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The cost to have a healthy population – The European Union's strategy

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Abstract. *In this article, the authors focus on the study of health as a fundamental element in having a population and, as a consequence, a work force capable of performing efficient activities. A comparative analysis of the current situation, from this point of view, in the European Union and the Member States, is highlighted, highlighting the shortcomings that occur. This article refers to the cost of maintaining health and the financial potential of each Member State. The focus is on the conditions in hospitals, the coverage of needs through the existing network, the facilities and, last but not least, the quality of the medical staff involved in the health field.*
From the comparative study undertaken, it follows that Romania still has a lot to do in order to reach a suitable, truly European standard. Measures are needed to determine the medical staff to accept their stay in the country. Data from the Eurostat source is used to highlight the arguments made by the authors.

Keywords: health, cost, strategy, health protection, accidents at work.

JEL Classification: H51, I10.

Introduction

The health system is organized and funded in different ways by the member countries of the European Union, but the most common system that is agreed by all Member States concerns access to quality protection that provides individual and social protection as far as possible of the entire population of a country.

This is a point in the health system of the European Union based on principles that lead to the expenses necessary to ensure it. The healthcare system also includes expenditures for the construction of hospitals, their endowment, the preparation of quality medical staff, their entire structure (doctors, assistants, auxiliary staff), as well as the provision of conditions for making available to people in need appropriate medication. In other words, maintaining health has a cost. The European Union has set a strategy by 2030, aiming at Member States to take measures to ensure a standardized but quality framework. These issues are carefully analyzed by the authors in order to understand the current state and direction of action over the medium and long term.

Literature review

Airesa, Gemez and Gibb (2010) investigated the extent to which European policies contributed to the prevention of construction accidents. Anghelache (1999-2017) performed a study of the evolution and structure of the Romanian population and its access to the health system. Beale and Hoel (2011) discussed ways to avoid aggression at work and managerial control of work. Cagnie et al. (2007) estimated the one-year prevalence of neck pain among office workers and determined the physical, psychological and individual factors that are associated with these prevalence. Giorgi, Arenas and Leon-Perez (2011) addressed issues related to harassment at work and the possibilities to prevent intimidation of employees and improve their welfare. Iavicoli et al. (2011) have developed a study to show that psychosocial risks and work-related stress are important occupational health and safety issues. Leka et al. (2011) outlines the process of developing the European framework for managing psychosocial risks. Lewchuk et al. (2008) developed a new approach to understanding the impact of less permanent forms of employment on workers' health. López-Alonso et al. (2013) studied the impact of investment in health and safety on the construction company's costs. Morillasa, Rubio-Romeroa and Fuertes (2013) have studied a number of possibilities for reducing workplace accidents and the potential for improving health and safety management in Spain. Leka et al. (2010) investigated the political context for managing work-related psychosocial risks in the European Union. Persechino et al. (2013) have developed a strategy for assessing work-related stress risks. Poterba, Venti and Wise (2010) addressed issues related to the cost of goods for poor health. Walker and Maltby (2012) addressed issues related to the need for an active social and public policy to incorporate active aging as the main paradigm for aging in the European Union. Woolfson (2007) analyzed the implications of rising labor migration for the new member states and wider EU labor standards.

Research methodology, data, results and discussions

The current level of health spending in Germany, for example, was 309 billion EUR in 2013, equivalent to 10.9% of GDP. In France, the total health expenditure was 231 million EUR and equaled 10.9% of GDP while in the Netherlands 11% of GDP was spent. Also, Sweden, with a high level of spending on health insurance, has allocated 11.9% of GDP. Other Member States of the European Union also used a very high percentage of the Gross Domestic Product to ensure the health of the population in those countries. Thus, in Switzerland, 11.2% of GDP goes to health, medication, free and compensated medicines, and treatments for diseases with a high impact on health and life.

But there are also countries in the European Union where spending on health is quite low. For example, in Poland, Lithuania and Estonia, less than 6.5% of GDP is allocated to maintaining and securing health with quality protection.

As far as Romania is concerned, we again find that we are in the last places, with only 5.2% of GDP allocated to maintaining health.

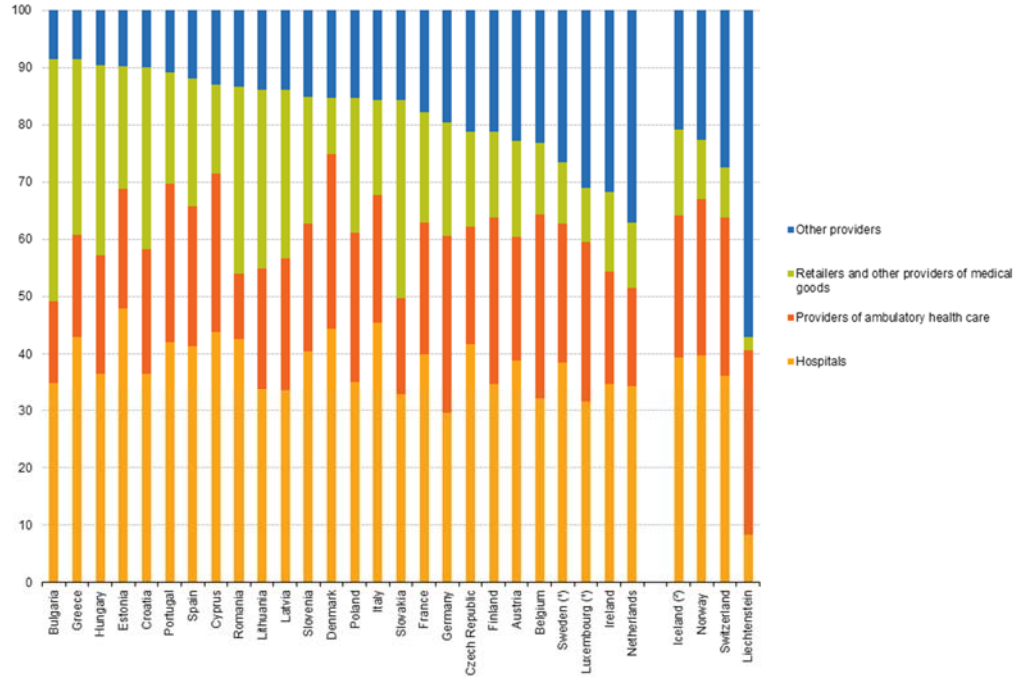
Another important element for maintaining health is the number of hospitals, the quality of these hospitals and the health services provided to the population. In general terms, it appears that in the European Union, in 2013-2014, the rate of health care spending allocated to hospitals out of the total of these expenditures averaged 29.5% for all Member States. In some countries, such as Germany, Estonia, these revenue-sharing allowances for the construction, maintenance and maintenance of hospitals were very high. Thus, 47.6% of all spending for these hospitals was allocated to Estonia. In Bulgaria, there are still problems with hospitals that do not have the highest quality, and where 31.1% of all spending is allocated to ensure optimal conditions for hospital maintenance and use.

Also, a high percentage of health care spending is allocated to provide the prospect of obtaining high-quality medicines to be used with a positive health-enhancing effect.

In other considerations, a fairly important problem of health care spending is how to produce the necessary preventive treatments, curative treatments and, moreover, to have the necessary effect, such costs high quality hospitals and quality health centers.

Another very important expense to be covered by the state is ambulatory treatment for health care. This includes vaccination, endowment and supply of medicines and vaccines, checking their quality. From the total expenditure, there is a large difference in allocation from the Member States. Thus, while Romania allocates 10.4% of outpatient treatment and health costs, in Germany and Belgium, these expenses amount to more than 30%. There are also states, such as Liechtenstein, which, although a very small state, allocates 31.7% of the total for maintaining health.

Figure 1. *Healthcare expenditure by provider, 2014 (% of current healthcare expenditure)*



Note: Malta and the United Kingdom, not available.
(*) Provisional.
(*) Definitions differ.
Source: Eurostat (online data code: hlth_sha11_hp)

Source: Eurostat.

In Figure 1 graphically presents the percentage structure of those four categories of expenditure that requires maintaining a high level of health. These are costs for hospitals, medical expenses and medication, out-patient health care, and other expenses. We find that the expenditures are diversified and in the case of Romania we can estimate that for hospitals we spend about 40% of the total health expenditures for outpatient treatment 10%, for obtaining and offering free and compensated drugs the percentage is about 30% and other expenses are about 20%.

It is noted that most EU Member States allocate important amounts for the construction, maintenance and equipment of hospitals that provide curative treatments for all citizens in this situation.

In Table 1 is the current expenditure for maintaining health, both in absolute terms and as a percentage of the Gross Domestic Product. We find that Romania allocates 7431 billion EUR for health, expressed in EUR per capita and purchasing power parity per capita, which is 767 EUR per capita which represents 5.2% of GDP. There are countries like Belgium, which allocates 40.0 billion EUR, which means 3,658 EUR per capita, totaling 10.4% of GDP. Germany allocates 308.5 billion EUR, which means 3,789 EUR per capita, thus having an extraordinary high per capita and overall. France spends 231 billion EUR at an expense of 3,267 EUR per capita, and so on, we can see that countries like Finland, Sweden and the UK are also spending extra costs to ensure the health of the people in those countries.

Table 1. *Current healthcare expenditure, 2014*

GEO/TIME	Million EUR	EUR per capita	PPS per capita	% of GDP
Belgium	40907	3658	3263	10.4
Bulgaria	3298	454	1034	7.9
Czech Republic	10895	1036	1593	6.9
Denmark	:	:	:	:
Germany	308526	3826	3739	10.9
Estonia	1136	862	1222	6.0
Ireland	:	:	:	:
Greece	15777	1439	1710	8.8
Spain	92700	1988	2110	9.0
France	231060	3515	3262	10.9
Croatia	3171	745	1177	7.3
Italy	:	:	:	:
Cyprus	1244	1443	1529	6.9
Latvia	:	:	:	:
Lithuania	2147	726	1253	6.1
Luxembourg	:	:	:	:
Hungary	7408	749	1369	7.4
Malta	:	:	:	:
Netherlands	71453	4252	3731	11.0
Austria	32729	3860	3521	10.1
Poland	25262	664	1264	6.4
Portugal	15477	1480	1844	9.1
Romania	7431	372	767	5.2
Slovenia	:	:	:	:
Slovakia	:	:	:	:
Finland	19319	3552	2854	9.5
Sweden	48375	5039	3540	11.1
United Kingdom	202721	3161	2736	9.9
Iceland	1013	3130	2789	8.8
Liechtenstein	287	7762	:	:
Norway	35130	6916	4134	8.9
Switzerland	57651	7127	4573	11.2

: not available

Source: Eurostat.

The concern of the European Union is to standardize and pursue in the same way that in all countries implementation of strategies for health promotion, treatment of diseases with rapid effects on health, to reduce the effects of death causes as little as possible. Health has its own cost, which must be achieved by using financial resources, endowments, improving the quality of medical staff, improving the quality of hospitalization conditions, and many other such desires.

In the European Union a priority objective is to allocate an average of 8-10% of each country's Gross Domestic Product to improve the conditions of population health insurance.

Table 1 summarizes the data for all Member States, including some states which, although not members of the European Union, are listed to show the very high level of spending allocated to maintaining health. In protecting the health of the population as well as in protecting it, an important chapter is the protection of work, in the context of avoiding labor accidents, serious accidents, and creating the conditions for fast, qualified and curative treatment.

In this context, European statistics show that national management, i.e. governments, the administration of each country, must pay close attention to avoiding accidents at work.

The indicator used at European Union level is given by the European accident statistics, briefly mentioned in the EAW. An occupational accident defined in this system is that in the goats during work they occur due to irregularities or phenomena that may occur spontaneously, accidents that can lead to injuries or may be fatal. Fatal or fatal accidents usually lead to death and, from this point of view, increased attention must be paid to avoiding the conditions that cause such work accidents.

In 2014, there were 3.1 million less-life-suppression crashes in the European Union, of which 3739 were fatal accidents. This shows that, although light accidents have been high, but as a result of the measures taken in the European Union, the number of accidents has been lower. Another curious issue of this situation is that in the total number of non-fatal accidents, i.e. low-risk, most have occurred in men, of course, they also have jobs at higher accident risk. The accident rate in the European Union is 2.3 accidents per 100,000 people, compared to a very high number that occurred in earlier periods.

An analysis in this respect can be based on the data in Table 2.

Table 2. *The number of fatal and high-risk or low-risk accidents produced in 2014*

GEO/TIME	Accidents at work involving at least four calendar days of absence from work			Fatal accidents at work
	Total	Men	Women	
European Union (28 countries)	3176640	2183494	992870	3739
Belgium	65587	46812	18771	52
Bulgaria	2246	1600	646	117
Czech Republic	42306	29797	12509	118
Denmark	54157	31920	22041	38
Germany	847370	631819	215552	500
Estonia	6288	4097	2191	16
Ireland	18115	12503	5583	47
Greece	3410	2551	859	28
Spain	387439	264010	123430	280
France	724662	454997	269664	589
Croatia	11669	7686	3981	26
Italy	313312	226263	87049	522
Cyprus	1613	1145	468	5
Latvia	1725	1154	571	41
Lithuania	3120	2025	1092	55
Luxembourg	7183	5701	1482	10
Hungary	19491	12674	6817	81
Malta	2632	2235	397	4
Netherlands	87964	55567	32397	45
Austria	65418	51352	14066	126
Poland	76274	50294	25980	263
Portugal	130153	93003	37150	160
Romania	3396	2629	767	272
Slovenia	12.314	9312	3002	25
Slovakia	8552	5910	2642	40
Finland	44434	30521	13913	22
Sweden	35296	19596	15700	40
United Kingdom	244948	156842	88064	239
Iceland	:	:	:	0
Norway	10108	6243	3865	61
Switzerland	86346	68492	17854	74

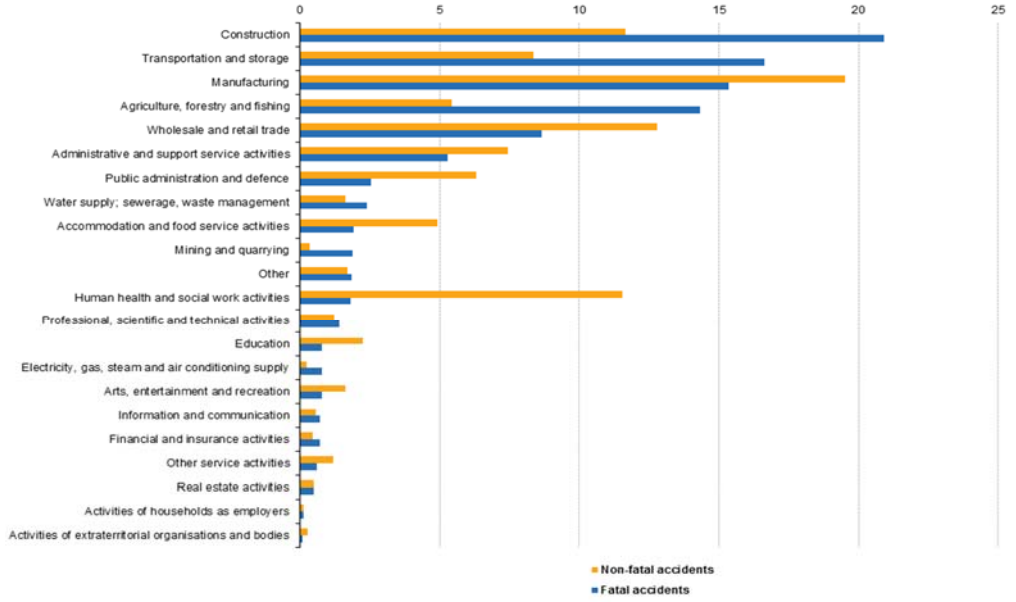
: not available

Source: Eurostat.

Romania had a total of 3,396 accidents (down compared to 2013 when there were 3,653 accidents), of which 2,629 male accidents (down 97 accidents compared to the previous year) and 767 accidents caused by female employees (with 41 accidents more than in the previous period). The fatal accidents, that is, at risk of death in Romania, totalled 272 people this year. Romania is well above the number of accidents, although we are overtaken by France - with 589 fatal accidents, Italy - 522, Germany - 500, but we must also report this situation to the size of the population in each country.

In Figure 2 summarizes the areas in which accidents occur. It is found that accidents, deadly or not, usually occur in the construction industry - with over 23% of all manufacturing accidents, manufacturing, transport, agriculture, and sales in detail. There are also less serious accidents in terms of social, administrative or other work in which there are no such high risks as those mentioned above.

Figure 2. *Fatal and non-fatal accidents at work by economic activity, EU-28, 2014 (% of fatal and non-fatal accidents)*



Note. Provisional.

Source: Eurostat.

The EU's policy is to take urgent, well-correlated measures to create conditions of protection for all employees and to avoid accidents in this way irrespective of the degree of risk to life present them.

Conclusions

From this article, we find that in the European Union a major problem lies in providing conditions for maintaining the health of the population. From this point of view, the conclusion is that more than half of the Member States have a reduced rate of spending on health expenditures in the Gross Domestic Product and therefore it is necessary to reconsider the percentage points that are granted for health.

As a particular conclusion, Romania is at the bottom of the conditions and expenditures for maintaining health, preventive, curative treatments and, last but not least, for ensuring labor protection and avoiding accidents of any degree of risk.

One final conclusion that we can present is the constant concern of the European Union to establish and standardize a tangible financial resource allocation system to improve the quality of health care, preventive, especially, and curative treatments especially in cases of which talks about very serious diagnoses of the risk of death.

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