

# Rights of Patients to Use Health Care from the Perspective of Legislation and the Real Possibility of Financing Them

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## SUMMARY

The patients' rights based on ex-Yugoslavian health insurance were very broad: unlimited number of visits and PPZ service, number of diagnostic services, hospital care in the in and outside the country, spa care and climatic treatment centers care, sick-leaves and unlimited number of many other health services. In that period, a great deal of social problems was handled through health care system. There are many examples for this claim, but the doctors that had worked at that time have practical experience (number of sick-leaves caused by an illness of a family member, old and chronic patients' long stays at hospital etc.) In the period after the war, citizens still had old habits of irrational exploitation of health services, and the legal acts helped them in that. Health Insurance Law and Medical Care Law from 1997 are just modified laws from before the war which kept breadth of patients' rights. Under the pressure of certain interest associations and groups (Crohn's disease patients, physically disabled persons – by war and other circumstances, chronic and malignant diseases patients, pressures of financing medical care abroad, etc.) patients' rights increased regardless of real financial possibilities. Insisting on bringing basic patients' rights from obligatory insurance over the years succeeded – by the end of 2008 the document went through law procedure and has been acquired. Unfortunately, the document did not create precondition for expense rationalization in medical service, like it was expected, but it was more like the sum of patients' wishes, except there were no longer people without insurance. A serious question is raised on financial funds that would follow such a broad patients' rights. Rate of paying from GDP in FBiH takes out 8.82%, which is a good rate of paying compared to the other ex-Yu countries (Croatia 7.5%, Montenegro 6.8%, Slovenia 8.4%, Serbia 8.0%) and EU countries (Sweden 8.9%, Norway 8.7%, Italy 9.0%, Austria 9.9%), and taking in consideration countries from the ex communist block, our rate is higher (Romania 5.7%, Russian Federation 5.3%, Check Republic 6.8%, Bulgaria 6.9%, Albania 6.3%). Unfortunately, statistics brought by simple math does not give us a real insight – all mentioned countries, except Serbia, Albania and Ukraine, have higher GDP than Bosnia and Herzegovina, some of them even seven times higher (Norway), and therefore their annual payment for medical care per capita is several times higher: Check Republic 1940 US\$, Italy 2623 US\$, Sweden 3119 US\$, Slovenia 2065 US\$, Croatia 1084 US\$. While Bosnia and Herzegovina has substantial GDP rate of paying for health care, on the other hand, annually, it has far smaller financial means per capita (FBiH 431.00

BAM – in 2007, and Sarajevo Canton 619.08 BAM per insured person). Based on 2007 data, a citizen of Sarajevo used medical service in these scopes: 3.7 services in PPZ, 3.29 visits in specialized health care, 1.51 per day, 15.7 diagnostic services, 1.13 physical rehabilitation services, 1.31 dentist services, in women health care 1.31 services, 6.7 medical prescriptions (costing 17.04 BAM which means 114 168 BAM). Sick leave reimbursement, orthopedic aids, health services abroad and any other possible (legally specified expense) should be added to this, the sum of these prices individually obviously goes far more than 619.08 BAM. If we take into consideration that also uninsured persons used medical care on some ground, then, it is clear that sum per capita is even smaller. How to continue without bringing collapse in financing and functioning medical services? We think that two possible ways of effect: the first one is revising the rights from obligatory insurance, primarily basic package; the other way is final initiation of additional/supplementary insurance, but it would be more successful if both of these ways would be implemented.

**Keywords:** insured person, insured one, insurance, GDP, expense, patients' rights, legal acts, additional/supplementary insurance

## 1. INTRODUCTION

Patients' rights based on health insurance in the former Yugoslavia were very broad: an unlimited number of visits and services in the primary health care, a large number of diagnostic services, hospital treatment in the country and abroad, treatments at the spa and health resorts, illness and weight of other health services whose number was limited.

At that time, a good part of the social problems was solved through health, there are lots of examples, and a great experience in that have doctors who then worked in ambulatory practice (sick leave due to a family member care, long stays in hospitals, elderly and chronic patients, departures abroad for treatment of diseases that are also in our country successfully resolved, a large number of simultaneous prescribing of drugs, etc.).

In the postwar period, citizens retained the old habit of irrational use of health services, and legal regulations go to favor of that. Health Insurance Law and the Health Protection Law from 1997 in essence are the modified pre-war laws that keep the width of the patient's rights. Under

COUNTRY	Health care expenses per capita	% paying rate from GDP for health care	GDP per capita
Bosnia and Herzegovina	794	8,3	6780
Croatia	1084	7,5	13850
Slovenia	2065	8,4	23970
Montenegro	117	6,8	8.930
Serbia	153	8,0	6782
Macedonia			2826
Romania	610	5,7	10150
Bulgaria	741	6,9	10270
Ukraine	542	7,0	6110
Check Republic	1.940	6,8	20920
Russian Federation	638	5,3	12740
Albania	358	6,2	5774?
Turkey	645	5,6	8410
Italy	2.623	9,0	28.870
Greece	3.101	9,9	30.870
Austria	3.545	9,9	35.808?
Switzerland	4312	11,3	40.840
Sweden	3119	8,9	34.310
Norway	4521	8,7	50.070

Table A. WHO- Statistics for 2006

Observed area	Expenses for healthcare per capita			% paying rate from GDP for health care			GDP per capita		
	2006.	2007.	2008	2006	2007	2008	2006.	2007.	2008.
Sarajevo Canton	592	675	721	-	-	-			
Federation of BiH	370	431		8,82	8,75				
Bosnia and Herzegovina	794			8,3			6.780		

Table B. WHO- Statistics for 2006

pressure from certain organizations and interest groups (people with Crohn's disease, civil and war disabled, those suffering from certain chronic and malignant diseases, pressures to fund treatment abroad, etc.) patients' rights have increased regardless of the actual financial capabilities. Many years of insisting on the adoption of the basic package of rights of patients from the compulsory insurance resulted in document at end of 2008; the document is passed through legal procedure and was adopted. Unfortunately, this document did not, as expected, created the preconditions for the rationalization of expenditures in health services, but is more like a collection of patients' wishes, with fact that there is no more uninsured people. This raises the serious question of financial resources that would monitor such a broad patients' rights. The rate of separation of GDP in FBiH is 8.82%, which is a good rate of spending compared to countries of former Yugoslavia (Croatia 7.5%, Montenegro 6.8%, Slovenia 8.4%, 8.0% Serbia, and Macedonia).

Compared with some European countries (Sweden 8.9% Norway 8.7%, Italy 9.0%, Austria 9.9%), it is similar to the rate of spending, and in relation to the countries of the former Communist bloc it is recommended far more (Romania 5.7%, Russian Federation 5.3%, Czech Republic 6.8%, Bulgaria 6.9%, Albania 6.2%).

Unfortunately, the very rate of spending on health does not give a true picture because all these countries except for Serbia, Albania and Ukraine, have a higher GDP than

Bosnia and Herzegovina, some seven times: (Norway), and their annual spending on health care by capita is many times greater: Czech Republic 1940 US\$, Italy 2623 US\$, Sweden 3119 US\$, Slovenia 2065 US\$, Croatia 1084 US\$. Bosnia and Herzegovina even with a substantial percentage of spending on health in GDP, in fact the annual per capita has far fewer resources: FBiH in 2007 431.00KM, and the Canton of Sarajevo 619.08KM per insured person).

In the U.S., 16% of GDP goes to health needs, but 47000000 (one sixth of the population) is uninsured, due to the recession in the period 2007-2008 health insurance lost fourteen millions (14000000) persons (employers stop paying during crisis), and per day health insurance lost 14000 citizens.

Experience of the United States is that a health system based on private insurance companies, which are profit organization, does not function well because revenues are not consistent with the services offered (number and type) because companies in the first place have their own profit. Analysts say that the U.S. health care system is not well resolved since the time of Franklin Roosevelt.

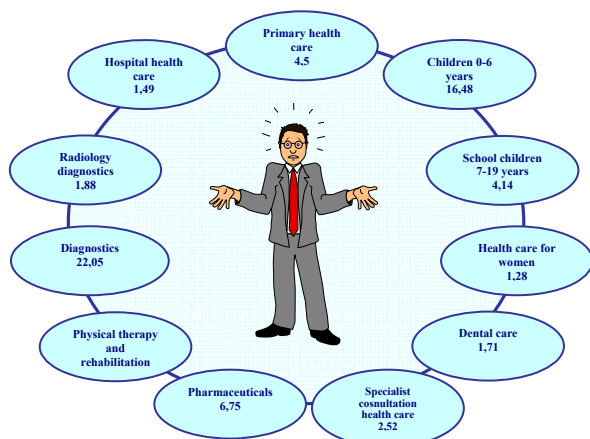
Analysis of work and funding of health activities in 2008 led to the fact that the inhabitants of Sarajevo in 2008 used the health services in volume: 4.5 primary health care services per person, health care of children offered 16.48 services, the health needs of school children services 4.1, 2.52 visits to a specialist health care, 1.49 in hospital days, 22.05 diagnostic services, physical rehabilitation services 1.13, 1.71 dental services, 1.28 provided services in health care of women, 1.88 service in radiology diagnosis-

STATE	Health expenditure per capita	Rate from GDP for health	GDP per capita
Bosnia and Herzegovina	794*	8,3	7434.146
Croatia	1084	7,5	18056.92
Slovenia	2065	8,4	27149
Montenegro	117	6,8	10879.79
Serbia	153	8,0	10679,46
Macedonia	-	-	2826

Table 1. Source: Outlook Database, April 2009. \*unknown method for calculation or source of data

State	Health expenditure per capita	Rate from GDP for health	GDP per capita
Romania	610	5,7	10150
Bulgaria	741	6,9	10270
Ukraine	542	7,0	6110
Check Republic	1.940	6,8	21028
Russian Federation	638	5,3	12740
Albania	358	6,2	4074
Turkey	645	5,6	8410
Italy	2.623	9,0	38996
Greece	3.101	9,9	32005
Austria	3.545	9,9	50098
Switzerland	4312	11,3	67385
Sweden	3119	8,9	52790
Norway	4521	8,7	95062

Table 2. WHO- Statistics for 2009



tics, prescription drugs 6.75 (18.38 kilometers = 114.168).

To this should be added compensation for sick leave, orthopedic supplies, treatment abroad, and other possible (legally prescribed fees), so the sum of individual prices is for certain much more than 672.92 KM what was allocated for the financing of health care by the insured person (or 637.99KM per capita ).

## 2. GOAL

To indicate anticoincidence of law for guaranteed rights of patients to health care and financial possibilities to cover the costs of using those rights.

## 3. METHODOLOGY

Analysis of patients' rights through Law on Health Protection, the Law on Health Insurance and the Decision on basic package of rights from health insurance. To analyze allocation of GDP for health and consumption of health care resources per capita.

## 4. RESULTS AND DISCUSSION

### Health Insurance Law (Official Gazette of FBiH, No.30/97)

Article 1 state that the social security in FBiH is a unique system in which health insurance is a part of it, or that the health insurance is based on the investment of funds of citizens, that citizens on the basis of this law required to invest funds for their health insurance in the Canton, the funds that citizens must invest in health insurance are used for health care and other forms of insurance on the principles of solidarity and reciprocity, in addition to the compulsory investment funds, funds can be invested in health care also on a voluntary basis. According to Article 2 of this law there are three possible forms of fundraising:

- Compulsory health insurance (13% of the gross income of employees and 4% of the gross income of the institution/company);
- Extended health insurance;
- Voluntary health insurance.

Article 3, 4 and 5 define the term—insured person – as person which pays contributions and insured persons and family members (which do not pay contributions). In 2007 the Federation had 2328359 inhabitants, of which there were **683629 employed** persons, giver of contribution

for health, and the total number of insured persons was **1947751**, which means that the relationship between the insured contributors and the insured person is **1:3.4084**. And unemployed persons (reported to the Employment Service) are eligible on this basis to health insurance, the Department reported one paid in average 6–20 km (each canton decides on the amount of contributions) in 2007 from the 518180 unemployed 325638 (63.14%) of them had the right to health care. Number of pensioners in the FBiH was 348000 (June 2009), a contribution from the Retirement Fund is 1.2% of the average pension, approximately 3KM per pensioners, which is far below the contribution of employees, and the disparity between the contribution and consumption of health resources to this category of insured achieved is a huge issue because people in the third age on average have between 3-5 diagnoses of chronic diseases.

The relationship of active insured and the insured persons (1:3.4084) is an unfavorable indicator, because the experts analysts say the relationship in which one employee provides more than three persons is not financially sustainable (the principle of solidarity has limits otherwise it collapse). Rights from health insurance guarantee to insured persons health care, salary compensation during sick leave for workers and travel expenses for implementation of health care.

According to Article 32 of this Law health care includes: EMS services, treatment of infectious diseases, treatment of acute and chronic diseases, treatment of malignant disease and insulin dependent diabetes, the detection and treatment of endemic nephropathy, healthcare for children under 15 years of age and students, pregnancy and maternity protection, protection of mental patients (especially serious cases), the protection of people with progressive muscle diseases, paraplegia, quadriplegia, cerebral palsy and multiple sclerosis, the implementation of compulsory immunization, treatment of injuries and occupational diseases, health care to citizens the third age, treating the disease of addiction and the function of blood collection services. In addition to the rights enumerated in the health insured persons have the right to orthopedic supplies and medications that are on essential list.

The Law provided for the provision of health services through the work of: Primary health care, specialist- -consultative services and hospital care.

### Health Protection Law (Official Gazette of FBiH, No.29/97)

Article 8 and 9 define the obligations of the Federation and Cantons in terms of their obligations to provide (finance): Prevention and control of infectious diseases subject to mandatory reporting, and prevention and treatment of quarantine diseases and ensuring the protection of HE minimum, and the organization and implementation of compulsory immunization, prevention and treatment of malignant disease, AIDS and tuberculosis, health education and promotion of public health, health care of war veterans and civil war victims (right above the level of compulsory insurance); health care for members of the Army of FBiH, a unique statistical information system

and statistical research in the field of health is of interest to the federation;

Canton provides HE activity, health statistics information systems, EMS, and medical social work in their area, ensuring the implementation of rights in the field of health insurance (by Law), provides health care for members of the Canton Police (above the level of compulsory insurance law), provides funds for the construction and equipping, and establishment of health institutions, providing coronary services.

## 5. MEASURES OF HEALTH CARE

**Decision on establishing the basic package of health rights (Official Gazette of FBiH, No.21/09, 7/02)**

- Right to health care
- Compensation paid (sick leave)
- Drugs (essential drugs list and the list of hospital care)
- The use of orthopedic and other aids (the list of orthopedic and other aids)

Ad 1 right to health care: promotion and health promotion, prevention and suppression of disease, early disease detection, diagnosis, treatment of disease, rehabilitation.

Health care is being implemented through the work of Primary health care, a public-health preventive and promotional activities, specialist-consultative care, and hospital health care, actually everything that is defined in the previous two laws. Novelty is defining the package of health rights for people uninsured.

**Package of health rights for people without insurance**

- Children and young people under 18 years of age (up to 26 years if they are full-time students) have all the rights as insured persons.
- Adult persons without insurance have the right to health care in case of: EMS, infectious diseases, health care of women (pregnancy, birth, after birth up to 6 months), the protection of mental patients, the protection of people with serious chronic diseases (malignancies, insulin dependent diabetes, endemic nephropathy, renal failure/hemodialysis, hemophilia, agamabulinemia), progressive muscular sclerosis, cerebral palsy, multiple sclerosis, paraplegia, quadriplegia, epilepsy, organ donation, blood transfusion. Not stated that these patients have a right to compensation, orthopedic supplies and medications, as it is included.

**Health services not covered by the basic package of health rights**

The basic package does not cover some of the health services that were not covered by the Law on health insurance: cosmetic surgery services, sports medicine, medical certificates, vaccinations as optional services, alternative medicine (homeopathy, chiropractic, acupuncture), spa treatment at health resorts, sex reassignment surgery, artificial insemination (over 37 years of age and other attempts), orthopedic aids, which are not on the list, drugs that are not on the list of essential medicines and hospital list.

Arguments can be said that the basic package covers

everything, not just basic needs for health services, and that the application did not makes easier the chronic lack of money in health services, and to recognize authors of the basic package of rights for the beginning predict the lack of about fifty million (49494898KM) in 2008.

## 6. CONCLUSIONS AND RECOMMENDATIONS

Growing poverty, the health consequences of war, lack of awareness among citizens about the protection and preservation of their own health leads to increase in the number of acute and chronic patients, and the number of requests for health services increases, and reduces the number of inhabitants/insured whose health state is assessed as well, who rarely or never use health services.

Patients' rights from the compulsory health insurance are very broad, funds allocated per capita are very small, the principle of solidarity in the future will not be able to maintain balance, and will reach the collapsing system.

Welfare policy and excessive use of patients' rights, and solving social issues through health, artificial maintenance of patients' rights on any grounds, will lead inevitably to a drop in standards of health care workers (wages, education, social status), on the other side and ultimately to the collapse of standards health care.

The main question raised is: How to continue further, and not to come to the collapse in the funding and functioning of health services?

More questions:

What is the future of funding and operation of health services in light of the recession and the emergency Law by IMF?

I think the following are possible directions for action:

- Review rights under the compulsory health insurance, primarily the basic package of health insurance (quantification of the number and types of services by the insured/capita at an annual level of participation in the cost of a number of services).
- The introduction of additional/supplementary insurance (no principle of solidarity).
- To oblige doctors in out-patient and hospital health care to be a factor of cost reduction of health care in terms of rational use of expensive diagnostic, sending patients to the next level and number of prescriptions that they prescribe.

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