FINANCING OF HEALTHCARE INSTITUTIONS AS A SOCIAL NECESSITY AND CURRENT PRACTICE

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Abstract

The issue of public revenue collection and distribution of public expenditures represents one of the biggest challenges for all countries of the world. On the one hand, the collection of income, through taxes, contributions and other forms of fundraising, increasingly burdens the incomes of citizens. Additionally, the lack of money among direct and indirect users of the budget due to increasing demands also leads to constant pressure on state budgets. Main subject of this paper will be collection of financial resources for the development of healthcare and the smooth functioning of the healthcare system, as well as proposals for overcoming the problem itself. The new technology used in healthcare diagnostics, the continuous development of modern medicines, and costs of their research represents a challenge for all healthcare systems. The paper will present models as well as recommendations for a different type of allocation and redistribution of budget revenues.

Keywords: finance, healthcare, current practice.

INTRODUCTION

Comparative legal analysis and preparation of the Study on the financing of healthcare and health insurance systems in European countries represents a great challenge for numerous institutions. The intention of such works is the preparation for active participation in the process of proposing measures and activities, as possible solutions within the reform of the healthcare and health insurance system, which is being implemented in the Republic of Serbia. Acquaintance with the experiences of European countries in this regard is undoubtedly valuable in the implementation of this necessary process. In this way, we can indicate the current state and problems in the functioning of the health system, but also provide us with the ways in which these problems can be overcame and improve the system as a whole in the Republic of Serbia. Certain researches in numerous published studies included several European countries, which were not selected randomly, but as representative, according to clear criteria. Namely, it started from the fact that the healthcare and health insurance systems of those countries are organizationally and functionally successful should be analyzed first. Another criteria that would be important for this paper is comparability with the Republic of Serbia, so the most relevant selected countries are the Republic of Slovenia and the Republic of Croatia, with which we have a historical, cultural, political and social heritage. In this paper, we want to give answer on questions which are important for the efficient and effective organization and functioning of the health system, while pointing out the strengths and weaknesses of certain healthcare solutions and health insurance politics.

HEALTHCARE SYSTEMS IN SELECTED COUNTRIES

The healthcare system includes all organizations, people and activities whose primary goal is to improve, restore or maintain the health of the population. It is a broad concept, which cannot be limited only to institutions, public or private, that directly

provide health services to the population, but also includes everything else that in any way, directly or indirectly, participates in that process. Thus, the healthcare system, in addition to these institutions, also consists of laws and other regulations in the field of health, insurance organizations that deal with health insurance, etc. Health policy represents one of the key economic and political requirements of all countries of the world, which try to organize the healthcare system in a way that, under the given circumstances, contributes the most to prolonging the life of the population, keeping the population healthy and insured against financial risk due to paying medical bills. Organizing the healthcare system, however, is not a simple task, especially today when the challenges facing its successful functioning are increasing. The three key factors that influence this are: first, the population is getting older in most countries, and the elderly have increased needs for health care; secondly, new medical technologies and medicines are constantly being found, the costs of which are high; thirdly, the expectations of health care users are constantly increasing, both in terms of quality and quantity. It is clear that all of this affects the increase in treatment costs, and thus the efficiency of the healthcare system, so it should not be surprising that the issue of reforming the healthcare is an obligatory topic of almost all modern political campaigns. A comparative analysis of the healthcare system in European countries, especially health insurance as one of the key elements of that system, shows that it is not organized and implemented everywhere in the same way. The roots of modern systems of health care and social health insurance are usually linked to Germany and the 19th century, where the government and its respective bodies for the first time undertook to solve this issue at the level of the whole country. This kind of modern health insurance systems are based on Bismarck's model of health insurance, and they are also known as non-profit or public health insurance systems. However, the first attempts to organize health care in Europe date back to a long time before that, because even in the Middle Ages, individual merchant associations, based on the principle of solidarity, organized health care for their members. From then until today, the number of people who enjoy health care based on the fact that they have health insurance is constantly growing, and today the rule is that everyone who has a residence in the territory of a certain country must have health insurance in that country.

HEALTH CARE COSTS

Almost all European countries finance healthcare in parallel from public and private sources. State (budgetary) revenues and other social benefits are used as public sources, which, as a rule, are collected within the framework of mandatory health insurance, while private sources of financing include funds that citizens pay out of their own pockets for health care needs, funds that pay for private health insurances, voluntary contributions, etc. When public and private sources of financing are compared, then the rule is that the public sector is the dominant source of financing healthcare and according to the available data, the percentage share of the public sector in the total costs of health care in certain countries is: more than 80% in the Netherlands, Scandinavian countries (except Finland), Great Britain and the Czech Republic; between 75 and 80% in Finland, Belgium, Germany, Austria, Italy and France; between 70 and 75% in Hungary, Poland, Slovenia, Turkey and Spain; below 70% is in Switzerland, Portugal, Greece and Slovakia. Based on these data, it can be concluded that the public sector participates in the total costs of healthcare with 72% and that percentage has not shown a tendency for significant changes in the last 20 years. Statistical data on healthcare costs show that they are constantly growing in all countries at a rate that is higher than the growth rate of the gross domestic product (hereinafter: GDP). The percentage share of total costs for health care in relation to GDP by individual countries for 2010 and 2020 (or the year closest to 2021 for which the data was recorded) is shown in Table 1, while Table 2 shows the cost of health care by per capita expressed in USD in the same countries for the specified years.

Table 1: *Percentage share of health care costs in relation to GDP*

Country		2010.	2020.
Austria		10,1%	11,0%
Belgium		8,5%	10,5%
Czech Rep.		6,8%	7,5%
Denmark		9,3%	11,1%
France		10,6%	11,6%
Germany		10,7%	11,6%
Hungary		7,6%	7,8%
Italy		8,3%	9,3%
Poland		6,3%	7,0%
Slovenia		8,6%	9,0%
Sweden		9,2%	9,6%
Switzerland		10,9%	11,4%
Serbia		5,8%	9,9%

Based on the data presented in the Table 1, the state of health care in certain countries can be seen to some extent. However, based on this, it is not possible to conclude which model of health insurance works better. For a cross-section and more adequate data, it is realistic to look at absolute amounts (shown in Table 2).

Table 2: *Health care costs per capita expressed in USD*

Country	2010.	2020.
Austria	3084	4395
Belgium	2542	3969
Czech Rep.	1194	1884
Denmark	2870	4464
France	2921	3974
Germany	2943	4338
Hungary	1114	1601
Italy	2235	2964
Poland	733	1389
Slovenia	1704	2428
Sweden	2702	3758
Switzerland	3673	5489
Serbia	229	565

From the above tables, we can conclude that all the countries are facing an increase in the cost of health care for the population, and the first attempts to establish control over those costs were already recorded in the seventies of the last century, while more serious and significant activities in this regard have been undertaken since the nineties of the last century. The ways in which this control is carried out are not the same, but they can all differ according to whether the measures undertaken are of a monetary or non-monetary nature, and according to whether they affect the providers of health services or their users. Practice shows that financial measures are most often taken, primarily those that affect users of health services. Namely, the insured are obliged to pay a certain amount out of their own pocket for the received service or medicine, despite the fact that this service or medicine is included in the mandatory package of health services. This obligation, which can also be labeled as "paying out of pocket", is represented today in numerous countries, including the most developed European countries, although not everywhere in the same form. Among the most common forms of out-of-pocket payment for health services are: a) contributions, which means that the insured pays a pre-determined, fixed amount on behalf of the received health service or medicine; b) nominal premiums, which means that the insured pays monthly from his own pocket the amount corresponding to part of the health insurance premium, as an addition to the mandatory health insurance; c) residential payment, which means that persons, users of health services in the country in which they do not have a residence, cannot obtain reimbursement of costs for those services. Regardless of that, patients are obliged to pay the costs for medicines and for health services that are not covered by the mandatory health insurance package. Some countries, however, in addition to monetary measures, also apply certain non-monetary measures in order to suppress health care costs. Such measures mainly affect health care providers, and certain acts are usually foreseen in this sense, i.e. recommendations for the actions of health care providers in certain situations. Some of those acts are: "clinical guidelines", "management of clinical procedures", "application of standardized procedures", etc.

METHODS OF PAYING FOR HEALTH SERVICES

Today, there is no universal formula by which the issue of payment for health services should be resolved, but in practice there are various ways in which it is resolved. What's more, states very often do not apply

exclusively one model of payment for all health services, but combine two or even more models so that the payment is best adapted to specific conditions and as such positively affects the economic efficiency of the health care system. Based on the experiences of OECD member countries, it can be said without a doubt that the issue of payment for health services is one of the most important political issues, because it decisively affects the behavior of health service providers, and therefore the level and quality of health care. From a comparative legal point of view, health services are today most often paid for in one of the following ways: 1. through salary; 2. by health service, 3. by capitation; 4. based on diagnostically related groups; 5. per sick day; 6. based on a predetermined budget. In the following, the basic characteristics of each of the mentioned systems will be presented, highlighting the advantages and disadvantages that have been observed during their practical application so far. We will list the most common model that is used in most countries as well as in Serbia.

PAYMENT THROUGH SALARY

A significant number of states use salaries to pay doctors at all levels of health care, both in the public and private sector. At the same time, somewhere doctors are paid only according to this system, while in some countries it is combined with some other method of payment. The basic characteristic of this system is that doctors' salaries do not depend on how many health services they provided in a certain period, nor on the quality of those services. Consequently, it is logical that they, and we are primarily talking about doctors employed in the public sector, are not particularly motivated to improve the productivity and quality of the services they provide. Furthermore, experiences in the application of this system show that it is most conducive to low morale among doctors, i.e. their susceptibility to corruption. To overcome these shortcomings, many states combine the salary system with other physician payment systems, primarily the capitation system. However, paying through salaries also has certain advantages, the most significant of which is that it successfully controls health care costs. In addition, in this system, health services are equally available to everyone, even if formally, and the administration that follows these payments is simple and does not require a lot of time or costs.

MANDATORY PACKAGE OF HEALTH SERVICES

Determining the package of services that includes mandatory health insurance is a key issue of every health system, but also the most important political issue because the mandatory package of health services, in principle, depends on whether the state will succeed in providing universal health care for the population, which is a prerequisite for achieving the basic goals health policy. In other words, the successful implementation of health policy is only possible if the state provides medically necessary, effective and financially efficient health services to all citizens. However, the understanding of what is medically necessary changes over time and what was previously considered to meet that requirement is no longer sufficient today. This should not be surprising when it is taken into account that the development of medicine affects not only the change in understanding about the effectiveness of medical treatments, but also the expansion of the concept of disease. A comparative analysis of modern European compulsory health insurance systems shows that, as a rule, they include various medical services in outpatient and hospital care, as well as reimbursement of costs for medicines, as a rule. In addition, in a significant number of countries, the mandatory package of services includes long-term care, while prevention, dental services, alternative medicine, etc., are not its usual content. Determining the package of services that includes mandatory health insurance is, in principle, an issue that is finally resolved through negotiations between the state, funds and doctors. Their role in those negotiations, however, is not the same and the dominant word, as a rule, is led by the state, that is, the government, because the issue of the mandatory package of health services, as already mentioned, is one of the most important political issues. However, the government rarely decides on this issue

completely independently, but in cooperation with the appropriate bodies. Thus, some countries, for example, the Netherland and Switzerland, have established special agencies that, among other things, are authorized to propose services to the ministry responsible for health affairs that should be included in the mandatory package of health services. There is also such an agency in Germany, but the Parliament is not obliged to adopt its proposal (in practice, however, the agency's proposal is very rarely rejected), while in France, for example, these agencies are less independent and work in cooperation, i.e. under the supervision of the authorities ministries. However, a distinction should be made between the content of the mandatory package of health services, on the one hand, and the price of those services, on the other, because prices, as a rule, are not within the competence of the aforementioned agencies, except in the Netherlands, but only when it comes to dental services. Mandatory packages of health services represent a list, ie a catalog of services covered by mandatory health insurance. These catalogs enable health care providers to inform themselves about the services for which they can expect compensation from the compulsory health insurance fund. At the same time, the catalogs are also useful for patients, that is, users of health services, because they can clearly see their rights based on mandatory insurance based on them. Catalogs on the mandatory package of health services are not immutable acts; on the contrary, they are subject to changes and additions in order to adapt to new knowledge and new technologies. However, those changes, more specifically the expansion of the list of services included in the mandatory package, do not come about so easily, not only because of the stipulated procedure, but also for other reasons. Namely, the introduction of new health technologies in the newspaper is not only influenced by their price, but also the efficiency of that technology, the medical necessity of its use, the opinion of public opinion and even political actors. When it comes to the mandatory package of health services, the question arises whether patients, that is, users of health services, can influence that package so that they receive some type of health care at the expense of mandatory insurance, despite the fact that it does not cover that treatment. In principle, the possibilities of patients are quite limited in relation to this issue and they, as a rule, can only use informal forms of influence for these purposes. However, an exceptional solution exists in Germany, where a procedure is provided for deciding patient appeals on decisions related to the mandatory package of health services. Namely, a patient who, for example, requests compensation for treatment costs that are not included in the mandatory package of services, can request from a specialized court competent to resolve issues in the field of public insurance (which includes health insurance) that this compensation be recognized and the court, sometimes, such requests are adopted.

CONCLUSION

Solutions related to the allocation and redistribution of budget funds represent an additional type of model, where the public-private financing model of the health system is particularly distinguished.

In this regard, we tried to take into account the choice of financing those models, applied and compared experiences from the countries mentioned above.

We can conclude that the model of combined state healthcare, which covers a mandatory health insurance with additional private insurance, is perhaps today the best form of bridging the lack of money in the state budgets of all countries, with special reference to countries that are still in that transition period.

A model of public-private financing could in the future lead to a serious healthcare reform in Serbia, where the choice of a clinic, hospital, and the possibility of performing a certain intervention would depend on the financial situation, but also on additional allocations from the income. The authors believe that it is not possible to find a model of an ideal healthcare system, but that each country adapts their system to its own needs and harmonizes it with existing social opportunities.

Given that the subject is very extensive, the authors plan to present the comparative

advantages in the future, in addition to the existing ones, with the countries that could be classified in this group, for example the Republic of Poland and the Czech Republic, because those countries had political system similar to ours, but they changed it almost a decade before us, so the reforms of the healthcare system started much earlier.

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