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Indicators of the effectiveness of the healthcare financing system in the Western Balkan countries – critical analysis

Pokazatelji efikasnosti sistema finansiranja zdravstvene zaštite u zemljama Zapadnog Balkana – kritička analiza

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Abstract

Background/Aim. The main objective of the health system is to preserve and improve the general level of health of the population. Every country is making considerable efforts to ensure a sustainable healthcare financing system that would enable the qualitative realization of basic social security rights, rights to healthcare. The aim of the study was to determine the difference between the health system and the concepts of financing through the critical analysis of the system/model and indicators of financing health care in the Western Balkan countries. **Methods.** An overview of the current state of the health care system in the Western Balkan countries was based on data collected from sources such as the World Bank, World Health Organization, United Nations Development Programme (UNDP) reports, health ministries, finance ministries and statistical institutes of all countries in the analysis. Following the classification of the data, some categories were created to identify differences and similarities between the funding methods used in the Western Balkan countries. The analysis was performed by measuring the effect of healthcare funding on variables by measuring performance. Because it is impossible to measure the relationship between variables in a single regression analysis model, several regression functions were used for accurately determining the relationship results. **Results.** The two indicators: a total expenditure on health services and institutions as a percent of gross domestic product (GDP), and health expenditure *per capita* shows weak positive correlation ($p = 0.3$) indicating that a higher amount of GDP *per capita* does not have a positive impact on the percentage of health expenditure in the Western Balkan countries observed. Despite differences in expenditures, all countries had a relatively similar funding method with different regulation that has impact on effectiveness of health system and resources used. **Conclusion.** The health sector in the Western Balkans is characterized by a lack of adequate administrative resources, legislation and regulations, as well as significant constraints in securing the necessary budget. Considering the resources devoted to the health sector in the Balkan countries, it can be said that the authorities in these countries do not see the health system as an important pillar of the country's development, as they do not devote sufficient financial resources to ensure the functioning of the health system.

Key words:
balkan peninsula; economics, medical; health care costs; health care sector; models, theoretical.

Apstrakt

Uvod/Cilj. Glavni cilj zdravstvenog sistema je očuvanje i poboljšanje opšteg nivoa zdravlja stanovništva. Svaka država ulaže značajne napore da osigura održiv sistem finansiranja zdravstvene zaštite koji bi omogućio kvalitativnu realizaciju osnovnih prava stanovništva na socijalno osiguranje, tj. prava na zdravstvenu zaštitu. Cilj istraživanja bio je da se utvrdi razlika između sistema i koncepata finansiranja kroz kritičku analizu sistema/modela i pokazatelja finansiranja zdravstvene zaštite u zemljama Zapadnog Balkana. **Metode.** Pregled trenutnog stanja sistema zdravstvene zaštite u zemljama Zapadnog Balkana zasnovan je na podacima prikupljenim iz izvora Svetske banke, Svetske zdravstvene organizacije, izveštaja Programa Ujedinjenih nacija za razvoj, ministarstava zdravlja, ministarstava finansija i zavoda za statistiku svih analiziranih zemalja. Nakon klasifikacije podataka, kreirane su neke kategorije da bi se identifikovale razlike i sličnosti između metoda finansiranja u zemljama Zapadnog Balkana. Analiza je urađeno merenjem efekata finansiranja zdravstvene zaštite na promenljive, merenjem učinka. Kako je nemoguće izmeriti odnos između promenljivih u jednom modelu regresione analize, u studiji je korišćeno

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nekoliko regresionih funkcija kako bi se tačno utvrdili rezultati odnosa. **Rezultati**. Dva pokazatelja – ukupni izdaci za zdravstvene usluge i ustanove, kao procenat bruto domaćeg proizvoda (BDP), i zdravstveni izdaci po glavi stanovnika pokazali su slabu, pozitivnu korelaciju (p = 0,3), što ukazuje na to da veći iznos BDP po glavi stanovnika nema pozitivan uticaj na procenat troškova za zdravstvo u posmatranim zemljama Zapadnog Balkana. Uprkos razlikama u troškovima, sve zemlje su imale relativno slične načine finansiranja sa različitom regulativom koja utiče na efektivnost zdravstvenog sistema i resursa koji se koriste. **Zaključak**. Zdravstveni sektor na Zapadnom Balkanu karakteriše nedostatak adekvatnih administrativnih resursa, zakonodavstva i propisa, kao i značajna ograničenja u osiguravanju potrebnog budžeta. Uzimajući u obzir resurse posvećene zdravstvenom sektoru u zemljama Zapadnog Balkana, može se reći da vlasti u tim zemljama ne vide zdravstveni sistem kao važan stub razvoja zemlje, jer ne izdvajaju dovoljno finansijskih sredstava za osiguranje funkcionisanja zdravstvenog sistema.

Ključne reči:
balkansko poluostrvo; ekonomija, medicinska; zdravstvena zaštita, troškovi; zdravstvena zaštita, pružanje usluga; modeli, teorijski.

Introduction

Modern healthcare systems differ the most in the methods of raising funds for health care, as well as in the payment methods of health care providers. Healthcare costs vary from country to country depending on its development. They are measured by the issue of *per capita* health supplies or as a percentage of total national income. The sources of financing the healthcare system are: state budget – general and specific taxes, insurance fund – compulsory health insurance (contributions), voluntary/private insurance (insurance premiums), participation (personal participation of the health insurer in the costs of using the health service), full price of the service (private practice) and donations and voluntary contributions from institutions, groups and individuals. The issue of defining healthcare financing involves not only the method of payment, but also the persons contributing to its payment, how the beneficiaries and providers are involved in the transaction and how much is spent on healthcare. Consequently, the way the health sector is financed is quite sensitive, as it can be a deciding factor for the various implications of the overall health care system.

The healthcare system must provide physically, geographically and economically accessible, integrated (vertical connection of primary, secondary, tertiary level and horizontal connection in the system and in relation to the local community) and high quality health care (continuous improvement of the quality of health care and the right of beneficiaries' physician choice and awareness), personal development of employees working in a healthcare system, sustainability of financing, decentralization of management and financing of healthcare, and placement of citizens at the center of the healthcare system and protection.

Given the demographic trends present throughout Europe, including the countries of the Western Balkan, and especially the increase in the proportion of the elderly, it is a fact that a larger number of individuals require some health care. Also, the advancement in the field of medicine requires the application of new and more expensive treatments, including new medicines and modern equipment. All this implies, in the long run, an increase in costs and the need for greater investment in the health care system.

The healthcare system in the Western Balkan countries is currently facing a number of issues related to health care financing [1]. In particular, some of the major financial problems that have accompanied the healthcare system in this region are the funding methods used in financing health activities and the attitude of the authorities in these countries regarding the performance and quality of health care. Regardless of the decision makers, those who bear the costs of the health sector are citizens of the Western Balkan countries whose social protection is deteriorating due to denial of access to quality health services [1].

The aim of the study was to determine the difference between the healthcare system and the concepts of financing through the critical analysis of the system/model and indicators of financing healthcare in the Western Balkan countries.

Methods

The current state of the healthcare system in the Western Balkan countries, was based on data from reliable and credible sources such as the World Bank, the World Health Organization, United Nations Development Programme (UNDP) reports, health ministries, finance ministries and statistical institutes of all countries and desk analysis was done; the narrative was presented as background in the text above. Variables proven to be important for cross-country financial comparisons are total health expenditure – total expenditure on health services and institutions as a percentage of each country's gros domestic product (GDP) in the Western Balkans and *per capita* health expenditure – total *per capita* expenditure of each country in the region for one specific year (2017).

Since it was impossible to measure the relationship between variables in a single regression analysis model, several regression functions were used in the study to accurately determine the relationship results. Statistical analysis was performed with SPSS version 20.0 statistic software package. The Kolmogorov-Smirnov statistics was used to assess the normality of the distribution of scores. A non-significant result (p value of more than 0.05) indicates normality. Since both variables had a normal distribution

($p > 0.05$), the dependence between them was determined using Pearson's correlation coefficient.

Results

Albania is a Balkan country whose health sector is funded by a combination of general tax, payroll tax, compulsory health insurance and voluntary health insurance expenditures, out-of-pocket payments and various domestic donors. Among them, the Ministry of Health and the Health Insurance Institute play the most important financial role. It has been shown that Albania has managed to increase its economic development, but the health sector is still significantly underdeveloped [1–3]. According to a report published by the World Bank, many indicators suggest that Albanian health care has progressed in recent decades, but other sources indicate that its health sector is not in a favorable position relative to Southeast European countries. According to World Health Statistics, published by the World Health Organization in 2017, total health expenditure in Albania was 6.9% of the total GDP (Figure 1), while *per capita* health expenditure was USD 520 (Figure 2), one of the lowest in the region [4].

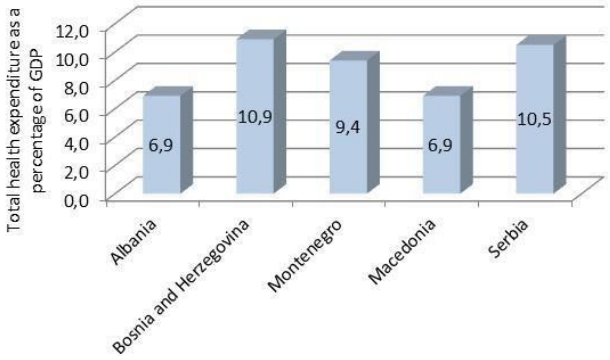

Fig. 1 – Total health expenditure as a percentage of gross domestic product (GDP) [4].

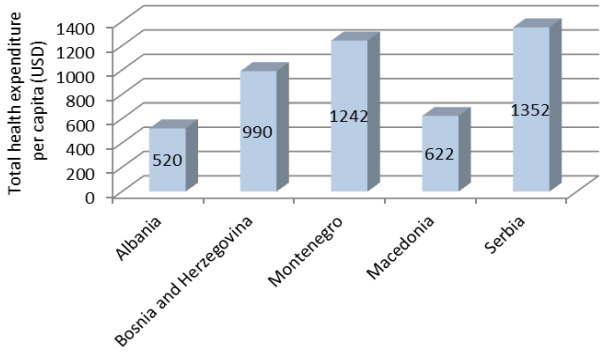

Fig. 2 – Total health expenditure *per capita* [4].

Due to low public expenditure on health care, out-of-pocket expenditures are high, accounting for 56.1% of total health expenditure and 99.8% of total private expenditure (Figure 3). High levels of payments from the Treasury are causing serious implications for "equity, poverty and the health sector". Moreover, a World Bank publication classifies healthcare quality in Albania as low, mainly because human capital remains isolated and unable to receive training to improve their skills [5].

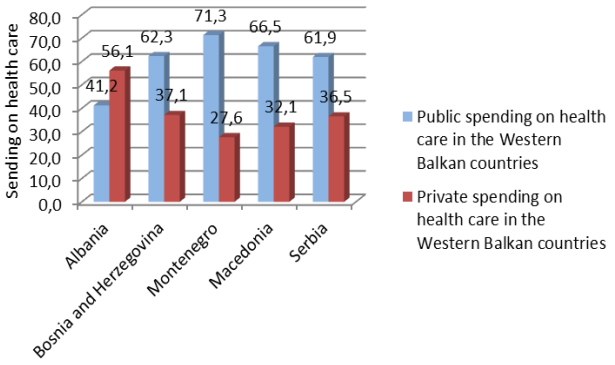

Fig. 3 – Public and private spending on health care in the Western Balkan countries [4].

Bosnia and Herzegovina is funded by compulsory national health insurance, state budget, private contribution and donations. The health system in Bosnia and Herzegovina suffers from inefficient administrative management because the system faces a large number of unnecessary staff due to the different socio-economic situations between the entities and the cantons [6, 7]. Moreover, a report published by WHO shows that the entire economy of Bosnia and Herzegovina is burdened by the effects of an unsustainable financial system in the health sector. WHO statistics showed the financial state of the health system in Bosnia and Herzegovina in 2017, where the total health spending was about 10.9% (Figure 1) of GDP, while *per capita* spending in the same year was $990 (Figure 2). In addition, statistics show that private health care expenditure accounts for 38.7% of the total spending, and that 100% of private expenditure is funded out-of-pocket [4].

In Macedonia, health care is funded through a combination of public and private funds. The Health Insurance Fund (HIF) is funded by the payroll tax, the pension fund, the unemployment fund and the government budget, while out-of-pocket payments consist of most private expenditures. According to a report released by the Ministry of Health, financial management in the health sector is quite poor due to the lack of training of the individuals needed. Basically, this report noted the absence of incentives to control the financial sector in healthcare, and is supported by patients and doctors, who do not report ill-treatment [8, 9].

As a result of poor financial management in the health care system, Apostolska and Tozija [10] argue that high out-of-pocket payments will continue to increase, thus increasing social inequalities between classes of people regarding health services. Total health sector expenditures in Macedonia in 2017 amounted to 6.9% of GDP (Figure 1), and *per capita* health care expenditures amounted to $622 (Figure 2). It is also important to note that out-of-pocket expenditures account for 33% of total expenditures and 99.1% of private expenses [4].

Montenegro is a country where the health sector is funded through mandatory health contributions, general government funds, out-of-pocket payments and donors. According to the development plan of the Ministry of Health in Montenegro, the country has experienced positive steps, but due to poor socio-economic conditions in the country, Montenegro's health is lagging behind compared to EU countries [11, 12]. Furthermore, the WHO World Health Statistics report showed that total health expenditure in Montenegro in 2017 was 9.4% of the total GDP (Figure 1), while per capita health expenditure was $1242 (Figure 2) [4].

The same report further explains that public expenditures are only 71.3% of total expenditures and 28.3% are private expenditures. Out-of-pocket payments include 26% of total health expenditure and 91% of private expenditure. High levels of payment out-of-pocket are some negative signals that the health care system is not functioning properly.

The health system in Serbia is funded by public and private contributions. The Republicn Health Insurance fFund (RHIF) is funded by mandatory contributions and is one of the key sources of financing for the health sector. Healthcare in Serbia is also funded by the state budget and out-of-pocket payments, which consist of almost all private expenditure and donations [13]. WHO statistics showed that the total health spending in Serbia in 2017 was 10.5% of GDP (Figure 1), while per capita spending was $1,352 (Figure 2) [4]. The same statistics also showed a high level of out-of-pocket payments; namely, 35% of total health expenditure and 92.2% of private expenditure, accounting for 38.1% of total expenditure. Out-of-pocket payments can easily create financial blockages and reduce the use of health prevention services due to the high cost of healthcare services [14].

Results of the Kolmogorov-Smirnov statistics are given in Table 1. It assesses the normality of the distribution of scores. A non-significant result ($p > 0.05$) indicates normality. Since both variables have a normal distribution ($p > 0.05$), the dependence between them was determined using Pearson's correlation coefficient (Table 2).

Table 1

Results of the Kolmogorov-Smirnov test for normality

Parameter	GDP/*capita* (USD)	Health expenditure (% of GDP)
Average value	4,868	8.92
Standard deviation	921.61	1.92
Kolmogorov-Smirnov Z	0.396	0.566
p	0.998	0.906

GDP – gross domestic product.

Table 2

Pearson's correlation coefficients (*r*) between GDP and health expenditure

Parameter	GDP		Health expenditure	
	r	*p*	*r*	*p*
GDP	1	-	0.3	0.624
Health expenditure	0.3	0.624	1	-

GDP – gross domestic product.

The value of Pearson's correlation coefficient ($r = 0.3$) shows a weak, positive correlation between the two observed variables, indicating that a higher amount of GDP *per capita* does not have a positive impact on the percentage of health expenditure in the Western Balkan countries observed.

Discussion

Authorities in Bosnia and Herzegovina, Serbia and Montenegro consider the health care system to be very important because they have allocated a relatively large portion of their GDP to secure the health care system in their countries. In 2017, health systems in Bosnia and Herzegovina, Serbia and Montenegro accounted for 10.9%, 10.5% and 9.40% of their total GDP respectively. Knowing this, it can be said that, as a percentage, these countries are on par with many developed countries and even have a higher share of health expenditure than them. On the other hand, there are countries with lower overall costs such as Albania and Macedonia, which are categorized with similar levels of expenditures, namely between 6.70% and 6.90%. Compared to other countries, this low percentage of total costs can serve as a key factor in determining the quality and performance of healthcare.

Focusing only on this variable and keeping everything constant, it can be implied that Bosnia and Herzegovina, Serbia and Montenegro should have their health systems competitive with developed countries, as they are on par with developed EU countries in terms of total health expenditure as a percentage of GDP, while other countries with lower health expenditures should have a less developed health care system because they are quite lagging behind compared to other countries in terms of this variable.

The Balkan countries are considered to have the Bismarck's and Beveridge's system of healthcare financing, but with significant changes in the overall funding methods. Basically, three major financial sources are recognized in the Balkans: Social Security Fund (mandatory contribution as payroll tax), government revenue (from the total budget), and out-of-pocket payments (direct payments by the service user). Nonetheless, voluntary health insurance and donor funding are other financial sources for the health sector in the region, which can be explained as voluntary payments by individuals to avoid catastrophic healthcare costs and payments offered as donations by various organizations.

The Western Balkans is a geopolitical region comprising: Albania, Bosnia and Herzegovina, Macedonia, Serbia and Montenegro. The Western Balkans covers an area of 196,047 km^2 with a population of 21.5 million. The Western Balkan countries have been in the process of transition for the last twenty years. While still a major challenge for the whole region for institutional and structural reform, positive macroeconomic characteristics are evident in the region. At the beginning of this century, the countries of the region recorded the highest economic growth since the beginning of transitional changes. The growth was mainly due to the rapid expansion of consumption and investment-financed loans, and one of the important drivers of progress

was foreign direct investment. However, the problem is that capital inflows in the region are mainly concentrated in several countries (EU candidate countries) and in the most attractive sectors by country (telecommunications; oil, gas and electricity production; food production; steel production and tourism).

In Albania, the health care system is generally public, while private practice has little market share. Albanian law guarantees equal access to health care for all citizens. Albania's public health service is the main provider of health services, health promotion, prevention, diagnosis and treatment for the Albanian population. Primarily, the Albanian Government finances the state health system. Other sources of funding include contributions from qualified employers, employees and the self-employed (a certain percentage of their salaries or income are deducted) and contributions to the insurance scheme [2, 3]. However, poverty in Albania is quite common and only a small number of people can afford such contributions [1]. As a result, many citizens do not receive necessary medical assistance and medication for their illnesses. The failure to raise a significant amount of contributions means that Albania's health care system relies heavily on charitable assistance for medical supplies and medicines.

The existence of catastrophic health care costs is a concern. Disastrous healthcare expenditures not only impose a higher risk of poverty for people seeking healthcare, but can also impose barriers to access to healthcare. Albanian authorities need to give serious consideration to reducing the total out-of-pocket payments, which amount to nearly 60% of the country's total health care expenditure. This is best achieved by ensuring the efficiency and attractiveness of formal health care financing mechanisms (general tax revenue and health insurance). Although improving the efficiency of such mechanisms requires better coordination and allocation of resources, attractiveness could be enhanced by adopting a contribution and participation structure to better reflect revenue sharing. Measures such as exemptions or subsidies for vulnerable groups have already proven effective in reducing catastrophic payments in other countries [15].

Conversely, the complete healthcare system in Bosnia and Herzegovina is characterized by marked fragmentation as it is organized differently in the Federation of Bosnia and Herzegovina, Republic of Srpska and Brčko District of Bosnia and Herzegovina. Viewed through organizational structure and management, it is realized through 13 completely different subsystems, at the level of entities, cantons in the Federation of Bosnia and Herzegovina and Brčko District, which greatly complicates the way health care services are provided, increases the costs of management and coordination and has a poor impact on the rationality of healthcare operations, primarily viewed through the prism of inadequate utilization of economies of scale [1].

The health sector of the Federation of Bosnia and Herzegovina is composed of a network of as many as 11 health ministries (10 cantonal and one federal), 11 health insurance institutes (10 cantonal and Federal health insurance and reinsurance institutes) and 11 public health institutes [6, 7].

When it comes to financing healthcare, it is mainly financed by compulsory health insurance contributions; namely, health insurance contributions from wages, salaries contribution paid by the employer, health insurance contributions paid by pension beneficiaries, farmers' contributions to the unemployed and other categories. In addition, each canton has its own Health Insurance Institute, which bears responsibility for financing health services at its own level. Although the law provides for other forms of financing (cantonal budget, Federation, donations, income of health institutions, participation, etc.), contribution financing is a major source of health revenue [6, 7].

The public health system in Bosnia and Herzegovina, with its current funding model, is clearly not capable of keeping up with the needs, expectations and habits of the population in terms of health services. The fact is that population expectations, demand and need for health services have also been increasing for a long period, mainly because health care is one of the most valuable and significant forms of personal consumption. Also important is the fact that the financing of the public health care system in the Federation of Bosnia and Herzegovina is not subject to a single regulation, but differs by canton. Only the calculation of the base and the rate of contribution for employees at the employer (12.5% at the expense of employees and 4% at the expense of the employer) is uniquely regulated, while the base and rate of contribution for other categories of population are defined differently based on decisions of cantonal assemblies. Therefore, cantonal health insurance institutions are in different financial positions (depending on the number of employees and average gross salary), which has a direct impact on the scope and categories of rights offered to policyholders [7].

Healthcare financing in Montenegro is based on the principles of Bismarck's social health insurance, which is funded by contributions to categories defined by law. According to the latest available data, more than 95% of the population is covered by this insurance. The missing funds for the functioning of the health system and the needs of healthcare are provided from the state budget. These funds relate to the payment of salaries of employees in public health institutions, as well as to the financing of the activities of the Ministry of Health, which implies a mixed financing system, and especially if it is kept in mind that the current legal solutions (Budget Law, Treasury system) are more appropriate to the system budget financing healthcare than insurance system. The minimum additional funding for healthcare financing in Montenegro comes from the personal participation of health care beneficiaries (participation), other payments and donations [11, 12].

The method of payment for healthcare institutions takes the form of budget financing by item. The Fund, based on the Decision on the allocation of funds of the Fund for the current year, allocates funds to health institutions intended for earnings, material costs, medicines and medical devices,

capital expenditures, etc. Health institutions know in advance the monthly amount of funds that the Fund will transfer to them and make payments within the available financial means, and due to the lack of funds to cover all the needs, they report outstanding liabilities. In Montenegro, there is no specific contribution rate for injuries at work and occupational diseases, as in some other countries in Europe, where employers pay special rates of contribution to insure employees from injuries at work and occupational diseases. This type of income differs and is contingent on the amount of risk expenditure [11]. The implementation of the said contribution rate is certainly one of the potential sources of additional funding.

In Macedonia, there are two types of health insurance under the Health Insurance Act: compulsory and voluntary insurance for some forms of health care. Mandatory health insurance has been established for all Macedonian citizens in order to provide social security and healthcare and exercise certain rights in the event of illness or injury and other health care rights set out in the Health Insurance Act. Compulsory health insurance is based on the principles of obligation and universal coverage, solidarity, equity and efficient use of funds in accordance with the law. This means that every insured person can use health services (basic covered by compulsory health insurance) and unlimited health insurance when needed. On the other hand, there is an obligation to all employees and other insurance carriers to continuously pay health insurance contributions. The contribution rate is the same for all employees, regardless of salary or income, or the frequency and amount of health care services used in a health insurance account. The principles of solidarity and fairness are mandatory [8, 9].

Some specific risks and services, which are not covered by compulsory health insurance, should be provided by the employers of certain groups of workers. Compulsory health insurance is a major source of health care revenue. The HIF income is used to fund programs for which the HIF is responsible. Health insurance costs for those who are not enrolled in the program, who are not insured by fund, and their healthcare costs are covered by the state budget. Direct contributions from employers and health insurance workers were 59.4% of the Fund's total revenues in 2017. In addition, their retirement and unemployed contributions include components used for health insurance for retirees, the unemployed, the disabled or social security recipients. These amounts, which amount to about 36.1% of the HIF's income, are paid out of state funds for pensions, unemployment and other social programs. The Fund's revenue from the general budget in 2017 was 0.4%. The Ministry of Finance establishes budgets for the Ministry of Health vertical programs and examines and approves the budget for the HIF [8].

The healthcare system in Serbia is constituted to provide access to all health services for the entire population. Insurance coverage covers all employed persons, pensioners, self-employed persons and farmers who make contributions. In addition, the state budget provides funds for health insurance for the unemployed, internally displaced persons and refugees. The special health insurance coverage system applies to the military, civilians in the military and retirees of the armed forces, as well as their family members and dependents. Healthcare financing in Serbia is a combination of Bismarck and Beveridge model. Basically, the financing of the healthcare system is based on the compulsory health insurance provided by the contributions (10.3% rate), which is the basis of the Bismarck model. On the other hand, for the persons who are not covered by compulsory health insurance (uninsured persons, refugees and internally displaced persons), financing from the budget of the Republic is provided, which is a characteristic of the Beveridge model. Therefore, healthcare financing in Serbia is characterized solely by the public source of financing, as it is largely financed from contributions and from the budget of the Republic [13, 14].

The most important source of financing the healthcare system in Serbia is the Republic HIF (RHIF). Within the public sector of healthcare financiers in Serbia, it was found that the predominant financier was RHIF with a share of 91.2% in 2007 and 93.6% in 2017. Consequently, the payment of the RHIF largely determines the public provision of services. Part of the public financing of health services is also provided by the Ministry of Health, through regional and local governments, the Ministry of Defense, the Ministry of Justice and the Military Health Insurance [13].

As mentioned above, there are four commonly used health financing methods in the Balkans. These four methods of financing healthcare are through direct contribution from the country's budget, health contributions (HIF), direct payments from patients and through donations. In addition to these general healthcare financing methods, many of them are subdivided into specific sources of health care financing. For example, contributions from the state budget can be collected through different types of taxes, while HIF contributions can be collected as a fixed amount for each worker or as a percentage of workers' pay. It is important to note that there is no country that depends solely on one way of financing healthcare, but in all countries, there is a combination of different ways of financing to ensure that there is sufficient budget for health services and to (conditionally) ensure the effective use of funding methods [15–18].

Taxation as a way of financing the health function is a way when certain authorities are responsible for collecting different taxes through different means than citizens operating in that country. These taxes create the country's budget, which allocates part of the budget to different ministries for different purposes. In this case, the Ministry of Health is responsible for receiving part of the budget earmarked for health, and it is the authorities that prioritize the projects and decide how the money will be allocated within the sector. Another way to finance healthcare is through HIF contributions, which are similar to the taxation method. As in the previous methods, HIF contributions are paid by contributors in two forms, in some places they are paid as a fixed amount by each worker, while in others they are paid as a percentage of wages, which means that the

higher the salary, the greater the contribution in absolute value. Unlike the method of taxation, HIF contributions from people operating in a particular country are not classified in the state budget category, but are directly categorized into the health budget separately [15–18].

Another important way of financing healthcare is the category of direct payments by patients. This category is part of private health spending because people pay directly for the health care services they use, without involving any third party in the transaction process. Direct payments, also known as pocket payments, refer to the process when patients visit healthcare facilities and pay directly for the services they use at those facilities. This method is widely used, especially in less developed countries, and is also common in the Balkans. Another method of financing, which is categorized under the umbrella of private expenditure, is through private health insurance. Through this method, patients purchase health insurance packages before needing medical services. Then, in case patients need medical services, they are covered by a third party, as an insurance company that pays for medical services for a patient who has already purchased health insurance. The next form of healthcare funding is through donations. This method occurs when an organization, whether internal or external, offers financial support to a country's healthcare sector. The grants are generally dedicated to less developed countries because they lack adequate financial resources to properly fund the health sector, and as a result, different organizations are constantly ready to assist different countries in establishing and maintaining their health systems [15–18].

Each of the explained ways of financing health care has a positive and negative effect on the health sector of a country. It can not be said that a particular method produces certain result in each country, since there are many other factors affecting country’s health care. Moreover, countries have different needs and priorities, so one method may be most suitable for one country, but not for another.

The issue of defining healthcare financing involves not only the method of payment, but also the persons contributing to its payment, how users and providers are involved in the transaction, and how much is spent on healthcare. Accordingly, the way the health sector is financed is quite sensitive as it can be a deciding factor for the various implications across the healthcare system.

The decision on how to pay for healthcare services is not only an individual issue, but also a matter for society as a whole. Potential alternatives to health sector financing are through public and private expenditures. Public spending refers to general tax revenues collected at different levels. Some countries may even introduce a special tax only to finance the health sector, while other countries only differentiate the fund from the overall state budget. Public expenditure is mainly focused on the well-being of the poor by allowing them access to health services. Businesses suffer large public expenditures because they face double costs, once they pay for their health care treatments and once they pay higher taxes to secure sufficient funds for public health expenditures. In addition, public expenditures in the healthcare system reduce the level of efficiency by reducing competition between public and private healthcare providers [17]. Competition is generally reduced by the fact that, through higher public expenditures, people receive more services in public health facilities; in this case, the readiness of physicians to work in the private sector is reduced. In a study by Jakovljevic et. al. [14], according to purely economic criteria, most institutions responsible for providing public sector services in middle-income economies in Southeast Europe show more than modest performance, which is in complete agreement with the results of this study.

All countries have a similar status in terms of quality and performance of the healthcare sector. Therefore, there is a tendency to believe that increased health expenditure in a country may not lead to improvements in the quality and impact of health care. In their book on whether more money translates into better health, Irvine et al. [18] argue that the question of whether higher costs lead to better health quality and performance is far more complex than it seems, and that the relationship between health costs and health quality is very complex to measure. They have concluded that financial resources are very important and affect many factors that determine a country's health quality; however, they argue that more money does not always lead to better quality of health due to mismanagement or misallocation of resources.

It is important to decide effectively how to finance the health sector in the country, because according to Thomson et al. [16], an efficient system minimizes the losses associated with raising and paying out income. However, countries decide at the individual levels which system best fits the strategies of the country and its citizens. Regardless of the type of financing of the health sector, all countries need to adjust their alternative to financing to achieve three basic principles: increase revenues to provide individuals with planned health care packages that provide health and financial protection against catastrophic medical costs caused by illnesses and injuries in a fair, efficient and financially sustainable manner; managing this revenue to pool health risks equally and effectively; ensure that payment or purchase of health services is done in a manner that is allocative and technically efficient [5].

Fundamentally, these are the main goals of providing an effective way of financing the health sector. Whether these goals are achieved, depends on the economic development and sustainability of the health sector itself.

Conclusion

The healthcare sector in the Western Balkans is currently facing a number of questions regarding health care financing. In particular, some of the major financial problems that have accompanied the health sector in this region are the methods used in financing health activities and the attitude of the authorities in these countries towards health performance and quality. Regardless of the decision-makers, those who bear the costs are the citizens of the Western Balkan countries whose social well-being is

deteriorating as a result of denial of access to quality health services.

Considering that a large part of healthcare activities is financed by private expenditure, especially payments from one's own pocket, the methods of financing healthcare in the Western Balkans are considered inappropriate for the region. In most cases, because of the poverty rate in the region, which is higher than in other countries, it can be said that out-of-pocket payments as a method of financing health care create obstacles for society to access health services. Due to such payment methods, most people living in the Western Balkans do not receive the necessary medical treatment because they are constantly faced with payment obstacles that impede their full access to health services.

Given the resources devoted to the health sector in the Western Balkan countries, it can be said that the authorities in these countries do not see the healthcare system as an important pillar of the country's development because they do not devote sufficient financial resources to ensure the proper functioning of the health care system. Although these countries have experienced economic growth over the years, the budget for health care has not changed in proportion to economic growth; instead, there was a very small increase relative to economic growth. This negligence on the health sector has caused inadequate functionality of the whole system in most Western Balkan countries. The consequence of such action may be considered to be poor performance of actors involved in healthcare, and especially because of the low budget, health systems in the Western Balkan countries have lost a lot of human capital in public health institutions, or their impact has been adversely affected by not having sufficient incentives to be fully dedicated to the health sector in general.

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