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SOME QUESTIONS REGARDING THE FINANCING OF HEALTH CARE IN MEMBER STATES OF THE EUROPEAN UNION

Summary: Before you deal with the primary aim to show that regulated health care systems have contributed and still contribute to the health of citizens of member states of the European Union significantly improved. That is why the older member states of the European Union (Austria, Belgium, France, Germany, Netherlands), prepared to spend most of their gross domestic product *(GDP)* on health care for its citizens. At the other member countries on the periphery of the European Union (Portugal, Italy, Ireland, Greece and Spain), better known as a group *(PIIGS-svinje),* due to falling into a debt crisis is not ready for such a step because of which their citizens are faced with big problems when using health care. The paper deals with problems of unequal access to health services and lack of health coverage that exist among individuals as well as in some social groups in many member countries of the European Union. Analysis of unequal access to health services was carried out based on the estimated level depending on its socio-economic status of user-non-users of health care, are not bypassed with the right of the insured and their acquisition. The rights of the insured whose roots are in agidumu Hippocratic Oath: *"primum non nocere"* – "first do no harm to" vary from very narrow to very broad and diverse framework.

The paper konstatatovano to the conduct of public finances in the Member States of the European Union is not without problems, especially where contributions for health insurance funding mechanisms dominate. Health care financing in member countries of the European Union, more important than other functions affecting the quality of health of citizens, the mood to invest in access to health services and universal health insurance coverage. Financing of health care policy is not the only link of many of them in a long chain of global politics.

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However, it is indispensable to measure the effects of decisions made, the application of specific measures aimed at systematic and analytical review of available health resources and in consideration of political factors, economic, social and technical character at all levels. Special attention is given to raise funds to cover expenses resulting from universal health insurance coverage.

Key words: European Union, the healthcare system, health care, universal coverage, fundraising, health care services

Introduction

Whether a country belongs or does not belong to an organization, union, union group and the like, in terms of financing health care, there must dominante at least the minimum regulatory stance. This means that in every country regardless of its social system, political participation and economic activity, health care financing policy must be enshrined in all government documents and proper issued declarations and / or resolutions. This is not to draw the line under the limited financial resources needed for the health care, but also provides a concrete answer to the question, who and how the paids or distributed among the various socio-economic groups, or users of non-users-health care. Consistent health policy or policies of the real allocation of health resources must to reflect systematic prioritization that apply not only to health, but also on his other complementary sectors. Financial policies in the health sector is a powerful lever that individuals, groups or the whole society relies on, and to take care of those who are fortunate within our own community has not smiled enough.

Health, good or bad is not a consequence of individual choice, but it is a premium value or unwanted state, which largely depends on the influence of political, social and economic factors, and global conditions in which people own it. Access to quality health services that can and must be counted, determine first, the right to comprehensive health care and second, the obligation to protect and promote health which further strengthens its social and economic dimensions. According to the final report of the World Health Organization (WHO) on the determinants of health (20), says that the poor health of the poor in particular categories of citizens among member countries of the European Union, is the result of unequal distribution of power, expressed social and health inequalities, imbalances of income and lack of quality goods and services at the national and global levels. In addition, many, visible to the naked eye and inequity circumstances, directly cause unequal access to health care, school and educational facilities, an adequate working environment and conditions for use of leisure time. No matter how thinking about the health of the people prevailed in the European Union, it is clear that citizens in some member states are not able to organize on your way prosperous, and life for their families and to adequately protect

and improve global health. Many of them did not have, and many will never have, promising chance to live in appropriate environments, decent housing, the regulated communities and cities clean. So we should not lose sight of how much risk people in many member countries of the European Union, must be calculated.

Politics of health care financing includes a range of functions, procedures and measures focused on the acquisition of resources necessary for comprehensive health insurance. It includes adequate volume of the health care, equal access to health services, technology, fundraising, distribution and allocation of fair and rational use. Famous scholars (McKee, Mossialos, Belcher) had no dilemma when they put ahead of all functions within the health services the function of collecting funds and their association. They knew that with some risks, this function tends to smooth the provision of adequate conditions for the provision of care to the population health who is considered the safest and universal resource (13, pp. 263-286). Financing policy in the Member States of the European Union is seen as the most vital part of health policy, because she only in the spirit of the legal rights of rules directs the necessary funds for their own satisfaction in the field of health insurance.

Aim

In each country-member of the European Union funding of health care is implemented in order to improve the health of their citizens, and mainly involves the function of collecting taxes, contributions, proceeds from the sale of health insurance and income from other sources. National authorities of each Member States of the European Union, joined the collected funds for the intended health funds (14, pp. 179-189). Pooling resources is linked to the risk that is always lurking somewhere. He is a permanent obstacle to improving effectiveness and reducing the uncertainties that are related to health insurance coverage and the right to use health care services under the same conditions (2, pp. 101-106). From an economic perspective, in relation to the above-mentioned means, it is important to bear in mind that health care costs are constantly increasing, and that spending on health protection from gross domestic product (GDP), although different from one country to another member, always moving the bar up.

Health care financing in the European Union

The function of financing health care in member countries of the European Union as no other known function, determines the overall quality of health of their citizens. At first has a very significant influence on the creation of anticipated benefits for the timely availability of health services and to ensure equal treatment for the insured

in all kinds of medical procedures. Health care financing and sustainable means permanently securing the necessary funds from the available resources at all levels, regardless of their exposure to various influences of political, economic, social and technical factors. Ensuring the sustainability of these resources is always the first goal, however, the promoters of health economics in each country-member European Union, are fully aware that only a continuous and sustainable financial resources are guarantee for the smooth financing of health programs and goals. Since health policy otherwise resembles the chain, its connective link in the true sense of the word, represents a certain events. Every each one of them is virtually tied for the election, determination, a clear formulation and methods of implementation of health goals and programs, or to prescribe the specific measures for their final realisation. In this regard, in terms of a serious understanding of the importance of this issue, the World Health Organization (WHO) (30) was founded in the 1984th, to promote the concept of Program Budgeting *(Budgeting-Programme),* implemented in the programming of the goals of health development, and budgeting according to the adopted priority health development programs. Interestingly, this program was adopted in the member states of the European Union, but also in the other countries of the world and in Europe (24, pp. 37).

Resentment of certain groups to collectively pay for subsidizing health care costs for others, day after day, especially in the poorer member countries of the European Union, increasing the resistance to the regular payment of taxes and / or contributions. Where the central authority for awarding grants to local governments or local health authorities, as a mechanism are using the local taxes and contributions (Denmark, Finland, Italy, Spain and Sweden), there is a big responsibility with regard to the obligation that lies ahead in raising funds that finance health facilities. Allocation of subsidies is a process that is mostly a matter of political debate after which follow a decision on the allocation of funds to poorer regions to ensure equal access to health care. As social security contributions are concerned, they collected the central government institutions (Belgium, Bulgaria, Estonia, France, Latvia, Netherlands, Poland and Romania) and collected in that way represents their own resources directed to health funds and held for financing social security (16, pp. 109-116). In some Member States of the European Union (Austria, Czech Republic, Germany, Greece, Slovakia) are provided mechanisms by which they try to avoid problems in raising funds for the emergence of various forms of risk. These mechanisms support the implementation of the realisation of ability to collect taxes and social security contributions and significant impact on finding opportunities to generate safe and sufficient funds to cover health care expenses. For example, Estonia solves this problem by shifting the responsibility for payment of the Health Insurance Fund of Estonia *(EHIF)* to the central government's tax collection agency. In 2009. in Germany contributes are centrally positioned and integrated into the new National Health Insurance Fund, so it already in 2011. became responsible for the timely payment of contributions.

However, despite the application of these and similar mechanisms, there are many examples where financial policies, especially in the last few decades, the newer member countries of the European Union, just drowning in the aforementioned problems. Whenever it's brought the debate on financing health care in member countries of the European Union (and beyond), inevitably it operates with the term priority, so it is advantageous to explain its essence and the reasons why so often is emphasized. Many theorists are prone, when it comes to financing health services, that as the reason for the priority of the term, as well as action often mentioned, to indicate poverty of the people more in peripheral than in developed countries-members of the European Union. Solving the problem of poverty inherent in peripheral countries-EU members, especially those from the group PIIGS (Portugal, Italy, Ireland, Greece, Spain), requires prior specific moral urgency and / or severity than making decisions about priority. Since there is a duty to provide adequate health care, making decision in accordance with that, is a support for it's beneficiaries, and prevail over the priority of urgency. Therefore, the urgency is, and as a term and as a practical fact, in supremacy in relation to priority. Therefore, as pointed out Douver, rather than to say the urgency of priority, because the idea suggests that priority should be establishing of some order in degrees of adverse conditions, with the easy chain access to the first one, then another one, and so on until the final situation (3, pp. 393-407). However, this is not always the safest way to determine or to be determined by the concept of health care for the rehabilitation of adverse conditions. It should be on the mind that opposed of that is a variety of aggravating circumstances. For example, one of these conditions is related to cost effectiveness and the cost of emergency of providing timely protection to human health in all segments, especially in finance. But that's not the only reason why is in relation with the financial function, much grateful talk about the urgency of the priorities.

Health care financing policies in most member countries of the European Union depends on the urgency of finding the right skills and solutions that provide secure resources, professional service providers, equal and unimpeded access to health care to all users at the end of administrative efficiency. In most member states, publicly raised funds intended to finance health care, are consolidated at the national level. This means that there are a healthcare fund responsible for collecting, storing and distributing funds from contributions for health insurance. The Fund is required to obtained during the distribution of compensation money to the poorer regions and to reimburse the funds to poorer citizens and / or those with a higher risk of becoming ill. According to the World Health Organization (WHO) (31) in Germany during 2004. the 77% of health care is financed by the German government and 23 % is funded by paying premiums for private health insurance. The total health expenditure was 10.8 % of the value of German gross domestic product (GDP). The system of public (state) health care in Ireland regulated the health question of its citizens in the 2004th when he established a new body *(Health Service Executive-HSE)* that is responsible

for providing health care and social services to everyone who lives in Ireland (6). The Ireland in 2005. for the protection of its citizens spent 8.2 % of gross domestic product (GDP) or U.S. $ 3,996 per capita. Of these, about 79 % of health expenditures was covered by the Irish government (11, pp. 152).

Health care in the Netherlands is financed by a dual system which came into force in January 2006. year. Dutch health care system compared with the health systems of the United States, Australia, Canada, Great Britain, Germany and New Zealand ranks first by far. Contribution to this was the adoption of the General Law on Exceptional Healthcare Costs (25). For all regular (short-term) medical treatment, there is a system of compulsory health insurance through private health insurance companies (9, pp. 5-29). Insurance companies are required to provide a defined package of treatment for the insured. In 2009. in this insurance cover is 27 % of all health care costs. Other sources of health care are paying 14 % taxes, citizens pay out of pocket *(OOP-out of pocket)* 9 %, the additional optional insurance packages for 4 % and 4 % other sources. Accessibility to health services in both cases is absolutely guaranteed. French health system is a universal system in which health care is largely financed by a national government. In its assessment of world health systems in 2000. year, the World Health Organization (WHO) said that France provides the "best overall health care" in the world (29). In 2005. year, France spent on health care, 11.2 % of its gross domestic product (GDP) or U.S. $ 3.926 per capita. Costs are much higher than average level of the Member States of the European Union, but are much smaller than those in the United States. Approximately 77 % of medical costs is covered by government health agencies that finance consumption. The expenses of health care in Spain in 2006. amounted to 8.4% of gross domestic product *(GDP).* They have per capita for 2006. year amounted to U.S. $ 2.458, which is less than the average OECD level, which is $ 2,824 U.S. (18).

Raising funds and importance of private health insurance

All member countries of the European Union for financing health care are using contribution as a basic mechanism, including public health insurance (taxes and social security contributions), private health insurance *(medical savings accounts-MSA)* and payments from their own pockets *(OOP-out-of-pocket).* So it is a direct payment for health services not covered by compulsory health insurance, cost-sharing (user charges) for services covered by the package's covered by compulsory health insurance and at the end of informal payments. Large changes in health care financing policy in many Member States of the European Union followed in early 1990's. Then gathering funds were transferred from the field of taxes, contributions to the field of social security which has become the dominant mechanism not only in member countries of the European Union but also in those who are not, and are located in Central or Eastern

Europe. Research shows that in many Member States of the European Union, health spending as a share of total public spending has been declining since the end of the twentieth and early twenty-first century, causing amazement but does not change a thing. Why? First, an increase of gross domestic product (GDP) in many Member States of the European Union is very elusive, secondly, in many of them their fall is a chronic phenomenon and third, although the percentage of expenditures for health care has increased significantly, it is not attacking seriously the integrity of the gross domestic product (GDP). It should be noted that, there is a small number of countries in the world, and therefore in the European Union, that on behalf of health care stand just over 6% of its gross domestic product (GDP).

The results of these studies on private health spending showing, that the direct payments *(OOP-out-of-pocket)* largely contributed to since 1996. year onwards, the total health care spending is growing continuously. However, up to date records and reports relevant authorities ignore or deny the above allegations, as in most member countries of the European Union, the expense of private health insurance do not exceed more than one third of total health spending. Private health insurance has little impact on the growth of health spending, so it is not and can not be helped, at least not to a greater extent, a contribute to its significant increase. Increased its influence in the health expenditure is very possible, in more recent member states of the European Union (Lithuania, Slovakia, Romania, Bulgaria), but very rarely in some of the older member states. On the contrary, a large number of scholars, experts in health economics believes that private health insurance policy holders guarantee unimpeded access to health care or access to the same level with those who have other insured. Under the same conditions at their disposal are all the health resources in accordance with the acquired rights in the domain of private insurance. Therefore, the governments of member states are forcing public health insurance, establishing national funds for its financing and encouraging the increasingly sharp competition among the buyers of its services. It looks like a good incentive for buying the services offered active in the field of private health insurance, however, there is concern that because of the risk that arises in the selection and purchase of health insurance, the costs might outweigh the rights of beneficiaries of compulsory health insurance.

The examples of Germany, Belgium, France and Slovakia (1, pp. 4-5) show that the decision on the selection and purchase of private health insurance is not an easy task, because an experiential purchase arrangement is the norm of experience and always warned of the danger of risk. The risk in all forms, inevitably weakens the incentive and interest in the offered package of services in the field of health insurance and regardless of the applicability of mechanism intended for its removal, it can be successfully eliminated. Offer scope of private health insurance in the health care services is an operational function of provider and strategic step towards the appropriate resources. Advocates of private health insurance drew attention to the discrepancy between what is currently spent on health care and what may be needed

to be spend in the future. They do so with the clear intention to draw the attention of prospective clients, that the only way to overcome this problem, their greater reliance on private funding of health insurance. In contrast there are those who approach this question by opposing him in public (state) funding of health insurance. McKee said that in some Member States of the European Union informal payments instead of a formal cost sharing has become a challenge for the implementation of health reforms (13, pp. 263-286). In the worst case considered Ensor and Moreno, this payment can be a form of corruption that could undermine official payment system which leads to a decrease or lack of access to health services. According to them, private funding of health care in relation to public funding, undermining the value of the health system and represents an attack on the poor. Centralized systems of raising funds, they say, have a better chance to enforce collection and generate more revenue than the systems that contribute to the health needs of individual funds collected (4, pp. 106-124).

Grosso modo here we have identified two broad trends of health care reform. First, many member states of the European Union have made a significant step in promoting equal access to health care customers, and expand the range of health services. Prevalence is reflected in greater coverage of the insured, the arrangement of the legal status of private health insurance carrier, the improvement of technology sharing health care costs and a strategy of allocating available resources. Second, was thrown more light on the provision of quality health care, also is emphasized its importance and practical value in relation to unemployment. Increased use of quality health care encourages the purchase of health insurance and daily improving and simplifying models of payment of medical services (28). In accordance with the above, the price of health services that are either motivation or demotivation in the choice of insurance and payment must not be ignored. In many Member States of the European Union, the cost of health services has fomented desire, to instead a formal division of health funds, supplement the cost of informal payments and further called for health care reform.

The availability of health services

The availability of health services World Health Organization (WHO) (31) defines as a "measure-the percentage of the population for their own purposes freely provides appropriate services." Equal access to health services means that adequate supply is closely related to their cost, acceptable species, physical presence and direct contact between their providers and users. Unimpeded access to health care in member countries of the European Union is strongly determined by socio-economic status of their citizens. Many citizens (secured or unsecured) due to unavailability of appropriate forms of health care can run into a competitive disadvantage and, that necessarily make them to belong to one of the vulnerable or socially disadvantaged

cathegories. The European Union has a great variety of vulnerable groups who may experience unequal access to different type of medical services (23, pp. 43-55). Vulnerable groups are deprived of any, not only for equal access to health services on what they are talking bad experiences, but still present an insurmountable barrier. Vulnerable groups include mostly members of various ethnic communities, people with physical disabilities, chronically ill, unemployed, homeless, immigrants, refugees, asylees, people without valid documents, the elderly and women. Devastating is that in this series of obstacles, each of them can prevent, for example, women, infirm or children to enjoy their basic rights to health care and quality health services. Some theorists (Huber) believe that these obstacles arise under the influence of many factors within the health system (8). By the way it is about the specifics and gaps in health insurance coverage, the scope of public health benefits, the division of payment, geographic factors (distance or lack of infrastructure), organizational factors (waiting list and hours), or the lack of-the inadequacy of information. In addition, it's the product of the factors related to characteristics of users of services, income, education, age, language, disability, sexual identity, cultural heritage, civil status and the like.

Access to health services can be viewed in two ways. First, as significantly limited because it deprives members of certain social groups in the total health care and second, as inappropriate, because even as it is available, health care is often not adequate to meet the needs of citizens. This indicates important differences in health status between populations of the member states of the European Union, and the conclusion that they are a result of close correlation between social and economic status. When the distribution of health meticulously observed adverse experiences, it should be pointed out that a significant number of them, regardless of the initiating inequality in no sense is not a natural phenomenon. They can be, and they are, firstly a result of poorly managed health and social policy which is reflected in an unrealistic setting, the adoption and implementation of health goals and programs, through the conclusion of unfair economic arrangements and the creation of socio-toxic combination. In this regard the opinion that the social determinants of health and the environment in which life takes place, are the great enigma in the biggest extent responsible for the pervasive health disparities between citizens of member states within the European Union. Universal access to health services, although in many ways typical of the health systems in individual member countries of the European Union, is the main goal of the long-term aspirations of their citizens. How much the principle of universal access to health services is as an important goal, shows us not only because he is explicitly stated in the constitutions of many countries-EU members, but also that is included in the Charter of fundamental rights. In Article 35. charter of Fundamental Rights states that everyone has a right of access to preventive health care and the right to use medical treatment under the conditions established by national laws and practices (15, pp. 184-186).. The authority that has a mandate, should direct the medical care

and put the contest to human health and to facilitate the promotion and improving access to quality health services.

World Health Organization (WHO) (20) recommends that primary health care should be a heart of every health system. In addition, the inclusion of more specialized health services such as sexual, reproductive and mental health should also be taken into account as much serious as possible. Access to health care services for a very long time is beyond traditional therapeutic frameworks and standards. Therefore, it's completely logical the strong encourageness of private health insurance, that in many member countries of the European Union was not sufficiently developed. In some Member States this issue is explained by providers-insurance agents who didn't always have the possibility to, with the available forces and tools, encourage level, that is certainly important, even strategic shoping. It is believed that the purchase of services that covers on large extent, would determine not only its economic and fiscal sustainability, but that would be the same and with the other types of insurance. Health care reforms are often not carried out properly, which constantly emphasized the need that many important details must be done more precise. First, in the context of linking the performances of paying and quality of health services, it was necessary to find appropriate mechanism to measure the ultimate outcomes. Some countries have made great efforts to expand health insurance coverage of the population and achieve the final results – almost universal coverage. However, as much as important the universal coverage, it is also important its depth and its scope, especially if it is well known that they significantly undermine the financial coverage of health systems. In some Member States of the European Union has become a trend, reducing the scope and depth of universal health coverage (12, pp. 172).

Global science has many standards recently put *ad acta*, and orientation to a broader approach to health is possible only through its specific promotion and quality over a wide range of different health services. The promotion of quality health defines all kinds of activities that people provide Increased control over their own (and others) health. Under this standard we mean, the provision of resources to finance health services, housing, food security, employment and quality of the environment and working conditions. This statement focuses every day more and more on necessary realistic estimate of available funds, without which there is no question about the desired accessibility to health services. They are for the most part, permanently dependent on the extent of available funds. Rating of available financial resources, allocated for the financing of primary health care is important from the standpoint of looking at the real possibility of its full realization through the timely provision of health services according to established standards. In addition, it is necessary to consider the portion of funds allocated to intermediate and central levels of health care or resources that go to expensive and less accessible health services that are missing to a large number of poor citizens. When we speak about universal or near universal coverage of population with health insurance, in most member countries of

the European Union it reaches a fantastic 98-99 % of the total population. Germany on this issue is an exception (5), because there is the legal coverage of about 88 % of the population. The most common basis for getting the right for health insurance and health care is staying in these countries.

Universal health care coverage

Health systems in the European Union is different (21) from one country to another member-country. The following legal doctrine of national health systems in the European Union is mainly divided into two categories. The first is the National Health System *(NHS),* which operates in many countries of the European Union member states (UK, Italy, Spain, Portugal, Greece) (7, pp. 21). Health care for the covered insured is financed from a provided tax, and the percentage of coverage is customarily high, and up to 99 %. The second category is the social security system which includes mandatory health insurance for all citizens or certain groups of citizens. Their connection with the Fund for health insurance is mandatory. For example, in the Netherlands in which the social security system works flawlessly, all residents are required to enter into contracts with private insurance companies. French health care system is a paradigm, it's an example of how one country should function in the social security system. His nature was defined by reforms in 1998. that significantly changed the overall health environment. Social security contributions have become the dominant mechanism for the collection of funds intended for financing the health costs of French citizens. Driven by changes Economic Council in 2006. adopted (19) a Declaration on common principles and values of health care systems of member states of the European Union. It literally points out the common value of universal coverage. It wouldn't be desirable that any of them remains outside the established framework or that may, eventualy, hampers the access to health care, or denies anyone the right to health insurance.

In its Strategy "Together for Health" (26, pp. 5), adopted in the 2007th , the European Commission pointed out the importance of universal coverage. Accordingly, Article 35 of the Charter of Fundamental Rights of the European Union stipulates that everyone has the access right to preventive health care, and the right to use medical treatment under the conditions established by national law and practice. Universal health coverage is the largest value in European legislation, and is defined as an area in which to the people is given the unrestricted access to all forms of health care. Health coverage, however, is different among the member countries of the European Union, as well as the benefits of citizens to enjoy it (27, pp. 47). Given that the difference has to be, it is certain that all member states as one believe that it is necessary that all the inhabitants have the right to a minimum level of health care, and benefits from provided-recieved health care. As a powerful tool that guarantees universal coverage and

financial support for health care of its citizens, the member countries of the European Union use financial subsidies. Subsidies can be questioned only if their assignment violates the Article 87 of the European Commission (10, pp. 232-233). Otherwise, it is certain that the interests of health care are regulated by applying positive rules that are respectable in the area of giving state european health. Community courts and the European Commission deal with the regulations of the Treaty of state help that are aimed at universal coverage to be integrated as it ones was prescribed. The realization of this objective will contribute to greater respect for health protection and health care, and more power will be left to the national authorities in member countries of the European Union. The agreement states that to the national authorities is left a lot of jurisdiction and plenty of space to intervene when it is required financialy, and to guarantee the access to health benefits to their citizents, and to promote universal coverage.

Responsibilities of Member States in the field of health care as the Lisabon Treaty provides for the obligation, are to include national authorities and allocate all types of resources athan can be useful for providing adequate health care in accordance with the level of universal coverage. What role in this case may play a universal coverage shows an example from Spain. Community courts have decided that the national Spanish health system *(NHS)* is a company, because it's financed from the social security contributions and funds from other state funds. Thus, health services are free for all persons associated with the fund for health insurance on the level of general coverage. The example shows that the principles of solidarity in health care and universal coverage are closely linked and that the principle of solidarity often leads not only to a redistribution of wealth, but also to a transfer of financial resources from healthy to unhealthy individuals. Finally, the definition of universal coverage is very simple, because it's about access that makes all kinds of health care and all kinds of benefits that derive from it, absolutely provided for all categories of citizens. *Prima facie*, the argument for universal coverage serves as the principle of solidarity that conferms the fact that it is something of general interest, which means that is the supreme value and general public good.

Conclusion

The intent to perform after all the real conclusion is justified by the thwarted dilemma, is there in the Member States of the European Union the optimal method of financing and providing of the full health care? Based on available information,it can be argued that, it exists when it comes to financing of compulsory health insurance that is widespread and even more superior from the other forms of insurance. However, no one knows until when will this supremacy last, if we look the current trends, everytime much poorer health vault decline in gross domestic product *(GDP)*

and more expensive medical procedures. Public financing in general contributes to a thorough and effective delivery of health care regardless of risk as a result of the disease picture of the insured. It has a particularly large impact in providing and grant funds in accordance with the needs, but much smaller effect on the solvency power of the insured. Health systems generally provide a high percentage of health include at compulsory insurance for customers who primarily covers preventive public health services, primary care, specialist outpatient and hospital care, prescription drugs, mental health care, dental care, rehabilitation and home care. In all Member States there are areas on which tolerance is covered by compulsory health insurance, and depending on the type and scope of health services, it may be required a cost-sharing. In addition, in some member countries of the European Union might exist a gap between what the insurance covers formal and official, and attending events that should be funded in everyday practice.

Contrary to the public, mandatory health insurance, private health insurance is recognized by the fact that the conclusion of contracts with clients, prospective insured, eliminates the risk of his poor health folder. Also, private health insurance is much more superior than the public (compulsory) insurance in the management of public finances. It demonstrates that supremacy through a secure payment of health insurance premiums by direct billing and revenue from health services. In addition, it provides a secure income through strategic procurement and on the basis of reduction of administrative costs. The references of this form of health insurance at first sight guarantee a high degree of economic and fiscal sustainability. But there is a long side of the coin. The danger to which is exposed a private health insurance is linked to the eventual deterioration of the health-insured citizens, and increasement in health expenditures due to its restoration. In addition, evry day there is much more present fear of falling member-countries of the European Union in the debt crisis (Portugal, Italy, Ireland, Greece Spain-*PIIGS*) (2, pp. 101-106), due to a slight impoverishment of citizens and their day to day less purchasing power. It will adversely affect private health insurance funds. Since it has not spared any mandatory health insurance, so it must be seriously reckoned to reduced access to health services and less health coverage, which means that universal coverage is seriously in question. Equal access to health services will be further aggravated by all the citizens for which the financial solvency does not guarantee the adequate health protection. In such circumstances obtaining money or techniques will not be meaningful, and health funds will become empty.

Many member countries of the European Union, especially those from the periphery in which the increasement of healt expenditure concerns both sides, citizens and the relevant authorities. A good example of this is Italy (17), where the health care spending in 2006. took part in the gross domestic product *(GDP)* to 9.0%, which was about U.S. $ 2,600 per capita. Of these, about 75% was spent on mandatory health insurance provided by the Italian government. Only three years later, in the 2009th

year, total expenditures for health care reached 9.5% of gross domestic product (GDP) or U.S. $ 3.027 per capita. Thus, the Italian health care spending is above the average of OECD countries, which amounts to 8.9% of gross domestic product (GDP) (18). According to quality, which is very important for comparative analysis, the Italian health system in the world ranks with a very high second place, behind France.

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