 | 68,34 | 54,92 |
| Nurses | 520,8 | 944,36 | 587,17 | 502,77 | 947,32 | 571,27 |
| Pharmacists | 11 | 119,79 | | 10,21 | 118,99 | 83,06 |
| **Hospital capacity** | | | | | | |
| Number of hospitals per 100.000 inhabitants | 1,02 | 2,89 | 2,66 | 1,02 | 2,94 | 2,59 |
| Number of hospital beds per 100.000 inhabitants | 350,36 | 500,12 | 639,78 | 346,14 | 506,78 | 640,97 |
| Average length of stay in hospitals (in days) | 7,5 | 8,3 | 7,5 | 7,4 | 8,4 | 7,6 |

Source: WHO, Regional Office for Europe, 2018

## 4. REFORM OF HEALTHCARE SYSTEMS IN EU COUNTRIES

According to the data of Eurostat, it is estimated that the population of European Union had the overall of 511,5 million people at the beginning of 2017. The young (0-14 years of age) represented 15,6% of the population, and working-age population (15-64 years of age) represented 64,9%. The rest

of 19,4% referred to members of older population, above 65 years of age and more, which, in this category represents an increase of 0,2% compared to the year 2016. Perhaps the data that carries even more significance is that this same research showed that for every person of 65 years of age or more, the European Union counted only a little more than three persons who were considered to be capable for work (15-64 years of age). In addition, the share of the population of 65 years of age and more, has been continuously increasing in every country that is a member of the European Union, a member of EFTA and in every country that has the status of a candidate (EUROSTAT, 2018) .

In the last 50 years, there has been an extension of the expected lifetime in all European countries. Only in the period from 2003 to 2013, the expected lifetime was increased for 3,2 years for men and 2,5 years for women. However, researches show that the extension of a lifetime does not necessarily mean a longer life spent in good health. On the level of European average, a man and a woman of 65 years of age have an expected lifetime of nearly 18 and 21 years respectively. Yet, according to EUROSTAT data, only 9 of the rest of 18, that is, 21 years are to be spent in good health. The rest of the lifetime is mostly marked by chronic diseases which result in a significantly lower quality of life which then automatically initiates the increase of a financial burden on the healthcare system. When we talk about concrete causes of death, 85% of mortality on the level of the European Union is caused by chronic diseases, including cancer, cardio-vascular diseases, chronic respiratory diseases, diabetes, and mental diseases (Brennan et.al., 2017). It is exactly chronic diseases that represent a separate matter of care, bearing in mind that they carry significant social costs in the sense of lower compensations, participation and productivity of working capable population and an increased number of early or invalid retirements. It is assumed that the need for expensive health interventions will have a significant increase in Europe in a middle term. At the same time, it is expected that there will be a limited economic growth as well as a stagnation of national budgets. All the above mentioned leads to the conclusion that reforms of the existing health models will have to be placed in the primary focus of all European countries. Defining health policy, financing as well as organizing health systems are all under the jurisdiction of EU members and so, as in other areas of legal regulations on the EU level, they are established only in case when it has been estimated that a certain problem cannot be efficiently solved on national, regional or local level. Only in some cases, such as smoking control, blood, cell and organ trafficking, the EU defines special regulations with which it tries to take care of and improve the health state of the population. (source:

http://ec.europa.eu/health/legislation/policy). As the consequence of this, all the previously mentioned models of healthcare systems are present in Europe (besides the market model), as well as their combinations.

The research made by OECD in 2009 showed that basic primary health care is present in practically all countries that are members of OECD. When we talk about European countries that were included in the research, it was concluded that automatic health insurance which covers the whole population and which is financed by taxes is present in ten countries (Denmark, Finland, Iceland, Ireland, Italy, Norway, Portugal, Spain, Sweden and the United Kingdom). Eight countries applies public health insurance which is obligatory for the whole or almost whole population and is financed through social contributions based on revenues (Austria, Belgium, France, Germany, Greece, Hungary, Luxembourg and Poland). In all countries, insurance is most often related to the profession, and it also includes emloyees' family members. „Security networks" exist so that they would subsidize the insurance or secure health services to the poorest groups of the populations. In this context, Germany represents a unique case because citizens with the highest income have the right to be exempted from social health insurance, that is, they have the right to choose private health insurance, which is the case with 15% of the population.

In two countries, Slovakia and Czech Republic, special arrangements have been developed. According to those, workers are insured by obligatory health insurance that is financed through contributions of employers and employees based on revenues. Their families and individuals who are not employed are insured through direct payments of national government that pays premiums to companies that deal with health insurance in the name of the user. On the other hand, in the Netherlands and Switzerland, health insurance is obligatory for all citizens but is not fully financed through contributions based on revenues. Instead of the above stated, individuals pay premiums to competitive funds of private health insurance. It is important to point out that markets of health insurance are strictly regulated with the aim of protection from market turbulences and assuring the universal approach to health care services– health insurers must not forbid insurance to clients, and there are mechanisms of risk adjustment so that cost and risk could be controlled. Therefore, health insurance in these countries is characterized as „social health insurance" rather than „private health insurance". During this research, Turkey implemented a combined system in which obligatory social and voluntary insurance is dominant for one part of the population, while one third of the population is marked as uninsured.

*Table 2: Characteristics of basic primary health care (end of 2008) (% population)*

| Country | Automatical insurance | Compulsory insurance | Voluntary insurance | No insurance | Provider of basic primary health care: |
|---|---|---|---|---|---|
| Austria | 0 | 98.7 | 0 | 1.3 | More than one insurer |
| Belgium | 0 | 99 | 0 | 1 | Scheme of common health insurance |
| Czech Republic | 0 | 100 | 0 | 0 | More than one insurer |
| Denmark | 100 | 0 | 0 | 0 | Local health services |
| Finland | 100 | 0 | 0 | 0 | Local health services |
| France | 2.5 | 97.5 | 0 | 0 | More than one insurer |
| Germany | 0.5 | 83.3 | 15.2 | 0 | More than one insurer |
| Greece | 0 | 100 | 0 | 0 | More than one insurer |
| Hungary | 0 | 100 | 0 | 0 | National Health Services (NHS) |
| Iceland | 100 | 0 | 0 | 0 | National Health Services (NHS) |
| Ireland | 100 | 0 | 0 | 0 | National Health Services (NHS) |
| Italy | 100 | 0 | 0 | 0 | National Health Services (NHS) |
| Luxembourg | 0 | 96.8 | 1.1 | 2.1 | Scheme of common health insurance |
| The Netherlands | 0 | 100 | 0 | 0 | More than one insurer |
| Norway | 100 | 0 | 0 | 0 | More than one insurer |
| Poland | 0 | 99 | 0 | 1 | Common scheme of health insurance |
| Portugal | 100 | 0 | 0 | 0 | National Health Services (NHS) |
| Slovakia | 55.7 | 44.3 | 0 | 0 | More than one insurer |
| Spain | 100 | 0 | 0 | 0 | Local health insurers |
| Sweden | 100 | 0 | 0 | 0 | National Health Services (NHS) |
| Turkey | 0 | 58.6 | 8.6 | 32.8 | Scheme of common health insurance |
| United Kingdom | 100 | 0 | 0 | 0 | National Health Services (NHS) |

Source: OECD, 2009

Apart from financial arrangements and right to insurance, countries are also differentiated according to the ways of securing primary health care organization. The previously mentioned research showed that National Health Services (NHS) are basic providers of primary health care in eight countries (Hungary, Iceland, Ireland, Italy, Portugal, Sweden and United Kingdom) while local health services have the same part in four countries (Denmark, Finland, Norway and Spain). Scheme of common health insurance are present in Belgium, Luxembourg, Poland, and Turkey. The possibility of taking insurance from more than one insurance providers is available in eight countries. In Austria, France and Greece, to „belong" to a certain insurance provider is not a matter of individual choice, but is usually related to professional status. On the other hand, in Czech Republic, Germany, the Netherlands, Slovakia and Switzerland citizens have the right to choose the insurer.

Legal frame of health is regulated by policies which do not directly refer to health sector and many inter-sector activities, that is policies that do not directly refer to healthcare, and which, as a consequence, can have impact on the area of healthcare as well. Bearing in mind that the purpose of this paper is to show the experience of EU members with the aim of making suggestions of reform directions in the healthcare system in Bosnia and Herzegovina, we will now show some of the changes in health policies which were taken over by EU members in the context of their response to the financial crisis.

When faced with economic shocks that hit the healthcare sector, policy makers can decide whether to increase, decrease or maintain the existing level of public health expense. In each of these alternatives, a redistribution of means within the health system is possible, so that they would increase efficiency and make adaptation of the system to new conditions. Thus, within three basic areas of politics, it is possible to use a number of tools:

- Change of income level policy (the size of national budget for healthcare, taxes from social insurance and transfers from health budget, aspects of fiscal policy such as taxes, transfer to private consumption in the form of fees or public health insurance).
- Scope and quality of publicly financed care (legal right to health services, population coverage, waiting periods for health services).
- Costs of publicly financed care (prices of medicinal goods, health workers' salaries, payments to suppliers, overheads, reconfiguration services).

In 2007, health care on average represented 13% of the overall European public cost. According to the data of World Health Organization, during the crisis and in the first period of recovery, from 2007 to 2011, the share of spending public means on health care was decreased in 44 out of 53 countries. This leads to the conclusion that many European countries decreased public expenses for health care and mostly so in the countries that were severely hit by the crisis, with a few exceptions (Azerbaijan, Norway, Denmark), while this was reversed in certain countries – healthcare expense was increased (Italy, Cyprus, Estonia and Czech Republic).

### 4.1 Change of income level policy

The activities aimed at the increase of revenues for health sector tend to strengthen the performances of the health system, that is, to promote health care and stability of income flow so that good quality and service availability

would be maintained. Policies of income increase also have the aim to promote equality in financing, as well as transparency and administrative efficiency. With regard to the previously said, it is justified to assume that healthcare system will be in need of more and not less resources. The ability of a country to maintain or increase the level of public cost on health care in time of crisis is thus of crucial importance for maintenance of the health system and with that the populations' good health.

### *4.1.1 Health budget*

In this context, health budget represents the overall available means in the healthcare sector regardless of the way of collecting these means. As it was previously stated, in several European countries, there has been a decrease of national budget for healthcare sector as a response to the financial crisis (Bulgaria, Croatia, Estonia, Hungary, Iceland, Ireland, Italy, Greece, Latvia, Romania, Portugal, Spain), where some countries (as Bulgaria and Latvia) decreased the budget for more than 20%. The decrease was partly caused by the increase of unemployment, which decreased the income from taxes for social insurance (Bulgaria, Estonia, Hungary, Romania). In other countries, revenues and expenses of social insurance are still increasing (Austria, Czech Republic, Poland, Slovakia, France and Denmark). In Denmark, the education budget was used to compensate the decrease in the healthcare budget. On the other hand, health budget was maintained on the same level in the period before and after the crisis in Belgium, England and Norway. Help also came from the World Bank, which approved a loan to Latvia, as an external source of financing health services for the poor. The last crisis has shown a special exposure of countries with significant fiscal balances, such as Greece, which was compelled to decrease the overall expense in the public sector, including the health sector, as a prerequisite to get help.

### *4.1.2 Fiscal policy*

Very few countries applied the use of fiscal policy as a means of increasing the necessary revenues for healthcare sector, although the increase of tax can affect the decreased need for government getting in debt. Italian regions which had big deficits in health care have increased local taxes in order to recover from the crisis. In France, new tax rates have been applied to certain income sources so that they would secure the financing of cost in the social sector (including the health sector). Hungary introduced tax on food and

beverages with a high percent of sugar so that they could finance the health sector. It is important to point out that, before the financial crisis, a big number of countries had not introduced dedicated taxes which are intended exclusively for financing health care and as an example we can suggest France in which around 13% of all revenues collected in the health sector come from dedicated taxes, so-called sin taxes, as well as taxes on turnover of pharmaceutical companies (Chevreul and others, 2010).

### *4.1.3 Taxes on health insurance*

Countries which apply the Bismarck Model of the healthcare system have the possibility to maintain revenues by increasing the amount of salaries, extending tax basis on other revenues, or by increasing the transfer from the state budget. These are all probably relevant options for governments that want to stimulate employment together with maintaining or increasing public expense on health care. The other alternative is to make national taxes anti-cyclic for economically inactive population categories and relate them to average salaries in previous years, as it was done in Lithuania and Slovakia.

As a response to the crisis, certain countries have made the decision to increase the rate of taxes either for all or for certain sub-groups of the population (Bulgaria, Greece, Portugal, Romania and Slovenia). On the other hand, Slovakia decreased national taxes for economically inactive persons. Hungary lowered the tax rate and the government increased budget transfers for the people who have the obligation but do not pay taxes, so that it would compensate for the loss in the fund of health insurance. In Austria and Romania, the governments introduced subsidies in order to help payment of debts and to prevent the funds of health insurance from further getting into debt.

### *4.1.4 Users' participation*

To increase revenues in health care on the one side and to lower "moral hazard" on the other is possible to realize by introducing or increasing of the existing participations. Several countries increased or introduced compensations for health services to users as a response to the crisis (Czech Republic, Denmark, Estonia, France, Greece, Ireland, Italy, Latvia, the Netherlands, Portugal, Romania and Slovenia) In some countries, compensations to users were introduced or increased in the hospital sector (Czech Republic, Estonia, France, Ireland and Romania), while in others, higher compensations were required for medicines (Czech Republic, France, Ireland, Latvia, Portugal

and Slovenia). In England, programs for introduction of free prescriptions were announced by the previous government, but they were not carried out. Users' compensations for ambulatory care were increased in Greece, Italy and Romania. Compensations for urgent services were increased in Ireland and in Italy they were increased even for services that were not considered to be urgent. Several countries introduced or increased costs for specific services such as in vitro fertilization (IVF) (Denmark and the Netherlands), ambulatory transfer (France and Slovenia), physiotherapy (the Netherlands), some services related to mental health (the Netherlands), dental prosthesis and some ophthalmic devices (Slovenia).

Contrary to this, other countries' responses were expanding the sets of services that are covered by health insurance aimed at groups with low revenues in the field of pharmaceutics (Austria, France, Ireland, Italy and Moldavia), decreasing users' compensations (Croatia, for primary care and medical prescriptions outside the hospital), or suspension of users' compensations for certain services (Italy and Hungary). (Mladovsky et al, 2012)

It is important to emphasize that all new members of the European Union and some of the old members had, within reform measures that refer to the health sector, introduced various ways of financing the health care even before, so that among the new EU members it is hard to find a state that finances the health sector only from one of the above mentioned sources (for more details on organization and financing of health sectors in all EU members and countries that are EU candidates, consult Pijalović, 2011).

### 4.2 Policies of influence on the volume and quality of health care

Subtle cost reductions in the healthcare sector do not automatically allude to worse performances of the health system. However, it is justified to assume that such reductions will have negative consequences if they are constant and if they are implemented in the already underfinanced health systems, that is, systems with high levels of direct (out of pocket) payments for health services.

Apart from that, in conditions of a serious crisis, the first function of a secure financial protection should be the guarantee that citizens will not be exposed to an additional financial pressure when using healthcare services. Equality in the approach to health services can be jeopardized in different ways. A growing unemployment and poverty in the crisis can increase the need of the population for health care and turn them away from using private

healthcare services especially in countries where direct payments were high even before the crisis. In addition, in crisis conditions, there is often the case of absence of prompt and efficient activities aimed at addressing deep inequalities and coverage of the population with health insurance.

### *4.2.1 Healthcare benefits*

In general, the legal set of services has not been radically changed in the crisis, but in some states there have been certain reductions. Registered reductions of obligatory coverage included: dental care of certain population categories (Estonia, Ireland), physiotherapy, mental health services and medical care coverage outside the EU (the Netherlands), esthetic surgery (Portugal), certain medicines, ambulatory services that are not urgent, dental prosthesis and some ophthalmic services (Slovenia), glasses (Switzerland), and temporary compensations for sickness leave paid by the legal fund of health insurance (Estonia, Hungary and Lithuania).

### *4.2.2 Population coverage*

Ireland is the only country that has undertaken measures which lead to a decrease of population healthcare coverage. Irish government has, namely, exempted rich members of the population from the legal primary healthcare coverage, although since the general elections in February 2011, the government has announced plans for wider coverage, that is, realization of a universal coverage. In Czech Republic, there has been a decrease in legal healthcare service coverage for foreigners. Cyprus advocates further prolongation of implementation of universal coverage during financial crisis, while Hungary introduced stricter controls so it could identify and punish those who avoid paying taxes.

### *4.2.3 Non-price rationing (waiting, weakening and delay of services)*

Supervisory Board of the Health Insurance Fund in Estonia tried to rationalize the scope of services by introducing the decision on increasing the maximum waiting period for ambulatory visits from four to six weeks. Other countries have not reported the increase of the waiting period as an explicit measure against the financial crisis. Instead, in countries such as Ireland, reforms of the healthcare sector have unintentionally lead to a prolongation of the waiting period, where changes of policies regarding healthcare sector lead to the

increase of the number of patients on waiting lists of 9% in the period between 2009 and 2010. (Mladovsky et al, 2012)

#### *4.2.4 Change in behavior of individuals (health prevention and promotion)*

Within this measure we can number several countries that have increased taxes on alcohol and cigarettes (Bulgaria, Estonia, Ukraine) or that have resorted to health promotion, such as encouragement of healthy nutrition and exercise (Belgium, Greece, Hungary and Moldavia).

### 4.3 Policies of influence on healthcare costs

In the first years of the crisis, a significant number of countries faced a serious volatility of public spending aimed at healthcare on per capita level. The biggest annual decreases in healthcare compensations were the result of government decisions (Greece, Ireland, Latvia and Portugal), and not of the decrease of revenues generated by the employed members of the population. A slower growth of costs in all areas of healthcare is noticeable in the period between 2007 and 2011 along with concrete decreases of costs in all areas except dispensary care. Decreases are mostly present in areas of stationary care, prevention and public health and medicines. Initial reductions in costs for administration in 2009 were followed by an increased spending in the following years. Logically, the biggest costs in the healthcare sector were registered in countries that were most severely hit by the crisis (Greece, Latvia, Lithuania, Portugal and Spain), although consistent decreases in countries that have not suffered any form of economic shock were also noticeable, which was the case with Poland.

#### *4.3.1 Prices of medical goods*

A great number of countries have introduced or have encouraged policies aimed at lowering of prices of medical products (medications, medical devices and equipment) or at improving rational consumption of medicines (Austria, Belgium, Croatia, Czech Republic, France, Estonia, Greece, Iceland, Ireland, Hungary, Latvia, Lithuania, Malta, Moldavia, Poland, Portugal, Romania, Russia, Serbia, Slovakia, Slovenia, Spain). A wide spectrum of measures was used, including generic substitutions, INN prescriptions, price negotiations and prolongation of prescription validity. It is a fact that these policies were, in most countries, already a part of ongoing reforms, but the crisis urged their

execution. Bulgaria and Czech Republic are in the process of increasing state regulations on procurement of medical devices. At the same time, the influence of VAT on the increase of prices has weakened the advantages gained by lowering product prices as a result of the reform and crisis.

### *4.3.2 Salaries and motivation of the employed in the healthcare sector*

Some countries decreased salaries of health professionals (France, Greece, Ireland, Lithuania, Romania). Some countries fixed these salaries (England, Portugal, Slovenia) or decreased their growth rates (Denmark). Other approaches to lower salaries included a significant increase of pension taxes in public sector and a decrease of benefits, which leads to de facto decreased salaries (England), reduction of overtime and night shifts, and to longer shifts which require fewer staff members and smaller costs (Iceland) and similar. In Czech Republic, physicians managed to stop lowering of their salaries through negotiations or protests.

### *4.3.3 Payment of service providers*

As a response to the crisis, several countries lowered tariffs (that is, prices) given to service providers (Estonia, Ireland, Romania, Slovenia) or connected paying with improved performances, so that they would achieve greater efficiency and lower accompanying expenses (plans on introducing diagnosis of related groups (DRG), hospital care fees in Bulgaria, paying for services (P4P) in Italy, primary care payments per capita in Portugal, working estimates and financing based on results in Moldavia.

### *4.3.4 General costs (restructuring of the Ministry of Health and Agency for Provision)*

Some countries restructured their Ministries of Health, Funds of Obligatory Insurance and other agencies in an attempt to decrease general costs and increase efficiency (Bulgaria, Croatia, Czech Republic, England, Iceland, Latvia, Lithuania, Portugal and Romania).

### *4.3.5 Providers of infrastructure and capital investments*

In a great number of countries, the economic crisis initiated the urgency of the existing process of hospital sector restructuring through closing, merging and centralization (Denmark, Greece, Latvia, Portugal, Slovenia), a shift to

ambulatory care ((Belarus, Ireland, Greece, Lithuania), an improved coordination with primary care or investment in primary care (Armenia, Lithuania, Moldavia, the Netherlands), merging of healthcare centers (Iceland) and reorganization of emergency service (Macedonia). Some countries (Romania) gave up on or suspended investment plans for building new hospitals, slowed down programs of modernization of hospital and ambulatory care, slowed down procurement of expensive equipment or lowered the share of capital costs. Opposed to this, some countries increased means for modernization of public health services by using the means from Fund of Obligatory Health Insurance or developed e-health systems, together with the implementation of an integrated health system for information and electronic health care management (Latvia, Macedonia), as well as the need for a new electronic system of signing prescriptions (Croatia). (Mladovsky et al, 2012)

## 5. CONCLUSION

Healthcare systems have been developed gradually and under the influence of various factors, the most important of which are: national history and culture, dominant politic ideology, local geographical and climate conditions and socio-economic development of a state. Healthcare systems can be classified according to different criteria, and the most important among them are ways of collecting means and ways of service payment. According to these criteria, we group health systems into the Bismarck model, the Beveridge model and Market model. The Beveridge model accounts for financing of health care directly from the budget, and the sources of financial means are general taxes. This model has good results in states that do not have problems with budget deficits and fiscal lack of discipline. The Bismarck model is based on financing through taxes and the Market model is based on financing premiums that are paid in to insurance companies.

Definition of healthcare policy, financing as well as organization of healthcare systems are under the jurisdiction of EU country members and they, as in other areas of regulations on the EU level, are only dealt with if it is estimated that certain problem cannot be efficiently solved on national, regional or local level. In the European Union there are all previously mentioned models of healthcare financing but we have to point out that among new EU country members it is almost impossible to find a state which is financed from only one source that has been designated by a healthcare model.

Faced with economic shocks which affect the healthcare sector, policy makers in the European Union made decisions to increase, decrease or maintain the existing level of public expense on health care. In addition, they used a number of tools within three main policy domains: (i) Policy of change of income level (size of national budget for health care, taxes of social insurance and transfers from the budget to health care, aspects of fiscal policy such as taxes, transition to private consumption in forms of fees or private health insurance). (ii) Scope and quality of publicy financed care (legal right to health services, population coverage, health services waiting period) and (iii) Cost of publicly financed care (prices of medical goods, health workers' salaries, payments to suppliers, overheads, reconfiguration services).

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ANU BiH АНУ БиХ

# SISTEMI ZDRAVSTVENE ZAŠTITE EVROPSKE UNIJE I ODGOVOR NA EKONOMSKU KRIZU


## Sažetak

Zdravlje populacije nesumnjivo predstavlja područje koje zahtijeva posebnu brigu države stoga je ta pažnja najčešće instituicionalizirana kroz kompleksne sisteme zdravstvene zaštite. Imajući u vidu fundamentalni društveni značaj sistema zdravstvene zaštite, može se reći da su rasprave na temu njihove funkcionalnosti i efikasnosti globalno sveprisutne. Značaj znanstvenog i praktičnog istraživanja u području zdravstvene zaštite, posebno dobiva na važnosti u nepovoljnim ekonomskim uslovima, kakvi jesu bili prisutni u većini zemalja svijeta tijekom i nakon ekonomske krize 2007. godine. Obzirom na ozbiljnost krize, veliki broj zemalja suočen je sa potrebom revidiranja postavki sistema zdravstvene zaštite kako bi se osigurala njihova održivost u novonastaloj nepovoljnoj i neizvjesnoj finansijskoj realnosti. Osim toga, iako je sisteme zdravstvene zaštite moguće grupisati odnosno pridružiti određenom modelu, ne smije se zanemariti činjenica da su zdravstveni sistemi različiti u različitim zemljama te da su njihovi atributi ogledalo historije, tradicije, političkog uređenja, ekonomije i nacionalnih vrijednosti konkretne zemlje kojoj pripadaju. Obzirom na navedeno, nije moguće ponuditi jedinstven set univerzalno efikasnih mjera za suočavanje sa posljedicama koje je kriza ostavila na zdravstvene sisteme. U ovom radu, analiziramo odgovore implementirane od strane zemalja Evropske unije u svjetlu posljednje ekonomske krize, posljedično najrazornije od svih s kojim se Evropska unija suočila od svog osnivanja.


**Ključne riječi:** sistemi zdravstvene zaštite, potrošnja na zdravstvenu zaštitu, ekonomska kriza