



Impact of the Application of Collective Agreements on the Financial Situation of Public Healthcare Institutions in the FBiH

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Abstract: *The signing of collective agreements in the healthcare sector at the cantonal level in the FBiH has to increase funds for employees' salaries in line with legal provisions as well as provisions of the collective agreements. The increase in salary allocations at the level of healthcare institutions, as a result of the application of collective agreements which was not accompanied by an adequate increase in revenue, could leave healthcare institutions in a difficult financial position. This paper focuses on assessing the financial impact of the application of healthcare collective agreements on the work of public institutions operating within the FBiH healthcare system. The primary aim of this research is to highlight the need for coordination and cooperation among all institutions of the system when entering into collective agreements with citizens. Lack of coordination may result in financial difficulties for public institutions when applying the collective agreements, which will be explained using the case of one public healthcare institution operating as part of the healthcare system in one of the cantons in the FBiH.*

1. INTRODUCTION

The application of collective agreements concerning the rights and obligations of healthcare employers and employees is a legal obligation of public healthcare institutions. This includes the calculation and payment of employee salaries in line with the collective agreement and labour regulations. Negotiations over these provisions require the participation of all stakeholders in order to come up with an applicable solution and secure the execution of all obligations pertaining to the provision of healthcare services. If either party is not adequately represented, this can lead to misalignment, i.e. a situation in which healthcare institutions lacks sufficient funds for uninterrupted operation because of the increased allocations for employee salaries, as required by the signed collective agreements. This occurs because their agreements on mutual relations in the provision of healthcare services with the health insurance institutes for the current year were concluded before the collective agreements were signed and entered into force, so any increased expenditures had not been considered in the calculations, nor do the agreements allow for subsequent corrections. This paper describes one such eventuality using a case study from one of the cantons in the Federation of BiH entity.

2. HEALTHCARE FINANCING SYSTEMS AROUND THE WORLD AND IN BOSNIA AND HERZEGOVINA

The purpose of public healthcare is to preserve and improve the overall health of the population through the enabling of healthcare services. Therefore, every country strives to adopt policies and prescribe appropriate measures to create the conditions for a healthcare system to function. In this, the key goals are to have good health protection and a rational and stable financing model.

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Every welfare state ought to guarantee an adequate level of social security and social insurance to its population, and the state government needs to enable the provision of a range of services to the population, such as healthcare, unemployment benefits, family welfare, and pension insurance. Funds for these programs are secured by the government through collecting taxes, contributions, and other fees.

The fundamental aim when it comes to financing healthcare is to secure sufficient funds, establish a system of economic incentives in the provision and use of healthcare services, and provide healthcare users with adequate access to individual health protection. The collecting of funds can be public and private. Public financing entails a societal commitment to humane and ethical objectives that have moral and political weight, wherein the state acts as a procurer of healthcare services on behalf of the population, and whereas with private financing, individual payments for healthcare are made by purchasing health insurance or making out-of-pocket payments in exchange for these services.

The current situation, when it comes to healthcare financing around the world, is marked by a general shortage of funds, while the growth of healthcare spending further exacerbates the problem. The increase in healthcare spending is caused by many reasons, with the most important being the widening array of healthcare services as a result of new medical and technological solutions and innovations, coupled with the rising income of the population as well as population ageing. Three key models for healthcare financing have been identified worldwide, and as such are prevalent in most countries. These are Beveridge, Bismarck, and the market-driven model.

The Beveridge model is characterized by the fact that healthcare financing comes from direct taxes paid by companies and individuals, and indirect taxes collected based on market sales of goods and services. This model has been embraced and is in use in the United Kingdom, Ireland, Italy, Spain, Portugal, Greece, etc. The Bismarck model is based on mandatory and universal social insurance. It functions on the principle of solidarity and reciprocity, with healthcare insurance payments being made in the form of contributions based on labour, while the rate is determined either by the government or by authorised non-governmental institutions. This model is applied in Germany, France, Austria, Belgium, and Switzerland. In the public healthcare system, financing is resolved by securing funds from a special tax paid by all employees, the labour force (employed and self-employed persons, and farmers). The market-driven model focuses on private insurance and risk insurance, while the social welfare component is disregarded entirely, and healthcare is financed through premiums, i.e. direct payments that award an individual the right to be insured for the period covered by the specified payment. According to available data, almost three-quarters of US citizens are using this model.

By its characteristics, the healthcare system in Bosnia and Herzegovina is closest to the Bismarck financing model, i.e. the model of mandatory social health insurance based on labour force solidarity in the form of their contributions for protecting the health of the population. In this model of mandatory social health insurance, contributions are calculated using a formula and the rate that varies from one country to another. Contributions are determined based on the gross salary amount, which includes the net employee salary, multiplied by the agreed coefficient, plus salary contributions. The healthcare contribution in the FBiH entity amounts to 12.5%, and 12% each in the RS entity and the Brčko District of BiH.

The rights awarded to the insured persons are usually comprehensive and cover both treatments and medication, which represents a stain on the economy as a large portion of GDP is spent on healthcare. Compared to other European countries, where healthcare expenditures match the economic power in terms of GDP per capita, Bosnia and Herzegovina, i.e. its entities and the Brčko District of BiH, would

have to invest a significant effort to achieve better macro-economic parameters that would enable them to resolve the issue of the healthcare sector's liquidity. Having in mind that the healthcare financing system is based on solidarity, it is justified that one of the ways to increase its financial stability would be to increase the number of workers who would cover the healthcare of the entire population with their health insurance contributions.

It is important to note that healthcare spending per capita has been rising significantly for years, which forces healthcare policymakers to insist on rationalisation measures in the healthcare system and the reduction of public spending on healthcare. This is further exacerbated by the fairly complicated organisation of the healthcare system, which is structured in a way that the financing, management, organisation and provision of healthcare services have been entrusted to entities and the Brčko District of BiH, with the Republika Srpska entity and the Brčko District of BiH having a centralized healthcare system, while in the FBiH entity it is decentralized.

Within this constellation, at the top of the centralized healthcare system in the Republika Srpska entity lies the Ministry of Healthcare and Social Welfare which holds authority over the Health Insurance Fund, the Public Healthcare Institute with regional public healthcare institutes, as well as clinical centres, general hospitals, primary healthcare centres, and outpatient clinics.

In the decentralized healthcare system of the Federation of BiH, we find the Federal Ministry of Healthcare and the cantonal healthcare ministries, with the former being superior in the hierarchy to the Federation Health Insurance Fund, the FBiH Public Healthcare Institute, and the Transfusion Medicine Institute. The cantonal healthcare ministries hold authority over cantonal health insurance funds, cantonal public healthcare institutes, as well as clinical centres, general hospitals, primary healthcare centres, and outpatient clinics.

Article 62 of the FBiH Law on Healthcare states that healthcare institutions shall secure the necessary funds through agreements with health insurance institutes at the level of the FBiH and cantons, followed by agreements with relevant ministries, and agreements with higher education institutions in charge of the training of healthcare professionals, through allocations made by healthcare institutions' founders, and through market-based operations in the form of selling products or services.³ In the other entity, Republika Srpska, Articles 124 and 125 of the RS Healthcare Law state that healthcare institutions can secure funding from the Fund, from budgets of the RS and local self-government units, insurance organisations, healthcare users, educational activities and scientific research, and other sources, wherein the Fund enters into an agreement on the provision of healthcare services with a healthcare institution based on the overall health of the population, the population figures and age structure, the level of urbanisation and development, road connections between individual areas, equal access to healthcare, the required scope of healthcare services, and economic capabilities.⁴

In the Brčko District of BiH, healthcare institutions can receive funding from their founder in line with the founding charter, from the District budget, the Brčko District of BiH Health Insurance Fund, other health insurance providers, patient participation, interest on bank deposits, market-based selling of services, educational activities and scientific research, donations, bequests, endowments, and other sources if collected in line with the law, the founding charter, and the statute of the healthcare institution.

³ "FBiH Official Gazette," no. 41/10

⁴ "RS Official Gazette," no. 106/2009 and 44/2015

3. COLLECTIVE BARGAINING PROCESS AND THE ROLE OF TRADE UNIONS

In line with the topic as outlined in the introduction, this section will provide a general overview of the importance of the collective bargaining process. The simplest definition of collective bargaining establishes it as "... a negotiation process between a trade union as the representative of the workers and one or more employers, to reach an agreement on regulating labour conditions",⁵ "thereby contributing to social order, adjustments to economic and social change, fight against corruption, and promotion of equality".⁶ Bargaining can be made at the national, branch, group, vocational, or company level.

International legal sources for collective bargaining primarily stem from the International Labour Union Convention 87 and Convention 98. "The bargaining process is very complex, and several stages have been identified in the course of the negotiation - bargaining, mediation, reconciliation, arbitration, strike, lock-out" (Učur, 2006, p. 547). The parties in the negotiation are workers as advocates of labour interests on the one side, usually represented by trade unions, and representatives of capital interests on the other, represented by employers or government bodies. The parties negotiate and conclude a collective agreement, which is a formal document as it has to be made in writing and co-signed by authorised persons representing the parties.

"Collective bargaining aims to achieve a good arrangement and conclude a collective agreement with a rational expenditure of time, energy and resources, and with mutual tolerance and respect among negotiating parties" (Učur, 2006, p. 550). "Legislation in the majority of EU member states defines collective agreements as formal written agreements whose nature is to regulate labour conditions for employees, with employers on the one side and worker representatives or trade unions on the other emerging as parties in the negotiation" (Bruun, 2003, p. 3).

It has already been mentioned that the interests of workers are represented by trade unions, with the trade unions' key objectives being the protection and improvement of labour conditions, the promotion of labour and social solidarity, building a society that respects workers' rights and the right to be paid a salary, caring for workers' dignity, and caring for workers' social security in case of unemployment, illness, or old age.

Collective bargaining and collective agreements are regulated by law in Bosnia and Herzegovina. According to the provisions of the Labour Law of the FBiH entity, "a collective agreement can be general, branch-level, or individual (with a single employer), with the general agreement being concluded for the territory of the FBiH, and branch-level agreements for the territory of BiH or one or more cantons."⁷ "The general collective agreement shall be concluded by the Government, the recognized employers' association, and the recognized trade union, while branch agreements shall be concluded by a recognized employers' association and a recognized trade union of one or more vocations founded on the territory of the FBiH or one or more cantons. Branch-level collective agreements for employees in civil service, judiciary, public institutions, and other budget beneficiaries shall be concluded by relevant ministries, i.e. the Government and relevant ministries and cantonal governments on the one side, and recognized trade unions of civil servants and appointees, public institutions, and other budget beneficiaries on the other.

⁵ <http://www.kolektivni-ugovori.info/kolektivno-pregovaranje>, accessed 24 May 2020

⁶ https://www.ilo.org/wcmsp5/groups/public/---ed_dialogue/-sector/documents/instructionalmaterial/wcms_554082

⁷ FBiH Labour Law, Article 137 ("Federation of BiH Official Gazette," no. 26/26 and 89/18), and RS Labour Law ("RS Official Gazette," no. 1/2016 and 66/2018), Article 239

Individual collective agreements shall be concluded by a recognized trade union at the employer, wherein, if the owner is the FBiH, a canton, city, or a municipality, their prior consent shall be required.”⁸

4. CASE STUDY – HEALTHCARE COLLECTIVE AGREEMENTS AT THE CANTONAL LEVEL IN THE FEDERATION OF BIH AND THE FINANCIAL IMPLICATIONS FOR HEALTHCARE INSTITUTIONS

Two healthcare-related collective agreements were signed in one of the cantons in the FBiH: the Collective Agreement on Rights and Obligations of Healthcare Employers and Workers, concluded between the cantonal Independent Autonomous Healthcare Workers Trade Union and the cantonal Ministry of Healthcare with the prior consent of the cantonal government, and the Collective Agreement on Rights and Obligations of Employers and Workers in the Domain of Medical and Dental Medicine Doctors concluded between the cantonal Independent Vocational Trade Union of Medical and Dental Medicine Doctors and the cantonal Ministry of Healthcare with the prior consent of the cantonal government.

According to the Collective Agreement on Rights and Obligations of Healthcare Employers and Workers in ZDC⁹, employers have an obligation to pay salaries to workers with whom they have a labour contract in exchange for their work out of the funds earned by the healthcare institution in line with the relevant law. 13 groups of individual jobs have been defined according to the complexity coefficient, with the lowest coefficient being assigned to jobs in group I, that includes less complex jobs requiring, in terms of education, an 8-year primary school degree, while the highest coefficient is reserved for group XIII that includes jobs categorized as complex and very complex, and their performance requires higher education¹⁰ and specialization. Parties have also determined the final coefficient values, specifying that reaching the determined coefficient value should be achieved in two stages, i.e. in two intervals. The outcome of the negotiation was that the party representing labour interests had secured a change of the complexity coefficient, wherein the complexity coefficient for the lowest group I was successively raised from 1.10 to 1.20, and for the top group XIII from 4.40 to 4.82.

On the other hand, the Collective Agreement on Rights and Obligations of Employers and Workers in the Domain of Medical and Dental Medicine Doctors in ZDC¹¹ regulates rights and obligations based on and arising from the work of medical doctors and doctors of dental medicine employed in public healthcare institutions founded by municipalities/cities or the canton. This collective agreement separates jobs and vocations of medical doctors and doctors of dental medicine into three groups according to complexity with respective complexity coefficients, and also specifies that reaching the agreed coefficient value would occur in two stages.

⁸ FBiH Labour Law (“Federation of BiH Official Gazette,” no. 26/16 and 89/18), Article 138, and RS Labour Law (“RS Official Gazette,” no. 1/2016 and 66/2018), Article 240

⁹ Collective Agreement on Rights and Obligations of Healthcare Employers and Workers in ZDC, https://zdk.ba/sjednicevlade/sjednice2020/90sjednica/90-09_28-12-2020.pdf, accessed 25 May 2021

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¹¹ Collective Agreement on Rights and Obligations of Employers and Workers in the Domain of Medical and Dental Medicine Doctors, <https://ssdmis-zdk.ba/wp/wp-content/uploads/2019/01/Kolektivni-ugovor-SSSDMiSZDK-2017-1.pdf>, accessed 25 May 2021

Table 1. Individual revenue types as a percentage share of the overall revenue of the healthcare institution

Revenue structure	Percentage share of the overall revenue (%)			
	2016	2017	2018	2019
Revenue from the cantonal health insurance institute	88.28	88.65	90.4	91.18
Revenue from invoiced services	6.2	6.41	5.28	4.53
Revenue from rent	2.11	2.13	2.08	1.95
Other revenue	3.41	2.81	2.24	2.34
TOTAL	100	100	100	100

Source: Data from the healthcare institution's business records

In order to assess the implications of the application of collective agreements on healthcare institutions, it is necessary to analyse the financial indicators of one healthcare institution in ZDC. Business records usually show four types of business revenue which together form the total annual revenue. These are revenue from the cantonal health insurance institute, revenue from charged and invoiced services, revenue from any rent of premises, and other revenue as shown in Table 1. The bulk of the revenue comes from the health insurance institute.

Every year, cantonal health insurance institutes sign agreements on mutual relations in the provision of healthcare services with healthcare institutions in the canton. The agreements need to observe provisions of the Law on Health Insurance, Law on Health Protection, Ordinance on Healthcare Standards and Norms Pertaining to Mandatory Health Insurance in the FBiH¹², Decision on the Basis, Criteria, and Indicators for Concluding an Agreement between the Cantonal Health Insurance Institute and Healthcare Institutions, and Ordinance on the Organisation and Financing of Specialist-Consultation Work in the Canton. The criteria and indicators for concluding a healthcare agreement include the number and structure of insured persons registered at the offices of the health insurance institute on the 30th of November of the preceding year, or if specifically mentioned in the Ordinance on Standards and Norms - the population figures according to preliminary results of the 2013 census per municipalities and settlements in the FBiH.

The structure of operating expenditures recorded in business records of a healthcare institution usually consists of employee costs, material costs, production service costs, amortization, intangible costs, financial expenditures, and other expenditures and losses.

Table 2. Individual expenditure types as a percentage share of the overall expenditures of the healthcare institution

Type of expenditure	Percentage share of the overall expenditures			
	2016	2017	2018	2019
Employee costs	78.06	78.64	77.89	80.98
Material costs	9.86	9.21	10.7	8.75
Production service costs	3.36	3.08	3.47	2.67
Amortization	5.08	4.81	4.44	3.95
Intangible costs	3.5	3.33	3.32	3.46
Financial expenditures	0.01	0.01	0	0
Other expenditures and losses	0.12	0.93	0.18	0.18
TOTAL	100	100	100	100

Source: Data from the healthcare institution's business records

¹² FBiH Official Gazette, no. 82/14, 107/14, and 58/18

The analysis of employee costs in the healthcare institution between 2016 and 2019, as shown in Table 2, indicates that they were relatively stable from 2016 until 2018, followed by a significant increase in 2019. In order to make an objective comparative analysis of this increase, one needs to first take into account the information about the number of workers in the same period, and we learn that the number of workers in 2019 rose by 18. Aside from the number of workers, the increase was especially affected by the obligations arising from the collective agreement which states that an employer may not calculate and pay a salary that is lower than the one determined by the collective agreement and labour regulations.

Table 3. Labour costs of the healthcare institution in the period 2016-2019

	2016	2017	2018	2019
Average annual cost per employee in KM	24,420	25,606	26,545	27,678
Average monthly cost per employee in KM	2,035	2,133	2,212	2,306

Source: Data from the healthcare institution's business records

The average annual cost per employee in 2019, shown in Table 3, when the application of collective agreement provisions entered into force, rose by 1113.61 KM per employee compared to the previous year, or 92.80 KM on a monthly level. The application of altered coefficients also meant an increase in the annual expenditures for employee costs pertaining to their salaries, as evident in Table 3.

Table 4. Comparison of annual and monthly costs per employee in the period 2019-2020

	2019	2020
Annual costs per employee	26,934.00	29,798.16
Monthly costs per employee	2,244.50	2,483.18

Source: Data from the healthcare institution's business records

Table 5. Difference in the increased cost per employee after the application of final coefficients

Description	Amount (in KM)
The difference in monthly costs per employee	238.68
The expected difference in costs per employee after the application of final coefficients	2,864.16

Source: Data from the healthcare institution's business records

The most rational approach to assessing the overall increase of salary costs is to compare data from a period in which there was no salary increase (in 2019) with a period in which salary expenditures were set to rise as a result of the application of the final coefficient based on the collective agreement (in 2020), as shown in Table 4. This enables us to establish the difference in costs per employee on a monthly and annual level (Table 5).

By multiplying the expected cost-per-employee difference with the number of employees of the healthcare institution, we can determine the exact employee cost increase on a monthly and yearly basis. Given that the existing agreements on mutual relations in the provision of healthcare services with healthcare institutions in the canton do not allow for any corrections to the agreed annual sums, the increased expenditures will result in the healthcare institutions not being able to cover all expenditures with available revenue, thus jeopardizing their overall operations. In such cases, a healthcare institution must proceed with the rationalization of expenditures, and they usually decide not to fund specialization of medical doctors, which directly leads to lower quality of provided healthcare services.

5. CONCLUSION

The application of collective agreements in healthcare, if there is a lack of coordination among institutions, can lead to financial consequences in the form of increased employee costs in healthcare institutions, because the available revenue envisioned by the agreements on mutual relations with cantons and revenue from other sources would not be sufficient for the institution to regularly function and fulfil all of its legal obligations. This means that relevant cantonal institutions which take part in pre-approving the signing of collective agreements must, as part of the financial impact assessment, anticipate and adopt appropriate measures to compensate for the healthcare institutions' increased employee salary costs, thereby enabling the execution of all health protection measures in the area covered by the said healthcare institution.

Furthermore, provisions of the FBiH Law on Health Insurance oblige cantonal health insurance institutes to undertake necessary measures if the available funds are not sufficient to cover the expenses on the basis of compulsory health insurance, to secure additional funds, with the health insurance institutes' steering boards deciding on securing additional funds, as well as means to cover potential losses arising from business operations. This law also states that funds for the financing of rights arising from mandatory health insurance should, among other sources, also be secured through allocations from the budget of the canton or municipality, and that "allocations from the cantonal budget may be approved to cover increased costs of healthcare caused by significant deviations from the planned health insurance budget due to extraordinary or otherwise difficult circumstances during the provision of healthcare, and that such allocations shall be approved by the cantonal or municipal legislative body based on a request authorised by the steering board of the cantonal health insurance institute using as the starting basis the planned budget for the provision of mandatory health insurance."

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