Possibilities of Development of Private Health Insurance in Bosnia and Herzegovina

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Abstract: *Increased rise in costs of healthcare in the last five decades has rapidly increased interest in the functioning of healthcare systems within every country. The reasons for growth in healthcare costs are related to demographic changes, technology advancement, increased number of educated persons, emergence of new diseases, etc. Financing the risk of poor health is mainly organized through programs of social and private health insurance. Regarding the management of the risks of poor health in Bosnia and Herzegovina (BiH), the social health insurance system is the basic solution for the population. However, in BiH, as in other countries in the world, the system of social insurance has become unfeasible and it is necessary to search for new solutions, that is, to reform the system. The research subject in this paper is private/voluntary health insurance offered by insurance companies, which can be an efficient addition to social insurance in BiH. It has become present on the market of private insurance in BiH only recently, so its share in the total premium of private insurance is still minor. Therefore, a primary research was conducted on the possibilities for its development as well as on the need and acceptance by the users of healthcare services. Besides, there was a need for examining the performance of the existing system of social health insurance, based on the principles of Bismarck's model of financing, and recognizing its disadvantages. By identifying and eliminating obstacles for development of voluntary health insurance, it is possible to improve performance of the existing system of health insurance in BiH.*

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Introduction

Health is the basic human right and one of the most important assumptions for economic development and life quality of a country's population. There is huge responsibility of individuals and communities regarding the prevention of disease occurrence and good health keeping and improving. Healthcare system is a complex entity whose functioning largely influences the level of population's health, which indirectly affects the economic system as well. Very often the level of country's development is represented as the level of health of an individual and the entire population. That is the reason why states are the bearers of the activities related to healthcare system management.

Every state has a specific healthcare system that can have some similarities when compared to other states. For many years, the awareness on the importance of health and health insurance has been growing stronger. Many make efforts to find the appropriate model that would satisfy the highest possible needs for healthcare services, along with low costs and higher quality of services. From the country's point of view, Bismarck's or Beveridge's model of healthcare system usually dominates, but there are other options that are combined or mutually corresponding.

Bosnia and Herzegovina (BiH) is characterized by the inherited Bismarck's model of social health insurance whose effectiveness has been long questioned, while the country's needs for healthcare increased significantly as the consequence of the war. Only in recent years, there has been more attention paid to the issues of the functioning of country's health system, quality of services provided and alternatives to social health insurance. Some reforms of primary healthcare have already been implemented (Atun *et al.* 2007), but the reform of current model of financing is necessary, and it should provide a framework for introducing other forms of health insurance, such as voluntary health insurance provided by private insurance companies. However, the present offer of voluntary health insurance is still at a very low level. The reason for this is the lack of legal regulations and low interest by the state for entering partnership in health insurance with insurance companies.

The aim of this paper is to establish the possibility for developing voluntary health insurance within the existing reform of the healthcare system in BiH. Due to that, based on the results of the secondary research, the most significant disadvantages were presented in terms of effectiveness of the existing system of social health

insurance. After that, based on the results of the primary research, the interest in the package of voluntary health insurance was registered by private healthcare institutions, citizens and insurance companies. The primary research was also to confirm the disadvantages of the existing system of social health insurance.

Healthcare System in BiH

Matter of health insurance needs to be observed in broad context of healthcare system, which is organized in a specific way in BiH. Healthcare in BiH is regulated on level of entities and Brčko District, and it esults in a very complex organizational solution, especially considering that on level of BiH Federation, besides entity ministry, there are also ten cantonal ministries of health. It is clear that this significantly increases costs of transactions and makes coordination in decision making more difficult (Kozarević, 2010).

Healthcare in BiH is regulated with laws on healthcare adopted on level of entities. These laws have defined the concept of healthcare, which basically comes down to set of measures focused on systemic management of risks of poor health of the citizens. In purpose of that, competencies of specific institutions were established in this system, whose purpose is to enable high inclusion of population with right on healthcare, according to principles of: universality, cost-effectiveness, fairness, freedom of choice and autonomy.

Health insurance within the social insurance in BiH is regulated with provisions of laws on health insurance on level of entities as well as corresponding regulations on Brčko District and cantonal levels. A special place in healthcare system belongs to health insurance institutes (funds) and public health institutes which were established on level of entities as well as Brčko District and level of cantons. Cantonal health insurance funds are formed for activities performed on level of cantons in BiH Federation. BiH Federation health insurance fund collects the assets of federal solidarity which are used to form Solidarity Fund of BiH Federation. Its purpose is to equalize conditions of compulsory health insurance in all cantons, to organize certain programs of healthcare in interest of BiH Federation and to enable providing of priority and most complex forms of healthcare from certain special fields. The assets of federal solidarity are provided from contributions for compulsory health insurance. Crucial difference in Republic of Srpska is in higher level of centralization through unified health insurance fund.

Public health institutes also play significant role, and they are performing public-health activities focused on planning and implementation of measures for: supervision over infectious and noninfectious diseases, providing of health safety of food, water, air and products for general use, monitoring of the environment, promotion of health, prevention of diseases and implementation of regular health-statistical researches. Besides that, public health institutes are also in charge for providing of information on leading health issues and priorities, as well as for proposals for their solving.

Literature Review

The issues of health insurance have been everlastingly urgent and they provide material for constant research. By founding the World Health Organization (WHO) on April 07, 1948, the United Nations particularly emphasized their work in the field of healthcare. Under the auspices of the WHO, numerous conferences were held, whose aim was to define the suggestions for improving population's health. One of the most important conferences for creating healthcare systems of the modern times was the one held in Alma Ata in 1978. Then the declaration "Health for All by the Year 2000" was brought that established the policies related to health protection on the global level.

Public discussions led in many countries related to healthcare are mainly concentrated on the amount of health allocations or the issues related to increased costs and the need for the control of spending the resources in the healthcare system. Zrinščak (1999) compares the countries by various indicators such as: health allocations, healthcare system model, most frequent causes of death, etc. Although many healthcare indicators are getting improved, the inequality of the countries in terms of access to healthcare and social inclusion is increasing. Zrinščak mentions the following possible ways of cost control: (1) Measures related to patients – copayment, modalities of paying sick leave compensations and introducing waiting days, discounts in cases when insurance premiums during one year are not used, and limitations in selecting doctors and hospitals, (2) Health funds – reducing administrative costs, competition between private and mandatory funds, (3) Measures related to hospitals and doctors – encouraging competition among doctors and various models of payment for medical services, and (4) Measures aimed at control of pharmaceutical costs expressed through various models: "permitted" and "prohibited" drug lists, state regulation of prices, determination of the highest price, budget financing, etc.

In the last few years there has been a particular emphasis on the reform of the health insurance in the USA. Booz & Co (2012) established in its research that nowadays employers move towards the model of contributions deposited on savings accounts. Thus, employees may use the funds to choose the insurance package as they wish, instead of the earlier model of benefits in which company created the insurance program for all. Vaughan E. & T. (2000) believe that, regardless of the fact whether the financing system is private or public, it is influenced by adverse selection. They emphasize that private insurers' premiums grow due to increased costs of medical services caused by population aging, improved medical technology, capacity overload and preventive medicine. Additional criticism to the US healthcare system is related to unequal access to medical care, unequal quality of medical services, significant misuse, inefficiency and frauds (Wiening and Rejda, 2007). While describing the reform of the health protection initiated by President Obama, Schansberg (2011) emphasizes that the state's solutions to health protection are not efficient and that the advocates of healthcare free market should provide convincing evidence in favor of a real reform and conduct it where possible. He believes that abolishment or at least reduction of subsidies to health insurance based on employment would be the first step towards the free market of healthcare, and that employers would try to present several options to their employees. The effect of economies of scale is also possible if the groups of employers are categorized in only several insurance types.

According to the analysis made by Deloitte (2012), as a direct result of the Affordable Care Act (ACA) it was estimated that some 32 million Americans by the year 2014 will have been insured. As of 2014, most of these individuals are to possess a minimum level of health insurance, whether by state-sponsored plans, plans sponsored by employers or plans provided on the market of individual insurance policies. In order to improve the access and respect patient's rights, the ACA introduced new commercial standards such as: abolishment of medical underwriting, elimination of age limit, prohibition of exclusion based on previous illnesses, and cancellation of cost share (participation) for preventive services. Health plans would also have to provide the guarantee and renewing option as well as the coverage for essential medical privileges. The ACA introduces new distribution channels that would make the access to health insurance markets easier. National health insurance stock markets have been established aimed at providing information to potential clients and the facts on the range of health plans. Stock markets are designed for those who are not included in Medicaid, Medicare or employer sponsored plans.

The study conducted by the European Observatory on Health Systems and Policies (2006), which discussed the private health insurance in Great Britain, showed that the number of new users is static, if not decreasing, that the market numbers for these types of insurance for corporations falls, and that insurance companies are to turn to smaller firms and individual policies. Vidojević (2011) describes the health system of Great Britain and the National Health Service (NHS) that is the basis of the entire system. The result of the economic crisis in 2008 is the plan for introduction of radical reforms, probably the most drastic ones in the last four years. In July 2010, the White Book Equity and excellence: Liberating the NHS was presented, which defines a new way of the NHS functioning. Patients will actively participate in making important decisions related to their health, in all stages of treatment. The feasibility of this change shall involve larger accessibility of medical documentation and the possibility for a patient to have an insight into it at any moment and, if he wants, to share it to a third party. Provided that all the planned measures are taken, in the following 4 years the savings should be achieved amounting to almost £20 billion that could be invested into the improvement of health service quality.

In terms of financing healthcare in the European Union (EU) member states, Totić (2012) emphasizes that the national bodies of every EU member states join the collected contributions into the health funds for that purpose. Such fact leads to reluctance of certain groups to collective payment of subsidized costs of healthcare for other people, especially in poorer EU member states. This consequently increases reluctance to regular payment of taxes and/or contributions. Private health insurance is suggested as an alternative. Janković (2011) states that private (voluntary) health insurance is usually specified for the part of the population exempt from mandatory health insurance based on their high income (the Netherlands), the part of the population that may, based on their high income, choose whether to stay in mandatory or opt for voluntary health insurance (Germany) or for the part of the population, the so called self-employed (Austria and Belgium). The level of coverage is in the range of 0.2% in Austria up to 24.7% in the Netherlands.

The search for a satisfactory system of financing healthcare is also present in Russia. Šolak (2007) believes that Russia needs a complete reorganization of the system of mandatory social health insurance. Fifteen-year long reforms did not lead to the goals that were set. One can notice the disruption of the proclaimed principles of social justice regarding the access of medical assistance, while the level of quality and culture in terms of health service is not appropriate to the modern needs.

Being a country in transition, on its way to healthcare reform, BiH suffers numerous problems due to its constitutional arrangement (two entities – BiH Federation which consists of cantons and Republic of Srpska – and Brčko District) and the fact that healthcare is regulated at the entity levels (Cain et al., 2002). The system in BiH Federation was decentralized too early, since every canton is responsible for its administration and the financing of healthcare. The system in Republic of Srpska (RS) is centralized and it has one body – the Ministry of Health that monitors the healthcare system. Due to the lack of appropriate legal mechanisms, coordination between the entities is rather poor, while in BiH Federation the cantons do not mutually cooperate at an appropriate level. Untimely decentralization brought a dramatic change of the system from the aspect of administrative structure and management, while the institutions continued their work without changes and kept the same functions as before the 1992-1995 war. The reason is that they were not able to develop the necessary skills and capacities that would stand such strong and complex processes of decentralization. That is why many functions in the cantons and entities are duplicated. The detected problems are also related to almost complete lack of planning function in healthcare, implementation of the passed laws, as well as a complex organizational structure. The implementation of health reform starts with a paradox including an innovative approach against the political resistance to changes as well as enthusiasm against obstacles. BiH cannot respond to all demands for healthcare and the situation is substantially worse than in 1992. A significant number of life-important medical treatments does not exist. There is a certain interest in the system reform, but nothing would move forward until the entities start cooperating and creating unified strategies for the entire country (CARDS Program 2005).

For the purpose of health statistic records, the Public Health Institute of BiH Federation (2012) specified a set of conclusions on the total health condition of the population. The healthcare reform in BiH Federation is oriented to strengthening primary health protections, with the emphasis on promotion of health and prevention of illnesses. However, there are still discrepancies present in the population's access to the teams of primary health protection in the cantons of BiH Federation. In accordance to the adopted Strategy for development of primary health protection, the process of implementation of family medicine in BiH Federation continued gradually. Even though there is a significant number of educated doctors and nurses and improved infrastructure, implementation of family medicine is still not satisfactory. A particularly evident problem is constant turnover of already

insufficient staff, medical doctors in particular. Implementation is more difficult mostly due to a slow restructure of departments within outpatient clinics, in accordance to the Strategy for development of primary health protection, non-stimulating mechanisms of payment, lack of managerial skills and insufficiently coordinated legislative.

Methodology

The existing systems of health insurance, not only in BiH but also in other countries in the region and world, show numerous disadvantages. The legal framework in BiH defined voluntary private health insurance as the option that citizens can use by their own choice.

The assessment of performances of the existing model of health insurance in BiH is based on the secondary source indicators, announced by Eurostat (2012), the World Bank (2012), Central Bank of BiH (2012), Federal Ministry of Health (2013), Public Health Institute of BiH Federation (2012), Public Health Institute of RS (2011) and Agency for Statistics BiH (2012). Special attention was given to the following indicators: level of health protection costs, in particular expenditure on drugs from personal resources of the population; state's allocations for healthcare; rates of natural population growth; leading causes of death; organizational structure of the health system; social and economic environment; availability and structure of healthcare personnel; characteristics of primary protection; amount of contribution for health insurance; populations' coverage by health insurance; population's structure by work status; development of the private sector of health protection and legal regulations, as well as population's familiarity with these regulations.

In order to reach research purposes, the development of voluntary health insurance in BiH is defined as the independent variable, while the improving the effectiveness and efficiency of the existing health insurance system in BiH is the dependent variable. The starting premise in the paper is that by identifying and removing obstacles for development of voluntary health insurance, it is possible to improve effectiveness of the existing system of health insurance in BiH. Therefore, the paper attempts to confirm that there is room for its development through the reform of healthcare system, extension of the existing model of social insurance and also that there is interest by insurance companies in a more serious approach to the offer of health insurance package. For the purpose of confirming the formulated hypothesis, the empirical research was conducted by survey of three groups of subjects: private

healthcare institutions, citizens, that is, the users of healthcare services, and insurance companies.

The questionnaire for private health institutions consisted of 12 questions, in which the respondent had offered answers. In some questions there was option of entering a new, own response that was not listed in the questionnaire. Private health institutions located in Tuzla Canton are listed on the web site www.bhzdravlje.ba, where they are classified according to the activity and the level of care they provide to their customers. Of the total number of these institutions, the survey answered 51 institutions located in Lukavac, Gračanica, Gradačac, Srebrenik, Tuzla and Živinice.

The second survey was focused on citizens and the questionnaire similarly consisted of 12 questions with multiple choice answers. A total number of 183 healthcare service users filled the questionnaire. One part of the survey was conducted online by the Internet news portal - www.lukavac-x.ba (115 respondents from different age groups).

The last e-mail survey was focused to private insurance companies. The questionnaire, consisted of 10 questions with multiple choice answers, was send by e-mail to all insurance companies registered in BiH. Since two insurance companies have branches in both entities, total number of active insurance companies in BiH is 22, and eight of them responded to the e-mail survey.

Results and Discussions

Disadvantages of the Existing System of Social Health Insurance in BiH

Based on the analysis of secondary source indicators, a general rate is that the existing system of health insurance in BiH has many disadvantages. There are many fields in the healthcare sector that require changes and improvements. The following part of the paper mentions the most significant results obtained on the basis of the secondary source analysis.

The rates of social insurance contributions are too high, even when compared to the OECD and new EU member states. The rate of social contributions in BiH Federation is 41.5% on gross salary, while in RS that amount is 33%. Over 50% of those covered by health insurance (retired persons, unemployed, invalids, war veterans) are exempt from paying contributions and their health insurance is

financed by the transfers from other non-budgetary funds and public revenue. Besides, the insured/retired number ratio grows in favor of the retired persons and is around 1.1:1, which is definitely not a desirable trend. It is well known that this ratio needs to be 4:1 in order for the social insurance system to function properly.

The total healthcare expenditures in BiH are around 10.3% of the GDP, which is a level much higher than in most EU countries. Almost 60% of the total healthcare expenditures are paid from public resources while more than 40% are financed by households from their own resources.

Unfavorable trends in the economy, war events, economic blockade, huge growth of unemployment, increased influence of grey economy, increased costs of healthcare, change in the structure of insured categories, etc., affected the increase in personal participation of citizens in the provision of health protection, economic situation in healthcare, and financial business activities of health insurance funds.

Natural rates of population growth change more rapidly in comparison to the EU countries. Also, due to higher mortality rates compared to birth rates, natural population growth (-0.8%) has a negative value and it leads to natural depopulation.

Regular healthcare statistics data show that chronic diseases are dominant in BiH when it comes to the leading causes of population diseases and mortality. Due to diagnostics costs, therapy, and rehabilitation of patients, such diseases are the leading health problems every year and they are a significant burden for the limited budget of the health sector and the entire community. Also, the results of the population surveys confirm unfavorable trends of life style and habits of the population with addiction diseases being dominant (smoking, alcoholism, drugs and psychotropic substances), inappropriate diet, overweight and obesity, as well as the lack of physical activity, which are the key risk factors for the health of BiH population.

Organizational structure of the healthcare system is rather complex with the fragmentation of the system present, particularly in BiH Federation, where the cantons have the authority over healthcare services. Therefore, the healthcare system in BiH Federation includes: Federal Ministry of Health, ten cantonal ministries of health, Federal Institute of Health Insurance and Reinsurance, ten cantonal institutes of health insurance and eleven public health institutes. The healthcare system in RS is centralized at the entity level.

A large part of BiH population is not covered by health insurance and does not have the right to healthcare. The largest number of the uninsured persons in RS includes the employees of the companies in which employers do not pay health insurance contributions. There is an additional problem in BiH Federation for the unemployed who miss the 30-90 day deadline for registration at the employment bureau and then lose all rights to health insurance through this bureau.

The public is not familiar enough with the process of passing and changing laws. The media do not sufficiently follow and inform on the laws in the field of healthcare that are in the process of passing and enacting in parliaments. Furthermore, authorities do not invest any efforts to make these new laws closer to citizens and introduce them to their rights.

Empirical Research into the Possibilities for Private Health Insurance Development

Research into Private Healthcare Institutions

Based on the answers received from private healthcare institutions, it was established that female persons have a bigger share in their user list (63%). From the aspect of patients' age structure, the highest number was in the range 19-55 years (41%), then 56-75 (32%), while the proportion of the patients aged 0-18 (15%) and 76-100 (12%) was relatively small. Almost all their patients have social health insurance (96%).

The officials of the private healthcare institutions presented the reasons why patients choose to use the services in the private sector. They are given in Table 1. The most important reasons for using their services are high quality and fast service. Most private healthcare institutions (71%) believe that their services are of higher quality than those provided by the public healthcare institutions.

Only 41% of the private healthcare institutions have contracts for certain services with the institutes for social health insurance. On the other hand, they are highly interested (75%) in contracting the services with these institutes. Table 1 shows that the satisfaction degree of those institutions that have the contracted services with the institutes is at a very low level (only 6% of them are completely satisfied).

Only 43% of the private healthcare institutions support the policy of a complete or partial opening the space in the healthcare system of BiH. The reason for this is that 27% of the institutions believe that their current position compared to the public healthcare institutions is poor. Private healthcare institutions offer certain suggestions for patient's better access to healthcare services, not only in private but also in the public healthcare sector as follows:

- Increasing the involvement of private institutions in healthcare (57%).
- Increasing the flexibility of contracts in terms of prices and other conditions (35%).
- Strengthening the monitoring of the contracted services and public announcement of data in terms waiting, quality, satisfaction, accessibility, etc. (47%).
- Improving the regulation in both sectors (37%).
- Other (12%): controlling public procurements in the public sector, defining patients' rights and obligations of medical service provider by introducing clinical guides into the law on health protection, providing a patient with the option to choose where to use healthcare services and equaling private and state healthcare.

Private healthcare institutions are highly interested in cooperating with private insurance companies (59%), but only a small number of them have already concluded the contracts with insurance companies (14%). Only 9% of the institutions replied that they did not see their interest in such type of business arrangement. The institutions that stated they do not have an opinion on the subject (20%) believe that they lack sufficient information on advantages and disadvantages of such arrangement.

Table 1: Surveys' Results

Survey of private healthcare institutions		
Reasons why patients choose private healthcare institutions:		
Service speed		68,63%
Service quality		84,31%
Impossibility of services in the public sector		45,10%
Higher patients' confidence		49,02%
Other		11,76%
Satisfaction by the conditions of contracted cooperation with the health insurance institutes:		
Completely		5,88%
Partially		17,65%
No, due to prices		13,73%
No, due to payment overdue		11,76%
No, for some other reasons		9,80%
Survey of users of healthcare services		
Reasons for using the healthcare services provided by the private sector:		
Impossibility for getting the appropriate service in the public sector		43,17%
Impossibility for getting fast service in the public sector		50,82%
Lack of confidence in the services provided in the public sector		21,86%
None of the mentioned		10,38%
Other		8,20%
Citizens' experience while using the services of public and private healthcare institutions:		
	Public	Private
Rude staff	27,33%	3,76%
Long waiting for some services (tests, referral letters to specialists, medications, etc.)	38,26%	10,22%
Unprofessional healthcare staff	18,33%	5,91%
Low quality treatment	12,86%	4,84%
Other	3,22%	75,27%

Source: Authors' research

Research into the Users of Healthcare Services

Most research subjects in the group of the users of healthcare services were male persons (67%). The largest number of them belongs to the age group in the interval 19-55 (87%), with significantly smaller proportions of other age groups 56-75, 0-18, and 76-100, in percentage 8%, 3% and 2%, respectively. Out of 92% of the subjects, who had social health insurance, 78% of them were not satisfied by the existing social health insurance. Only 20% of the subjects stated that they do not frequently use the services provided by the private healthcare sector. The reasons are given in Table 1, and it is evident that their reasons are rather similar to those stated by private healthcare institutions meaning speed of services, lack of certain service in the public sector, and higher confidence in the private sector.

Regarding the quality of private versus public healthcare institutions, 73% of the subjects believe that the services in the private sector are of higher quality. The reasons for dissatisfaction by the existing social health insurance are given in Table 1, parallel with the rate given for the services provided by the private sector. It is evident that the subjects who had already used the services provided by the private sector rated their quality as much higher than in the public institutions. Similarly, Table 1 showed that the private healthcare institutions recognized long waiting for some services, unkind and unprofessional staff and low-quality treatment as the same reasons why patients/clients opt for the private sector services.

More than 93% of the subjects believe that their social health insurance should provide them with a broader coverage of healthcare services. Only half of the subjects are familiar with the possibility for health insurance via insurance companies, while 86% of them would opt for private health insurance provided that their price is affordable.

Research into Insurance Companies

Underdevelopment of the private insurance market in BiH is evident from the realized structure of the premium on the market. The largest share belongs to the compulsory motor third party liability insurance. In the entire premium structure, the share of health insurance is 1.59% (BiH Federation 1.87% and RS 0.78%), and this is mainly for traveler's health insurance. The market itself is highly fragmented, with a significantly higher number of insurers than needed for such a small market. As many as 14 insurers have the market share below 3%. Domestically owned

insurers cover less than half of the market. There are 10 active insurers on the market that are under majority foreign ownership, but they cover almost the entire life insurance market. The owners of these insurers are in Austria, Croatia, Serbia, and Slovenia. One company for reinsurance is also present on the market.

Although all the insurance companies surveyed plan to introduce voluntary health insurance, only two of them currently offer these products. The insurance companies that provide the package of voluntary health insurance offer various products including those that cover the basic package of healthcare services to those that cover a wide spectrum of services. Female persons make 55% of the insured structure while the dominant age group is 19-55 (70%). Cooperation with the private healthcare institutions is registered for only one third of the products and 50% of the subjects believe that the private healthcare institutions are cautious because they are not well informed about the voluntary health insurance. Thirty-three percent of the subjects think that these institutions are interested in cooperation while the remaining 17% believe that the healthcare institutions are not interested as they do not see any benefit from such cooperation.

Half of the subjects think that the insurance market is ready for the offer of voluntary health insurance package, while the other half estimate that the market is still not mature enough for such offer. Most of the insurers (83%) think that the reform of the healthcare system should envisage the room for voluntary health insurance provided by private insurance companies.

Conclusion

The research described in this paper shows the current situation in the healthcare system of BiH. A large number of indicators point at the system crisis, inefficiency, dissipation of scarce resources, large dissatisfaction of all participants, and other disadvantages. Regarding the private voluntary health insurance as the addition to the existing system of social health insurance, it is not developed due to many obstacles that need to be passed. On the other hand, interest in the introduction of such type of insurance, as showed by the results of the primary research, is high in the private healthcare institutions, users of healthcare services, and insurance companies.

Development of voluntary health insurance is necessary and perhaps the only way out of the current situation. Unsustainability of Bismarck's model of healthcare

system, not only in BiH but globally as well, is obvious, and there are numerous arguments that prove this statement. That is the reason why for a long time alternatives have been sought as well as additions to the traditional models of healthcare systems. The main causes of unfavorable relationship between the payer of health contributions and the users of health protection are demographic changes, that is, an immense increase in the participation of the old population (retired persons) and high unemployment rate. Consequently, this reflects in the decrease in the number of those who pay contributions and the increased number of health protection users.

Unfortunately, there is no universal solution or an optimum model of healthcare system that would be widely acceptable. However, depending on the country itself and its characteristics, it is possible to create a combination of one of the models with the additional insurance options such as voluntary health insurance provided by private insurance companies. In this respect, the development of voluntary health insurance in BiH should be observed as an important breakthrough towards the improvement of health protection.

The disadvantage of the voluntary health insurance lies in the fact that it does not have social solidarity. This means that those with higher risks of diseases pay higher insurance premiums (sick, old, smokers, etc.). A good thing for these categories of citizens is the fact that they would still have their social insurance. In other words, relieving the burden of the healthcare system by means of voluntary health insurance would leave more room for more endangered categories of the population.

Finally, it has been confirmed that in the forthcoming reform of the healthcare system, which is obviously necessary, one should search for the room to develop voluntary healthcare insurance provided by private insurance companies. By removing the obstacles for development of this type of products of private insurance, it is possible to make significant improvement of the existing system of health protection in BiH.

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