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Health Policy as a Specific Area of Social Policy

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Abstract:
Purpose and Originality: The aim of the article was to analyse the work of the health policy which is a very specific part of social policy. In the work we focus on its financing, which is a very important issue in the health care. We try to show, what is the role of the state in the health care system as well as the creation of resources and control costs in the health sector. The work is finding such as financing health care in Slovakia and in other selected countries, and which could be changed for the best operation.
Method: The analysis was carried out on the basis of the information which I drew from books and Internet resources. The work is divided into two parts. Contains 9 tables and 3 charts. The first chapter is devoted to a general description of social policy, its funding, with a focus on health policy than its specific area. The second chapter analyses the financing systems of health policy in Slovakia and in selected countries.
Results: The results showed that the Slovak health care makes is trying hard to catch up with the level of the best health care systems. However, there are countries, which are doing much worse than us, in terms of funding.
Society: It is important to properly invest money but also communication between states. To get help on health and to ensure that citizens know states the best conditions of health care.
Limitations / further research: This work is focused on how to bring closer health care and its financing in several different countries economically. IN doing so some other aspects such as what is best level of services, etc. were put aside.

Keywords: social policy, health policy, financing health care.

Introduction

Social policy and its funding is a complicated phenomenon and includes a wide range of activities and measures, which are part of this topic. To deal with the whole of this issue would greatly exceed the purpose of this work. For this reason the work is focused on one of the areas of social policy, that has a specific status, and it is a policy, whereas health is a prerequisite to achieve a full life of individuals, and thus society as a whole.

The topic of funding health care resonate as a current problem, just not the need for a steady increase in the volume of funds spent for the financing of this area, but in particular the effective control of expenditure in the health sector.

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The aim of the work is based on general theoretical basis for issues of social policy, conduct an analysis of the financing systems of health policies in selected countries, and subsequently compare the selected indicators. For the purposes of the work, in addition to selected countries whose health care financing systems in Slovakia reached a peak as the Netherlands, Denmark and Sweden, but also the country whose health is placed last in the rankings of the quality of health care provision.

1 Theoretical background of social policy and its financing

1.1 Characteristics of social policy

Despite there are many definitions of social policy, the majority of authors limit themselves to basic description of the field and subject of regulation..

Tomeš, defines very specific social policies, both continuous and purposeful efforts of the various social actors in their interest to keep or change in the operation of, or to support the development of your or another social system, respectively. The result of this continuous and focused effort is an activity, whether the change of its own development or of another or the system tools. There is a ruling, and the activities of the social actors. In practice, this means that social policy is a concern relating to the improvement of the social situation, which is systematically monitored and targeted on the standard of living of the individual, as manifested in the effort or activity and is focused on the functioning of, or change in the social system (Tomeš, 2010, p. 29).

Social policy is a complex multidimensional phenomenon that involves the six core areas: education, employment, housing, family policy, health policy and social security (Geffert, 2009, p. 18).

1.2 The nature and objectives of the social policy

Social policy regulates and controls the human coexistence of all citizens in society. Represents a set of activities and measures which are geared towards the development of the human being, the way his life purposefully, to ensure social security of sovereignty, whether in the context of the political and economic choices (Polonský-Pillárová, 2002, p. 7).

Social policy is directed to ensuring some social standards of society. Therefore, social policy objectives can be described as desirable conditions of social sphere of company in the future. There is no absolute and forever the social policy objective, because each entity keeps track of your interests and goals, whether it is a partial or final targets. After reaching the ultimate goal is that the status of the starting point for the next target. The objectives of the social policy change in time according to changes in the social environment in which it operates, or according to the changes in the interest of the operator (Polonský-Pillárová, 2002, p. 7-8).

1.3 The features of social policy

Features of social policy have evolved in different points in time, space and the socio-economic situation. The main features include the following (Stanek, 1999, p. 28):

- the protective function – responds to the situation within the meaning of the removal or mitigation of the consequences of an unfavourable situations (unemployment, illness, old age, death, loss of revenue).
- distribution function – applies the principle of equity and is associated with the reallocation of already divided. This is not just about the distribution of income, the income, but also of living options and the default should be to alleviate the unequal status of citizens.
- the incentive function – supports towards the social behaviour of individuals or families, or applicants, has the task of promoting them in an attempt to resolve a precarious life situation, but not to create policies that are no longer encouraging the Elimination of the root causes of such situations.
- preventive function – leads to the adoption of measures to eliminate the causes of the unfavourable social situations, or to prevent their formation. May also occur if the situation called for. social comfort, when citizen nor a desire for a solution to their situation and just waiting on the steps of the State (Polonský-Pillárová, 2002, p. 12)
- homogenisation function – closely related to the distribution and redistribution functions, its importance in the implementation of equalization (income, pensions) in order to reduce social inequalities and unjustified differences. This feature applies only to prevent overflow below the level of the subsistence minimum, not the creation of social equality of the society, which is undesirable and mostly impossible (Stanek, 1999, p. 29, Polonský-Pillárová, 2002, p. 12).

1.4 Instruments of social policy

Tools are the means for the implementation of some activities and in social policy is applied. Their use is subject to the particular social situation, to which they are to be applied, but it is also necessary to respect the basic principles of social policy, are thought to have their limits, and allow you to pursue the objectives and functions of social policy (Krebs, 2007, p. 62).

Geffert (2009) defines three groups of instruments of social policy; legal, economic and social tools. It is an essential tool of social policy we can mark different legal standards of legal force (by the Constitution and international treaties to the generally binding regulations at the local level). The next set of tools make up the economic instruments, which represent the measures aimed primarily at redistributing available resources so as to achieve the objectives effectively. Including fiscal instruments (transfers or credits), credit (loans and loans), de-commoditisation (guarantee of minimum subsistence level) and price regulation (regulation of prices of selected goods and services). Among the social tools we include primarily social documents (concept, plans, projects and programmes of the State institutions and

organizations, which sets out the objectives and instruments of social policy) (Geffert, 2009, p. 47).

2.1 Actors and objects of social policy

For formulation and implementation of social policy it is necessary to distinguish who social policy forms and develops, and for whom is formed and developed. The term entities are marked with units that make up social policy, while the objects are those for which social policy is targeted and that they benefit (2010, p. Tomeš, 101). One participant, however, can act as an object and entity at the same time, it is therefore often used and of the concept of social policy actors (Potúček, 1995, p. 55).

2.2 Subjects of social policy

Entities of the social policy are subject of a public or private law. Public entities, collectively referred to as a State, are the central authorities of the State and municipal corporations. The central authority of the Government, ministries and their local affiliates include, e.g. labour offices and tax offices. The municipal corporation may have the status of regional (counties and municipalities), European Trade Union (public insurance) and interest (e.g. Medical Chamber). Private social policies are legal persons, under certain conditions they may also be natural persons. Private-law entities shall be broken down according to whether they are profitable or unprofitable. Further subdivision is possible according to the nature of the organisation of such services (e.g. Civil Association) or providing the money (and funds) (Tomeš, 2011, p. 102).The most powerful entities in the social policy of the State. That ensures their human rights, which declared, in particular the Constitution. Parliament by adopting the law defines the legal framework of this warranty and the Government, together with regional and municipal administrative authorities responsible for the implementation of these laws. Purpose of the State is to create the conditions for stability, to regulate the social climate, reduce social tensions and the development of social activities, stabilize the picture in the society so that social players to realize their objectives (Geffert, 2009, p. 21).

2.3 The objects of social policy

In the political and economic sense, the relationship between the participants in social policy is not equivalent, because the participants are not comparable to the inputs and outputs. One usually adds to the needs of the other. However, both parties are legally free to decide and to act as equal under the law laid down the rules. The efforts of the entities of social policy is always directed to the people. Those are in the literature and the practice of marking a variety of clients, recipients of benefits, services, users, etc. The nature of socio-political relations, we can deduce that the target group are the recipients of the results of the entities of social policy, and thus are objects (Tomeš, 2010, p. 129).

In developed countries the main target the object of social policy, is the family. It is enshrined in the State social support, which is part of the social security system. The State becomes the sender and addressee of family support (e.g. child allowance, parental allowance, etc.) when

the State recognized social events (e.g., the birth and the presence of a dependent child in the family) (Juska, 2002, p. 31).

The family acts as socio-political body, because traditionally takes care of persons in need of special care: children, old and sick members. Nursing roles usually falls to women (Potúček, 1995, p. 55)

The individual stands out as an object of social policy, both as a participant in the system, because its members, employees or to a system of paid contributions (e.g. insurance), but also for his use, which has a social system to satisfy in the case of socially excluded individuals such as the unemployed, the poor, the sick, the elderly, etc. Last but not least the social system provides protection to the individual, and this intervention into private law relations (job security, working conditions, etc.) (Tomeš, 2010, p. 130).

3.1 Health policy as a specific area of social policy

The efforts of health care fall into the field of medicine, but also social policy. The concrete procedures of healthcare, although they belong to the health, but the availability of health care is a matter of social policy (Tomeš, 2011, p. 39).

The World Health Organization (WHO) defines health as "a state of complete physical, mental, social well-being, not only as the absence of disease state of weakness". While this is an exact definition, but given the nature of the human being can be regarded as idealistic and mechanism. According to this definition, most of the population was not healthy. Nevertheless, it is necessary to understand health as national treasures. Any disturbance to health is reflected in all human activities, which ultimately affects the operation of the company.

Health is the main condition for the activity of man, his active participation in the allocation of resources. The lack of health, therefore, can be a cause of social exclusion, loss of work ability, whether short-term or long-term (Tomeš, 2011, p. 39). Therefore, the health policy can be considered as a specific area of social policy.

3.2 The social aspects of health care

Health issues include health and non-health factors. It is estimated that approximately 80% of the issues are related to the non-health factors, such as environment, way of life, the working environment (external factors) and genetic predisposition (internal factors). It follows from this, that health may affect the health status of the population, up to a maximum of 20% (Krebs, 2007, p. 315).

Health care of citizens is not only medical care, since it consists also from other, predominantly societal factors. In this manner, societal aspects of health care can be described as (Jusko, 2002, s. 55):

- the socio-economic aspect, the main condition for the existence of a functioning health system is the transparency of its financing.
- socio-educational aspect – emphasised the health awareness of the public; stepping up the personal responsibility is able to provide a solution to many health-social risk factors (e.g., diet, drug addiction, etc.).
- socio-environmental aspect – the impact of the company on the environment in terms of health care can be seen in three planes: the environment, the working environment and the family environment.

The experience of developed countries shows that it is necessary to move from the bio-medical health care orientation (which is associated with the extreme specialisation and fragmentation of health services) to socio-medical care. To the solution of medical problems must be involved and those who participate in, or ensure that your procedure an existing condition. It is first and foremost a company (e.g., non-intensive manufacturing in favour of an environmentally and work), Organization (knowingly hiding problems, polluted water, air, etc.), and last but not least the inhabitants (who inappropriately used the free time to the wrong lifestyle, stress, etc.). The solution can help overall social health care system (Pechová, Stanek, 2010, p. 12).

3.3 The role of the State in the health care system

Health policy can be characterized as a purposeful action of the State and other entities, economic and social policy, which focuses on prevention, protection, support and rehabilitation of the health of citizens of that State (Geffert, 2009, p. 121).

This widely defined health policy contains two types of activity (Krebs, 2007, p. 312):

- activities focused on treatment, thus removing the already generated negative changes in the health status of the person, for the renewal or restoration of health, this health policy is a policy of ex post and its implementation is costly.
- activities within the meaning of the health protection and promotion, that is, prevention activities designed to prevent adverse health condition-this is a health policy health policy ex ante.

The implementation of health policies consist of certain connected steps. First of all it is necessary to identify problems, analyze them and choose the key problems. On the basis of knowledge of the problems it is necessary to formulate objectives and procedures, then, subsequently, their solutions to introduce and implement the procedures through defining resources. Finally, the chosen procedures are evaluated through the system of selected indicators in order to achieve the effect (Pechová, Stanek, 2010, p. 17).

The role of the State in health policy lies in the fact that it allows the individual to realize his self-preservation efforts. The rate of application of State influence in the protection of the health of the individual States, and these differences are given primarily to differences in social arrangements and even economic level of the country. At present, all developed

democratic States in politically mixed economies are also in the functioning of essential public health policy interventions.

Healthcare systems built on the principle of social solidarity to separate the provision of health care by ability to pay, provide for the posts of health care according to the financial possibilities and redistributing the funds collected for the benefit of socially disadvantaged (Stanek, 2011, p. 289).

It enters the State of the relationship between health care providers, payers and patients these activities (Krebs, 2007, p. 320):

- legalization of compulsory solidarity.
- the creation of pharmaceutical policy.
- the regulation of the prices of health services.
- contribution payments from the State budget and the performance of the property rights of medical facilities.\u000athe guarantee of the quality of health care through the education system for doctors and medical personnel.
- supervising the activities of public health insurance.
- check the network of health care facilities.
- ensuring the protection of the health (hygiene, cleanliness of water, prevention of vaccinations, etc.).

The constant increase in health spending is hitting the barriers, which are given options and is not accompanied by a proportional effect in improving the health status of the population. The main criterion of the quality of health policy is the real health condition of the population. Health policy is not just focused on raising the quality of health care, but must also have the necessary financial resources and allocate them effectively. The result of this is that part of the health policy is also a definition of the role of the State in the economic sense, i.e., in the search for an effective system of financing health care (Krebs, 2007, p. 314).

3.4 Creating resources and control costs in the health sector.

The provision of health services systems has three basic forms (Geffert, 2009, p. 127):

- the health care is provided in the form of the notice with the dominant role of the State in the creation, distribution and consumption of health services with a minimal part of private sources.
- health care is provided in the form of semi-market with the lower part of the State in the creation, distribution and consumption of health care services and a higher proportion of private funding.
- health care is provided by the market on the basis of the direct payments between the patient and the provider, or the use of commercial insurance; When this form is characterized by the lack of public resources.

There are several ways of financing health care. In addition to funding from the Government budget to social insurance, private insurance, individual savings accounts and community individuals to health care and cash payment. The modern system of financing health care are asked the following requirements (Pechová-Stanek, 2010, p. 95):

- must be transparent.
- must ensure a secure and stable source of funding.
- must not be in conflict with other socio-economic objectives.
- must contain a positive feedback, may not initiate unwanted behavior of its participants.
- It must not consume a substantial part of funds raised on their own functioning.

Insurance as a method of financing health care in the world worked as an acceptable form of compulsory solidarity (Tomeš, 2011, p. 63). Health insurance is inherently a non-life insurance. It has its specifics, because it includes modifiable risks (e.g. consequences of smoking), the uncontrollable risks (hereditary disease), with the combined risks causing factors (regional climate) and also non-insurable risks, including high cost of disease in old age. From an economic point of view, it is therefore very risk insurance, however, is in the public interest. Since it became legal, insurance, non-profit and the joint and several. Health insurance we distinguish between public (required) and private (voluntary). Compulsory insurance is based on the principles of solidarity, equality, no-profit, performance, autonomy and compliance with the public, while the voluntary insurance works on primarily on one's principles and profit (Pechová, Stanek, 2010, p. 111).

In any system of financing health care in the world, has in recent decades generally troubled by the lack of financial resources. The cause of this condition is both the ageing population, the rising incidence of chronic diseases, but above all the constant growth of the availability of new diagnostic and therapeutic methods and procedures, including the new medicinal products. Whereas it is not possible to provide the necessary volume of public resources to meet health needs, it is necessary to control the costs of health care based on public funds. A balanced balance sheet management system can occur only if the scope of regulated health care costs will be covered by the volume of public resources for their consideration (Pask et al., 2006, Supplement 1, p. 2).

2 Analysis and comparison of systems of financing health policies in selected countries

The health status of the population's socio-biological process, which affects the development of the company, both in a positive, but also negative sense. The health of the population for the economic value of the company, which is in absolute terms, however, hardly measurable. Since health care is becoming an increasingly important factor in economic growth, health

care costs represent a significant investment in the development of society as a whole (Stanek, 2005, p. 10).

Systems of financing the health sector in the European countries have a lot in common, but also among them there are significant differences. In this complex system are all member countries of the EU have to comply with legally binding acts of community law published in the official collection of the legislation of the EU. However, due to the differences in national legislation are the conditions of payment for provision of health care various, sometimes even inadequate for the citizen (Ležovič, 2007, p. 1).

For the purpose of the work was to analyse the Slovak republic selected both very developed countries, where health care is second to none (the Netherlands, Denmark, Sweden), but also countries whose healthcare systems are still developing and the members of the EU have become only recently (Bulgaria, Romania).

2.1 The Slovak Republic

The right to health is enshrined in article 40 of the Constitution of the Slovak Republic, according to which: „everyone has the right to protection of health. Citizens on the basis of public insurance the right to free medical care and to medical aid under conditions to be laid down by law.“ Although the Constitution of the Slovak Republic dictates the existence of free compulsory education in the overall functioning of the system, allows you to determine the health policy by law. The Constitution of the Slovak Republic refers to a body of law for the protection of the health of each concept, which goes beyond the legal category of citizenship (Barancová, 2008, p. 28).

Article 1 of the Constitution of the Slovak Republic guarantees the equality of citizens. This constitutional right to equality and to the implementation of the right to protection of health, equal access to health care performance regardless of the type of insurance, and does not exclude private supplementary insurance. Every natural person must be, regardless of the means, the rule of law is secure at least the essential health care. Even with the existence of health insurance is a State sponsor of executing the necessary services irrespective of the property and the social origin of the authorised person, but only to the degree of medical urgency. In accordance with Act No. 576/2004 Coll. on health care, services related to the provision of health care and on amendments to certain laws, has every right to medical treatment, but does not create a legal entitlement to reimbursement of the cost of this care.

For the functioning of the Slovak health care system has the meaning of paragraph 1 of article 13 of the European Social Charter: „to ensure the effective exercise of the right to social and medical assistance, the parties undertake: 1. to ensure that any person without sufficient financial resources, which is not in a position to provide them, whether one's own efforts or from other sources, in particular benefits from the social security system to provide adequate assistance and necessary care in case of illness that her condition required.“ Under this

formulation, would any person unable to finance their treatment, should be eligible for State aid. It is not clear whether this can be considered as well. benefit in material need. If you should have an address in the system (e.g. requiring co-payments on drugs) is not in accordance with the provision of (ex-, 2009, p. 18).

An interesting way to health policy is also the Convention for the protection of human rights and the dignity of the human being with regard to the application of biology and medicine, and that article 3 read as follows: „States parties shall take appropriate measures within their jurisdiction to ensure equitable access to health care, and will take into account both the need for health care, as well as available resources.“ The rights relating to health care, the constraint is added to take into account not only the needs, but also to opportunities in the form of resources that are available. This Convention is necessary to determine the health and paves the way for funding by a determination such as health services, which are not necessary and are not sources of them.

2.1.1. The financing of health care from public insurance

Slovakia's health care is financed, in particular, on the basis of the system of public health insurance with the mandatory payment of dues to the health insurance companies. Health insurance company subsequently reimbursed health care provider payments for procedures of healthcare provided by their policyholders. Range of health care is build on the basis of public health insurance Act 577/2004 Coll. on the scope of health care under the national health insurance on the basis of a public call for the services related to the provision of health care (hereinafter referred to as Act No. 577/2004 Coll.). Health care beyond the insured person must pay them separately and may decide whether the standard of care to pay directly, or on the basis of individual health insurance. On the basis of public health insurance in the Slovak Republic is fully paid:

- preventive examinations within the limits set by the law;
- urgent medical care;
- expenses leading to disease;
- provided for the treatment of diseases that lead to:
  - save lives;
  - cure disease;
  - preventing serious health complications;
  - avoid worsening the severity of the disease or in the chronic stage;
  - the alleviation of the symptoms of the disease;
  - effective prevention (Act No. 577/2004 Coll.).

The amount of insurance contributions is in the conditions of the Slovak Republic Act No. 580/2004 of exhaustively addressed. health care insurance and on amendments to certain laws. Since there is no possibility of an individual, the differences between the health

insurance companies are virtually meaningless. Health insurance companies therefore have no reason to look for more effective ways of delivering health care to obtain more insured persons (Baláži, 2012 , p. 4).

On the basis of public health insurance are fully covered drugs provided in the framework of the institutional health care and within the framework of outpatient health care and self-prepared medicines. From public health insurance is fully paid the obligatory vaccinations.

2.1.2. the revenue and expenditure Structure of the Slovak health care

The volume of resources for health care is determined by the macro economy and politics. A crucial determinant of the volume of resources for health care are the parameters of the job market. As a result of the economic recession in 2009 and a slowdown in wage growth or decline in employment have developed adversely reduce the basis for premium calculation. During the first quarter of 2010 with growth of the economy has recovered, but it was a turning point in the development of hostile to the end of 2010. The development of resources in the health sector is particularly sensitive to the dynamics of wage growth, which was at the time of the recession only 3%, while in the period of 20072008 was around 8%. Political determinants of the rate of height for the payment to the State for a limited circle of persons (Chub et al., 2011, p. 194).

The legal basis of health insurance, it is provided for in law No. 580/2004 Coll. on health insurance and on the amendment of Act No. 95/2002 Coll. on insurance and on amendments to certain laws.

Most of the sources of financing of the health sector in the Slovak Republic is based on the secondary distribution, that is, the charging of the primary income of the company. Of the identified data indicate that approximately 75% of the sources of financing of the health system comes from a redistribution of income. Total revenue for health care in the year 2010 consisted of 7.3% of GDP, and over the years, the 2006-2008 moved to a lower level, 6.5% of GDP.

In table 1 it is summarized the evolution of distribution of resources in the system of public health insurance in the Czech Republic in the years 2002-2010. Based on these data, the apparent decline in the proportion of funds from the working population and related increase in State contributions for insured persons economically inactive.

Table 1: Sources of health insurance as % of GDP and the breakdown of the structure of the economically active and inactive population.

	2002	2003	2004	2005	2006	2007	2008	2009	2010
Public health insurance as a% of GDP	5%	4,9%	4,9%	5%	4,9%	4,7%	4,8%	5,2%	5,2%
The contributions of the economically active population as a% of GDP	3,6%	3,6%	3,5%	3,5%	3,4%	3,3%	3,4%	3,4%	3,2%
Economically inactive population as a% of GDP, contributions paid by the State	1,4%	1,3%	1,4%	1,5%	1,4%	1,5%	1,5%	1,8%	2%
Public health insurance	100%	100%	100%	100%	100%	100%	100%	100%	100%
The contributions of the economically active population as% of public health insurance	72%	73%	72%	71%	71%	69%	69%	65%	62%
The contributions of the economically inactive population as% of public health insurance	28%	27%	28%	29%	29%	31%	31%	35%	38%

Source: Chub et al., 2011, p. 200

According to table 2, it is clear that expenditure on the financing of health care, are on an upward trend, both in absolute terms, but also as a proportion of GDP. The origin of the expenses is to see the changes in the light of the decline in the share of public expenditure, it follows that private sources make up a growing percentage of total expenditure on health care.

Table 2: Health care spending per capita in purchasing power parity, the expenditure as % of GDP, and the proportion of public expenditure of total expenditure.

Parameter/year	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**
The total expenditure per 1 inhabitant (in USD)	604	664	730	791	1057	1139	1351	1619	1862	2067	2097
Total expenditure (% of GDP)	5	6	6	6	7	7	7	8	8	9	9
The proportion of public expenditure of total expenditure (%)	89	89	89	88	74	74	68	67	68	66	64

Source: own processing with the WHO Global Health Expenditure Database

The reasons for increasing the share of private sources of funding include:

- enhancing supplements for medicinal products;
- higher spending on over-the-counter drugs;
- more frequent use of private health facilities;
- the ever-increasing costs above the standard treatment;
- increase in the various fees for administrative tasks;
- informal payments.

2.2 Netherlands

The data in table 3 show that expenditure on the financing of the health care in the Netherlands have an upward trend even in absolute terms and as a share of GDP. In the origin of expenditure are thus evident changes in the sense of increasing the share of public expenditure, it follows that private sources make up an increasingly smaller percentage of total expenditure on health care.

Table 3: Expenditure on health care per inhabitant in purchasing power parities, expenditure as % of GDP, and the proportion of public expenditure of total expenditure

Parameter/year	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
The total expenditure per 1 inhabitant (in USD)	2341	2554	2833	3098	3309	3451	3703	4411	4730	4935	5112	5123
Total expenditure (% of GDP)	8	8	9	10	10	10	10	11	11	12	12	12
The proportion of public expenditure of total expenditure (%)	63	63	62	67	66	66	82	84	85	85	85	86

Source: own processing with the WHO Global Health Expenditure Database

2.3 Denmark

According to the data in table 4 it is clear that expenditure on the financing of health care in Denmark recorded an increase, both in absolute terms and as a share of GDP. However, in the period under review there has been almost no change in the proportion of public spending against private.

Table 4: Expenditure on health care per inhabitant in purchasing power parities, expenditure as % of GDP, and the proportion of public expenditure of total expenditure

Parameter/year	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
The total expenditure per 1 inhabitant (in USD)	2508	2678	2870	2894	3124	3578	3578	3767	4057	4386	4467	4654
Total expenditure (% of GDP)	9	9	9	10	10	10	10	10	10	11	11	11
The proportion of public expenditure of total expenditure (%)	84	84	84	85	84	84	85	84	85	85	85	85

Source: own processing with the WHO Global Health Expenditure Database

2.4 Sweden

According to the data in table 5 shows that the expenditure on the financing of health care in the Netherlands have a slightly increasing tendency. However, in terms of the total expenditure in terms of GDP share we observe relatively constant value, and to 9% in the

period 2001-2008 and 2011, while 10% in the years 2009-2010. The origin of the expenses in the period under review are not present more significant changes, the values are moving at 81-82%.

Table 5: Expenditures on health care per one inhabitant in purchasing power parities, expenditure as % of GDP, and the proportion of public expenditure of total expenditure

Parameter/year	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
The total expenditure per 1 inhabitant (in USD)	2287	2507	2697	2832	2953	2963	3195	3431	3656	3711	3760	3870
Total expenditure (% of GDP)	8	9	9	9	9	9	9	9	9	10	10	9
The proportion of public expenditure of total expenditure (%)	85	82	82	82	81	81	81	81	82	82	81	81

Source: own processing with the WHO Global Health Expenditure Database.

It should be noted that the Swedish healthcare workplaces are perfectly equipped and it is possible to implement all the performances at the highest world level. Also a way to register data and link medical documentation belongs to the world leaders. At a very high level, as well as communicating with health care professionals, patients, medical ethics application in everyday practice, respect for the rights of the patient and his integrity (Ležovič, 2007, p. 3).

2.5 Bulgaria

The data in table 6 show that expenditure on the financing of health care in Bulgaria recorded a surge in 2010 were spending per capita doubled compared to 2001. This has occurred as a result of improving the economy and reducing unemployment. In terms of the total expenditure in terms of share of GDP in the period under review range values at the level of 7-8%. In the proportion of public expenditure, however, appear extreme value, in 2010, the proportion of public expenditure of only 56% of the total, which means that the share of private spending is among the highest in the EU.

Table 6: Expenditure on health care per inhabitant in purchasing power parities, expenditure as % of GDP, and the proportion of public expenditure of total expenditure

Parameter/year	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
The total expenditure per 1 inhabitant (in USD)	385	505	575	624	650	719	764	843	970	991	1057
Total expenditure (% of GDP)	6	7	8	8	7	7	7	7	7	7	8
The proportion of public expenditure of total expenditure (%)	61	58	61	62	61	61	57	58	59	55	56

Source: own processing with the WHO Global Health Expenditure Database.

2.6 Romania

Based on the data in table 7, it is evident that the expenditure for the financing of health care in Romania have an increasing trend. We observe a more pronounced increase in 2008, when the expenditure per capita amounted to twice the value of the year 2003. After a year of 2008 is only a slight increase. The total expenditure expressed as a percentage of GDP increased in the years 2009-2010 to 6%, while in the previous period in the years 2002-2008 this value is maintained at a level of 5%. In the proportion of public expenditure to appear more significant changes, the values are moving throughout the period under review, around 80%.

Table 7: Expenditure on health care per inhabitant in purchasing power parities, expenditure as % of GDP, and the proportion of public expenditure of total expenditure

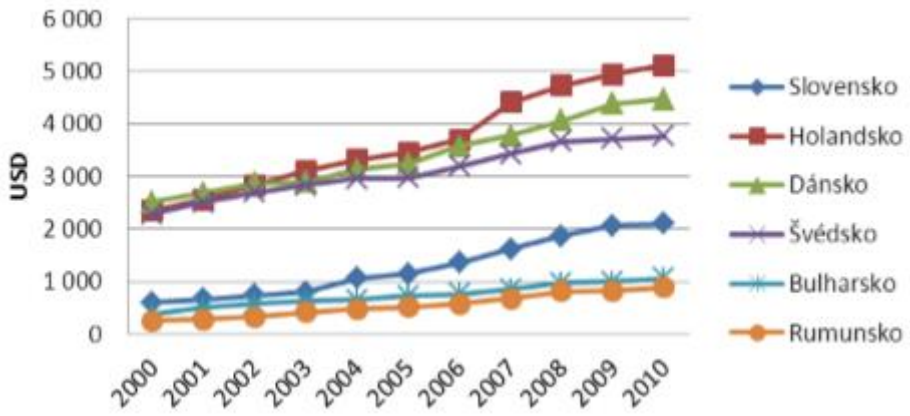
Parameter/year	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
The total expenditure per 1 inhabitant (in USD)	248	280	323	409	479	516	568	670	815	826	881
Total expenditure (% of GDP)	4	4	5	5	5	5	5	5	5	6	6
The proportion of public expenditure of total expenditure (%)	81	81	82	85	75	80	80	82	82	79	80

Source: own processing with the WHO Global Health Expenditure Database.

2.7 Comparison of selected indicators of health financing policy in selected countries

Of the total expenditure expressed as a% of GDP (table 8) once again leads the Netherlands, where the proportion of expenditure on health care represents 12% of GDP. Compared to Romania it is double. The value of this indicator is in Slovakia, the Netherlands and Romania in 2010 increased compared to the year 2001 by 50%, while in the other countries we observe over a period of more moderate growth (graph 1).

Graph 1: Total expenditure on health care per inhabitant in selected countries in purchasing power parity (in USD)



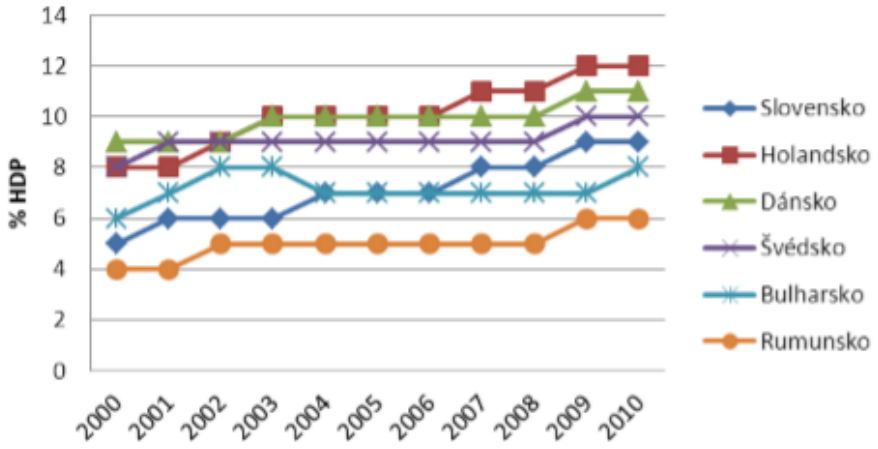
Source: own processing with the WHO Global Health Expenditure Database.

Table 8: Total health expenditures in selected countries (in % of GDP).

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Slovakia	5	6	6	6	7	7	7	8	8	9	9	-
Netherlands	8	8	9	10	10	10	10	11	11	12	12	12
Denmark	9	9	9	10	10	10	10	10	10	11	11	11
Sweden	8	9	9	9	9	9	9	9	9	10	10	9
Bulgaria	6	7	8	8	7	7	7	7	7	7	8	-
Romania	4	4	5	5	5	5	5	5	5	6	6	-

Source: own processing with the WHO Global Health Expenditure Database.

Graph 2: Total health spending in selected countries (% of GDP)



Source: own processing with the WHO Global Health Expenditure Database.

In the structure of health care spending occurred in some countries during the period considered evident changes (table 9, Figure 3). In the United States in 2003, maintained a share of the public expenditure to the rate of almost 90%, but since 2004 we observe a decrease and in 2010 this proportion amounted to 64%.

In the Netherlands, by contrast, the value of this pointer to an upward trend. In 2005, the share of public spending accounted for about two-thirds of total spending on health care. There was a break in 2006, when the value has risen to 82% and record another, although a slight increase.

Denmark and Sweden have a relatively constant the structure of spending on health. The share of public expenditure in Denmark formed throughout the period under review no 84.85%, while in Sweden a little less, and 81-82%.

In Bulgaria, the proportion of public spending did not change significantly. In the year 2008 is maintained in the range of 55-60%, in the years 2009 and 2010 there was a slight decrease to 55-60%. The share of public expenditure in Romania also can be considered a constant. Throughout the period under review, the ratio ranged between 79-82%, with the exception of

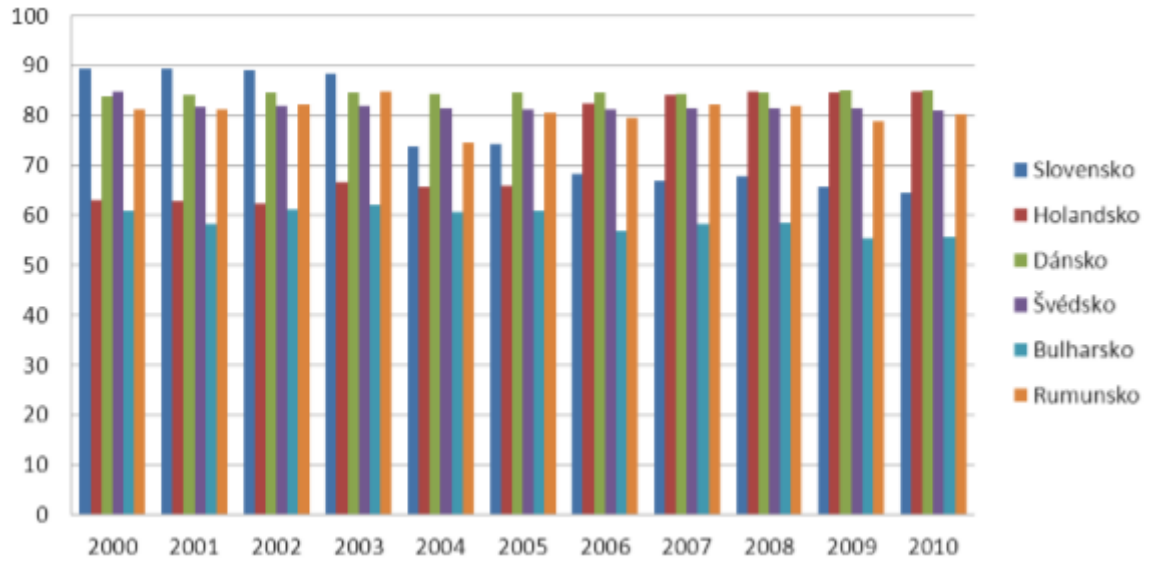
2003, when the share of public spending has risen to 85% and the year 2004, when on the contrary fell to 75%.

Table 9: Proportion of public expenditure of total expenditure on health in selected countries (%)

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Slovakia	89	89	89	88	74	74	68	67	68	66	64	-
Netherlands	63	63	62	67	66	66	82	84	85	85	85	86
Denmark	84	84	84	85	84	84	85	84	85	85	85	85
Sweden	85	82	82	82	81	81	81	81	82	82	81	81
Bulgaria	61	58	61	62	61	61	57	58	59	55	56	-
Romania	81	81	82	85	75	80	80	82	82	79	80	-

Source: own processing with the WHO Global Health Expenditure Database.

Graph 3: Proportion of public expenditure of total expenditure on health in selected countries (%)



Source: own processing with the WHO Global Health Expenditure Database.

The order in which they were placed under the first two of the investigated variables correlated with their position in the ranking of the Euro Health Consumer Index, which assesses the health care systems in Europe on the basis of the quantity indicators. In 2012, the Netherlands was in first place, Denmark second, Sweden ranked sixth, Slovakia, approximately in the middle, at the sixteenth position while Romania and Bulgaria have ended up at 32. and 33. position (http://www.healthpowerhouse.com). On this basis, it is possible to conclude that the quality of health care has significantly depends on the volume of resources used to finance health care expressed in absolute numbers or as a percentage of GDP per capita.

When comparing the structure of spending, one can see that in this period, more significant changes happened (among the selected countries) only in the Netherlands and Slovakia. Although models of financing health care in these two countries are similar, share of the

public expenditure of total expenditure on health care in the Netherlands was increasing, while in Slovakia has a decreasing trend.

3 The conclusions and recommendations

Financing of health care systems in European countries have a lot in common. Most of the funding to cover expenditure in this area comes from public sources and expenditure on health care is increasing every year.

There are a number of proposals on how to ensure a greater influx of funds in the health sector, but due to the ever increasing costs in the form of new materials-technical equipment and more qualified labour force, it is almost impossible to reach a state where they would be ample money in the health care sector.

Creation of resources to fund health policy depends on the determinants of macroeconomic policy as well. Constantly raising the volume of these resources, however, does not automatically mean the improvement of health care and improving the health of the population. The increase in the volume of resources for the financing of the health sector will never lead to ideal, or at least satisfactory condition without effective regulation costs and improve management. To effectively control the cost of providing health care through patient motivation may be, on the one hand, as well as the health care provider on the other.

The patient, if he is entitled to free health care, may be used without restriction, including in cases where it is not warranted. The big problem is the fact that patients neglect prevention and doctor visit up in case of trouble. Expenditures on prevention are incomparably lower than on treatment and therefore it would be beneficial to the prevention of patients to motivate not only information booklets in the halls, but also a form of financial benefits, for example. a bonus for failure to take medical care or, in the case of good preventive results. Additionally, patients and citizens should also have a broad selection of supplementary individual health insurance options, which would be based on accommodating their needs.

Health care providers could be motivated by insurance companies in terms of reduction of differences in refinance the preventive and therapeutic performances. This would lead to the active conduct of providers in terms of preventive care.

Health is not a commodity, unable to buy, yet the issue has revolved around an increasingly larger amount of funds, whether from public or private sources. The responsibility of each of us is to take care of health, since it is our most valuable, entire society recognized value. The role of health policy should represent a summary of such activities and measures that would be in accordance with the basic principles of social policy, and should be a positive impact on the health and quality of life of the company, thus also on its productivity.

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