Mirza Totic[1]

THE REVIEW ON HEALTH SYSTEMS OF SEVERAL EUROPEAN UNION MEMBER STATES

Abstract: *The paper deals with issues related to the functioning and development of national health systems in several Member States of the European Union (EU). The debate also includes the United Kingdom health system, regardless of its recent outbreak (Brexit) from this large family, as it imprinted a strong seal and left a deep trace in the European and global health sector. The main goal of the paper is to make a review on the creation of the necessary health personnel and its mobility, on financing of business processes and medical procedures and general problems that health systems in the European Union (EU) are facing on a daily basis. Health policy makers (for this occasion) in selected Member States (Denmark, France and United Kingdom) are working continually to find the best solutions for their inhabitants to have a quality health and the ways in which the latter will continue to exist in the same condition for as long as possible. Unable to find adequate solutions, healthcare workers in many European Union Member States consider that the functioning of the health sector in general is less dependent on the way of obtaining the necessary financial resources, their amounts and sustainability of sources, and considerably more from the globalization processes that, as hurricane disrupt systems (inadequate and professional staff) without legal and economic-medical facilities. Since the authors are not fully compliant with that statement, they pledge to the health policy makers to devote the greatest attention to policy of financing, human capital and its improvement and the elimination of health inequalities, especially in the field of primary health care. In addition to above mentioned issues, the paper deals the relationship between the public and private health sector, the possibilities for providing complete, non-discriminatory and adequate health care, forms of health insurance, and also discrepancies that are urgent to be eliminated in the best interest of citizens.*

Key words: *Member States, health system, insured persons, human capital, resources*

[1] Mirza Totic, Assistant professor in the Department of Law, Universitiy of Novi Pazar, e-mail: m.totic@uninp.edu.rs

Introduction

For the undisturbed functioning of health systems, each Member State of the European Union (EU) is obliged to define the national strategy, or a mantra according to which the modern health care should be organized in order to become an integral part of internationally integrated healthcare activity. The organization of the national health system in all its Member States is mostly left to healthcare workers and associates, but also to political and other factors that exert a usual pressure on the profession, to adopt decisions that at a given moment correspond to a political establishment. There would be nothing controversial in this, nothing that already is not part of the common goal (that the profession provides comprehensive, high-quality, timely and adequate healthcare), when political representatives carried out by the functions would not often imperatively demand from health professionals the behavior contrary to the profession. This is reflected in the process of the adoption of inadequate, enforced decisions, the establishment of unrealistic health programs or while taking the certain actions for which no adequate conditions have been created, for example, the installation of modern information technology and new medical equipment at all costs, or poor quality logistics. Until recently it was assumed that the fate in every health system in the European Union (EU) was exclusively in the hands of scientific medicine and that it has been hermetically sealed or highly elevated above the others. The role of outsiders has traditionally been reserved for other professions and occupations. However, in modern conditions under the influence of expansive globalization processes, the world has become one of the places where intensification of relations between individuals, institutions and organizations at the global level has occurred (26), which means that the circumstances have significantly changed.

Medicine is a supreme science which imposes the need to other scientific disciplines, activities, institutions and individuals, not only in the Member States of the European Union (EU), but also globally, for permanent and radical changes which influence will connect different societies to tackle human health together, as the universal human value. Many activities within the European Union (EU) have made significant progress thanks to the impact of medicine, but this does not mean that the latter has declined, on the contrary, it made many advanced steps. It is still the main pillar of health care and it will probably remain to do so. Since the functioning of health systems in European Union Member States depends on the available (firstly professional) medical staff that perform their tasks in a professional manner, the reality is that the basic goal represents the improvement of the quality of health care, but also the caution which always reminds on problems for which there are often no adequate solutions. The health system is social trait of each Member State of the European Union (EU). Therefore, they use their own professional strength, various policies and patterns, to regulate it at the national level as a scientific basis and safe refuge for citizens / insured persons within which they can protect and promote per-

sonal and other's health under the same conditions. (1) Since in the European Union (EU) exist different health insurance models, first of all, it needs to be answered on the question – who is a European insurer? Extracted from various directives, laws or regulations, the given answer usually will be that it is an ordinary person, a motor that launches all activities, to the person who treats and to whom is treated, or to the beneficiary of health services and the taxpayer of payment of taxes and contributions from which the protection and promotion of health is been financed. He is located in a health center and creates the necessary conditions for the protection of health of new generations, creating a health policy for the future, which must ensure undisturbed functioning and development of the health system across the European Union (EU).

The modern practice has offered a number of arguments on the position of the insured, which say more than any resolution, declaration or directive. The most convincing argument is that as the insured may appear any person able to use health care in the health service in any Member State of the European Union (EU) to the extent in which is capable to allocate adequate funding. They will be directed to financing of modern health systems in order to provide new generations of experts whose knowledge and skills (assisted by modern instruments) will provide more effective treatment for insured / patients. Understanding the seriousness and importance of health care, the European Union Council has articulated challenges faced by national health systems and highlighted the need for their sustainability. It implies universal coverage of citizens by health insurance, a greater degree of solidarity in financing, equal access to all forms of health care, and timely provision / use of quality health services and other forms of medical care and treatment. (23)

The goal of the paper

The main goal of the paper is to make a review on the existing ways of collecting of financial resources for financing the health services provided / used within health systems. Their collection (regardless of the health insurance model) in each Member State of the European Union (EU) is reduced to one single goal: covering the health expenditures incurred as a result of the provision / use of health care for a certain period of time. Most European healthcare systems provide their financial potential on the basis of payment of contributions to health and social security funds. This, in addition to obtaining the necessary funds, glorifies the merits of the steel bureau chancellor Otto Eduard Leopold von Bismarck-Schönhausen, the creator of the first health insurance model and the initiator of the first Law on Compulsory Health Insurance of Workers in 1883. History has not and will never forget that, however, his model increasingly tackles modern demands and globalization processes that are provoking radical changes on a daily basis. After all, this is best confirmed by the health insurance reform taken in 2010, exactly in Germany. In other European Union Member States,

the basic sources of financial revenues include public payments (taxes), typical for the Beveridge model (William Henry Beveridge), which originated in United Kingdom known as the National Health Service (NHS)). In addition to taxes, sources also include medical savings, out of pocket payments, direct payments, or user charges for services which do not include a user package that guarantees users the law, cost allocation, and informal payments. (4)

Most expert authorities believe that Beverage's health insurance model, or, the fiscal way of raising funds is more effective than Bismarck's, and the percentage of citizens' coverage under equal conditions is higher regardless of their working status and other commitments. That's why the dilemma remains, why, once former Prime Minister of Great Britain, Margaret Thatcher tried to persuade the British Parliament through all the available means to start the introduction of private health insurance leading the example of the United States. The "Iron Lady" mission had relative success because the Global Budget was incorporated into the health system of Great Britain, which was quickly accepted by Sweden, Norway, Finland and Canada. This move was interpreted as taking a concrete initiative to implement the Primary Health Care Declaration, which was adopted at the World Health Organization (WHO) in 1978 in Almaty, Kazakhstan. (25)

Providing healthcare professionals and mobility challenge

Healthcare workers and associates are the most sophisticated form of capital available to every healthcare system in twenty-eight European Union Member States. Due to their knowledge, demonstration of expertise and specific skills, they are extremely admired by large number of citizens in all Member States and they cast confidence of the highest level. In practice, they have shown to be adequately trained, expert, skilled, humane and that sometimes win lost battles which is evidenced by the results that have substantially strengthened the healthcare activity and made it elastic, comprehensive and accessible to the wide popular masses. However, despite the proven quality, the skeptics think differently, they tend to challenge that fact for the reasons known only for themselves, to diminish obviously successful results, although for that there are no solid arguments. They have to accept the defeat because they are facing a formation of 1.8 million health workers and associates or 8.5% of total staff in the European Union (EU). Thus, the sector that managed to increase its human capital by 13% between 2008 and 2016, to create opportunities for opening new jobs (mostly for doctors) and to significantly improve the quality of citizens' health, must really be given recognition. In eight years inside the health care systems of the Member States of the European Union (EU) has been achieved the largest absolute increase in employment among all economic sectors and public services, which is something that does not leave much space for talking with animosity. The contribution of employed

health workers (and associates) is among direct provision of classical health services, or implementation of procedures in the treatment of patients also reflected in a wide spectrum of promoting of healthy lifestyles and activities such as health education. Their main goal is to identify and prevent the cause of the disease, and after that only to follow the suppression of the latter, such as, the diagnostics, medicamentosa and ambulatory, hospital or stationary treatment.

Professional medical staff in all aspects of health care increases the health quality of citizens in the European Union Member States and creates new opportunities for employment in many sectors, which is a direct contribution to economic growth and social cohesion. In this regard, the European Center for the Development of Vocational Training (CEDEFOP) foresees that until 2025 around 1.8 million workers will reach new jobs, which is comparing to 2016 an increase for 7.8%. (11) This fact is best proof that in the frame of European Union (EU) exists a firm resolve to create the conditions for reduction of unemployment rate along with preservation and improvement of global health, and to give optimism to the generations of coming experts. The approach is in full accordance with the opinions of experts in medical profession issues, where each of them in their own way (Matthias Wismar, Heinz Joachim Sajtz…) has emphasized the importance of taking serious actions in order to improve human health policy and create the necessary professional staff. It is an academic appeal, for all those dealing with the medical profession to understand more seriously the essence of the problem and to use all available methods and proven principles for the successful creation of a professional medical nucleus. In the last decades, especially in developed Member States of the European Union (EU), it has contributed to the emergence of a very small number of high school graduates which decided to go on medical studies that, in their opinion, last for a long time, take away most of their time, while their youth ends where it once started – in the school bench. Young people in less developed countries of the European Union (EU) believe that medical studies are more likely to be decided in the form of a future well-paid job in another and more developed country, which is something that youth in the advanced Member States do not even consider as an option.

Eurostat *(European Commission- Eurostat)* (14) finishing with 2015, has precisely regulated data on the number of health workers which accounted for about 1.8 million in 28 European Union Member States. The registration criterion was their number per 100 thousand inhabitants. For example, in German health care system, there are 338 doctors per 100 thousand inhabitants. In Italy there are 233, in France 208, in Great Britain 182, in Spain 179, etc. About two thirds are employed in these countries, or 63.5% of doctors. The curiosity is that the less developed Member States have a significantly larger number of doctors per 100,000 inhabitants. Greece, which belongs to the poorer group of European Union Member States known as PIGS, has the largest number of doctors, 632 per 100,000 inhabitants. It is followed by Austria with 510, Portugal with 461, Lithuania with 434 doctors, etc. On the other hand,

Luxembourg, Ireland, Slovenia, Poland and Romania have less than 300 doctors per 100,000 inhabitants. This number is increasing every year. The reason is either an increase in the number of graduated medical students or a decrease in the number of inhabitants. The largest increase in the period from 2010 to 2015 was recorded in Portugal. In five years, the number of doctors per 100,000 inhabitants rose from 384 in 2010 to 461 in 2015. By contrast, their number in relation to the total population in the observed period, for example in Denmark, United Kingdom and / or France, was not significantly changed.

In the last decades of XX and in the first decades of XXI century, the increasing mobility of health workers becomes more noticeable, especially among doctors specialists who want to use their knowledge in order to provide a higher standard of living and more certain existence. Mobility is a two-way and universal expert-demographic category. The first direction of movement of health workers is directed to leaving the country of origin and going to a neighboring European Union Member State. For example, leaving Italy for Austria or France, moving from Portugal to Spain or Italy, from Belgium to Netherlands or from France to United Kingdom or Germany. In this case, although very important, the wages are not the main reason for leaving because they can be equal or approximately the same as in the home Member State. However, obtaining a desired specialization, advancing in the profession, building a career or status, working atmosphere, proximity of the chosen country to the country of origin, etc., represent very strong motivation. The second direction of movement is exclusively motivated by the amount of earnings, while working conditions, career building or improvement, at least initially, are entirely in the second plan. Regardless of the fact how far the selected country is, the doctors move from South to North (from Portugal to Great Britain, from Spain to Germany or Sweden, from Bulgaria, Romania or Cyprus to Germany or France). Thus, the mobility of health personnel has significantly changed the medical population map of the European Union (EU), but its change it not yet completed. An increasing number of doctors and other medical staff from less developed countries are always ready to go on a road that promises more, with no need to ignore the large number of migrants who have flooded Europe. Economists would say, and lawyers confirm, that you must not prevent migrants from coming to a country, because the labor force would eventually appear there, and then hard times come for business titaniums and bosses.

Regardless of the desire of many to look for new destinations, most European Union Member States are not interested enough for them and reluctantly decide to look for their chance in these people. By joining the European Union (EU), Slovenia considered that, because of the fantastic conditions and the way its health system operates (modern equipment, European salaries, a small number of insured persons, a great chance for specialization and promotion) will be interesting, and that firstly by doctors, and then another medical staff, will be freely occupied. Indeed, there were arrivals, but from non member countries of the European Union (EU), so everything

instead of "occupation" ended with hopes. Similar thing has happened in Finland and Sweden. In addition to sporadic cases, many health systems continue to rely on foreign labor, either from a wider European area, covering European Union Member States or those coming from Asia, Africa and / or South America. With full respect for the mentioned trends in European mobility, it must be emphasized that all doctors who have left their own countries for certain reasons would preferably end up in United States or Canada (30), which, along with Australia and New Zealand, represent a vast territory with expressed health needs. For many, the doors are always and wide open so that a large number of medical workers from various European countries can get jobs in the profession, not just doctors, but dentists, pharmacists, technicians, nurses and laboratories. (27) Mobility of healthcare staff is not always a good solution. Every expert has the right to make its own choice, for which there is no dilemma, as the latter is the greatest individual freedom. (29) However, with the marked departures, the human side of medicine loses its significance. It is disastrous when health workers, humanists leave for their own interests and on that occasion ignore the needs of their former patients. Wismar wants to relax this problem of departure by calling it dispersal "because many health workers are really leaving, but many do not get a job in the profession ... they end up in a lot of other activities ... so he wonders how to prevent people from leaving and doing jobs outside of the profession, in another sectors ... and responds that most educational systems provide education to the wrong people. "(33)

Mobility is detrimental also because in many Member States there is a problem of older workers, which is why the number of pensioners is expected to increase, so there will be no opportunities for adequate replacements at least for the next ten years. Mobility is (especially during the second decade of the 21st century) strengthened and an increasing problem, since it is not necessary to have hope that any of the selected European Union Member States will be a welfare state or its copy in which many see the possibility of fulfilling their own wishes. In this connection, Offe notes two important facts: "... the first is that when it comes to the richest states of the world, which explicitly and without exception oblige themselves to aim for general well-being as an important goal, and the other is that all developed countries by their structural mechanisms create endemic (domestic) system problems and a broad scale of unmet needs of people, regardless of their degree."(20)

Health coverage of the population / some European systems

National health systems within the European Union (EU) are different from one Member State to another. Referring to the legal doctrine, national health systems in the European Union (EU) countries can be observed from two organizational aspects. The first aspect focuses on the National Health System (NHS), which functions successfully in the United Kingdom, but also in Italy, Spain, Portugal and Greece

(13). It is established on the basis that fiscal policy, health care and health insurance in its domain are financed from the state or other budgets, or based on the collected revenues made up of taxes and other parafiscalities. This system is characterized by the fact that the percentage of coverage of the population by insurance is very high and ranges up to 99% of the total population. The second aspect is directed at its counterpart, the Social Security System (SSS), in which, on the basis of payment of contributions for health insurance and health care, the necessary funds are provided for many citizens or their particular groups. Convinced in successful results achieved by health systems in many European Union Member States, the European Council (2006) adopted the Declaration on Common Principles and Values of the Healthcare System, which has binding force. (5)

The Declaration on Common Principles and Values of the Healthcare System states that universal coverage represents a shared value. Its content insists that it is not advisable for any Member States to remain outside of the established framework or to hinder in any way the access to healthcare, which would represent an exciting example of denying the citizens right to health insurance. In "Together for Health" Strategy (32) adopted in 2007, the European Commission (EC) put a special emphasis on the importance of universal coverage. It is the highest value in European legislation and it is defined as a place where citizens have been able to have unobstructed access to all forms of health care. However, health coverage varies among the Member States of the European Union (EU), as well as the benefits that its citizens have from it. (34)

The competencies of the Member States of the European Union (EU) in the field of health care are regulated by the Lisbon Treaty, which came into force in early December 2009, after ratification in 27 Member States. It introduced changes in European law and institutions that envisage the obligation for national authorities to include and allocate all types of usable resources as logistics in providing adequate health care. In this way, a criterion has been established that each Member State which has institutions for the preservation of democratic governance, human rights protection and a functioning market economy must show willingness to accept the obligation arising from the intention of the European Union (EU). This fully relates to the aforementioned health insurance systems which, as institutions, are designed to preserve human rights (25) among which the preservation and improvement of human health represent the peak. Healthcare preservation is one of the main obligations of all health systems, which by implementing the *acquis communautaire* of the European Union (EU) demonstrate their human and legal capacity. In legal terms, this trend is in direct correlation with the degree of universal coverage of the population.

Kingdom of Denmark

The health system in Denmark functions at a high level thanks to the model established by the Institute for Quality and Accreditation in Health, which means that the government does not have a major influence on its functioning. The role of the government is quite limited given that, in addition to the public, also functions the private health sector. If it performs certain functions, they mainly refer to regulation, coordination, advice and determination of responsibility for the realization of set goals. Government bodies (Ministry of Health, Health Protection Agency, Pharmaceutical Chamber) are responsible for implementation of national health policy, regulation of national health legislation, formulation of measures and regulations, establishment of cooperation between different stakeholders in health care, provision of necessary information regarding the quality of health and treatment at the patient's complaint. Since the health authority in Denmark is set as three-stage (municipal or local, regional and central), it introduced the Financial Stability Act in 2012, which allows all municipalities and regions to maintain 1.5% of the funds for internal needs from their budgets. As for the central government, it approves the opening or the commissioning of new specialized or closure of existing, redundant healthcare facilities and capacities. (6) In Denmark, the public health spending in 2016 was 5,205 $ per capita or very high 10,4 % of gross domestic product (GDP), which ranks sixth in the European Union (EU). In the same year, about 84% of total health expenditures were covered by budget funds, or taxes whose rate of total taxable income was set at 8%. (18)

In addition to public (state), in Denmark also functions the private health insurance. The report made by the Organization for Economic Cooperation and Development (OECD) for 2016, states that the private spending on health care was 831 $ per capita, or almost 1.7% of gross domestic product (GDP). (3) The inhabitants of Denmark, according to the mentioned law, have the possibility of choosing between two different categories of health care. The first category includes a large number of general practitioners paid for their work in a combined way, through the principal and basic fees for providing health services, similar to those in United Kingdom. Nearly 99% of Danish residents are classified in this category. Insured persons belonging to the second group (only 1% of them) have the possibility, in the case of need, to visit among general practitioner any specialist if they are willing to participate in covering of the health costs incurred on the basis of their visit. [22] The inhabitants of Denmark have good health and in this area they are more successful than residents of most other European Union (EU) countries. A large number of Danish residents are satisfied with the quality of their health and they do not pay attention on significant income differences, despite the fact that in the European Union Member States many people believe that higher-income people have better health than those with lower ones. Given that in Denmark the duration of the human life is rather prolonged (from 77.9 years in 2005 to 80.6 years in 2015), more and more elderly people are being exposed to

various health problems. However, the Danish healthcare system with great success prevents cardiovascular diseases and strokes, so mortality from myocardial infarction is reduced to one of the lowest among the European Union Member States.

The influence of social behavioral factors causing certain disorders and behavioral risks is generally favorable. For example, tobacco consumption has experienced a sharp decline over the last ten years, which is a great success, however, Danes, both adults and adolescents, consume alcohol uncontrolled and represent the leading nation in the European Union (EU) in that area. This social deviation is directly related to the rate of mortality which is higher in Denmark than in most other Member States. In general, the Danish healthcare system is well organized, technologically equipped, effective and very open, enabling insured persons to have unrestricted access to all forms of health care. It employs the highest number of nurses per capita in the European Union (EU), since on 100,000 people it comes 294 doctors. (15) It is the one of not only European but also world leaders in the use of modern info-technology, and that's why it's IT infrastructure is first-rated. With certain amendments, it will soon be fully integrated, which promises a high degree of sector interoperability. High health technology is currently mostly used by employees in the primary health care sector, in which almost every doctor has electronic records that complement the clinical functionality. (16) This success in the process of development of Danish healthcare system was mainly contributed by health reforms initiated in 2007. Their goals to unite the three-level health authorities for the benefit of future development, to alleviate the rise in health spending, to accelerate the quality of health care and improve public health policy, were almost fully achieved.

France

The health system in France was declared the best in the world in 2008 by the World Health Organization (WHO), which used the criterion of organization as a whole, accessibility and quality of health services. (35); (10) It is financed partly by the social security model, or by the payment of contributions to the earmarked funds, which is why it is also called funded and based on other sources, such as dedicated taxes and direct payments from the insured (out of pocket). According to the Law on Social Security (9), the social insurance is defined as it provides protection against risks form: 1. diseases, maternity, disability and death, 2. accidents at work and occupational diseases, 3. age and death of spouse and 4. family (children) adds. Compulsory health insurance in France has been established within the social security system and represents a symbiosis between public and private providers of health and subjects of health insurance. Public (state) insurance is financed at the expense of employers and natural persons (employees). The most important source of funding for compulsory health insurance are contributions to health insurance that employers and employees

are obliged to pay. Participation in contributions from health insurance funding is 42%. Prior to 1998 reforms, contributions amounted to 12.8% on employer's income, or 6.8% at the expense of natural persons (employees). After the implemented reforms, or the adoption of the Social Security Act in 2001, the contribution rate is cumulative and amounts to 13.55%. The employer pays 12.8% and the employee 0.75%. Prior to the reform, the contribution rate at the expense of natural persons (employees) amounted to 6.8%, which, after their implementation, was reduced to the current level of 0.75%. The impression is that this represents a radical reduction, but not so. The space that was created by reducing the tax on employed persons was filled with the introduction of dedicated taxes on games of chance and all kinds of gambling.

Private health insurance in France is a form of supplementary health insurance. Using that right, insured persons can only achieve supplementary (complementary) health care against the risk of illness. Bearing in mind that compulsory health insurance only partially covers the costs of health services, private insurance is called upon to cover the difference between the full price of medical products and healthcare services and the compensation of their costs. It should be pointed out that private health insurance contracts could not be concluded in order to avoid compulsory health insurance or to provide health services for which only the holders of compulsory health insurance are entitled. Complementary health care in France is provided by three types of private insurers: 1. mutual insurance companies, 2. insurance undertakings and 3. savings institutions, with mutual insurance companies being established and operating on the principles of mutual assistance and solidarity, traditionally having a dominant role in the private health insurance market. (28) Since private health insurance is complementary to the public, the share of direct payment of health services (out of pocket) is still the smallest among the Member States of the European Union (EU).

As for the allocation for health expenditure from gross domestic product (GDP), they are subject to deviations from one to another institute which publishes such data. Thus, for 2011, France allocated 11.6% or 4.086 US $ per capita for health sector needs from gross domestic product (GDP), which was significantly higher than the average in the European Union Member States, while for 2015 the allocation amounted to 11.5% or 4.508 US $. The French government finances public funds between 70% and 80% of health care expenditure, and for patients with severe illness to all 100%, (2) while the rule remains that all citizens must pay contributions for compulsory health insurance. According to the latest regulations, doctors of general medicine have the function of guardians of the "health vault." In their hands there is a dense sieve throughout which through specialist doctors can pass only those patients who have a just cause. However, the Law on Health Security guarantees the full freedom of choice of physicians, with no restrictions on whether it is about the employed in a public or private health institution. The health system in France functions in an impressive way because of the clearly divided roles and high degree of responsibility among the few of the functions and policymakers. The government's responsibility is to monitor,

correct and standardize (fix) the movement of treatment costs and other expenditures related to the provision / use of health services. The Ministry of Health conducts direct negotiations with pharmaceutical drug producers and drug dealers around the price of medicines and seeks to place it in the same level as the average sales / purchase in the neighboring European Union Member States. The government is also responsible for the proper management of secured financial resources and therefore maintains constant oversight of the health insurance institutions in order to make sure that the received amounts are spent in accordance with objectives. Otherwise, what makes the French healthcare system special is the impressive coverage of the population with health insurance of 99.9%. (21), which means that besides the citizens of France, certain programs are covered by foreign citizens. Despite the great success, responsible persons in the healthcare system make additional efforts to ensure lower health spending, high quality health, enviable success in treating patients, lowering the mortality rate of the population in all categories, and a high degree of satisfaction of health care users. (24)

Despite the qualities under which the French health system is recognizable within the European Union (EU), it could not boast of a constant inflow of financial resources into the budget, but also into funds. After all, this is a primary problem in the whole world, even in the Member States of the European Union (EU) and therefore in France. Due to the aforementioned obstacle, which is not the only one, there is a constant fear among the insurers of the possible increase in the tariffs for direct payment (out of pocket). In addition to the problems with financing the scope of health care and health insurance, the system is most often faced with the appointment of doctors and other health workers. This means that much was not achieved due to the fact that in France, there are 208 medical doctors and 965 nurses per 100 thousand inhabitants, (12) if the problem is their departure into insufficiently attractive geographical areas. In order to solve this problem, French Ministry of Health has taken a number of measures to promote more effectively the employment conditions, as well as the longer stay of doctors and other health workers in underdeveloped regions. The third big problem is the permanent departure of doctors (especially from the public sector), which is more than a clear signal for alert, since there is a fear that their number will be insufficient soon enough. That is why the Ministry of Health responded to this question by "opening" the *numerus clausus*, which simply increased the enrollment quota for medical schools by 6%, which began in September 2017.

France, like many other countries, is confronted with asocial behavior of its citizens. At first, it was considered that asocial appearances result from belonging to the poorer strata of society, inequality in access to health and other content, but time has shown that it was not the case. Many wealthy members of the French population are more prone to enjoying tobacco, consuming alcohol, opiates, and static life than the poor ones. Different forms of negative behavior are increasing on a daily basis the rate of mortality from non-communicable diseases and more and more aggressive

obesity. Enhanced state policy can affect the reduction of social inequality, but it does not have the mechanisms to change the behavioral map of especially young French citizens. The life expectancy of a French citizen has increased significantly and amounts 79 years for men and 85 for women, which raises the question, up to what extent the limits would be set if the vices were not higher than the average among the European Union (EU) countries. Although tobacco and alcohol consumption have been reduced in the last ten years, vices among Frenchmen are more than average regarding other European Union Member States, with an increasing trend.

United Kingdom

The National Health Service (NHS) in the United Kingdom next to England includes Northern Ireland, Scotland and Wales. It is also known as William Beverage's health insurance model, because it was as a match of Bismarck model formally established in England in 1942 by the mentioned Lord. The Beverage model is also used in Ireland, Canada, Denmark, Finland, Sweden, Italy, Spain, Portugal and Greece, but some of these countries do not have it as the basic model, which means that there are other forms of health insurance. (16) The United Kingdom allocates 9.9% of its gross domestic product (GDP) to the National Health Service (NHS). Its basic characteristics are that all health activities are financed by public (state) funds, which means from the state budget, that the coverage of the population by healthcare is complete and it reaches 99% of the total population, the citizens are provided with free access to health services and public control of all flows of financial assets. There is a specific curiosity associated with it which refers that the public (state) ownership of health assets, therefore, land, buildings, accommodation facilities, equipment and all other contents used for the purpose of protecting human health is dominant. State institutions (in particular the Ministry of Health) decide on design of a network of appropriate health capacities, prescribe measures and ways of organizing, managing and directing of healthcare activities and assign tasks to the National Health Service (NHS).

In the epicenter of the mentioned service there is a general practitioner. The latter is the embodiment of the institute known as home doctor who is paid according to the number of patients with a bonus depending on the number of provided health services. The number of employed health and non-health workers at the end of 2017 amounted to 1,187 thousand, of which 113 thousand were medical doctors and 320 thousand were nurses, while the rest was made up of other qualification groups. (19) According to the same source, only one year before, the number of employees amounted to 1,164 thousand out of which 111 thousand were doctors and 319 thousand were nurses. In 2017, there was a negligible increase in the number of employed doctors by 1.02% and nurses of only 1%. (31) Among the doctors employed in the National Health

Service (NHS) there is a large number of members of various nationalities, since on three doctors the one is obligatory the foreigner. Over 21,000 are Europeans, while the Indians, Pakistani, Nigerians and Egyptians are the most numerous nationalities outside of the continent. Otherwise, there are 182 doctors and 675 nurses on 100 thousand inhabitants. Multinationalism is understood as an adhesive that makes the health system a harmonious community, which strengthens its human structure and contributes to overall functional quality. In spite of the qualities characteristic for this service (known as the largest individual health care system in the world), the British media reported in 2017 that the Care Quality Commission (CQC) provided adverse information: the system of The National Health Service (NHS) is too strenuous, close to the seams and with no certain future.

The National Health Service (NHS) largely finances its activities from fees charged in accordance with the changes made in the Immigration Law in 2014. According to the Health and Social Care Act 2012, which came into force in April 2013, all right-handed residents of the United Kingdom were granted the right to free use of all health services provided in one place. The well-known free-of-charge health care at the place of use represents the basic principle set by the government when establishing the National Health Service (NHS) in 1948. This practically means that the right to free use of all health services has every person with a full and legitimate status on the basis of a registered place of residence in United Kingdom, regardless of nationality. This category of users does not include non-resident British citizens. (31) However, it is notable that citizen's safety is endangered by the dropping out of medical staff, which in some respects is related to the government's failure to fulfill its own promises. Only in 2016, the number of general practitioners was decreased by 1.2 thousand, which in some areas certainly aroused concern among the insured, (8) regardless of the fact that it is one of the largest healthcare employers in the world, but also a consumer of funds intended for protection of the health of English citizens

More than 1 billion £ Sterling is spent in the primary health care sector, but also in other areas of health, including patients treated in private health care facilities, private hospital care, self-financing treatment, private dental services and supply of medicines and other medical products. Visible economists have calculated that only in one second 4,3 thousand Sterling are being spent in order to provide all services provided by the National Health Service (NHS). Since 1948, when the proposed National Health Service (NHS) was enacted, the possibility of using private health insurance, which is now used by about 8% of the population, has been established. It is in most cases the added amount of sums under which health services are provided in the domain of the National Health Service (NHS), which is considered as a charge for the extended scope of their use. The United Kingdom government has been successful in collecting of general taxes and in the health sector financing policy, where 2014 was a good example since 110 billion Sterling was allocated for the functioning of the budget. The share of private health spending has been rising rapidly. During 2010, it

amounted to 4.1bn £ Sterling, while in 2016 reached a fantastic 8.7bn £ Sterling. (8) This is a major problem that the National Health Service (NHS) will face continuously in the future, unless official British policy changes its course and begins to regulate the system in accordance with new, more modern and non traditional recipes of very demanding British citizens.

For 2020 and 2021 the National Health Service (NHS) has provided 30 billion £ in Sterling for financing the actions in order to combat behavioral incidents. The government expects these funds to be effective in the positive direction, as this would represent the right choice of measures of its policy. The United Kingdom Ministry of Health is making great efforts to achieve a shift in achieving positive results in changing of the behavior of its citizens. Enjoying tobacco, alcohol and narcotics, especially among young people, stands at a high level. These vices are, as everywhere in the world, supplemented by problems of psychosomatic disorders and social deviations. Health officials in United Kingdom can be criticized, since they do not notice that these deviations are the product of incorrect assessment of the quality of health of citizens and differences in education and income. That is why the results are unsatisfactory, even though children under 5 years of age are involved in many activities to combat social vulnerability. Based on this fact, the Care Quality Commission (CQC) did not make a mistake while informing the public about possible sewing breaks. Namely, the Emergency Medical Assistance Center received over 25 thousand calls a day (on number 999) in 2015, and unfortunately, none of them was false. This number of calls is alarming, but at the same time it represents the best check of operator's patience which is one of the most important features in their business. Employees of the National Health Service (NHS) in United Kingdom on a daily basis are experiencing the embarrassments on workplaces in the face of harassment, abuse or direct threat from the users of health services (in primary health care, departments, hospitals, etc.), their relatives and also from other citizens. During 2014, 14% of employees had some sort of bad experience with physical violence and frequent confrontations with a large number of people diagnosed with psychological disorders. Only in 2014 were submitted 57.1 million receipts for antidepressants, which is more than 100% more than 10 years ago. It is disastrous that this problem is most prevalent among young people, among whom out of five, one necessarily experiences anxiety or some form of depression.

Conclusion

The health system in each Member State of the European Union (EU) is, according to its structure, a vital social segment whose purpose and function is best understood by those who actively participate in the creation of its quality. Its formation, functioning and development are in the service of citizen's health, the primary premise of human value which has no alternative. Therefore, the role of the health

system is unmatched when it comes to nurturing and improving human health. Within this, the importance of professional personnel, modern technology, characterized by medical equipment and instrumentation, which defines its correct structure and high organization is aimed at the realization of a multitude of goals, among which the preservation of human health represents the goal without any premise. Since the healthcare system is regarded as a modern system in which all its components function smoothly, it should be emphasized that, as such, it was created and shaped under the influence of accelerated industrialization program. The programs have deeply rooted expectations that its higher level of development will directly contribute to health expansion, which actually has happened at the end of 20th century, when some health systems experienced a real boom in their development. This is inherent in the health systems of those European Union Member States who have worked hardly (many have succeeded) to accelerate the national health upgrade through proper health policy, to achieve material well-being by redistribution processes, the proper redistribution based on social needs and to lift health security to a higher level.

The function of health care financing in European Union Member States is more important than all other public functions, because it determines the quality of human health and makes the decisive decision when and how much to invest in its protection and improvement. Belcher, Mossialos and other expert authorities claim that a healthy population within the European Union (EU) is universal and for all the safest resource, so it does not matter what health insurance system is on force or how health care is being financed, so what is really important is the health balance of citizenship in practice. Namely, none of the methods used to obtain the necessary financial resources provide total security, given the rapid increase in health expenditures, that the revenues for their coverage will be sufficient and consistently sustainable. Therefore, those responsible for the functionality of the healthcare system in the European Union Member States determine the strategy of its development, which is an important document that contains sensitive areas on which a security lever could break, ultimately causing many contradictions. They are most often in the policy of financing business processes, in resolving personnel issues and the lack of adequate conditions for the timely implementation of scientific and technological achievements. Many strategies do not live long enough to become implemented, which is not a good solution, therefore it is expected that the European Union (EU) expert group, which is in charge of assessing the functioning of the primary health care system, make its full contribution in order to change the situation on the field. It is currently working on identifying of the tools and methodology for assessing of the achieved results. The presentation of the final reports was announced by the end of 2018. The first information is that health expenditures in almost all European Union Member States are growing rapidly, that they are very high and that for their growth is not particularly important whether the financial resources for their servicing are secured from bills, tax collection and other fiscals (United Kingdom, Finland, Italy,

Ireland) or from the payment of contributions to health insurance funds (Germany, France and the Benelux countries).

The aforementioned drain of medical education in the Member States is not a problem of a recent date. Member States that are aware of its gravity and who are able to apply the import strategy of already made medical experts, do not ignore the engagement of the latter and do not pay attention to the harm they inflict on others. On the other hand, the practice shows that underdeveloped countries are enrolling the excess medical students almost to the level of hyperproduction among which many will go on places where they can realize their dreams. Their mobility will be directed to places where more money and greater possibility of material, career and professional advancement is offered. Over time it finally has been understood that the impact of European policy on determining health in Europe for a long time was insufficient. The main reason for that was the latent believe that all actions going in that direction have no synchronous effect with practice and, therefore the desired results were missing. However, in recent years, the formula was completely changed so its impact is stronger and successes are greater. What has been set up by the correct strategies has been achieved, so health systems that are well organized expressively affect the national and European space, protection and improvement of health, equity mechanisms, cross-subsidization of costs and decentralization of health sectors.

References

1. Akcioni program Zajednice u oblasti zdravlja (2007-2013). P6TA 0093. U Briselu, Evropski parlament, Savet Evropske unije (EU).
2. Ballas, D., Dorling, D., Hennig, B. The Human Atlas of Europe. Bristol: Policy Press. 2011, p. 79.
3. Bech, M."Restructuring Hospital Planning Denmark". Health Policy Monitor. Health Economics Research Unit University of Southern Denmark. Archived from the original on 2011-11-18.
4. Berridge V. Public Health Activism. British Medical Journal (335), 2007, pp. 22-29.
5. Borhart, K. – D. Abeceda prava Evropske unije, Kancelarija za publikacije Evropske unije, Luksemburg, 2013, str. 129.
6. Britnell, M. In Search of the Perfect Health System. London: Palgrave. 2015, p. 88.
7. Busse, R. B., Figueras, R. J. Social health insurance systems in western Europe /World Health Organization. Regional Office for Europe. European Observatory on Health Systems and Policies. Issue Date: 2004, p. 112.
8. Campbell, D. (editor The Guardian), Health policy (15 August 2016). „How much is the government really privatising the NHS" – via The Guardian.
9. Chevreul, K., Perronin, M. France: Health system review, Health Systems in Transition, vol. 12, br. 6/2010, World Health Organization, 2010, pp. 221-244.

10. Cline, M. "The Health Care system i Want is in France." ABC News. (April 15, 2009).
11. European Commission, State of Health in the EU: Companion Report, Chapter 4. Creating a health workforce resilient to future challenges, Luxembourg: Publications Office of the European Union, 2017, p. 71.
12. Eurostat, 2013 or 2014.
13. Hervei, T. K., Mekhejl, J. V. "Zakon o zdravstvu Evropske unije", Kembridž, 2004, str. 21.
14. *http://ec.europa.eu/eurostat/statistics-explained/index.php/The_EU_in_the_world_-_health.* Posećeno: 8 april 2018, 23:37
15. Kierkegaard, P. Health in Denmark: A Case Study. Journal of Medical Systems, December, 37 (6): 2013, p. 14
16. Klein, R. "Why Britain's conservatives support a socialist health care system." Health Affairs 4#1 (1985): pp. 41-58.
17. Mary, S., Weinrich, M. „Home-and Community-Based Long-Team Care: Lessons from Denmark". Gerontologist. , 41 (4): 2001, pp. 474–480.
18. Mossialos, E., Wenzl, M. 2015 International Profiles of Health Care Systems, Australia, Canada, China, Denmark, England, France, Germany, India, Israel, Italy, Japan, The Netherlands, New Zeland, Norway, Singapore, Sweden, Switzerland, and the United States, London School of Economics and Political Science, Robin Osborn and Dana Sarnak, The Commonwealth Fund, January, 2016, p. 180.
19. "NHS Staff Headcounts"
https://www.google.rs/search?ei=LsjMWog9jKeyAYHYjOAI&q=%22NHS+Staff+. Posećeno: 11. april 2016. 12:34.
20. Offe C. Advanced Capitalism and the Welfare State, journal: Politics and Society Vol. 2. No 4/1972, p. 479-488.
21. Polton, D. „Recent reforms affecting private health insurance in France", Euro Observer, vol. 6, br. 1/2004, pp. 4-5.
22. Protti, D. J., Bowden, T. and Johansen, I. 2009. "Adoption of Information Technology in Primary Care Physician Offices in New Zealand and Denmark, Part 5: Final Comparisons," Informatics in Primary Care, May 2009 17(1): pp. 17–22.
23. Radić, I. Vodič kroz pridruživanje Evropskoj uniji, edicija: Vodiči, ISAK fond, centar za međunarodne i bezbednosne poslove, uz podršku Savezne Republike Nemačke i ambasade Nemačke u Beogradu, Beograd, 2007, str. 29.
24. Rodwin, V. G. *"NIH & American Journal of Public Health"*. American Journal of Public Health. 93 (1): (10 September 2002, pp. 31-37).
25. Saltman, R. B., Busse, R., Figueras J. Social health insurance systems in Western Europe. Berkshire/New York: Open University Press/McGraw-Hill, 2004, p. 174.
26. Smith, S., Baylis, J. The Globalization of World Politics, Oxsford Press, New York, 2011, p. 14.
27. Svetska zdravstvena organizacija (SZO) *Komisija za socijalne determinante zdravlja, 2008.*
28. Thomson, S., Mossialos, E. „Private health insurance and access to health care in the European Union", Euro Observer, vol. 6, br. 1/2004, pp. 1-4;

29. Templton, Dž. M. Knjiga životnih zakona, 200 večnih duhovnih načela iz celog sveta, Mladinska knjiga, Beograd, 2012, str. 520.
30. Totić, I. Ekonomika zdravstva, Državni univerzitet u Novom Pazaru, Novi Pazar, 2016, str. 343.
31. "UK Dentist Prices – Compare NHS and Private Dental Treatment Costs". *https://www.google.rs/search?q=%22UK+Dentist+Prices+%E2%80%93+Compare*. Posećeno: 10.april 2018, 16:23.
32. „White Paper",Together for Health: A Strategic Approach for the EU 2008-2013' COM (2007) 630 final, p. 3.
33. Wismar, M. Na kraju svi odu u SAD ili Kanadu, Prva konferencija srpske medicinske dijaspore od 2-4 septembra 2010. godine, (u: Glasnik, Lekarska komora Srbije, Beograd, 6/2010, str. 24-30).
34. Wismar M., Palm, W., Figueras J., Ernst K., van Ginneken E. Cross-border health care in the European Union, Mapping and analysing practices and policies, World Health Organization 2011, on behalf of the European Observatory on Health Systems and Policies, pp. 47.
35. *"World Health Organization Assesses the World's Health Systems"*. Who.int. 8 December 2010.