THE FINANCING OF THE HEALTH SERVICES - FINANCING MODELS

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Abstract

The health systems of the EU Member States are essential to ensure a high level of cohesion and social protection in Europe. Health systems in the EU are varied and reflect the various choices of society. Despite the differences in terms of organization and financial means, they are based on the common values recognized by the Council of Ministers of Health in 2006, through the Tallin Book: universality, access to good quality care, equity and solidarity. Also, it is widely recognized the need for health systems to be fiscally sustainable, so that these values are guaranteed in the future.

Keywords: *health services, financing, analysis, model, public spending*

JEL Classification: H51, I15

Introduction

Over the past decade, European health systems have faced similar, increasingly sharpened challenges, namely: Europe's population is aging and becoming more exposed to multiple chronic diseases, leading to increased demand for medical assistance and fiscal pressure; the costs of innovative technologies and medicines are increasing and are a burden for public finances; health professionals are unevenly distributed, there are deficits in some areas of care and access to health care is not evenly distributed, which leads to inequalities in health outcomes at the societal scale. The Commission's communication on effective, accessible and resilient health systems has defined a strategic agenda for EU health systems.

The Joint Report on health and long-term care and fiscal sustainability systems, drawn up by the European Commission and the Economic Policy Committee, also contributed to this agenda. In principle 16 of the European Pillar of Social Rights, adopted in April 2017, it is stated that every person has the right to rapid access to preventive and curative healthcare of good quality and financially accessible. Quick access means that anyone can get medical care whenever they need it. This requires a balanced geographical location of medical institutions and health professionals, as well as policies that minimize long waiting times. The accessibility of health care financially means that the use of the necessary care services should not be hindered by

too high costs. Good quality of healthcare refers to the fact that it should be relevant, appropriate, safe and effective. EU health systems are increasingly interacting with each other. The Directive on the application of patients' rights in cross-border healthcare has been an important milestone in creating a legal framework and policy tools to foster such cooperation, in particular because it provides clear rules and provides patients with reliable information on access to care. medical insurance in another EU country and reimbursement of related costs.

Literature Review

In 2009, Stuckler, Basu, Suhrcke, Coutts, McKee, M made a first analysis of the effects of the economic crisis on population health. There is widespread concern that the current economic crisis, especially its effects on unemployment, will adversely affect the health of the population. They investigated how economic changes have affected mortality rates over the past three decades and identified how governments could reduce adverse effects. Thus, rising unemployment is associated with significant short-term increases in premature deaths caused by intentional violence, while reducing traffic deaths. Active labor market programs that maintain and reintegrate workers into jobs may mitigate some of the negative effects of the economic downturn on health. These multilevel financing models have been analyzed and presented lately by Duran and Saltman, 2013, which analyzes the shift from offering direct health services to health service providers. In 2018, Saltman analyzes the impact on health services caused by slower economic growth. Thus, his paper evaluates the recent strategies for reforming the health sector in Europe adopted since the outbreak of the financial crisis of 2008.

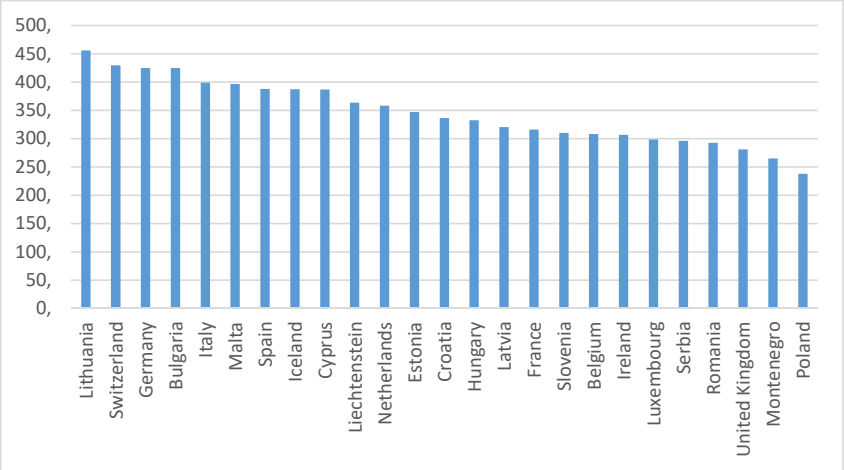
Methodology, data, results and discussions

The health sector is a major source of jobs The sector „health and social assistance" is the sector that has registered the largest increase in the number of jobs in recent years, with over 2.6 million new jobs (between the first quarter of 2009 and the first quarter of 2017). In this sector, the increase in the number of available jobs had the following distribution: in the „human health" subsector: 960 500 new jobs, representing 36% of the total of new jobs created in the whole sector; in the sub-sector „residential care", 946 500 new jobs (35% of the total); and in the „non-residential social assistance" sector, 776,700 new jobs (29% of the total). In the first quarter of 2017, 24,014,500 people were employed in the sector „human health and social assistance". Most of them - 13,601,700 - were working in the „human health" subsector. The sub-sector „residential care" registered 5 066 800 employees,

and 5 346 000 workers worked in the field of „social assistance activities without accommodation". However, not all new jobs are in line with the new demands for healthcare: in order to benefit from effective care, Europe's aging population needs different skill sets and ways of working across all sectors and disciplines. . There are inconsistencies both in terms of nature and the distribution of competencies in the different health professions. It is possible that through new forms of care provision, which will ensure a transfer of tasks (for example, from doctors to nurses) and better integration, safer and more efficient care can be ensured, at lower costs.

Number of doctors per 100,000 inhabitants in 2017 in the EU states

Table 1



The workers in the health and social care sector have a much higher level of education than the average of all sectors. The number of workers with higher education (university degree or graduation of another higher education institution) is constantly higher in the health and social assistance sector than in the entire economy. In 2016, 33.9% of all EU workers had higher education; in the sector of health and social assistance, their proportion was 43.4%. The percentage of workers with high school or post-secondary education was 48% for the entire economy and 45% in the health and social assistance sector. To complete the picture, 17.9% of the total workers had at most a lower secondary education diploma, this percentage being only 11.5% in the health and social assistance sector6. The health and social care sector remains predominantly female-oriented: four out of five workers in this sector are women, and the proportion remained virtually unchanged during the period analyzed.

An effective and accessible health sector also indirectly contributes to economic growth and prosperity: it helps people to achieve good health and maintain it, thus ensuring increased labor market participation and higher productivity.

The public sector plays a major role in the financing of health services: in two thirds of the Member States, more than 70% of the health expenditure is financed by the public sector. This situation risks endangering the sustainability of public finances, especially in the context of population aging.

The share of public and private financing of health systems in EU countries in 2017

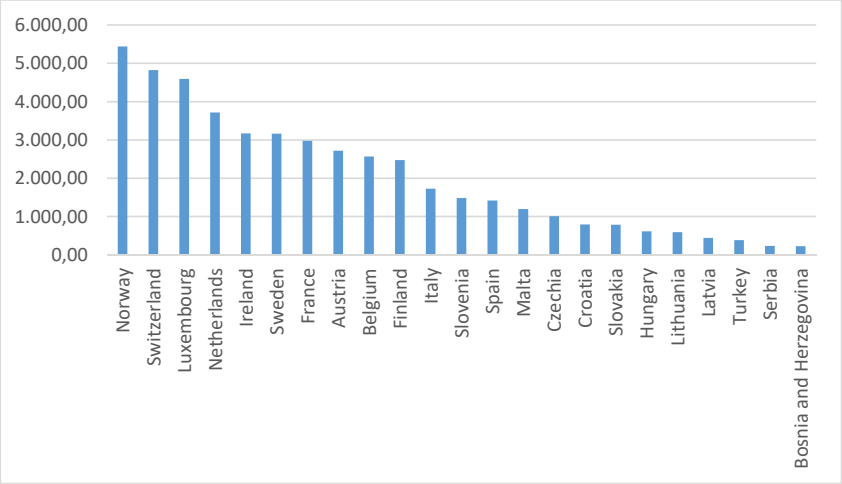
Table 2

GEO/TIME	Total financial value	Public system financing	Private system financing	% Public system financing	% Private system financing
Germany	368,597.00	310,959.00	57,638.00	84%	16%
Luxembourg	3,031.08	2,546.90	484.18	84%	16%
Denmark	29,597.66	24,869.14	4,728.52	84%	16%
Sweden	52,363.75	43,825.80	8,537.95	84%	16%
Czechia	13,864.05	11,381.55	2,482.50	82%	18%
Netherlands	74,448.03	60,710.19	13,737.84	82%	18%
Slovakia	5,721.14	4,573.41	1,147.73	80%	20%
United Kingdom	78225,186.54	177,449.56	47,736.98	79%	21%
Romania	9,671.85	7,607.11	2,064.74	79%	21%
Finland	20,613.63	15,491.82	5,121.81	75%	25%
Estonia	1,518.31	1,134.93	383.38	75%	25%
Austria	38,457.19	28,459.21	9,997.98	74%	26%
Italy	152,705.00	112,845.00	39,860.00	74%	26%
Ireland	21,130.45	15,487.25	5,643.20	73%	27%
Spain	103,488.62	73,079.63	30,408.99	71%	29%
Hungary	8,534.65	5,906.27	2,628.38	69%	31%
Lithuania	2,724.47	1,811.83	912.64	67%	33%
Portugal	17,456.49	11,576.49	5,880.00	66%	34%
Switzerland	74,249.89	47,223.33	27,026.56	64%	36%
Greece	14,492.25	8,815.84	5,676.41	61%	39%
Bulgaria	4,182.67	2,178.20	2,004.47	52%	48%
Cyprus	1,313.10	559.67	753.43	43%	57%

Table 2 shows the share of public and private financing of health systems in EU countries. The Member States in which a relatively large share of health expenditure comes from the private sector are Bulgaria (48% of total health expenditure), Greece (39%), Cyprus (57%), Latvia (33%). The Member States in which health expenditure is predominantly government-funded are Denmark (84%), Germany (84%), Luxembourg (84%), the Netherlands (845) and Sweden (84%) and the Czech Republic (82%).

The value of health services / 1,000 inhabitants at the level of 2017

Table 3



For governments, public spending on health is among the largest and fastest growing items. Table 2 shows the countervailing of the consumed health services / 1,000 inhabitants. Thus the countries in which the share of public health expenses is over 75% and the same in that they are the highest values of health services per 1000 inhabitants at the same level in 2017.

In an analysis of the increase of the share of public expenditure in the field of health as a percentage of GDP in the period 2008-2014, it is noted the average annual increase of the real public expenditures for health, per capita, in the same years. In combination, these two indicators provide a better mirror of public spending on health. The level variations of health expenditure related to GDP are, in fact, the result of the combination of the trends recorded by public health expenditure and GDP, respectively.

A relative increase in spending on health as a percentage of GDP may actually be the net effect of decreasing both figures, with GDP declining more than spending (and vice versa). Therefore, per capita values provide additional

information for assessing trends: if health expenditures increase as a share of GDP and decrease as per capita, it is likely that the country's GDP will fall faster than health expenditures. Growth trajectories should be analyzed in conjunction with the initial value. A starting point below or above the average may lead to a different interpretation of the increases and decreases in healthcare spending.

The access to effective health systems contributes to social cohesion The most common obstacles to access to healthcare have been caused by the inability and / or reluctance of patients to pay for medical products and services. In some countries there was also the problem of waiting times or the distance traveled. The waiting time problem can arise from a variety of reasons, including some related to insufficient or inadequate allocation of resources or active management choices made by decision makers in the health system. Also, access to healthcare could be hampered by insufficient availability of medical infrastructure and health workforce.

Throughout the EU, there are gaps identified by patients themselves regarding access to good quality health care, despite the fact that Member States agree with the common principle of equity within health systems. There can be multiple obstacles to equity in access to health care, including financial, administrative, geographical, legal, cultural and organizational factors. The unmet medical needs reported by the patients themselves should also be analyzed in the light of objective indicators regarding the use of healthcare and the related expenses. An example of an indicator is the level of public, private and direct expenditures on healthcare, which also provides information on the financial protection of the population against the risks of illness and on the current use of health services. Ensuring universal and sustainable access to high-quality care requires increasing the efficiency and effectiveness of health spending, amid increased demand and limited resources. The difficulty lies in identifying cost-effective ways of financing, organizing and providing healthcare, leading to improved health status with more rational use of available resources. Undifferentiated expenditure reductions, which aim to save in the short term and do not target the overall profitability of the system, could lead to higher costs in the medium and long term. It is worth mentioning that many Member States perceive as a difficult step the improvement of access to financially accessible medicines. The reality is that for the coming years a large number of new drugs are expected to be launched, which will create greater financing needs compared to the last decade. The nature of new drugs is gradually changing: innovations are based on complex and expensive biopharmaceuticals and are increasingly targeting smaller population groups. Public and private entities paying for healthcare are increasingly facing the

problem of how they can afford to pay for these increasingly numerous drugs. Many deaths still occur too early in Europe.

In 2014, 1.69 million people under the age of 75 died in the EU. Of these, approximately 562,034 deaths could be considered premature, as they could have been avoided given current technology and medical knowledge. Together, heart attacks and strokes have caused almost half of these total preventable deaths. The concept of preventable mortality through health care is based on the idea that certain deaths (for certain age groups and because of certain diseases) could be „avoided". In other words, they would not have occurred at this stage if effective healthcare services had been available in a timely manner. The preventable mortality indicator through health care is used in the global context of health system performance assessments to provide an indication of the quality and performance of health policies. In 2013, the proportion of preventable deaths through optimal medical care and the total number of deaths in persons under 75 years of age varies considerably from one Member State to another.

After 2017, several Member States have introduced and implemented substantial measures to increase access to health services, while maintaining the quality and sustainability of the system. Thus, Bulgaria, Estonia, Malta, Austria and Poland have introduced substantial reforms to strengthen primary health care and better coordinate it with hospital and specialist care. In addition, Sweden has allocated increased funds to improve the accessibility of health services. Cyprus has committed itself to redesigning its health care system to provide the entire population with access to healthcare and to reduce large direct payments. In 2016 and 2017, Portugal underwent significant reforms to ensure universal coverage health services. Bulgaria has taken steps to expand outpatient health care to areas where low levels of provision of these services through the public system make certain people's access to healthcare difficult. Austria has introduced a new system, based on homogeneous groups of patients (GOBs), for payment in the outpatient area of hospitals, in order to reduce the pressure on the hospitalization sector and to stimulate the use of day-care and outpatient services. Hungary and Romania have taken the first measures to increase the salaries for health professionals. Latvia, Poland, Portugal and Romania announced measures to attract doctors and nurses to peri-urban or rural areas. Latvia and Malta have reduced waiting times, and Romania has reorganized parts of the outpatient care system. Italy, Malta, Portugal and Slovenia have developed and implemented ICT solutions to reduce waiting times in health services. Spain, Italy, Portugal and Slovakia are implementing reforms such as centralizing procurement and adopting generic drugs. The ultimate goal is to increase access to medicines and ensure their

cost-effective use. Latvia and Romania have implemented plans to increase the degree of responsibility and mechanisms for ensuring transparency in the health system.

Conclusions

Several Member States have introduced and implemented substantial measures to increase access to health services, while maintaining the quality and sustainability of the system. Raising health priorities and total public spending are key factors in facilitating the transition to health financing in all countries, whereby additional internal health resources are mobilized to gradually replace high out-of-pocket payments. Sustained increases in the amount, equity and efficiency of health financing are essential for achieving universal health coverage and for improving health outcomes globally.

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