

Health Care Systems in BiH

Financing challenges and reform options?

MARKO MARTIĆ AND OGNJEN ĐUKIĆ, SARAJEVO

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- High expectations and increasing needs of citizens have influenced a relatively high share of private expenditure in total health expenditure (28% in 2014) which is double the EU average (14%). In 2014, the private household health care spending of a family with three members averaged 50 KM monthly, which may pose a serious burden for the families living below or near poverty line. It indicates a certain degree of inequality in access to health care services among the citizens of BiH.
- There is a high level of inequality of public expenditure in health sector among the cantons by insured person in FBiH (from 453 KM to 875 KM), given that revenues from the employees' contributions "return" to the canton they were collected in. It can be said that the principle of solidarity does not extend beyond the cantonal level in this way. In order to achieve a higher level of equality in the public resources for health sector among the cantons, it is necessary for the cantons or the Government of FBiH to find other resources to make it possible.
- High dependence of this system on the contributions from the employed is not an optimal solution for BiH taking into account a low employment rate and population aging process. Among the EU countries applying mainly the Bismarck's model, a trend of movement towards the so-called "mixed model" can be noticed – model involving greater participation of other sources of financing, in addition to the wage-based contributions.
- It should be further stressed that the contributions are relatively "regressive" manner of healthcare financing (they cause more inequality among the overall population), as they do not tax other types of revenues that are mostly earned by wealthier parts of population, such as, for instance, profit, dividend, or property income. Taking everything into account, Bosnia and Herzegovina does not have much choice, but to opt for more reliance onto so-called "non-contribution" revenues.

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Introduction

The subject of this study is the broadest conceptual issue of how to arrive to a financial model that will allow a sustainable and stable method of financing the healthcare in Bosnia and Herzegovina, thus creating the preconditions for making it high-quality and accessible to all citizens. This issue is primarily viewed from the aspect of selection of various sources of financing for the healthcare sector and the manner in which the citizens exercise their right to healthcare, which is in direct connection to the degree of their coverage. In our analysis of this issue, we did not attempt to analyze other aspects of the financial model (such as the arrangement of services with the service provider, the role of the private sector, quality control methods etc.), which also have impact on the financial sustainability of the health care system.

The fundamental principles that we bore in mind are universality, access to high-quality healthcare, solidarity and equality – the values in the field of healthcare that have been jointly defined by the EU countries, which is something BiH gravitates to. Universality means that no one is denied access to health care; solidarity is linked to the financial arrangement of the system and the need to ensure accessibility to all; equity relates to equal access according to need, regardless of gender, age, social status or ability to pay¹.

The Reform Agenda for Bosnia and Herzegovina for the period 2015-2018, one of the most important reform documents of BiH during the above-mentioned period, refers a great deal to the healthcare sector, saying inter alia:

“The governments of the Entities, the Cantons and Brčko District will seek financial and technical assistance of the World Bank to implement the reform of the health sector. The reform is to include a solution for outstanding debts in the health sector, introduction of the treasury system and the definition of new models and sources of funding, with a more precise regulation of the network of health care institutions.”

The existing public health care systems in FBiH, RS, and BD are traditionally based on the so-called Bismarck Model, in which the access to health care services is provided through mandatory health insurance. The basic source of funding for the system are the contributions paid from salaries of the employed, while the contributions paid for other types of the insured are significantly lower. Taking into account the population aging and ever increasing need for health care services, on the one hand, and low rate of employment and limited amount of average salary, on the other hand, the question arises as to whether Bosnia and Herzegovina requires a reform of the basic elements of the existing model, and if so, in what way?

The first chapter offers an overview of the structure of the health care system in Bosnia and Herzegovina (its territorial organizations, existing institutions, degree of coverage, etc.). The second chapter analyzes the spending in health care from various aspects (share of GDP, spending per capita, public and private spending in health care, consumption expenditure by consumption purpose, etc.). The third chapter represents the movements and relations between revenues and expenditures in the public healthcare sector in the Federation of BiH and Republika Srpska. The fourth chapter analyzes the sources of financing, the structure of the insured, potential options and new solutions in this regard. The fifth chapter gives an overview of the impact of “out-of-pocket” healthcare payments on the poor. The sixth chapter analyzes the models of financing in EU countries, changes/trends in this regard and recommendations of the European Commission. The seventh chapter considers various options for reforms in Bosnia and Herzegovina, and the eighth chapter gives an overview of the recent political initiatives in this field.

¹ Council Conclusions on Common values and principles in European Union Health Systems, Official Journal of the European Union C 146, 2006.

1. Health care system structure

Health care system in Bosnia and Herzegovina is characterized by extreme fragmentation considering the fact that the system is organized in various ways in the Federation of BiH, Republika Srpska and Brčko District. In terms of the organizational structure and management, this system operates through 13 completely different sub-systems at the level of entities, cantons and Brčko District, which significantly complicates the way health care services are provided, increases management and coordination costs and adversely affects the rationality of management of healthcare institutions, primarily through the prism of untapped opportunities of economy of scope. An overview of the health care system structure is given in the text below, separately for the Federation of BiH, Republika Srpska and Brčko District.

1.1 Federation of BiH

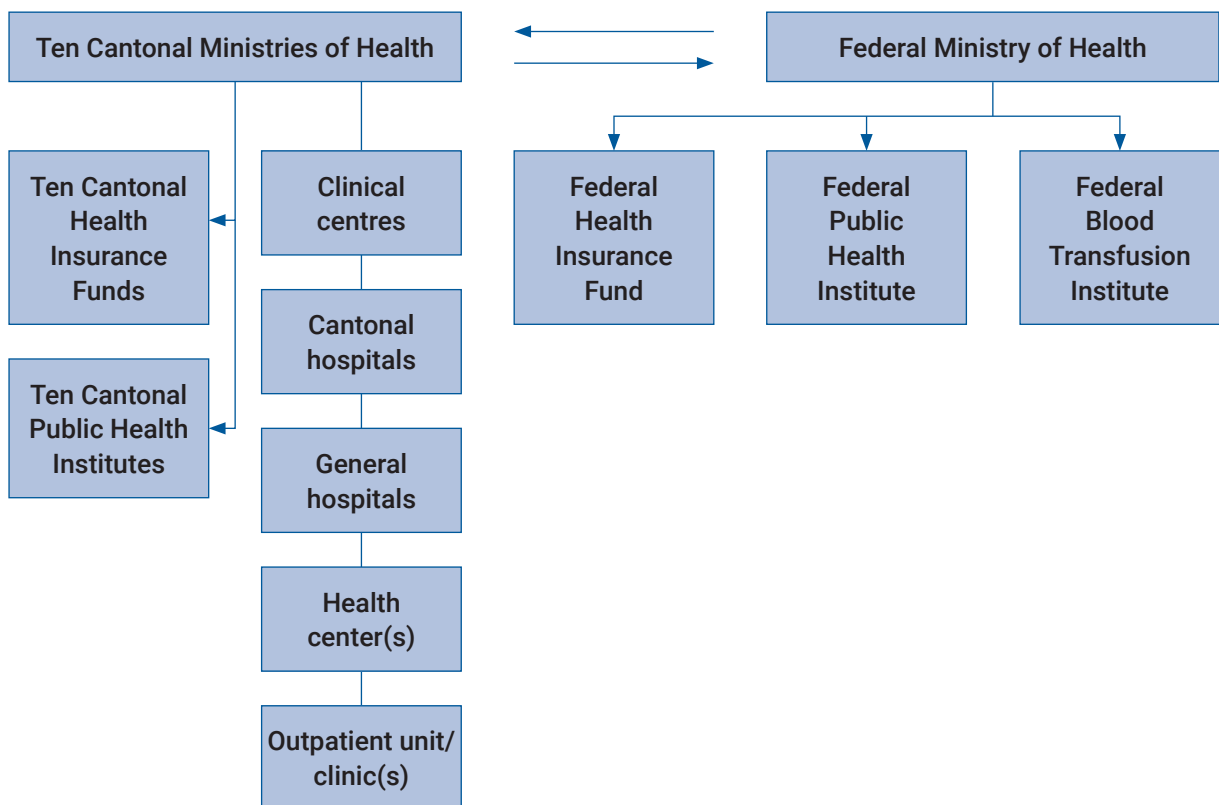
Two fundamental laws regulate the health care sector in the Federation of Bosnia and Herzegovina: Law on Health Insurance² and Law on Health Care³. The Law on Health Care governs the principles, way of organization and delivery of health care, while the Law on Health Insurance regulates health insurance as a part of social insurance, which is based on the principles of solidarity and mutuality of the citizens. In accordance with the Constitution of FBiH and the relevant legal framework, health care system in FBiH is decentralized and majority of jurisdictions and responsibilities are assigned to the cantons.

As shown in the Chart 1, the health sector in FBiH consists of a network of as many as 11 ministries of health (10 cantonal and one federal), 11

² Official Gazette of the Federation of BiH, 30/97, 7/02, 70/08 i 48/11.

³ Official Gazette of the Federation of BiH, 46/10 i 75/13.

Chart 1- Organizational structure of the health care system in the Federation of BiH



health insurance funds (ten cantonal and one Federal Health Insurance and Reinsurance Fund) and 11 public health institutes. The legal framework determines that the health care is provided according to the principles of solidarity, availability and integral approach (regardless of age, sex, religious background and ethnicity), and health care services are delivered at primary, secondary and tertiary levels. Despite the fact that the legal framework is established within the divided jurisdictions between the Federation of BiH and the cantons, there are cases in practice when the federal policies and laws regulating the health sector are not being enforced at cantonal level which will be elaborated in more detail in the chapters below.

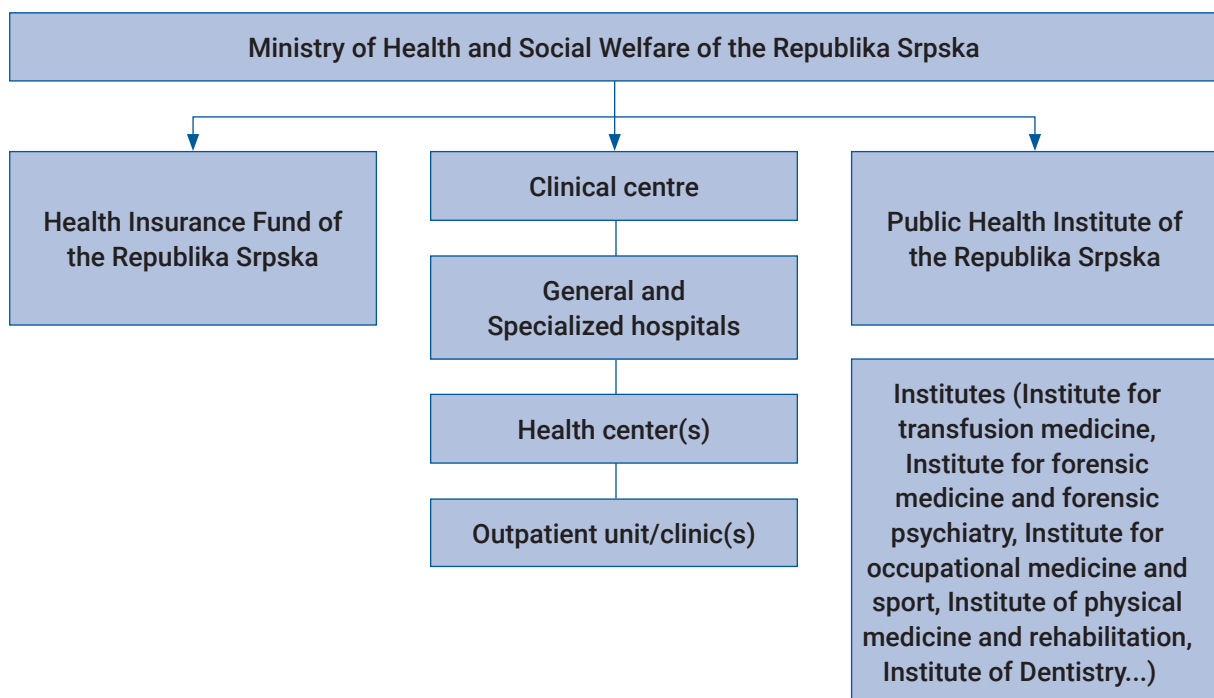
With regard to the health care financing, that segment is predominantly financed from the compulsory health insurance contributions, i.e. contributions for compulsory health insurance paid by employees, contributions for compulsory health insurance paid by employers, contributions for compulsory health insurance paid by pension beneficiaries, contributions paid by the farmers, for the unemployed and other categories. In so

doing, each canton has its Health Insurance Fund responsible for the financing of health care services at the level of the canton. Although the legal framework provides for other financing schemes (cantonal budget, the Federation, donations, revenues of health institutions, participation fees etc.), contribution-based financing is the primary source of income in the health sector.

1.2 Republika Srpska

Unlike the organizational structure in the Federation of Bosnia and Herzegovina, the health care system in Republika Srpska is centralized with key authority held by the Ministry of Health and Social Welfare of RS, Public Health Institute and Health Insurance Fund. The Ministry of Health and Social Welfare, as the central institution of the system, coordinates the activities in the healthcare sector, creates business policies and development strategies, plans and coordinates the work of the health institutions network, etc. In addition to the Ministry there are other institutions operating within the system including the Public Health Institute of RS (conducts research

Chart 2 - Organizational structure of the health care system in Republika Srpska



and education in the field of public health, health promotion and monitoring the population health status), Health Insurance Fund of RS and a number of health institutions delivering primary, secondary and tertiary health care services. Currently, 364 health institutions are recorded in the Health Institution Register with the Ministry of Health and Social Welfare of RS.

Concerning the health care system financing in Republika Srpska, the contributions for health care, similarly as in the Federation of BiH, constitute the main source of the Fund's income including the contributions for health insurance paid from salaries, the contributions for health insurance paid by the pension beneficiaries, contributions of farmers, for the unemployed and other categories.

1.3 Brčko District

In accordance with the Statute of Brčko District and the Health Insurance Law of Brčko District, enforcement of laws and regulations of the responsible authorities in the institutions of BiH and Brčko District in the health sector as well as other services are under supervision and instructions of the mayor. In line with that, the Department of Health carries out professional, administrative and other duties within the powers and competencies of the Government which relate to the health sector in that region. The health care is organized through a number of health institutions providing the services to their beneficiaries at primary, secondary and partially tertiary level (General hospital in Brčko, Health center in Brčko, Health center in Bijela, Health center in Maoča, Center for mental health, etc.).

The health care financing in Brčko District is performed through the Health Insurance Fund, as in the Entities, primarily from the contributions paid for the employed, unemployed, retired persons, self-employed, farmers, etc. The Assembly of the Brčko District, at the proposal of the Health Insurance Fund, passes the *Decision on the base and rate of contribution for health insurance*.⁴

1.4 Health insurance coverage

⁴ Official Gazette of the Brčko District of BiH, 37/2009

The Laws on Health Insurance in both Entities recognize the persons obliged to pay contributions and fall in the category of the insured persons. The insured are divided into several categories, depending on whose name the insurance is paid to and the level of insurance coverage. In addition to the persons who pay health insurance in their name and who are directly insured, there is a category of persons who are insured although the insurance is not paid for them⁵ (family members of the insured), persons insured just on the ground of occupational diseases and work-related injuries, and foreign nationals insured on the ground of the signed bilateral agreements. The citizens of BiH prove their right to health care by a certified health insurance card. A health care card, as a rule, is certified (extended) at least once a month in the branch office of the Health Insurance Fund while the health insurance cards for the particular categories such as children and farmers are certified (extended) on quarterly basis. In both Entities, personal health insurance for children aged over 15 who do not continue schooling is obtained by their registration with the Employment Bureau. The unemployed persons acquire their right to health insurance by their registration with the Employment Bureaus.

Regardless of relatively high share of population covered by health insurance, the manner of exercising the right of access to public healthcare services yet results in the exclusion of certain groups from the health care system and therefore leads to discrimination.⁶ In practice, more than 15% of BiH population is outside the public health care system and are not covered by health insurance. The percentage of public health insurance coverage is lower in Republika Srpska (about 70%) compared to the Federation of BiH (about 86%). The reasons for that may lie in a higher share of population engaged in agriculture, commonly not included in the public health care system through payment of compulsory contributions.

⁵ Those persons are insured through the insured persons, i.e. holders of insurance and no contribution for health insurance is paid for them.

⁶ Mostly, they are the workers whose years of service have not been "linked", self-employees not paying their own health insurance contributions, the unemployed who failed to extend registration with the employment bureau, and the like.

Table 1 - Overview of the health insurance coverage in FBiH and RS

YEAR	2008	2009	2010	2011	2012	2013	2014	2015
Federation of BiH	83.9%	85.1%	84.6%	85.6%	86.5%	86.5%	86.4%	85.9%
Republika Srpska	67.1%	71.2%	66.1%	69.5%	68.7%	77.84*	77.74*	77.76*

*Methodological explanation: Abrupt increase of the coverage in RS is primarily a result of the change in the health insurance coverage calculation. Namely, the preliminary results of the 2013 census were somewhat lower in RS as opposed to the population estimates being used up to that period. Had the previously estimated population number been retained, the health insurance coverage in RS would have remained around 70%.

Table 2 - Overview of health insurance coverage in FBiH by cantons

CANTON	POPULATION HEALTH INSURANCE COVERAGE – in percentages					
Year	2010	2011	2012	2013	2014	2015
Una-Sana	72.98	73.25	73.78	73.96	73.35	72.16
Posavina	79.11	79.12	79.31	76.69	76.44	75.46
Tuzla	87.82	87.87	89.4	89.72	88.86	88.11
Zenica-Doboj	82.47	86.29	86.65	86.9	86.75	85.9
Bosnian-Podrinje	77.62	78.24	79.2	80.82	79.37	78.6
Central Bosnia	84.23	85.32	86.82	85.46	86.32	85.79
Herzegovina-Neretva	84.36	84.21	85.07	85.22	86.13	86.61
West Herzegovina	89.65	92	91.79	97.32	99.95	96.5
Sarajevo	93.94	94.49	95.74	95.08	94.92	95.64
Canton 10	66.84	66.7	67.07	63.84	63.94	63.7
TOTAL	84.55	85.55	86.52	86.47	86.43	85.96

Source: Federal Insurance and Reinsurance Fund

When analyzing the data on health insurance coverage significant differences can be seen in terms of health insurance coverage by the cantons in the Federation of BiH. It is evident that the highest health insurance coverage is in the Sarajevo Canton and Western-Herzegovina Canton (over 95%) while, for example, the coverage in the Canton 10 is below 64%.

Having in mind that the health care system in both Entities is based on the principles of equality, significant differences in health insurance coverage between two Entities and cantons suggest that certain population categories are at risk of discrimination (rural population, the poor, the Roma, uneducated persons etc.). It should be noted here that the part of the population without publicly funded health care provided by the law is forced

to seek the health care services in the private sector which imposes an additional, and often very considerable, burden to their budget.

2. Health care sector expenditure

The latest National Health Account data of the Agency for Statistics of BiH show that total spending in the health sector in Bosnia and Herzegovina amounted to 2.669 billion at the end of 2015. Out of that, the public expenditures amounted to 1.895 million KM or 71% and private 774 million or 29%. Moreover, the growth in total health expenditure is evident. In the period from 2010 to 2015 only, it increased by 600 million KM.

Public and private expenditure have proportionally grown together with the total expenditure, whereby

Chart 3 - Total expenditure in health sector in BiH



Source: National Health Accounts Statistics

Table 3 - Total health expenditure in BiH by type of service (in 000 KM)

Types of health care services	All sources	% as public expendit.	% as private expendit.
All sources of funding	2,669,796	71%	29%
HC.1 Treatment services	1,461,119	80%	20%
HC.2 Rehabilitation services	72,832	65%	35%
HC.3 Long-term medical care	26,617	100%	-
HC.4 Ancillary health care services	211,359	83%	17%
HC.5 Medical equipment for outpatient care	729,341	45%	55%
HC.6 Preventive health care	43,651	100%	-
HC.7 Health administration and health insurance	124,876	97%	3%

Source: 2015 National Health Accounts

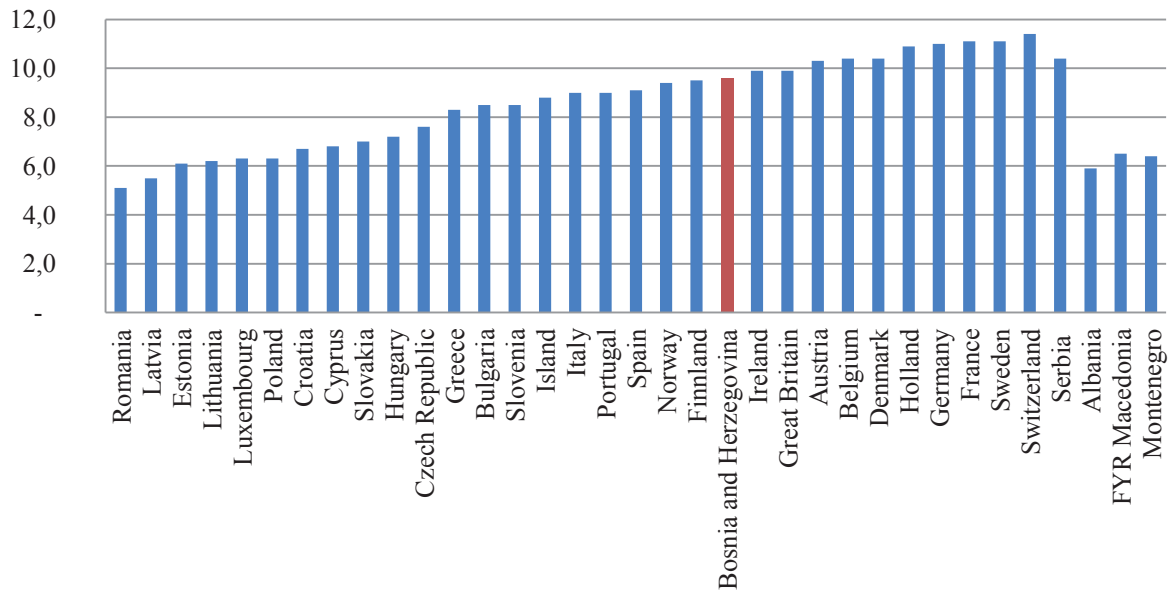
the private expenditure for health increased from 693 million KM in 2009 to 774 million KM in 2015. Analyzing the structure of health spending, it is evident that the highest share of spending goes to the medical treatment services (more than 50%), followed by medical supplies for outpatient-care services (financed mainly from the private resources), ancillary health care services etc.

In addition, if we place total health expenditure in the international context, in relation to GDP, it

may also be observed that the expenditures for health in BiH are relatively high considering that BiH allocates more than 9% of its GDP for health, which is more than in the majority of the European countries (Chart 4).

The European countries that allocate more than 10% of their GDP are Switzerland, Sweden, France, Germany, Netherlands, Denmark, Belgium and Austria. Unlike them, the total health spending lower than 6.5 of GDP was recorded in Romania,

Chart 4 - Total expenditure for health as a percentage of GDP



Source: World Health Organization Database for 2014 (<https://data.worldbank.org/indicator/SH.XPD.TOTL.ZS>)

Latvia, Estonia, Lithuania, Luxemburg and Poland. To illustrate this, total health expenditure in Germany amounted to 321 billion EUR in 2014 - the highest amount among the EU countries and 300 times higher

Viewed statistically, the data point out to relatively high level of health expenditure in BiH; however, when one adds to that statistical picture the data on total health spending per capita, then BiH with 464 USD⁷ per capita is placed at the lower end of the European scale. For the sake of comparison, in countries such as Germany, Netherlands, Denmark, Norway and other developed countries, those expenditures are by 10 to 20 times higher per capita. It means that health expenditure per capita in Bosnia and Herzegovina is really low, primarily due to low GDP. That is partly the reason for the increase in the demand for health care services in the private sector. In other words, private health expenditure in BiH is conditioned by relatively low public expenditure per capita that obviously cannot satisfy high expectations of citizens in terms of health care services (high level of population awareness, availability of information, links to the European countries etc.) which further

⁷ Data of the World Health Organization for BiH in 2014.

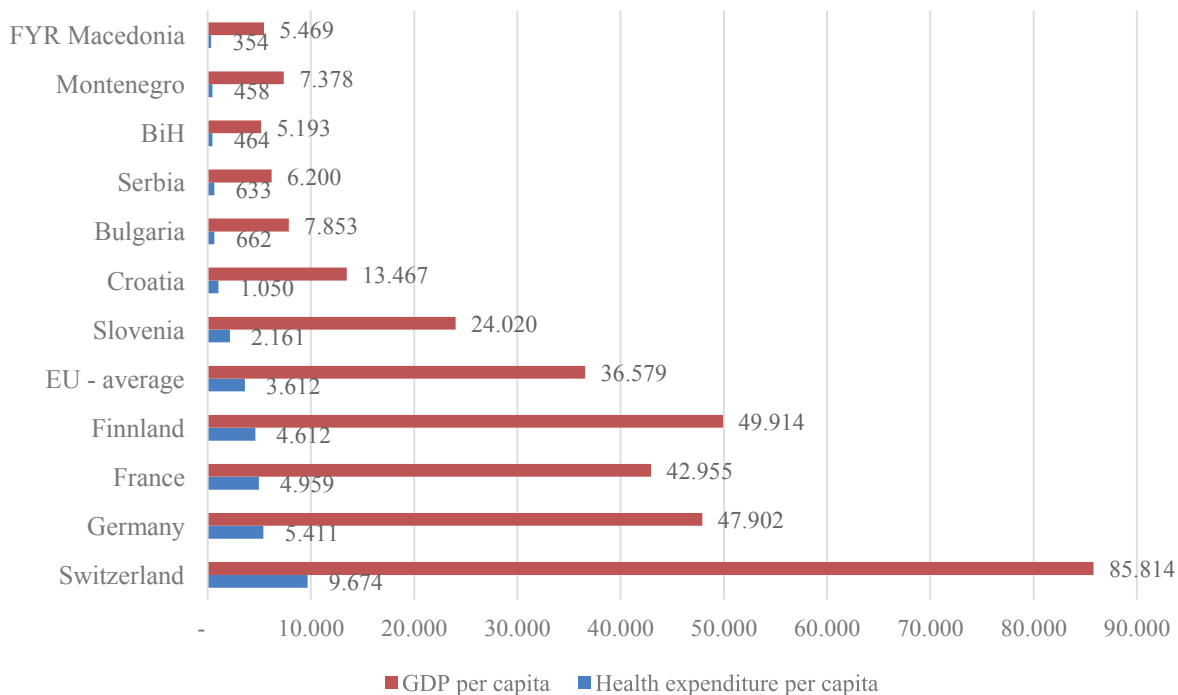
influences seeking those services from private sector⁸. The data on private spending for health services (Chart 5) confirm the foregoing claim.

Unlike the low total expenditure per capita, Bosnia and Herzegovina has a relatively high share in private expenditure the population allocates for health care. Observed in relation to GDP, the private expenditure share in BiH is relatively high – 2.76% of GDP. For the sake of comparison, the 2014 data of the World Health Organization showed that private healthcare spending in Croatia amounted to 1.4% of GDP, in Slovenia 2.6%, while the EU average stood at 2.2%. Private healthcare spending in BiH is high and if observed in relation to the total expenditure, it is significantly higher than in the majority of the European countries and the EU average (see Chart 6).

The system of public healthcare in BiH based on present financing scheme cannot keep up and satisfy the needs, expectations and habits of the population in terms of health care services. The needs, demands and expectations from the healthcare have increased globally, primarily due to the fact

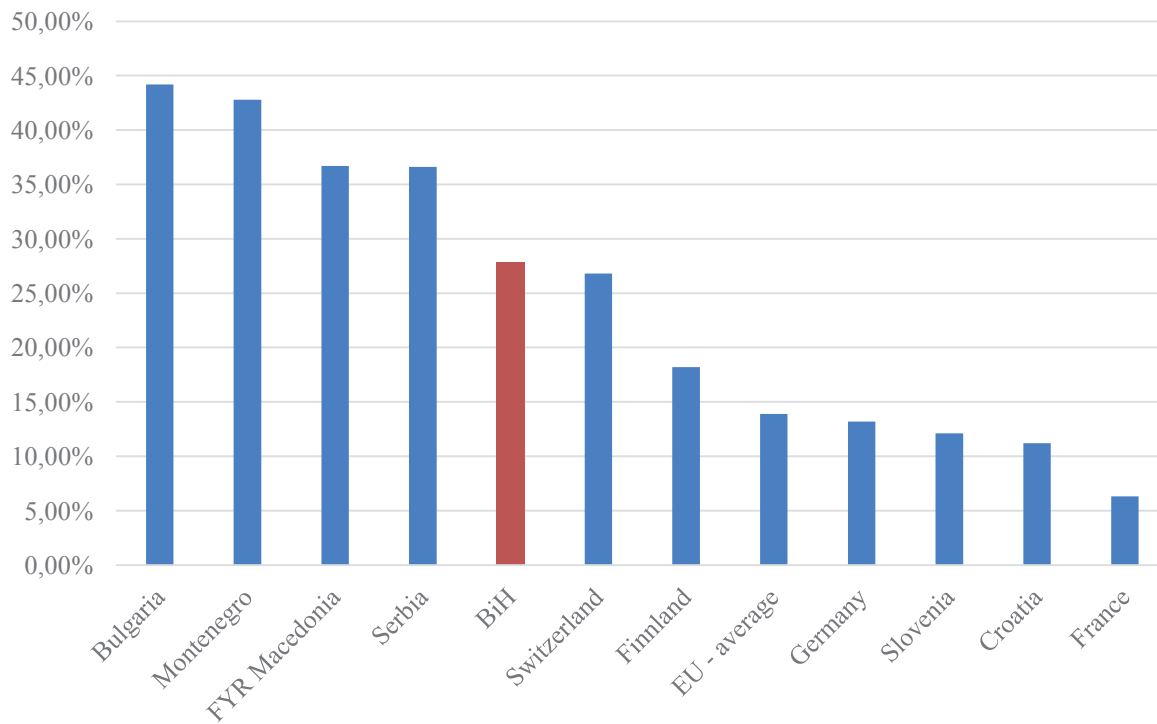
⁸ National Health Accounts in Bosnia and Herzegovina – report for period 2009-2011, Reform of Public Health II in Bosnia and Herzegovina

Chart 5 - Total health expenditure per capita in relation to GDP per capita



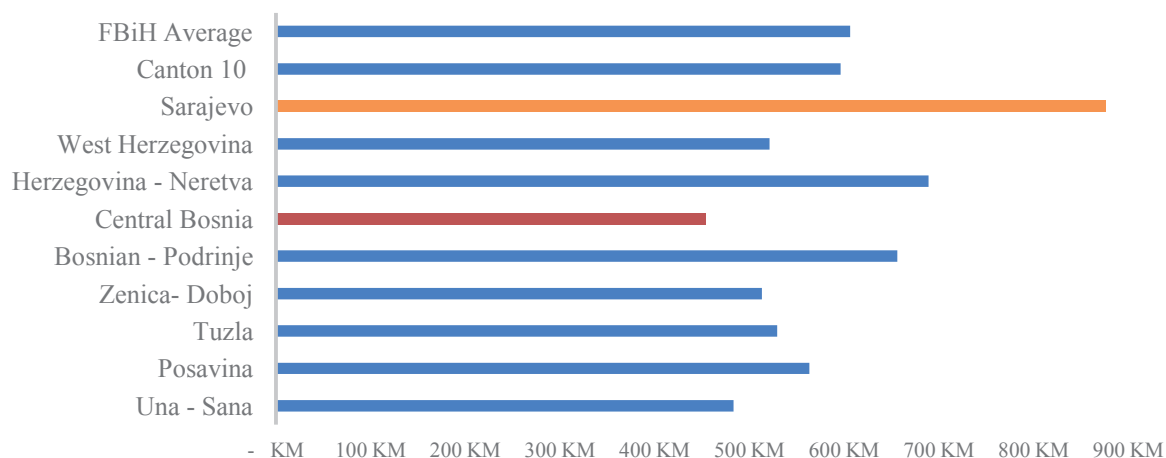
Source: World Bank (<http://data.worldbank.org/indicator/SH.XPD.PCAP>)

Chart 6 - Share of private expenditure in total health expenditure



Source: World Bank (<http://data.worldbank.org/indicator/SH.XPD.PCAP>)

Chart 7 - Average consumption from the compulsory health insurance per an insured person in FBiH



Source: Federal Ministry of Health – Information on healthcare situation in the Federation of Bosnia and Herzegovina, June 2016

that healthcare is one of the most precious and most important aspects of personal spending. In addition to this trend being present in Bosnia and Herzegovina, the continuing development of medical technology also creates new needs for health services. A wide range of healthcare services available to the population in the previous system, hasn't significantly reduced. For instance, unlimited access to all services provided in the area of primary health care, a large number of specialist consultancy diagnostic services, hospital treatment in the country and abroad, spa facilities, hospitalization and a number of other health services, were available to the population at the time of SFRY. In a way, that created with the population the habit of irrational use of health care services, without taking into account the financial capabilities of the previous and the current systems of public health care in BiH. Due to the low public allocations *per capita* for healthcare services, an increasing number of people opt for seeking health services in the private sector.

Private expenditure has further been stimulated by much more efficient availability and more comparative supply compared to the public sector, especially in the areas such as dentistry, diagnostics, over-the-counter drugs, and therapeutic and specialist services. Confronted with serious financial

problems, public health insurance funds do not have the opportunity to invest in new technology, equipment or development of new services, which makes users opt for seeking these services in private or overseas institutions. Faced with the disparity between the financial possibilities and the demands of the population, public health-care systems in BiH operate in a way that generates financial deficits from year to year, while on the other side, customer dissatisfaction grows simultaneously.⁹

The problem of health care financing is also reflected in a number of other aspects, including the fact that access to health services and their quality are not the same throughout BiH. The differences in cantons within the Federation of BiH are particularly conspicuous, as shown in the Chart 7.

The average total spending from the compulsory health insurance per the HIF (health insurance fund) member in the Federation of BiH in 2015 amounted to 606 KM while the average spending ranged from 453 KM in the Central Bosnia Canton to 875 KM in the Sarajevo Canton. The principle of equality and availability is obviously distorted with

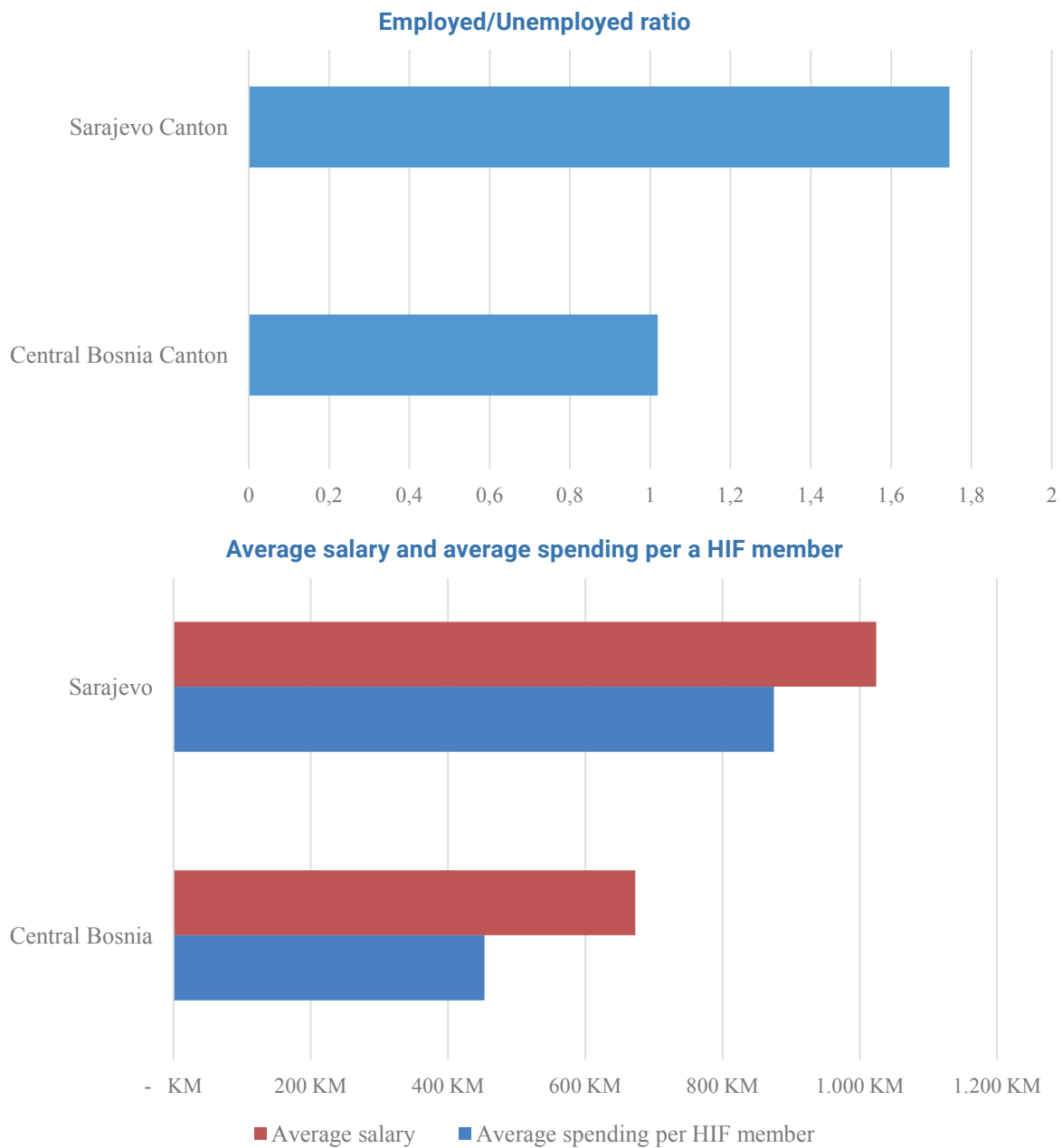
⁹ National Health Accounts in Bosnia and Herzegovina – report for period 2009-2011, Reform of Public Health II in Bosnia and Herzegovina

regard to the realized spending per a HIF member in exercising their right to healthcare service as well as other health rights including prescription drugs at the expense of health insurance. Apart from the health insurance coverage, availability of health care as one of the parameters of equality also depends on the size of individual cantonal

territories, health institution network, the level of infrastructural development and territorial connectedness. Since the healthcare regulation varies across cantons, it brings about overall inequality .

It is important to note that the financing of the public healthcare system in the Federation of Bosnia

Chart 8 - Difference in economic power and health insurance allocations between the Central Bosnia and Sarajevo Canton – 2015 data



Source: Authors' calculation

and Herzegovina is not regulated in a unique way but differs from canton to canton. Only the calculation of the base and the rate of contribution for the employees with the employer (12.5% for an employee and 4% for an employer) are uniformly regulated, while the base and the contribution rate for other categories of the population are determined differently on the basis of the decisions of the cantonal assemblies. Accordingly, the cantonal health insurance funds are in a different financial position (depending on the number of employees and the average gross salary) which has a direct impact on the scope and categories of rights that are offered to insured persons.

Such model of financing by cantons, which predominantly rests on the contribution funds paid for the employees by the employers, stimulates inequality in the exercise of the rights of insured persons depending on the economic position of the canton and the place where the insured persons live. In the cantons with fewer employees and lower salaries, there is a lower health insurance coverage and lower allocations for public healthcare services per insured person. On the other hand, citizens living in "poorer" cantons have the same needs for health insurance as those who live in "the richer". It should be also noted that the institutional stakeholders in the Federation of Bosnia and Herzegovina, being aware of this problem, have attempted to solve it by establishing the Solidarity Fund and by making several relevant decisions¹⁰ without any tangible success.

These attempts directed to reduce inequalities in the exercise of the right to health services have not so far included interventions and approaches that imply redefining the structure of funding sources.

¹⁰ Decision on Determination of Basic Package of Health Rights and Decision on the Maximum Amount of Direct Participation of Insured Persons in the Costs in Using Specific Forms of Health Care in the Basic Package of Health Rights (Official Gazette of Federation of BiH, 21/09)

3. Income/Expenses Ratio

When it comes to their financing, the health care systems in Bosnia and Herzegovina have been encountering serious challenges for a rather long time. Typically, almost every year, expenses exceed the income of health insurance funds in both Entities and cantons. According to the RS Supreme Office for the Public Sector Auditing and the RS Health Insurance Fund Report, total public health sector revenue in Republika Srpska amounted to 625 million and 700 thousand KM in 2016, while the expenses in the same period amounted to 654 million and 230 thousand KM which means that that segment of the public sector operated only in the past year with a loss of more than 20 million KM. The public health sector in RS lacks an average of 15 million KM per year, as shown by income/expenses ratio realized over the past few years.

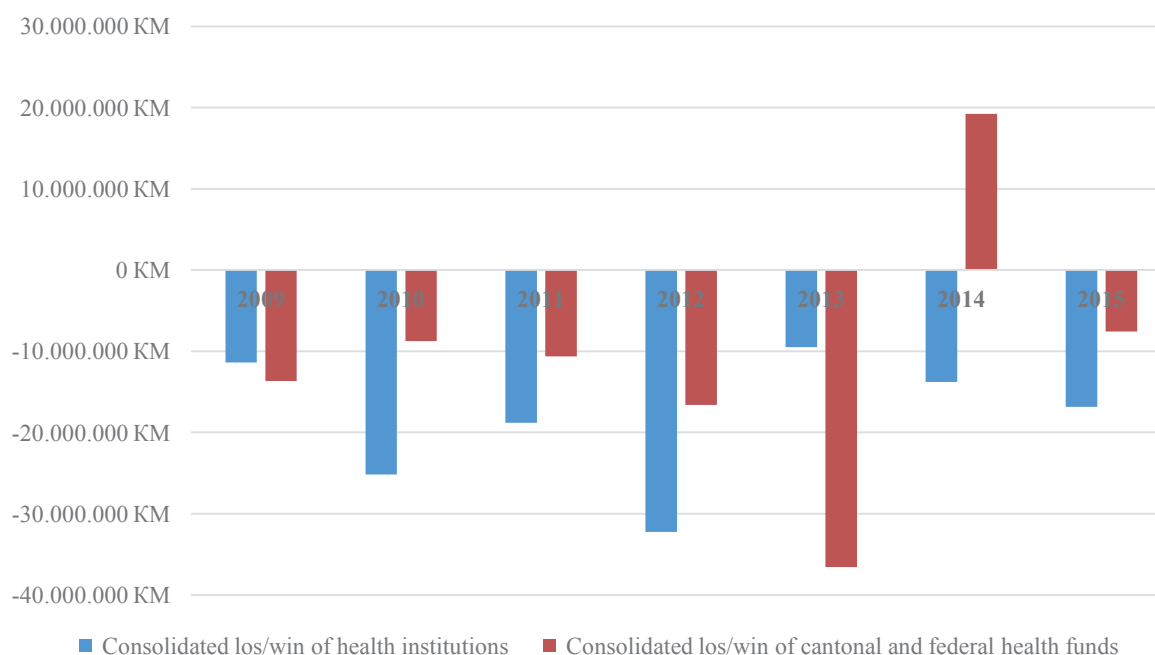
Table 4 - Overview of income and expenses in public health sector in RS in the period 2006 – 2016

Year	Income (in 000 KM)	Expenses (in 000 KM)	Results (in 000 KM)
2006	331,197	334,231	-3.034
2007	345,627	344,838	789
2008	487,274	496,473	-9.199
2009	486,786	496,473	-9.687
2010	483,84	538,188	-54.348
2011	547,728	545,454	2.274
2012	549,857	588,915	-39.057
2013	583,405	601,003	-17.597
2014	622,918	635,285	-12.366
2015	677,631	667,697	9.933
2016	625,726	654,233	-28.507

Source: Supreme Office for the Public Sector Auditing in RS, Health Insurance Fund reports

The inability to finance the rising costs of healthcare from its own revenues, first of all from the collected payments on the basis of compulsory health insurance, forced the Health Insurance Fund to address the Government of Republika Srpska for additional funds and to take out loans.

Chart 9 - Performance of FBiH financial sector as a whole in the period 2009 – 2015



Source: Annual Accounts in FBiH health sector – Health Insurance and Reinsurance Fund of the FBiH

According to the data for 2016, total credit liabilities of the Fund amount to 185,245,483 KM, out of which long-term liabilities by credit debts are 138,569,632 KM, and credit liabilities falling due in 2017 amount to 46,675,850 KM.¹¹ The specificity of the current financial position of the Health Insurance Fund is that health institutions are both debtors and creditors at the same time, considering the large receivables based on the unpaid health insurance contributions for the employees of health institutions themselves and of other budget beneficiaries.¹²

FBiH sees a similar situation. According to the consolidated data in the Statement of Accounts

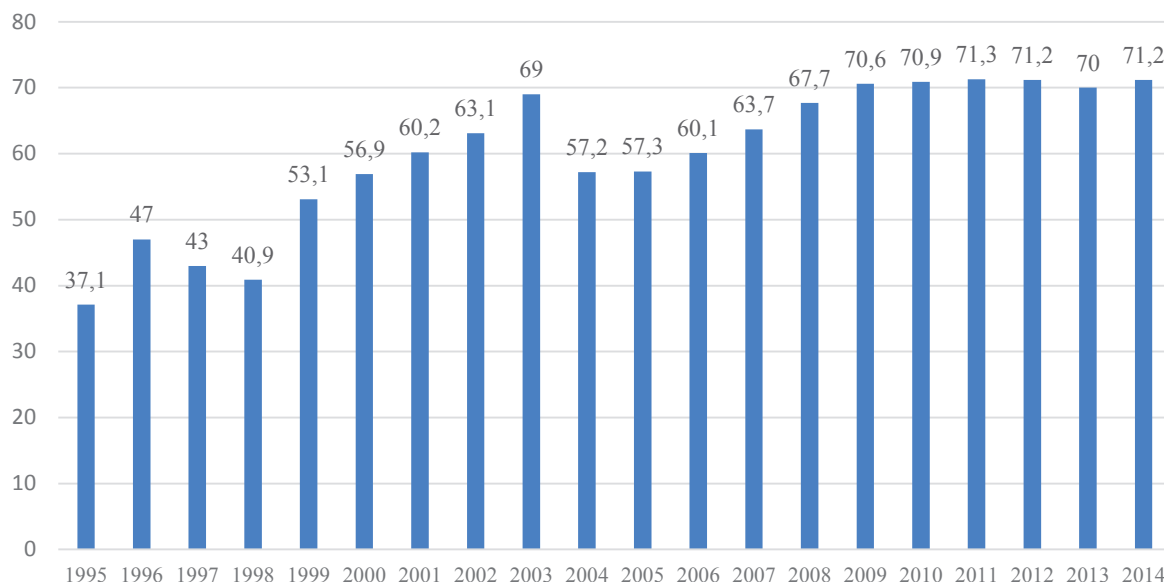
¹¹ Answer to a delegate's question <http://www.narodnaskupstinars.net/?q=la/narodna-skupstina/poslanicka-pitanja-i-odgovori/narodni-poslanik-milan-%C5%A1vraka-fondu-zdravstvenog-osiguranja-republike-srpske>

¹² Total debts of all tax payers for the health insurance contributions as at 31.12.2016 to the FHI amounted to 279,695,819 KM. According to the data of Health Insurance Fund of Republika Srpska, health institutions, the government of Republika Srpska and other budget users, based on the contributions for health insurance, with payments balance as at 31.12.2016, were debited for total amount of 103,778,313, out of which amount the debts for 2016 amounted to 73,169,711 KM, and debts from previous period amounted to 30,116,916 KM.

of the Health Insurance and Reinsurance Fund, a consolidated loss in the total amount of 24,422,534 KM was reported in the health sector of the Federation of BiH in 2015. The excess of expenses over income is reported in federal and cantonal health insurance funds in the total amount of 7,585,478 KM, while in health institutions and employees (public and private) the loss amounted to 16,837,056 KM. Of this, the biggest losses were generated in three clinical centers (UKC Sarajevo, SKB Mostar and UKC Tuzla).

When it comes to the financial results of the Cantonal Health Insurance Funds, there are significant differences, both in terms of health care implementation and the results reported in the operations of health insurance funds and health care institutions. The Health Insurance Funds of Una-Sana Canton, Tuzla, Zenica-Doboj, Central Bosnia and Sarajevo Canton had positive operational results and in 2015 they achieved a positive result in the total amount of KM 7,870,872 while the other cantonal funds were operating with a loss in the total amount of 15,456,350 KM.

Chart 10 Public health sector expenditure indicated as % of the total health expenditure in BiH, assessment of the World Health Organisation



Source: World Health Organisation

As in Republika Srpska, Federal and cantonal health insurance funds in the Federation of Bosnia and Herzegovina are also faced with the chronic problem of illiquidity, and in 2015, total unpaid claims of funds amounted to KM 120,338,853, which represents an increase when compared to the same period in 2014.

4. Sources of financing and structure of the insured persons

According to the Statistics of National Health Accounts published by the Agency for Statistics of Bosnia and Herzegovina, of the total health expenditure in 2014 which amounted to 2 billion and 587 million KM, 71% was funded from public and 29% from private sources.¹³

Historically, in the post-war period the share of public sources has increased. In 1995 it was

¹³ Public sources are compulsory health insurance funds and budget funds, whereas private sources include various forms of participation, direct payments at private practitioner's for drugs and other therapeutic aids as well as informal (i.e. unlawful) payments for medical services.

37.1%, and in 2009 it reached 70.6% and stayed on the level of 70-71%, which may be seen in the Chart 10.

In relation to other 29 European countries with which it was compared, based on this parameter, in 2014 BiH was ranked 17th and below the average for EU members which was 76.2%. The Netherlands was ranked the first with 87% and the last was Albania with 49.9%. Among the former Yugoslavia Republics, Croatia was the highest ranked country with 81.9%, and Serbia was the lowest ranked country with 61.9%, as indicated in the Chart 11.

What are the sources of public health expenditure financing and what are the sources of private health expenditure financing in BiH (Table 5)?

4.1 Public Expenditure Funding Sources

According to the detailed data¹⁴ available for 2011, the largest portion of public expenditure is covered by social and health insurance, participating with more than 90% in public expenditure (and in the total expenditure with 65%). Budgets of all levels of government cover only 9% of public expenditure (i.e. 6% of the total expenditure).

In BiH budget, the health funds are predominantly used for capital investments funding and some public health and prevention programmes. Some investments on the primary level are financed by local budgets. The share of Entities' and cantons' budgets in public expenditure was 4.9% and 4.0% respectively, where the share of local community budgets and institutions from the BiH level was 0.3% in total.

Compared to other countries, the share of budget in financing the total health expenditure in BiH is among the lowest ones. It means that BiH largely relies on financing through insurance (Bismarck model), primarily from health care contributions which constitute an integral part of the gross salaries of employees. This means that economic cycles (which influence developments in the number of employees and amount of average salary) strongly influence the funds available, causing certain financial instability of the health system.

Contributions accounted for 88.5% of the health sector public revenues in the Federation BiH in 2014 (where contributions of the employed even reached the level of 94.4%).¹⁵ The share of contributions is also high in Republika Srpska. According to the 2016 data, employers' contributions constituted 83.9% of the health sector public revenues in RS.¹⁶ It means that the burden of health insurance financing based on the current scheme is carried by employees and employers

to the greatest extent. At the same time, they are the only categories of population contributing to the public health care system in financial terms (they pay more than they spend) unlike all other categories (the unemployed, pensioners, pupils, students, farmers, etc.).

It should also be noted that BiH has a relatively high share of the informal economy (which does not contribute to generating public revenues for the health sector) whose size is estimated between 25% and 57% of GDP as various research have shown.¹⁷

The data shown in the Chart 6 also indicate the problem of unequal share in the health insurance risk. What is peculiar to BiH, unlike most other countries, is the fact that there is no uniform contribution rate for all categories of the insured persons, or the rate with smaller difference between contributions for the employed and rates for pensioners. According to the current financing scheme, the employed (making a little more than one third of the total number of the insured) cover "deficit" of revenues from "surplus" of their contributions in relation to average expenses of all other categories of the insured persons.

Table 6 - Structure of the insured persons and shares in the total revenue of the RS Health Insurance Fund

Category of the Insured	Share in the total number of the insured	Share in the total revenue
Employees	35.1%	83.9%
Pensioners	33.4%	2.9%
Farmers	0.4%	0.3%
Unemployed persons	24.6%	7.3%
War invalids	0.8%	0.1%
Refugees and displaced persons	0.1%	0.1%
Foreign insured persons	5.3%	4.9%
Social Work Centre	0.4%	0.4%

Source: 2014-2018 Strategic Plan of the RS Health Insurance Fund

¹⁴ Data from *National Health Accounts in Bosnia and Herzegovina-report for the period 2009-2011*, Public Health Reform Project II in Bosnia and Herzegovina.

¹⁵ *Calculation of health funds in the Federation of Bosnia and Herzegovina*, Insurance and Reinsurance Institute of FBiH, 2015.

¹⁶ *Strategic and Development Plan of the Health Insurance Fund of Republika Srpska for the period from 2014 to 2018*, Health Insurance Fund of Republika Srpska, 2014.

¹⁷ Data from *Taxation of Wages and the Informal Economy*, GEA Association, 2016.

Unfavourable structure in the ratio between the number of employees and the number of pensioners threatens the sustainability of the current scheme even more. A monthly pensioner health insurance contribution in RS amounted to BAM 3.1 on average in 2013 and it was far lower than the average cost of health insurance of this category of the insured.

In most of the European countries as well as the neighbouring countries, the share of pensioners in the total revenues is much bigger than in Republika Srpska and the Federation of BiH. According to the 2011 data in Serbia it was 24%, in Montenegro 19.9%, in Macedonia 21.8%, and in Slovenia 16.6%. Apart from that, the unfavourable trend of the number of employees and pensioners suggests that the health insurance funds in both Entities (particularly in Republika Srpska) will be exposed to additional pressure in the coming period as far as their financial position is concerned.

Data on health funds deficits in FBiH and RS undoubtedly point to unsustainability of the existing healthcare schemes in both entities.

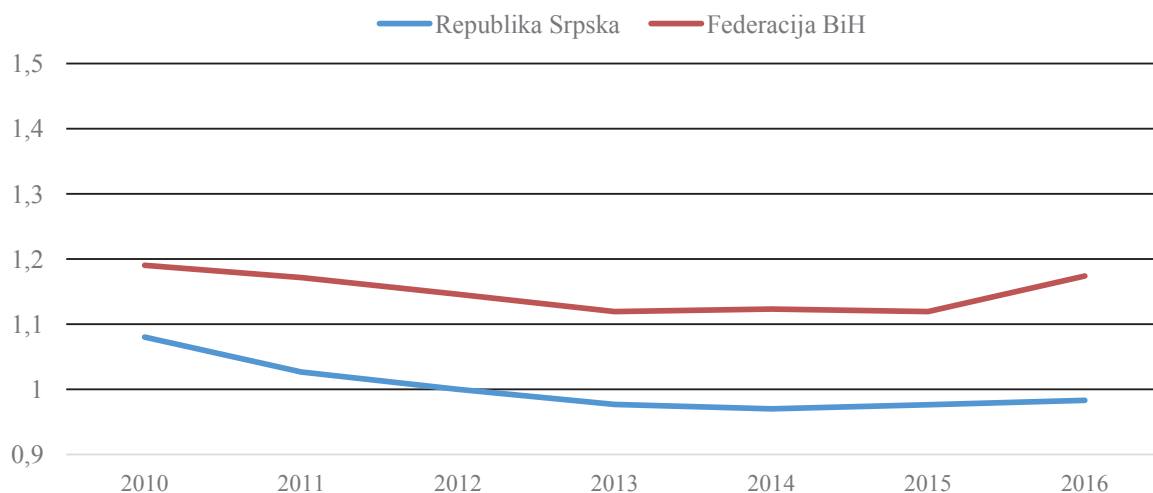
Partially under the influence of the international community, the strategic commitment of

governments in BiH is that it is necessary to reduce the level of labour taxation to stimulate employment in the formal sector and to strengthen the national economy competitiveness. Specifically, the Reform Agenda for Bosnia and Herzegovina 2015-2018 (signed by the Council of Ministers of BiH, Entity and cantonal governments and the Brčko District Government) foresees a reduction of health contributions.

Leaving aside potential health sector cost savings through various reforms, all the aforementioned suggests that there is a need of moving toward reduction of contribution share and relying more on funding from other ("non-contributory") sources of revenues. The Reform Agenda for BiH has defined a measure to that effect - increase of excise duties on tobacco and alcohol as direct revenues for health insurance funds of the Entities, cantons and Brčko District.

Further reduction of health contributions is possible by increasing other taxes, e.g. VAT. It should be underlined that such "tax shifting" (from labour taxation to final consumption taxation) may have stimulating effects on economic performance of BiH through:

Chart 12 - Trends in the number of employees and pensioners in the period 2010-2016



Sources: Federal Office of Statistics and Republic Institute for Statistics of RS

- Stimulating employment through reduction of the employer's total labour costs;
- Enhancing competitiveness of national economy through reduction of labour costs and increased taxation of imported products (increased VAT rate);
- Creating possibilities to increase personal earnings of workers, if one part of labour taxation reduction is used for this purpose.¹⁸

4.2 Sources of financing private expenditure

According to 2014 findings of the Agency for Statistics of BiH from the latest national health accounts, the share of private expenditure in the total expenditure on health was 29.2%. In the structure of private expenses, the household out-of-pocket expenses were dominating (96.9%), while the remaining percentage accounted to enterprises and voluntary health insurance.

According to the detailed data for 2011, medicines and therapeutic aids constituted the biggest share of household spending, meaning that significant amounts were paid for medicines which were not on the lists or cost participation. This was followed by expenses for out-of-hospital and hospital treatment, and informal (i.e. unlawful) payments have a big share in hospital treatment, suggesting a high level of corruption in the health sector. Of the total funds spent on out-of-hospital dental protection in BiH, 65% was funded from private sources, suggesting that vast majority of the population uses services of private dental practitioners.¹⁹

5. Impact of "out-of-pocket" payments on the poor

It has already been stated that the total health expenditure in BiH in 2014 was over 2.5 billion KM, where the share of private expenses was 774

million BAM or 29%. With regards to the private health expenditure, one should bear in mind that it includes contributions of the private health insurances and out-of-pocket payments. Basically, if the public expenditure is decreasing, the private expenditure is increasing, and vice versa. It is often said that the quality of the health system of a state also depends, inter alia, on the amount of out-of-pocket payments for the health care. The states with the best health care systems in Europe, such as France, the Netherlands, Germany, Slovenia, Austria, Sweden, also have the lowest contributions out of patients' pockets (see Chart 13).

It should be emphasised that direct payments out of the pocket include formal and informal payments, where the formal payments, according to the method of development of the National Health Account, include participation in public health services and participation fee for medicines, other direct payments to private health professionals (dentists, specialists, diagnostics, purchase of glasses, and the like) as well as payment for non-prescription medicines and other therapeutic aids. Informal payments for hospital services are the highest ones and they are related to unlawful payments for health services.

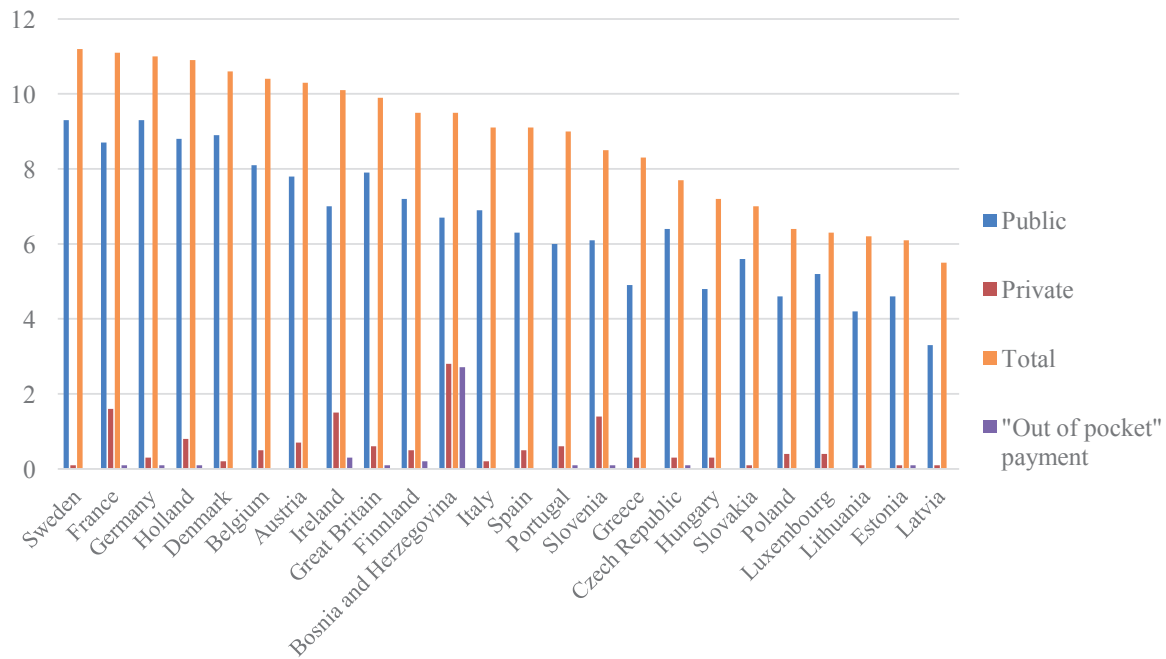
More importantly, out-of-pocket payments for healthcare are those contributions which the poorest households and people usually cannot afford. These amounts are most frequently the reason for delaying and avoiding treatment which is also confirmed by findings of the previous surveys, suggesting that inequality in access to health services is generally higher in the countries with higher out-of-pocket payments (*Buzeti et al.*, 2011, p. 63). If the data from the National Health Account of BAM 756 million of private contributions for health services are compared to the percentage of contributions "out of pockets"²⁰ and the number of inhabitants in BiH, then we can get the amount which BiH citizens give on average out of their pockets for health services yearly. According to the 2014 data, those contributions for a three-member household exceeded BAM 50 monthly.

¹⁸ *How to reduce labour taxation without affecting public funds*, Đukić, O. and Tomić, M. 2013.

¹⁹ Data from *National Health Accounts in Bosnia and Herzegovina—Report for the period 2009-2011*, Public Health Reform Project II in Bosnia and Herzegovina.

²⁰ According to the World Bank data (<http://data.worldbank.org/indicator/SH.XPD.PCAP>) 96.9% of private contributions for health in 2014 related to 'out-of-pocket' contributions.

Chart 13 - Total public, private and 'out of pocket' payments in healthcare in relation to GDP – 2014 data



Source: World Health Organisation, National Health Accounts

On the other hand, according to the results of the 2015 survey on household spending, the relative poverty rate of the population of Bosnia and Herzegovina was 16.9%. It means that in 2015 over 500.000 inhabitants lived below the relative poverty threshold (the monthly threshold of relative poverty for one-member household in Bosnia and Herzegovina in 2015 was BAM 389,26, and for a four-member household with two adults and two children younger than 14 was BAM 817,45 monthly). Monthly out-of-pocket costs for healthcare represent a serious burden to this category of people. Therefore, almost half a million people often delay buying needed medicines, seeking healthcare services and preventive healthcare especially. There is no doubt that out-of-pocket payments for health services are a great burden to this population group of almost a half a million inhabitants which considerably limits their abilities to get out of the poverty zone.

6. Financing models in the EU countries

Health care models in EU, according to the source of financing, are usually divided in three basic models, as follows:

- Bismarck model of compulsory health insurance where the health care is funded from public funds.
- Beveridge model of universal health care where the financing is also provided from public funds but they mainly come from general taxes, i.e. from budget funds.
- Voluntary health insurance model funded by private payments and it most frequently functions as a supplemental health insurance.

Although the source of financing is only one aspect of a health care model, these divisions are often used to convey significant political messages. For example, in many former socialist countries reference to the reform as transition to 'the insurance

system' is used to send a message about the change of the previously hierarchically controlled health system by the state. However, source of funding does not have to define the sector organisation itself or fund allocation mechanisms. Spain represents an example of a country which has made a great change in the sources of financing (from the system primarily funded from the health insurance contributions to the system which is predominantly funded from the general taxes) but the conceptual change did not occur in the relation between population and the health system.²¹

In most of the EU countries the health care system is based on one of the first two models (but the financing is supplemented from other sources). Universal health insurance is provided in most EU member states, while the coverage is almost universal in a few countries, for example in Germany – 88% through public system and 10 % via private insurance, in Greece 95 % and Austria 98%.²²

We may say that a combination of sources for health care financing exists in most of the countries, but the public sector controls most of the funds. In some countries having the compulsory health insurance the share of private insurance funds (which pay for health care of their insured) is large, e.g. in the Netherlands. Only a small portion of health care financing in EU comes from the model of direct patient payments for services.

Participation of patients in the health care financing exists in all EU countries in varying degrees, but the main reason is higher efficiency in the cost management. Various forms of participation are applied, and the most frequent one is patients' participation in payment for prescribed medicines in a percent amount or in a fixed amount. The participation for payment of specialist services is rather frequent (very rarely the payment for services of general practitioners) while some countries apply participation in payment for hospital services. Persons with low income and other

vulnerable groups are exempt from participation in most of the countries.²³

As for health insurance contributions, it is known that a great number of EU countries face the population aging process due to low fertility rates, which directly results in decrease of working-age population compared to the total population. As the share of working-age population is decreasing, it is becoming increasingly difficult to largely rely on contributions from salaries for funding of health sector expenses. According to the World Health Organisation for that reason it is critical for these countries to further diversify their sources of financing.²⁴ Indeed, according to Eurostat 2014 data, no country in EU had a share of contributions and all forms of compulsory insurance (including also compulsory medical savings accounts) above 80 % in the total funding. Germany with 78 % had the largest share of these sources.

The EU countries which largely relied on the compulsory insurance scheme are Slovakia (76.2%), the Netherlands (75.8%), Luxemburg (73.9%), but also Croatia (72.7%) and Slovenia (67.6%). On the other hand, countries which mainly provided for funding from the government budget are Denmark (84.2%), Sweden (83.4%), Italy (75.5%), Ireland (69%), Spain (65%), Portugal (65%) and Finland (62.2%).

Household out-of-pocket payments account for largest share in Cyprus (49.9 %) and Bulgaria (45.8 %), while their lowest share is in France (7.2%).²⁵ This indicator usually directly relates too inequality in the access to health services. As it has already been stated, the main conclusion is that inequality is higher in societies where out-of-pocket payments for health have higher share in the total expenditure.

The voluntary health insurance had smaller shares, with the biggest share in Slovenia (14.8%), France (13.7%) and Ireland (12.7%). In seven countries voluntary schemes had the share below 1%, and

21 *Health Financing Policy: A Guide for Decision-Makers*, WTO, 2008.

22 Information taken from: *Financing Health Care in the European Union – Challenges and Policy Responses*, Thompson, S., Foubister, T., Mosialos, E. 2009.

23 Ibid

24 *Health Financing Policy: A Guide for Decision-Makers*, World Health Organisation, 2008.

25 *Health Inequalities in Slovenia*, Buzeti, T., et al. 2011.

Chart 14 Expenditure for health care according to the financing scheme
(% of current expenditure on health care)

	Government schemes	Compulsory contributory health insurance schemes & compulsory medical saving accounts	Voluntary health insurance schemes	Financing schemes of non-profit institutions serving households	Enterprise financing schemes	Household out-of-pocket payments	Rest of the world (non-resident)
Belgium	11.4	66.2	4.4	0.2	0.1	17.8	:
Bulgaria	8.8	44.2	0.3	0.5	0.4	45.8	:
Czech Republic	11.6	71.9	0.2	2.4	0.7	13.2	:
Denmark	84.2	:	2.0	0.0	:	13.8	:
Germany	6.6	78.0	1.5	0.5	0.5	13.0	:
Estonia	10.0	65.6	0.2	0.0	1.4	22.7	0.0
Ireland	69.0	0.3	12.7	:	2.6	15.4	:
Greece	28.4	31.3	3.6	0.1	0.0	35.4	1.2
Spain	65.0	4.8	5.2	0.4	:	24.7	:
France	4.1	74.5	13.7	0.0	0.7	7.0	0.0
Croatia	2.5	72.7	8.1	:	:	16.7	:
Italy	75.5	0.3	1.5	0.4	0.3	22.0	:
Cyprus	43.6	0.6	3.8	0.2	1.5	49.9	0.5
Latvia	59.9	:	0.9	0.3	:	38.9	:
Lithuania	10.1	57.5	0.8	0.0	0.1	31.5	0.1
Luxembourg	8.5	73.9	5.5	1.4	:	10.7	:
Hungary	9.4	57.6	2.6	1.4	0.6	28.4	0.0
Malta	:	:	:	:	:	:	:
Netherlands	4.8	75.8	5.9	0.3	0.9	12.3	:
Austria	31.2	44.7	4.9	1.4	0.2	17.7	:
Poland	9.2	61.8	4.5	1.0	0.6	22.9	:
Portugal	65.0	1.3	5.4	0.0	0.8	27.5	0.0
Romania	14.9	64.4	0.2	0.4	0.1	19.9	0.2
Slovenia	3.4	67.6	14.8	0.1	1.1	13.0	:
Slovakia	4.0	76.2	:	1.4	0.4	18.0	:
Finland	62.2	13.2	2.5	0.7	2.3	19.1	:
Sweden	83.4	0.0	0.6	0.1	0.4	15.5	0.0
United Kingdom	79.5	0.1	3.6	1.6	0.6	14.8	0.0
Iceland (*)	52.1	29.0	0.0	1.5	0.0	17.5	0.0
Liechtenstein	13.9	49.1	12.5	0.2	0.6	23.6	:
Norway	74.5	10.8	:	:	0.3	14.4	:
Switzerland	18.6	46.5	7.1	1.0	:	26.7	:

(*) Definitions differ.

Source: Eurostat

the lowest share was reported in Czech Republic, Estonia and Romania (all 0.2%).

Therefore it can be concluded that most of EU countries use a kind of 'mixed model' of health care financing and that the dominant source of income in every country depends on the historical legacy and implemented reforms.

It should be noted that the EU countries have established common values regarding health care in the form of conclusions of the Council of Health Ministers from 2006, and those values are: universality, access to high-quality health care, equality and solidarity.²⁶

According to the European Commission, to achieve and maintain these values it is necessary,

inter alia, to provide for stable financing of health systems bearing in mind the existing challenges: increase of health care costs, aging of the population related to increase of chronic diseases which leads to increasing of demand for health services and inequality in the access to health care.

The stable financing allows adequate planning of investments and health care continuity. Health systems whose financing is based on less stable sources bear negative effects of external shocks more frequently. For example, systems which mainly rely on contributions from salaries are more exposed to consequences of the fall of employment. The European Commission considers that in these cases reserves or other counter-cyclic formulas for transfers from the budget may help to stabilise the available funds.²⁷

²⁶ Council Conclusions on common values and principles in European Union health systems, Official Journal of the European Union C 146, 2006.

²⁷ Communication from the Commission on effective, accessible and resilient health systems, European Commission, 2015

7. Current initiatives for reform of health financing schemes

Chronic problems in financing of the health insurance system in BiH triggered several initiatives and reform processes in the past. The latest one is an attempt to implement the health sector reform within the Reform Agenda for BiH for the period 2015 - 2018. Precisely, the Reform Agenda stipulates that: *"The governments of the Entities, Cantons and Brcko District will seek financial and technical assistance of the World Bank to implement the reform of the health sector. The reform is to include a solution for outstanding debts in the health sector, introduction of the treasury system and the definition of new models and sources of funding, with a more precise regulation of the network of health care institutions. Through a DPL programme, the World Bank will be asked to provide technical and financial support for the reorganisation of the health sector. The Entity, Cantonal and Brcko District governments will use these funds for the settlement of outstanding liabilities of the health sector (contributions in particular). In parallel, the authorities in BiH will support an increase in excise duties on tobacco and alcohol which will be the direct income of the health insurance fund of the RS and health insurance funds in the FBiH, Cantons and Brcko District."*

In addition, the Reform Agenda foresees that within public finance the burden on labour will be decreased, through reduction of contributions, whereas the provision of additional funds from the excise duties, the health sector may expect only after the reforms have been implemented. According to the adopted Reform Agenda the governments of both Entities have developed and adopted the action programmes. One of them is also the initiative of the FBiH Government attempting to reduce the health insurance contribution rates, by extension of the basis for contribution calculation.

Several other initiatives also addressed the need to change the method of health funding in the past. The health development strategic plans in both Entities suggest that the current financing scheme is not sustainable, primarily from the perspective

of the number of those persons who pay the contributions, and those who use the public health system services. In that regard *Strategic Plan for Health Development in the Federation of Bosnia and Herzegovina from 2008 to 2018* states *"We still have a high percentage of the uninsured in FBiH (16%). In the structure of the uninsured persons the number of the insured from the categories for whom the contributions are paid in symbolic amounts (pensioners and the unemployed) shows an increasing trend in relation to the employed by employers who carry the burden in provision of funds for health care from the compulsory health insurance, therefore the question is raised how long the employed, or their employers will be able to carry the burden of the health solidarity in such disproportions, which is the basic principle of the established health insurance system. The issue of the health sector financial stability is raised under such circumstances and trends."*

Unequal possibilities for exercising the right to the health care in cantons of the Federation of BiH is particularly serious problem directly related to bad financial position of the Federation and cantonal health insurance institutes. To start solving the problem, the Government of the Federation BiH has prepared a special *decision on equal financing of the missing portion of funds per canton by the Government of the Federation BiH*, but it has not been rendered yet, because currently it is impossible to allocate additional funds from the budget for its implementation.

In the light of equitable healthcare financing in the Federation of Bosnia and Herzegovina, it is necessary to mention current initiative by the mayor of Tuzla, Jasmin Imamovic, who advocates rationalization of the healthcare system in FBiH by abolishing the system of healthcare management at the cantonal level and transferring competencies to the Entity and local levels. This initiative came into being due to the evident irrationality and unequal regional representation of public health services seen through expenditures of cantonal health insurance funds, as has already been elaborated in the previous chapters of this document. The initiative proposes the merging of health insurance funds and accordingly the rationalization

of costs (the estimates presented indicate potential savings of tens of millions of KM annually). On the other hand, it should be mentioned that this initiative caused different political reactions in FBiH and that there is still no unanimous political opinion on the matter nor the willingness to implement the solutions proposed by the initiative in the current administrative and political framework of FBiH. Without further elaboration of the feasibility and quality of the initiative itself, it can certainly be stated that it has contributed to the public dialogue on the necessity of the reform on health insurance funding system in FBiH, as well as throughout BiH.

Examples from other countries can contribute to the discussion on the benefits and possible negative effects of (de)centralization of the healthcare system. Among others, examples from Sweden, Switzerland and Netherlands prove the advantages of decentralized healthcare systems, primarily through greater flexibility, quality of services, adaptation to the users' needs and increased competition among health service providers.²⁸

On the other hand, what can be used as a good basis for the analytical process of redefining public policies in the Federation of BiH are certain studies by World Health Organization as well as experiences of other countries where reforms have been undertaken in the direction of unifying of institutions of the healthcare system, proving the benefits of the centralized system in terms of better cost management, greater efficiency and more rational approach to business.²⁹

Also, the Strategic Development Plan of Republika Srpska Health Insurance Fund for the period 2014 – 2018, states the need to redefine the existing sources of health services funding, as follows: *If the contribution is the only source of compulsory health system financing, with reduced contribution rates and current health system organisation, it will be almost impossible to maintain the existing contents and scope of health insurance entitlements*

28 *Fiscal Federalism and European Health System Decentralization: A Perspective* - Joan Costa-i-Font, The London School of Economics and Political Science, December 2012.

29 *The Health Systems Financing: The path to universal coverage*, WHO – World Health Organization, 2010.

and to achieve the stability of health care institutions.” Seriousness of the problem is illustrated also by the information that the first strategic goal refers to achieving the sustainable financing. Accordingly, the Management Board of the Health Insurance Fund adopted the Programme of measures for overcoming financial problems, which, among other things, proposes introduction of additional sources of financing as it has been done in Slovenia and Croatia. To that end, in September 2012 *the Analysis of compulsory health insurance financing* was adopted whereby the RS Government has revisited the proposal of introduction of additional sources of financing and pointed to possible rationalization of expenses within the health system.

Conclusions and possibilities for reforms

We have established that there is an extremely heavy dependence on health funding through insurance across BiH, classifying our country in the group of countries with the so-called Bismarck model, where contributions of the employed both in FBiH and RS account for over 80% of the total public revenues used for the health care. Contributions for other groups of inhabitants fall under the remaining portion of public revenues (the unemployed, pensioners, farmers, disabled, etc.), transfers from the budget and other revenues.

High dependence of the entire system on contributions from the employed is not an optimum solution for BiH having in mind the low share of the employed in the overall population and the population aging process. This situation with increasing expenses and needs of the health sector leads to the lack of funds, losses and debt accumulation

Economic recessions followed by a drop in the number of employed persons (as it happened in our country from 2009 to 2012) and irregular disbursement of salaries indicates the health sector financial instability based on such model. Here we can mention an absurd phenomenon that employees in some companies in BiH have no health insurance due to delay in payment of contributions

unlike the unemployed who are registered with the employment offices. It is evident that using a ban on access to the health system, as a sanction for "those who do not pay", leads to a departure from the principle of universality and equality in the health care.

Considerations of possible reform directions for BiH in this research are based on the basic values in the health care which have been jointly defined by the EU countries in the form of conclusions: universality, access to high-quality health care, equality and solidarity.³⁰ These conclusions will also fully apply to BiH, after its accession to EU, and the values mentioned above have already been incorporated into the existing legislation to a great extent. Those values, inter alia, mean that each person should have equal access to a high-quality health care and that the public health should not depend on their social and economic status.

Employment rates and amount of salaries used to calculate health care contributions vary to a relatively large extent between the cantons in FBiH. Given that the revenues from the health insurance contributions of employees usually "return" to the canton where they have been collected, there is a high level of discrepancy in expenditure for health care per capita among cantons. In that regard, the average expenditure on health care in 2015 was ranging between BAM 453 per the insured person in the Central Bosnia Canton and BAM 875 per the insured person in the Sarajevo Canton. It can be stated that by such solution the principle of solidarity, as defined by the Law on Health Care of FBiH,³¹ in that regard is not applied beyond the canton level. If a higher level of equality is to be achieved in the health care financing between cantons, it would be required that cantons or the FBiH Government find other funds to ensure that.

For the level of BiH – if financial preconditions should be established for equal public health expenditure developments per capita throughout BiH, it is necessary to plan adequate funds of the Entities and BD.

Out-of-pocket payments for health care of an average household in BiH in relation to the household budget are higher than the average of the same payments in other OECD countries. This suggests the risk of unequal access to health care services among BiH citizens. In 2014 average health care expenditure of a three-member family from the household budget was around BAM 50, which may be a great burden, particularly for the families below or near the poverty line. In 2015, monthly relative poverty threshold for one-member household in BiH amounted to 389 KM.

Due to all the aforementioned, it is evident that the health systems in BiH need to change to establish the basis for sustainable and stable health care financing model, which is a precondition for it to be good in terms of quality and availability to all citizens

Croatia and Slovenia are the countries in EU which predominantly rely on the compulsory insurance for health care financing (Bismarck model) suggesting that the legacy of the former SFRY has a strong influence on the current models. However, in the group of EU countries shifting towards the so-called mixed model, i.e. the model where other sources of funding are getting bigger share is notable. Considering the process of decrease of the share of working-age population in those countries as well (aging of the population), it is natural that the share of contributions by the employed in the total health sector expenditure also decreases. In accordance with that, the World Health Organisation emphasises the importance of diversification of sources of financing.³² The European Commission points out that it is more difficult to ensure the health care continuity when the current financing depends on the payment of contributions and the employment drops considerably.³³

Given that this research addresses the issue of finding the adequate financing model for the health care systems in BiH, the question is raised as to what needs to be changed in that area to

30 Council Conclusions on common values and principles in European Union health systems, Official Journal of the European Union C 146, 2006

31 Official Gazette of the Federation BiH, no. 46/10 and 75/13.

32 Health Financing Policy: A Guide for Decision-Makers, WHO, 2008.

33 Communication from the Commission on effective, accessible and resilient health systems, European Commission, 2015.

create preconditions for achieving the aforementioned values in health care.

In any case, we have seen that it will require the continuous increase of health expenses in the coming years. The existing high salary tax rates in FBiH and RS, as well as the low standard of the majority of other groups of the insured (pensioners, farmers, entrepreneurs and others) indicate that the revenue ranges through the increase of the health care contribution rates are limited. It can be stated that a possibility to increase revenues from contributions exists through decrease of the informal sector and developing higher tax responsibility, but this can only be a gradual process.

Accordingly, this leads to the conclusion that BiH does not have many choices but to start diversification of the funding sources and relying more on the so-called “non-contributory” revenues. It can be said that certain institutional initiatives have been started in that direction (Government of FBiH, the Republika Srpska Health Insurance Fund) but they still haven't resulted in any concrete improvements or financial effects. *The Reform Agenda for the period 2015-2018* foresees, among other things, *defining new models and funding sources* for the health sector. It is often forgotten that the health care financing from contributions is a relatively “regressive” model for it (causes higher inequality) because, apart from salaries, it does not include other types of revenues which richer groups of population gain, like for example, profit, dividends or revenues from the property.

Therefore, the question is only to what degree and how to optimally pursue the mentioned diversification. We may conceptually divide intensity and type of diversification in three groups:

1. **Ensuring alternative sources of revenues maintaining the same level of the contribution rates.** Alternative revenues may be provided through planning of systemic increase of budget transfers to the health insurance funds (which would require adequate allocations within the budget) or through introduction of additional earmarked revenues (e.g. increase
2. **Ensuring alternative sources of revenues by reduction of rates of contributions paid from the salary - tax restructuring.** This option in relation to the previous one includes also the tax relief on salaries through decrease of health insurance contributions. This approach has been planned in *the Reform Agenda for BiH*, and in addition to reduction of contribution, the increase of excise duties on tobacco and alcohol has been foreseen. It has been written and said a lot about the tax relief on salaries in BiH, and those advantages include: stimulating further employment, stimulating the decrease of “illegal” and “semi-legal” employment, increase of price competitiveness of national economy and creation of space for increase of earnings of the employed.³⁴ Depending on the financial needs of the health sector, this reform may also include additional alternative revenues (e.g. increase of any other indirect tax, including VAT, and the property tax). One of the major elements of such reform is assessment of the impact on the most vulnerable groups of population and adequate addressing of negative effects, for example through directed social transfers.³⁵
3. **Total modification of the model – transition to financing of health care from the budget revenues.** This reform requires transition from the compulsory health insurance scheme (Bismarck model) to universal insurance scheme (Beveridge model). In essence it means that all citizens would be entitled to access to the health care provided by the state without any preconditions (naturally, it does not mean that participation, private insurance or private expenditure on the supplementary

³⁴ See *How to achieve lower labour taxation without affecting public funds*, Đukić, O. i Tomić, M. 2013

³⁵ Ibid.

health services would be excluded). In terms of tax, there are many ways in which this reform could be implemented, and all imply termination of health insurance contributions and introduction or increase of one or more other direct or indirect taxes. From the point of view of the aforementioned values-universality, equality and solidarity - this scheme surely contributes to their implementation because persons such as employees for whom no contributions are paid, farmers and entrepreneurs would have ensured access to the health care. Apart from that, if a great part of health expenses would be covered by consumption taxes, such as excise duties on luxury goods or VAT, the health system financing would be more progressive (i.e. paid more by the richer classes of the population because they consume more). The bigger progress would be achieved in case of higher funding degree from direct expenses such as taxes on property and profit. In 2001 Spain adopted this radical reform of health financing.³⁶

All the above considerations were made without analysing other aspects of the financial scheme (method of fund collection, method of service contracting with service providers, role of private sector and others) which also have a direct effect on the financial sustainability of the public health sector. Therefore, all reforms leading to improvements in those areas should be supported.

References

Agencija za statistiku BiH (Agency for Statistics of BiH). Taken on 12 July 2017 from: www.bhas.ba

Đukić, O. and Tomić, M. (2013) „Kako do nižeg oporezivanja rada bez štete za javne fondove“ (*How to achieve lower labour taxation without affecting public funds*), Centar za istraživanja i studije GEA (GEA Research and Study Centre).

Eurostat. Taken on 12 July 2017 from: ec.europa.eu/eurostat

Federation Institute for Insurance and Reinsurance. Taken on 12 July 2017 from: <http://www.fedzzo.com.ba/>

Federation Institute for Statistics. Taken on 12 July 2017 from: <http://www.fzs.ba/>

Federation Health Ministry. (2016): „Informacija o stanju u zdravstvu u Federaciji Bosne i Hercegovine“, (*Information on the situation in the health care in the Federation of BiH*), June 2016.

Funkcionalni pregled sektora zdravstva u BiH – Završni izvještaj (*Functional review of the health care sector-Final Report*). Available at: <http://parco.gov.ba/wp-content/uploads/2016/09/funkcionalni-pregled-sektora-zdravstva-u-bih-završni-izvjestaj.pdf>, p. 23-29.

Glavna služba za reviziju javnog sektora u RS, izvještaji Fonda zdravstvenog osiguranja RS (*Supreme Office for the Republic of Srpska Public Sector Auditing, reports of RS Health Insurance Fund*). Taken on 12 July 2017 from: http://www.gsr-rs.org/front/reportsearch/?query=Fond+zdravstvenog+osiguranja&cat=0&entity_type=0&report_period=0&report_year=0

Godišnji obračuni sredstava u zdravstvu Federacije BiH (*Annual calculation of Health Funds of the Federation BiH*)-Institute for Insurance and Reinsurance F BiH. Taken on 12 July 2017 from: <http://www.fedzzo.com.ba/bs/clanak/obracun-sredstava-u-zdravstvu/42>

³⁶ *Health Systems in Transition: Spain*, Duran, M., Lara J., van Waveren, M. World Health Organisation, 2006.

Health Care Systems in the EU – A Comparative Study, European Parliament - Directorate-General for Research (1998). Taken on 11 May 2017 from: http://www.europarl.europa.eu/workingpapers/saco/pdf/101_en.pdf.

Health Financing Policy: A Guide for Decision-Makers, World Trade Organisation (2008). Taken on 10 May 2017 from: <http://apps.who.int/iris/bitstream/10665/107899/1/E91422.pdf>.

Communication from the Commission on effective, accessible and resilient health systems, European Commission (2015). Taken on 10 May 2017 from: http://ec.europa.eu/health/sites/health/files/systems_performance_assessment/docs/com2014_215_final_en.pdf.

National Health Accounts in Bosnia and Herzegovina – Report for the period 2009-2011, Public Health Reform Project II in Bosnia and Herzegovina. Taken on 8 May 2017 from: http://mcp.gov.ba/org_jedinice/sektor_zdravstvo/programi_projekti/Nacionalni%20zdravstveni%20racuni%20za%20BiH.pdf.

National Health Accounts in Bosnia and Herzegovina for 2014. Taken on 12 July 2017. sa: http://www.bhas.ba/saopstenja/2016/NZR_2014_bos.pdf

Narodna skupština Republike Srpske (Republika Srpska National Assembly). (2017): „Odgovor na poslaničko pitanje“ (*Response to the delegate's question*). Taken on 12.7.2017. sa: <http://www.narodnaskupstinars.net/?q=la/narodna-skupstina/poslanicka-pitanja-i-odgovori/narodni-poslanik-milan-%C5%A1vraka-fondu-zdravstvenog-osiguranja-republike-srpske>

„Obračun sredstava u zdravstvu u Federaciji Bosne i Hercegovine“ (*Calculation of health funds in the Federation of Bosnia and Herzegovina*), Institute for Insurance and Reinsurance of FBiH (2015). Taken on 9 May 2017 from: <http://www.fedzso.com.ba/bs/dokument/obracun-sredstava-u-zdravstvu-fbih-za-2015-godinu/390>.

Republic Institute for Statistics of Republika Srpska. Taken on 12 July 2017 from: www.rzs.rs.ba/

Official Gazette of the Federation of BiH, 30/97, 7/02, 70/08, 21/09; 46/10, 48/11 and 75/13

Official Gazette of Brčko Districta BiH, 37/2009

Official Gazette of the Federation of BiH, 21/09

Statistika nacionalnih zdravstvenih računa u Federaciji BiH, 2015, (*Statistics of national health accounts in the Federation of BiH*) Taken on 12 July 2017 from: <http://fzs.ba/wp-content/uploads/2017/05/12.7.pdf>

Statistika nacionalnih zdravstvenih računa (*Statistics of national health accounts*) Taken on 12 July 2017 from: http://www.bhas.ba/saopstenja/2014/NZR_2009_2012_bos.pdf

Strateški plan FZO RS 2014-2018. (*Strategic Plan of the RS Health Insurance Fund*) Taken on 12 July 2017 from: https://www.zdravstvo-srpske.org/files/dokumenti/strateski_plan_2014_2018.pdf

„Strateški razvojni plan Fonda zdravstvenog osiguranja Republike Srpske za period od 2014. do 2018. godine“, (*Strategic Development plan of the Health Insurance Fund of Republika Srpska*)

Fond zdravstvenog osiguranja Republike Srpske (2014), (*Health Insurance Fund of Republika Srpska*). Taken on 9 May 2017 from: https://www.zdravstvo-srpske.org/files/dokumenti/strateski_plan_2014_2018.pdf.

World Bank. Taken on 12 July 2017 from: <http://data.worldbank.org/indicator/SH.XPD.PCAP>

World Health Organisation. Taken on 12 July 2017 from: <http://www.who.int/en/>

Council Conclusions on common values and principles in European Union health systems, Official Journal of the European Union C 146, 2006.

Zavod za javno zdravstvo Federacije Bosne i Hercegovine (*Public Health Institute of the Federation of Bosnia and Herzegovina*). Taken on 12 July 2017 from: <http://www.zzjzfbih.ba/>

Abbreviations and Acronyms

BD	Brčko distrikt	Brčko District (BD)
BDP	Bruto društveni proizvod	Gross domestic product (GDP)
BIH	Bosna i Hercegovina	Bosnia and Herzegovina (BiH)
DRG (DTS)	Novi model plaćanja bolničkih usluga (srodni dijagnostičko-terapijski slučajevi)	Diagnosis Related Groups (DRG).
DZ	Dom zdravlja	Community Health Centre (CHC)
EU	Evropska Unija	European Union
FBIH	Federacija Bosne i Hercegovine	Federation of Bosnia and Herzegovina (FBIH)
FZO RS	Fond zdravstvenog osiguranja Republike Srpske	Health Insurance Fund of Republika Srpska (HIF RS)
JPP	Javno-privatno partnerstvo	Public-private partnership (PPP)
KM	Konvertibilna marka	BAM
KSZ	Konsultativno-specijalistička zdravstvena zaštita	Consultative and Specialist Health Care (CSHC)
MZSZ	Ministarstvo zdravlja i socijalne zaštite	Ministry of Health and Social Care (MoHSC)
PDV	Porez na dodatu vrijednost	Value Added Tax (VAT)
PU RS	Poreska uprava RS	Tax Authority of RS (TARS)
PZZ	Primarna zdravstvena zaštita	Primary Healthcare (PHC)
RS	Republika Srpska	Republika Srpska
RZZS	Republički zavod za statistiku	Republic Institute of Statistics
UKC	Univerzitetsko-klinički centar	University Clinical Centre (UCC)
USD	Američki dolar	US Dollar
ZO	Zdravstveno osiguranje	Health Insurance (HI)

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