

Snezana Maric - Krejović; Ibrahim Totić\*

## **FINANCING OF HEALTH CARE NEEDS AND CALCULATION AND PAYMENT OF HEALTH SERVICES**

**Abstract:** The classical understanding of health care and health services in the last few decades have significantly changed. This was mainly contributed new scientific knowledge. World Health Organization is far 1978th in Alma-Ata established strategy "Health for All to 2000. The "where the primary health care is accepted as a universal commitment to provide health services. Extensive experience in the scope of work based on classical medicine, which often viewed the man as the object of his action, showed that it will not long be able to precisely without the need for classification of health and financial support to provide quality health services. Missing support that enables a productive social and economic life in which the association will be balanced physical, mental, social, moral and spiritual condition.

In the world even in our country the permanent growth of population illness, accidents and death that cause particular diseases non infectious modern age. Among them is dominated by cardiovascular diseases, malignant neoplasms, diabetes mellitus and other disorders and accidents. Therefore it is recommended that when considering the needs in health care always distinguish between those that are purely medical and those related to health care. Why? Because pure medical needs met through services that provide only Highly medical workers whose work is specified and standardized laws that apply in health care. On the other hand, the needs of health care that primarily no related to the quality of life and promote health, meet within certain social and not always medical subjects. At their meeting there is always a disproportion between the demand and opportunities and is constantly engaging necessary only highly or strictly medical workers.

Any engagement of human capital (human resource) in the health field is focused on providing certain kinds health services. Health services

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<sup>2</sup> Clinic Arilje; State universities in Novi Pazar

medical aspects of the act of creating a direct, public, or discrete, and based on se medical cret contact between its providers and users, and determines the type of health care. The sociological aspects of health services represent an attack on a certain budget, and with the financial revenue of health care institutions, but also an expression of public spending for each of them has a financial value. Financial health practice knows more ways to their billing and payment.

## ***INTRODUCTION***

Degree first contact between the individual and the health care system in the field of primary health care in which health services for users to enjoy and provide health care workers. Health services are reported determinants of health needs, where every individual or collective aims to help them with the appropriate executor or certain health teams meet in the way the subject is provided how established standards. All types of health needs meet is rarely direct and indirect contact with health workers and community that typically operate a team.

Health needs and health services are differ depending on their providers / users. The differences are sometimes large, which depends on the level of different approaches in evaluation of development not only health but also the global, or economic-political and social system. Besides health needs differ and the ways and possibilities of their satisfaction, the reasons that led to their emergence and whether to meet the medical care or their satisfaction possible in health care, which directly determines the types of services that should enable their satisfaction. The modern demands, provoking different needs and prosecute people in their use. Methods of meeting health needs and the way health services are intended to democratize the field of medicine, without which people can not exist.

Problem of public health to deal with everyone, not just doctors, said Andrew Stampar (founder of the first health house in Vukovar 1923rd year). Medical science would not have made sense to its services that provide health care workers do not derive from the needs presented by representatives of the people. It is actually based on cooperation with the people he is also subject and object of the medical and health care. Today, often the question whether the World Health Organization consistently perform its tasks set by the Constitution passed in more at the international conference which was held in New York back in 1946th year. Implementation health care involves satisfying health needs through direct or indirect provision of health services. This process requires a strong mobilization of all forms of assets relating to health. However, in many areas of health needs are neither precise enough nor are adequately met. It is believed that the failures of government policy primarily of certain countries that are considered to develop a permanent health only accessory goal. It would be extremely useful (recommendations to governments) based on the stated needs, as an expression

of their political commitment to improve access to some government health care, to examine the possibilities increase funds for health resources allocation, to encourage and support various ways of financing and providing health services and to perform connecting sectors with the sectors that need them to meet the health care services.

### ***Aim***

Defining health needs and funding opportunities. Consideration of the model used for calculation and payment provided / used health services.

### ***The determination of health needs and their financing***

World needs is unlimited, endless, and resources every day less and poor important. This finding compels a man to Economists and most rational searching for methods to satisfy them. The need is strong motivation and desire for something to which a man stopped for something which for him is a useful feature and something in his life he attaches great importance. Each has a financial need in the preparation of any particular program or at the time of their meeting. It is believed that the psychology of the first scientific discipline that has begun to seriously deal with the phenomenon needs, defining them as stopping no satisfaction and increasing pleasant feelings and a sense of necessity for removal of deficiencies. Alexander Maslow his theory of needs based on their hierarchy and the degree of satisfaction that occur as urgent and watching them from the standpoint of higher and lower, **ie**, the structure of the needs of developed and undeveloped world. According to R. Musgraveu needs are...the mother of all inventions and are not possible without the work on the development of consciousness...and coming to a state of comfort is not all equally possible.

Economic and medical science are quite late defining needs. However, one can not ignore that any definition wherever came intentionally or accidental, postulate a priori economic and medical standpoint. Nikola Rot says prejudiced man as being immanent biological needs, man as a social being immanent in social need. Given that this is a very close definition of the attitude of health sciences, it is logical that she classified them according to priority, accidental occurrence and intensity of subjective integration of human and social beings. The needs of the health system is defined as experience disabilities or disorders and perceived as a real organic defects or bodily requirements. Just a moment away from financial requirements. To repeat, is an important aspect of the medical priority of needs satisfaction, but even a little less important financial aspect.

Will we be able to in the domain of health needs and their health services present large chains and to create substantially different, humane and historical features

depends on which we have with the concept of action and priority chosen. What is the strategy of development and financing of health care, which are technological opportunities and challenges prepared by modern medicine, if it is known for its resourcefulness never have enough financial means.

What we should not forget is that all the access needs and their satisfaction in the concepts of medicine and financial policies partially overlap, although often not **istosmerno** movement. It is a conflict with the scope of the health needs of both medical and financial aspects. The needs in health care are determined together users health care services and providers their. The first condition for planning health needs and their Funding refers to the demographic structure of population (age, sex, educational level, social characteristics, working career, the possibility distribution of health care in a particular territory, etc.). Health needs are determined on the basis of direct and trusted information about the overall disease, the overall state of health and population data vitality type. In addition the structure of health needs and social factors determine the working environment (housing conditions, diet, working conditions, communications, etc..) As well as other elements influencing the development of certain standards.

Ecological range of factors has recently expanded. Water Supply, Disposition of waste water and waste things, air and other elements and how you determined the structure and scope of health needs. Finally, the economic crisis was visibly shaken every pillar on which rests **health** and social insurance. Some of them have endured rush of the crisis and fears have already collapsed. Will be held and for how long, Bismarck model and the model of the National Health Service (National Health System) which architect English lord, economist and statesman William Henry Beveridge? All models have the opportunity to compulsory social insurance do not have the light of the perspective. However, it should be a short wait as the Far West, Barack Obama in the war with the Republicans vying for the introduction of compulsory health Insurance that more than a century exists (and is slowly disappearing) in Europe.

### **Method of payment of health services**

Economically and providers and users of health services are aimed at better interest earnings in the system of providing health services. To **bu** it could have decided for a strategy that allows them the following:

- 1) increase the number of health services,
- 2) prescribe the number of drugs required for the acquisition of affection insured
- 3) do not accept patients whose case requires long and expensive treatment,
- 4) unnecessarily repeating the search and examination and
- 5) exploit expensive and superfluous equipment.

At issue are the preferences of individuals or groups, but it was a warning and suggestions for avoiding excessive and unnecessary costs and harmonize the interests of providers and users of health services. The method of payment of health services concerned them in the present health-economic practice any more but next particularly important.

**Pay-per-service** - includes charging each of health services directly from the patient or indirectly by sending invoices to the competent health insurance. Rates of health services were established when the price list approved by the competent authority of health insurance with the consent of the Ministry of Health. Prices expressed in current work include the amount of medical personnel, material costs incurred by providing services, depreciation and other medical equipment and rental costs (eventually) and services by third parties and the like. If health insurance has limited financial resources, and when that does not have the ability to control spending their, to say the least should avoid this form of payment. The negative side of this *modality* are that, as the overproduction health services everyday practice. Here then the low level of professional services, shortening the working engagement, and all together it seems that this model also the most expensive or **najneisplativiji** insurance but most effective for billing services. Complicated the administration is a particular problem. Because of the accumulation of invoices and other documents often affects the validity of the medical procedure, but also because of the high amount of incoming invoices.

**Pay-per case** - here is the entire treatment of paying the single price, regardless of the number of procedures (search). The model is too destimulations for cases that require complex testing and long-term treatment. In close connection with the diagnosis of disease. He is the reason for the adoption of a detailed diagnosis of the list with average prices that include medical work and material costs. However even modified failed to correct the problem that most related to the diagnosis and treatment of complicated cases. Equally it is used in out-hospital and hospital services. While there are advantages in relation to the payment of the service, because it prevents the "overproduction" of services, and it has flaws worth attention. Use the expression of patients with severe diagnosis and condition than the reality, the charge is non-existent procedures and services, reduces quality services in general, reduces the engagement, the use of materials and the like. Especially destimulation of receiving serious listen.

**Pay-per insured person** - This method of payment of health services involves covering the entire cost of health insured persons in a certain amount for a certain period of time. Usually operates with one calendar (fiscal, business) year. It is based on an assessment of the expected use of health care in its certain types and certain types of health institutions. Applicable how to out-hospital and in hospital services. Usually, in applying the so-called, double capitation - payment per insured, especially for prevention, especially for hospital treatment. The primary health protection contract is concluded with health care facilities, and if such then there is no individual with

a physician who is insured knowingly chooses. Determination of selected doctors in hospital services is complicated because it involves the conclusion of contracts with a physician, for example, employed in the health institution whose headquarters hospital to another territory, or outside the parent's insurance.

Price calculated is based on estimated medical costs of labor, wasted materials and other elements, and so the resulting amount is divided by the number patients in particular health institution. To maintain the quality of service are usually received reduce number of patients. Capitation has advantages for donors and recipients health services and insurance. Stimulating in the implementation of preventive work, in the early detection of disease, treatment timely as a result of disciplined and complex procedures of examination and treatment. Insurance is also an advantage. No uncertainty in the total funds that will be engaged to pay for services performed. Administrative jobs are small scale, are not expensive or complicated. Change the insurer by the insured is possible after the expiry of one year which takes effect the signed contract.

**Payment of salaries and by providing material costs** - includes download obligations that provides insurance to pay contributions for health care workers and material costs that are included in rent, fuel, etc. handling funds. Typical for systems in which health insurance owner health institutions and health workers in health care are employed with insurance. When health insurance is not the owner of health care institutions, then gladly accept this model of payment because it has complete control over spending and other flows of funds. This method is destimulation for health workers who are paid regardless of working effect. The system hides many weaknesses, such as long queues in waiting rooms, careless and indifferent attitude towards infected health care workers, **protekciju**, use "links" to avoid waiting time, bribery and corruption; designed scenario providers or their intermediaries-the people from the shadows or other plan.

**Budget payment method**-based on the contract at a certain amount of money that is paid by the health institution or individual physician. That money to cover all costs incurred within the health care that are realized in a period of time. Healthcare institutions that make such an agreement shall bear the risk of a possible deficit, but could achieve a surplus (excess of revenues over expenditures). Health insurance in this way may be to pay larger amount than the actual costs. The contract may provide for adjustment clauses and contractual amounts for extraordinary circumstances to receive an epidemic, pandemic, and the like. Methods of payment services is applicable to all health care facilities other than pharmacies. In them, the number of prescriptions issued depends on the doctor and therefore can hardly be precise *ex ante* to determine the appropriate amount. Budget payment method showed good results in terms of reducing the growth of total health spending. Noteworthy, however, and negativity that is primarily manifested savings on medicines and medical supplies to safeguard the larger volume of funds for payment health staff (salaries) and for other

purposes. We noticed the negativity can be eliminated only competition between health care institutions.

**Pay-per-day hospital** - is only used in hospital treatment. Price contained patient on all charges, medical supplies, shelter and food, ie, (medical and pension costs) and always the same regardless of patient diagnosis and treatment. Calculated by the total hospital costs from the previous period, the division of the number of hospital days in the optimal utilization rates beds capacity is 85%. Price adjustment may be corrected with expected inflation, or adding funds intended for investment in medical equipment. Correction of the regular price, and may be imposed when it comes to prices of medicines and medical and other inputs. Only difference in price may be due categorization hospitals in relation to their departments. Administration is simple, cheap, and the only problem is that the reduction of costs affects the overall quality of health services (treatment, housing, nutrition, etc.). Prolonged treatment, patients receiving light and the like. are very frequent, and with it very negative phenomenon.

### **Conclusion**

Mentioned modalities of payment service providers may have their advantages and their disadvantages. In recent times, therefore, in the last few decades, have created problems that adversely affect the quality of health services. Present other than the waiting list, disorderliness supply supported by long and unnecessary procedures for the implementation of large and small purchases and respect for noble legal provisions. On the other side is very weak and insufficiently generous materiality party insured, users of health services. Particularly striking double system (*Double Health System*), where certain services are provided / used in a health institution which is not disputed, but he continued profitable part of the same doctor but in his private practice. It is a problem that can not be any form of payment to eliminate, even capitation condition to be applied as the leading method of payment

It would be inappropriate and non long-term practice that, for example, a health care institution to be paid to the service and its employees are still based on the specified collective agreement. Methods of payment service provider is responsible and serious work and during the application of a model should take into account who is paid to the system.

The primary health care, introduced to the line method of payment of health services a large number of countries started to apply different models. Lately, the most mentioned model of capitation (Italian capita) which means head, pay per head, poll tax and the like. The model includes the possibility that doctors, their contributors and health care facilities use to charge their income by the number of persons oriented the insured who knowingly choose your doctor and the type of health insurance. For every person who is registered, a doctor (medical institution) receives capitation and

a certain amount which should be fully secure and consequently provide all health services in the domains of soybean activities .

Selected forms of payment service providers have a major impact on the overall state of health care costs and therefore must be conscientious and responsible elected and enforced. The real way would be the one and only one, which can enable the realization of the objectives of the available financial framework. No less important are not the standards and norms as well as the nomenclature established health needs. The fact is the basis for planning health protection. Only on the basis of postulates so collected may be realistic to plan the scope and types of health services as well as parameters for their evaluation and for determining the price health protection.

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