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RIGHT TO HEALTH CARE AFTER THE ECONOMIC CRISIS[1]

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Abstract
Today, there are numerous challenges that citizens and public policy makers face in terms of securing and financing health care. This problem can be seen in the broader context of socio-economic, financial, cultural and other social events in the world and in our country. The issue of the availability and comprehensiveness of health care, in line with the principle of equality in health, is posed as particularly challenging to standardize and implementation of legal rules. All these countries face the challenges. This problem is particularly acute after the global economic crisis in 2007, when most countries have acceded to the redefinition of health policy. The paper analyzes the impact of social change on defining health policy by applying the normative, comparative and sociological method, above all, the consequences of the economic crisis to health policy making in Serbia. Limited financial allocations for health in the face of significant socio-economic changes and the necessity of achieving equality in health for all social groups, on the other hand, are in conflict, thus it is necessary to determine an adequate way of overcoming them, all in the context of the sustainability of the system. In the further work, the authors point to the collapse of the health care system in Serbia, which began at the end of the last century, with the process of transition, and then further disturbed by the global economic crisis. Critical consideration of current health policy developments to identify alternative ways and to meet the conflicting interests of all stakeholders, i.e. policy makers, providers and users of health services, has been

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identified as a core subject of research, which will be considered in accordance with a holistic approach to the realization of human rights.

Key words: *health care, health insurance, social needs, economic crisis, transition*

INTRODUCTION

Human health in each country depends on the official government policy and strategy and health policy and results in the context of the achieved health objectives, programs and adequate management of available resources. Good health is crucial to economic and social development, and a basic concern in the life of every person, family or society. Enabling people to have control over their health and its determinants strengthens the society and improves the lives of individuals (World Health Organization 2012, 5). However, the quality of health of every citizen is largely dependent not only on his or her relationship with one's or another's health, but also on many other factors: social, political, economic, and technical (Totić 2015, 31).

Special attention is paid to health care as the most vulnerable segment of social policy. Health care can not be considered only as a social, but also as an economic potential of a country. Observation of the health care system from an economic standpoint in terms of its sustainability has particularly been actualized in recent years (Sovilj 2018, 143-144). This has contributed to the transition process that has begun at the end of the last century and is still present in our country. In addition, the global economic crisis in 2007 contributed to an even greater collapse of the health care system, deepening the gap between the financial ability of the state and the citizens' expectations in terms of realizing the right to health care. Therefore, the paper emphasizes the role of the government as being crucial when it comes to creating the health policy, adopting measures, programs, and achieving the strategic objectives. The aim is to increase the coverage of the population with health care, to achieve the highest possible level of quality of health services in the conditions of scarce economic resources and financial possibilities of developing countries, such as Serbia.

From a sociological point of view, health care services represent an attack on the country's budget, while from an economic or financial standpoint, they represent both income health facilities and a reflection of public spending, given that each of them has its own financial value (Totić & Marić – Krejović 2010, 46).

THE IMPACT OF THE ECONOMIC CRISIS ON REDEFINING HEALTH POLICY

Health policy represents only one of a number of public policies, whose social significance is of great value. The reasons we can list regarding its importance are numerous. We shall mention some of them. First of all, it represents a very sensitive issue of health and diseases. Namely, a successful treatment, as well as all other forms of health care, are observed with special attention, since possible errors can have fatal social consequences. Secondly, the financing of health care is very expensive, regardless of whether it is a matter of public or private financing.

Third, in modern societies, health systems are largely socialized, and represent one of the pillars of the welfare state (Zrinščak 2007, 194).

Good health is the basis of social and economic development. However, the economic and financial crisis that many countries have faced after 2007 have jeopardized the positive progress made in health care system. The emerging financial insecurity, the lack of social cohesion, environmental hazards, and the increase in the number of chronic diseases have affected the deterioration of health and put the sustainability of health systems and social protection systems in jeopardy (WHO 2012, 7).

The starting hypothesis is that public health can not respond to the needs of all citizens, due to the insufficient investment in this sector and the inefficient allocation of resources. In most countries in the world, a part of the national budget allocated to health care has never been greater, while the cost of health care progressively increased in relation to the country's GDP. Costs are primarily caused by the development of technology, new invasive methods of treatment, higher expectations of people in the context of reducing the risk of disease, as well as access to quality health care.[2]

The continuous development of medical science, and the prolongation of life expectancy,[3] has contributed to the increase in health care costs. On the other hand, in some countries of Southeastern and Eastern Europe, the opposite tendencies are observed. The high unemployment rate followed by a complete collapse of the social and health care, has led to the tremendous growth of poverty and a drastic rise in mortality. In the countries of the former Soviet Union, the total mortality rate increased by 35%, while for the population of men, between the ages of 25 and 39, the rate increased by 90%. Between 1991 and 1994, in Russia, the average life expectancy of men decreased from 64 to 57 years. Other Eastern Bloc countries (Belarus, the Czech Republic, Poland and Slovenia) that went through the transition process have resisted shock therapy and avoided a major increase in mortality (Katić 2014, 2).

In his text Katic says that as long as the economic crisis was deep and heavy, they do not kill. They are killing the modern medicines with which the crisis is lurking - shock therapy and a policy of big budget savings. Unhappy families, permanently sick people and in the end lost lives, are the price of such economic policies. In contrast to stock market index and indicators of economic growth, which sooner or later resurrection, the dead remain dead, when the economy recovers after the crisis.

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[2] In recent decades, healthcare expenditures in most OECD member countries have been increasing at least 1% per year faster than real GDP growth annually. For example, the average health expenditure in the OECD countries has increased from 5% of GDP in 1970 to 9% in 2010. (WHO 2012, 8).

[3] Life expectancy at birth in the Republic of Serbia has increased in the period from 1950 to 2002, and for men from 53.5 years to 70.1 years and for women from 56 to 75.1 years. Analyzing by regions, the longest life expectancy was recorded in Zlatibor district, while the least expected duration of life in the North Banat District. Strategy for palliative care, *The Official Gazette of RS,* no 17/2009. In China, the gradual transition accompanied by enormous economic growth contributed to an increase in the average life expectancy of the population from 67 to 75 years.

The last decade marked a significant increase in gross domestic product (GDP) for health care system in almost all developed countries. According to the World Bank, in the aftermath of the economic crisis and recession of the economy, the United States increased the allocation for the health care sector to 17.1% of GDP in 2014. At the same time, the EU Member States allocated on the average between 9 and 11% of GDP to the health sector. The largest allocation to the health sector was recorded in the Netherlands, which accounted for 12.7% of its GDP. In the reporting period, Serbia allocated 10.6% of GDP to the health care sector, which is at the level of Denmark, Austria, Greece and Belgium. In absolute terms, it was $ 6270 in Denmark in 2013, and only $ 475 in Serbia (Stošić & Rabrenović 2015, 34).

We note that the allocation of minimum health resources in absolute amount is the result of a relatively low gross domestic product. Taking into consideration the fact that expenditure on health care in Serbia, compared to the gross domestic product, is higher than in other countries in transition, and that the results of health care are at the average level, we conclude that there are significant inefficiencies in the national health system (Veselinović 2014, 154).

THE STATUS OF HEALTH CARE IN SERBIA IN TRANSITION AND PERSPECTIVES

Structural changes that occurred in the region of Eastern and Southeastern Europe at the end of the last century and after the beginning of transition have drastically disrupted social cohesion and stability in most countries, and their consequences are still felt today. These changes did not only affect Serbia but also other countries of the Eastern Bloc that in the meantime became full members of the EU - Bulgaria, Romania, Slovenia, Latvia, Lithuania and Estonia. The negative effects of the reform have been present in almost all countries and spheres of economic and social life, and they have not bypassed the health care system. Most citizens, except the owners of large capital, consider these reforms as hostile (Zekić & Šegrt 2015, 5-6).

The objectives of the transition in economic and political terms were clearly defined – these are the free market and democracy. The economic and social consequences of the transition have been fully reflected in health security. Also, the process of European integration and globalization has contributed to the collapse of the health care system (Zrinščak 2007, 199-200). Despite numerous achievements, positive trends have been interrupted by transition. The general social crisis, which arose from the collapse of the country, civil war, UN sanctions, hyperinflation, which culminated in bombing, led to the collapse of the health system in the country (Perišić 2011, 275).

The period of transition in the health insurance represented a continuity during the period of socialism. Until 2005, when the Law on Health Insurance was adopted, there was only a mandatory social health insurance (Čolaković 2013, 31). The law retains the principle of mandatory health insurance and foresees the possibility of introducing a voluntary health insurance. In fact, the economic crisis, a chronic lack of sources of financing health care and private practice led to the need for the introduction of voluntary health insurance in early 2004 before its legalization (Janković 2011, 79).

The beginning of the transition marked the process of creating a parallel private health sector. Private medical practice has provided better conditions of treatment by hiring doctors normally employed in state health institutions to work illegally. Given that there was no integration of the private and public health sector, citizens were forced to pay double for their health care services. In addition to payment of contributions for mandatory health insurance on the basis of which they could not exercise their rights, the citizens were forced to pay for health care both in private and state health institutions. The high cost of health care and the constant lack of funds in the health insurance fund have led the patients to bear their own costs of diagnostics, treatment and procurement of medicines and medical supplies (Perišić 2011, 276). The financing of mandatory health insurance was further burdened by numerous companies that underwent the process of privatization, reorganization or bankruptcy and that had not paid healthcare contributions to their employees for years.[4]

Although the chronic deficit in the health fund was to be substituted by the introduction of private health insurance, the significant progress has not been made so far. The growth of the private insurance market is not significant, as it was originally expected. In addition to real financial incapacity, i.e. low purchasing power of the population, the sociological motives should also be taken into consideration. The heritage of a generous system from the age of socialism does not contribute to the strengthening of a private initiative. People consider that the state is obliged to provide them with all the necessary health services. Therefore, they do not want to invest additional money in private health insurance, considering it "a futile waste of money". This attitude prevails in countries with a strong egalitarian tradition, including the Slovenian and Nordic countries. The essential difference between the Scandinavian countries and Serbia is that horizontal cohesion, solidarity and investment are much more pronounced in Scandinavian countries, on the other hand, in Serbia it is expected from the state to provide help, while the payment of taxes and other charges is being avoided (Zekić & Šegrt 2015, 7). In that particular leading the owners of large capital.

Although more funds for financing health care system have been set aside for years now, the Republic Health Insurance Fund is continuously decreasing a package of health services financed from the budget. For example, a package of mandatory health insurance used to cover the services of treatment in military hospitals in our country and abroad, fees for medication and medical supplies purchased on the private market (Gajić - Stevanović, Dimitrijević, Vukša, Jovanović 2009, 15). The 2005 Health Insurance Act significantly reduced the mandatory

[4] There are numerous examples. We will mention the case of "Magnohrom" from Kraljevo. After the privatization, complete destruction of production capacities, sales of production machinery, non-investment was completed. The damage that created was estimated at between 20 and 50 million euros. Employees of "Magnohrom" did not pay their agreed earnings and contributions before, during and after the privatization. Also, they have not been certified health cards. The same fate hit workers of the Car Factory Priboj (FAP). The workers were not paid monthly wages, nor have they been certified health cards. The company was in the process of restructuring for twelve years, but recovery did not occur. The reforms did not miss employed in public institutions. Suddenly, 4.000 employees were dismissed from health care system, and 5.000 from education system (Novaković 2017, 206- 239).

health insurance package. Among other things, the Act of 2005 abolished the right to compensation for funeral expenses. Also, the novelty constituted a condition for exercising the rights of former insured persons, justifying the policy makers' view that the content and scope of the right were aligned with the available funds (Perišić 2011, 281). The international financial institutions, primarily the International Monetary Fund and the World Bank, promoted further rationalization of the package of health services covered by mandatory health insurance. In contrast to previous periods when the dental services were free, the right to dental services funded by the Republic Health Insurance Fund now have children, pregnant women, persons older than 65 years and emergencies (Gajić – Stevanović *et al*., 2009, 15). Thus, a large part of the adult population has no mandatory health insurance when it comes to covering the cost of dental services.

Despite the fact that every year more funds from the budget to finance health care are allocated, it is concluded that they are still insufficient (Arsenijević, Pavlova & Groot 2013, 19). The reasons for stating so are numerous. Firstly, the increase in costs is affected by the growing needs of the population (demographic changes, an increase of chronic diseases, etc.) (Gajić – Stevanović 2014, 2-17). Secondly, the intense development and application of new and innovative drugs, which are more effective in the diagnosis and treatment of diseases, affect the increase in the overall cost of treatment. On the other hand, the number of health care users, primarily elderly[5] and chronic patients,[6] increases from year to year, which, from the economic point of view, greatly burdens the health system by both taking a regular therapy and using a hospital accommodation and treatment services (Mitrović & Gavrilović 2013, 150-151).

A significant progress has been made in raising the health care quality, primarily by investing large resources in the rehabilitation of state health care institutions and the supply of modern equipment. However, the out-dated equipment is often changed for a new one, without rational purchase. For example, doubling capacities in more developed environments were noted (Perišić 2011, 284). The practice of non-use of the equipment supplied was also recorded since there was no trained staff.

Taking into account the current state of health care system in the Republic of Serbia, primarily, the problems with financing and maintaining of the health care system, there is a constant need for active involvement of the state authorities in resolving this problem. First of all, it is necessary to determine the extent of the rights of health care users on the basis of compulsory health insurance by implementing systemic laws. This would solve the on-going meaningless practice

[5] The share of the elderly (65 years and over) in the total population, after the initial decrease in the period from 2007 to 2011, increased from 2012 to 2016, and in 2016 amounted to 19.2% (Institute of Public Health of Serbia 2017, 70).

[6] In accordance with the aging process of the population, the participation of chronic patients is increasing. Chronic diseases (heart and blood vessels, malignant tumors, diabetes, obstructive pulmonary disease) are the leading causes of illness, disability and premature dying (65 years of age). In Serbia, annually, every other citizens die of cardiovascular disease, every fifth of malignant tumors, and one in ten of diabetes and obstructive lung disease. Over the past 20 years, the highest increase in mortality in the population has been caused by malignant tumors and diabetes (Institute of Public Health of Serbia 2017, 43-45).

that patients, due to their inability to exercise their rights under mandatory health insurance, allocate additional funds for the provision of the same health services with the inability to refund those funds from the Republic Health Insurance Fund (Sovilj 2018, 151-152).

Despite the existence of a large number of private health institutions and proclaimed reform objectives, there is still a lack of adequate co-operation between the public and the private health sector. Frequently, this cooperation goes to the detriment of citizens. This problem is reflected in the impossibility of prescribing prescription drugs, the lack of opinion of the private practitioner when approving the sick leave or evaluation of the medical commissions, and the difficulties when it comes to referring to hospital treatment (Vuković 2009, 170). On the other hand, successful cooperation between the public and private sector exists, since health professionals are enabled to continue their work in private health institutions after completing work in a state institution. Moreover, the law allows healthcare professionals and associates who are employed in a health institution or private practice to conclude a contract of supplementary work with their employer, or at most three contracts of supplementary work with another employer, for a total duration of up to one third of full-time work.[7] In contrast, in Germany, a physician employed in a state health institution, does not work at the same time in private clinics.

In the previous period, the Law on Patients' Rights[8] and Zoja's Law[9] were adopted, which for the first time regulate patients' rights in a systematic way. This surely represents a major step forward in domestic health legislation, but it will be necessary to pass the long path until the rights of patients guaranteed by law are realized in reality.

"The wave of reforms" which spawned the adoption of a number of other laws (which is very typical of all countries in transition), drew closer the national health service to the modern achievements of European and global health care system.[10] At the same time, the current financial difficulties were resolved in the short term. This was achieved by reducing the extent of the rights to mandatory health insurance and increasing participation for a range of health services. However, it does not solve the key problems of financing and the availability of health care in the long term (Zrinščak 2007, 193).

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[7] Law on Health Care, *The Official Gazette of RS*, no 25/2019, Article 60.

[8] Law on Patients' Rights, *The Official Gazette of RS*, no 45/2013 and 25/2019

[9] Law on Prevention and Diagnosis of Genetic Diseases, genetically conditioned Anomalies and Rare Diseases, *The Official Gazette of RS*, no 8/2015

[10] The reform of the health care system has been followed by strikes and protests by health workers against the measure of savings, the reduction of earnings and pensions, and the lack of jobs. In Spain, the health staff protest in the period from November 2012 to February 2013, due to the announcement that the number of 75,000 employees would be reduced and that several state health centers would be closed. The patients also protested. In Madrid, 10.000 invalids protested against the layoffs of their abandonment and the abolition of centers for the disabled. After the economic crisis, in the period from 2010 to 2014, massive protests against health reform took place in other countries: Portugal, France, Germany, Great Britain, Italy, Greece, Slovakia, Romania, Bulgaria and Macedonia (Novaković 2015, 100-104). Novaković says that the protests were successful in the developed capitalist countries, but did not in the over-indebted countries and those on the periphery of the capitalist system.

In the forthcoming period, the resolution to the problems concerning further development and improvement of health care should be sought in a collective insurance, that is, in the insurance sponsored by the employers. It is necessary for the state to provide tax incentives for participation in the system of voluntary health insurance. At the same time, we should work on increasing the package of health services. If the conditions were such that citizens would prefer treatment in the private sector to the state health institutions the state insurance fund would be dissolved (Zekić & Šegr 2015, 8). This would create new job opportunities for health personnel in the private sector.

CURRENT SITUATION IN HEALTH CARE SECTOR AND SOCIAL NEEDS

In recent years there has been an increase in diseases the populations suffers from and a rapid rise in mortality caused by unhealthy diseases of the modern age. The social needs and health services vary depending on their providers or beneficiaries. The differences are sometimes very pronounced, depending on the approach in considering the development of not only health, but also global, economic, political and social system (Totić & Marić – Krejović 2010, 46). Hence, it is recommended that when considering social needs in the field of health care, a distinction should be made between those that are purely medical and those related to health care. The medical needs of the population are satisfied with the services provided by a highly professional health personnel, whose activity is regulated by the systemic laws in the field of health care.[11] On the other hand, health care needs, which primarily refer to raising the quality of life and improving the human health, are realized within the broader social, not just medical subjects (Totić & Marić – Krejović 2010, 45).

Health care systems around the world face numerous problems. Primarily, the problem is to provide all necessary health care services from mandatory health insurance funds. This problem is complicated by the fact that the population is older and that it needs adequate health care and treatment. The aging population problem is present in almost all European countries. An additional problem is a smaller number of working population, where the number of employees paying contributions to the National Health Insurance Funds decreases from year to year (Zekić & Šegrt 2015, 5). Adding this to the extension of the lifetime, which inevitably leads to the extension of the working age, we are faced with a serious imbalance in the mandatory health insurance budget. Although the measure of extension of the working age is aimed at reducing the number of retirees, it prevents young, working-age people from having a work relationship, and thus becoming contributors to health insurance. The result is the brain drain of young and educated people.

The right to health care is a universal human right, and is considered a part of modern society. In most countries around the world, the right to health care enforced through a mandatory health insurance. However, despite the worldwide

[11] The activity of health personnel is primarily regulated by the Law on Health Care, which was recently adopted in Serbia. Law on Health Care, *The Official Gazette of RS*, no 25/2019

spread of the mandatory health insurance, no country can provide its citizens with all medical services at the expense of the state budget (Zekić & Šegrt 2015, 4). Hence, there is a need for introducing alternative ways of financing the health care. A Voluntary health insurance is an alternative to the mandatory health insurance.

There are various health insurance systems in the world. Although the system of mandatory health insurance is predominantly in the countries of the European Union, there is a growing presence of some form of the voluntary health insurance. In contrast to European countries, the United States is dominated by a private health insurance system. The market model of the private health insurance is based on the purchase of a health insurance policy, which includes a defined package of health services (Mihaljek 2008, 283-285). Given that the US health insurance system assumes a highly developed financial market with a pronounced presence of risk, it is not applicable to European countries (Marković & Vukić 2009, 192). A key feature of the American health care system is that it is socially unfair. The persons with minimal cash income, due to inability to pay insurance policies, remain without health insurance. This problem has been partially resolved by adopting a national health insurance program that covers persons older than 65 years - *Medicare* and socially vulnerable groups - *Medicaid* (Kovač 2013, 551).

In Serbia, the system of mandatory health insurance prevails, which covers the majority of the population, more specifically 97.2% in 2016. Despite the high coverage of the population by health care, the incidence of unsatisfied health needs remains high. The most common causes of dissatisfaction with health services in the period between 2014 and 2016 are primarily financial (the inability to afford a healthcare service because it is expensive), followed by the lack of free time, the expectation that the health condition is improved, waiting lists,[12] and corruption. The financial reasons for not meeting the health needs in 2016 are more common with women, the poorest, the elderly working population (45 to 64 years of age), and those older than 75 (The Government of Republic of Serbia 2018, 250). Additional dissatisfaction of the citizens, with the quality of provided health services, caused by the corruption, which is widespread at all levels of health care system. Based on the conducted investigations of the perception of corruption in Serbia, it was noted that citizens believe that corruption is well represented in health care sector. *Van Duy's* research shows that 73.6% of citizens in Serbia have this opinion. In a survey conducted by the *United Nations Development Program (UNDP)*, 68% of Serbian citizens perceive health as an area affected by corruption. In the survey of citizens' attitudes about corruption, it is noted that out of the total number of direct corruption cases, 47% refers to physicians (Vasiljević & Prodanović 2015, 99).

In parallel with mandatory health insurance, there is also a voluntary health insurance, introduced by the 2005 Health Insurance Act and the Voluntary Health

[12] The average length of waiting for a specific intervention in 2017 was: for the implant installation in orthopedics, on average, 387 days; for cataract surgery and intraocular lenses 285 days; in the field of cardiovascular surgery for an average of 184 days; for the installation of a pacemaker for an average of 98 days; on an overview of magnetic resonance an average of 83 days; for diagnostic coronarography and / or catheterization of the heart for an average of 71 days; for the procedure of computerized tomography for 35 days. (Institute of Public Health of Serbia 2018, 10-11).

Insurance Regulation in 2008.[13] Regulating the field of voluntary health insurance, the legislator was aware of the limited scope of mandatory health insurance. The main reasons for the reduction of the package of compulsory health insurance is a chronic lack of funding sources and financial (un)sustainability of the Republic Health Insurance Fund.

By adopting the new Law on Health Insurance in 2019, the conditions and procedure for organizing and conducting voluntary insurance, as well as the obligations of the contracting parties, are regulated in detail. The Law envisages three types of voluntary health insurance: supplementary, additional and private health insurance.[14] Following the example of solutions in international and comparative law, the law provides for the prohibition of discrimination of insured persons by age, gender or health when concluding a voluntary insurance contract. This seeks to ensure the principle of equity of the insured in terms of scope, content and standards for exercising rights from voluntary health insurance, irrespective of the personal characteristics of the insured (Sovilj & Stojković Zlatanović 2017, 296).

In recent years the structure of users of voluntary health insurance has changed. There is an increase in the number of people who can afford adequate health care through voluntary health insurance. It has been detected a rise of the new population category, wealthy citizens and successful individuals, IT professionals, experts and managers of successful foreign companies that operate in Serbia. These persons and/or groups conclude private insurance contracts with insurance companies that operate internationally and transnationally. They are ready to pay a higher monthly premium insurance to save time, and in return get the best health service when they need it (Zekić & Šegrt 2015, 6). However, despite the initial positive trend, the number of users who pay some form of voluntary insurance is still insufficient, taking into account the total population. According to the available data, nearly 25,000 of voluntary health insurance contracts were concluded in Serbia. On the other hand, the underdeveloped voluntary health insurance market is affected by the low purchasing power of the population (Kočović, Rakonjac-Antić & Rajić 2013, 554). Taking into account the fact that the average salary barely covers the cost of the minimum consumer basket, there is little room to meet other needs, and thus to conclude some form of voluntary health insurance.

Based on the analysis of the current situation, voluntary health insurance should be supplementary to mandatory health insurance. Within the framework of voluntary health insurance, it would be necessary to insist on providing health services that are not covered by mandatory health insurance, that is, the provision of services of a higher volume and quality (Sovilj 2018, 158). This would avoid negative practices, otherwise very widespread, that patients allocate double funding for the provision of health services. Namely, the citizens are obliged to pay contributions to the Republic Health Insurance Fund, but due to the inability to

[13] Law on Health Insurance, *The Official Gazette of RS*, no 107/2005, 109/2005, 57/2011, 110/2012 – resolution CC, 119/2012, 99/2014, 123/2014, 126/2014 – resolution CC, 106/2015, 10/2016 – other law, Regulation on Voluntary Health Insurance, *The Official Gazette of RS*, no 108/08 and 49/09.
[14] Law on Health Insurance, *The Official Gazette of RS*, no 25/2019, Article 174.

exercise the right to health care services within a reasonable time, they pay the same services in the private sector from their pocket.

In industrialized and developed countries, there is a practice of cooperation between the state health insurance and private health insurance fund. A basic package of health insurance is mainly provided from the state budget, while the larger scope of rights can be arranged through private insurance. For example, in Germany and Austria, the legal requirement is that each person must be ensured. This is why the state funds and private insurers compete for high-yield customers: managers, IT professionals, notaries, lawyers, engineers, etc. Precisely, the existence of competition contributes to raising the quality of services and the overall progress of health care (Zekić & Šegrt 2015, 6).

CONCLUSION

Finally, we observe that even in the developed countries of the world there is no perfect health care system, which would be able to meet the needs not only of health care users, but also the needs of health care professionals, economists and policy makers. It is undeniable that certain positive developments have been made in the overall improvement of health care system, such as prolonging the average life expectancy, reducing the infant mortality, and so on. On the other hand, there are numerous complaints regarding the normal functioning and financing of the health care system. Above all, it is noted a pervasive discontent of citizens regarding the access to health services. Patients are often forced to pay for private health care services due to the inability to exercise their right to a healthcare service within a reasonable time. In addition to this, the health care stuff is dissatisfied with both the height of average earnings and the working conditions. Therefore, the elements of corruption are presented in certain sectors.

The global economic crisis has influenced the redefinition of health policy. In years after the economic crisis, public health allocations have risen parallel to GDP growth. However, they were still insufficient to cover all costs. The continued development of medical science and the discovery of innovative methods of treatment contribute to the progressive growth of costs of treatment in relation to the economic growth of society. The issue should be sought in alternative ways of financing health services.

From the beginning of the transition, the reforms in health care have been permanently implemented in Serbia. Unfortunately, the objectives of the proposed reform is not implemented. The problem complicates the structure of the health care system, which is dominated by state ownership, while the private sector is not sufficiently integrated into the health care system. It is, therefore, necessary to focus on the integration of the private sector into the health care system, the empowerment and promotion of voluntary health insurance, the public - private partnership and the linking of private and state health institutions.

The reconfiguration of health care services and the introduction of incentives and changes in the structure of payments can contribute to better health care. The health sector is committed to cooperation with other sectors in order to improve people's health and contribute to raising the quality of health care. In this regard, it is necessary that the health sector should adapt to the daily challenges and

harmonize health policies with new changes. Future progress will be reflected in the country's ability to use new technologies to improve health and well-being of current and future generations.

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