

The Financing Mechanism of the Social Health Insurance System in Romania and in other European Countries

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Abstract

The social insurance system is part of the social security system and it works based on the payment of a contribution through which risks and services defined by the law are insured. The social security system, independent of the structure or political and economical order of a state, has the attribution of giving help to those in conditions of social helplessness, as well as preventing such circumstances. In this paper we made a comparative analysis of the financing mechanism of the social health insurance system in Romania with other European countries.

Keywords: social health insurance, financing mechanism, social security system

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1. Introduction

In any civilized country, the state takes on the obligation of guaranteeing a *social security system*, through which, based on the law, it supports people who are in situations in which they need help. There are five main methods of financing health care systems: financing from the state budget; financing by social health insurance; financing by private health insurance; financing by direct payment; community financing.

Financing from the state budget, by this method of financing the funds are collected to the state budget, and then distributed to the sanitary sector. The population coverage is general, people contributing based on their income and not on individual risk. The funds have several sources: general taxes; taxes with special health destination; other budgetary revenues.

General taxes have three main sources:

- import/export taxes;
- taxes applied to economic agents;
- salary taxes, as well as global income taxes.

Most of the times, funds thus collected do not constitute a stable source for financing the health sector. The explanation is that for some governments, health is not a foreground domain, situation that, together with the economic instability of the transition, leads to a fund crisis in the health department.

In practice, the political game plays a decisive role in the distribution of funds towards the health sector, and within its bounds, some domains may be discriminated in favor of others, due to subjective criteria, induced by some sphere of influence. We may take, for example, directing money especially towards 317 health programs with a definite purpose, like preventing and fighting off the pulmonary diseases, etc.

Donations and external loans may come from international organizations like OMS, UNICEF, the World Bank that ensure financial and logistic support for the sanitary field in the poor countries. The reason why they are all together in this area is that credit reimbursement comes from the state budget.

No matter the sanitary system, the state budget represents a source of financing. But when this is the main financing method, we are talking about national health systems. They work out in countries like: the United Kingdom, Canada, Spain, Ireland, Greece, The Scandinavian Countries, and New Zealand, Australia. The United Kingdom, for example, is perceived like a nation where the sanitary field entirely relies upon the state budget. In fact, only 76% of its health funds come from the budget, 11% of the funds come from the social health insurances, 10% from the private insurances and 2% from direct payments.

2. Financing by health insurances

The health insurances are a way in which many of the countries with average or high incomes significantly cover their expenditures from the sanitary field. There are two main health insurances: the social and the private insurance.

There are two main differences between the social insurances and the private insurances. First of all, the social insurances are compulsory. Each person from the eligible group must enlist and pay the corresponding amount of money. Secondly, bonuses and benefits provided by the social insurances are established by the law in force; this is a reason why they may be more easily modified than those included in the private insurances that are stipulated in a contract with juridical value, conjunctly signed by both parts.

Because social insurance is compulsory it could create confusion about the differences between social health insurance system and finance system through government funding. Most important differences between them are the following:

- Social insurance is not a right for all citizens, but only of those who are eligible and pay their contribution;
- insured perceive that they pay a premium for services that could benefit at a time, so they become aware that health costs
- contributions are intended for social health insurance fund and thus separated from government funds, obtained, as shown by taxes. This should lead, at least in theory; the diversion of these funds prevented them not being able get a destination other than that for which they were collected
- value of insurance premiums and service package provided can not be changed by unilateral decision of the executive. These laws may be amended by legislation which requires the agreement of all interested parts.
- unlike the system of financing by government funds social health insurance system is bound to keep under its own solvency. Those who manage are responsible for collecting and managing funds, there is so much transparency for taxpayers.

Financing social health insurance system is achieved by mandatory contributions, usually in equal parts from employees (as a percentage of salary) and employers. In some countries, to include those who work outside the formal sector, contributions can be calculated as a percentage of income of those people (e.g. farmers).

In social health insurance scheme, the government contributes funds to the state budget to finance specific targets, which are not covered by insurance: health programs of national interest, construction and rehabilitation in the health sector, equipped with high performance equipment, etc. Also in government task should fall and disadvantaged groups not included in the social health insurance. In terms of fund management, there are two main types of social health insurance:

- administer health insurance fund by the government, by government agencies;
- social health insurance administered by insurance homes, public and private.

Social health insurances administered by governmental agencies - In this situation, the government establish the level of the contribution as well as the package of services to be provided. The sanitary units included in the insurance plan can be the government's property exclusively, or can be mixed, governmental or private, in this case the insurant having freedom of choice. It is obvious that the first model, that of the State's monopoly over services providers, has more disadvantages, among which bureaucracy and the beneficiary's lack of choice, both lowering the quality of the medical activity.

The major disadvantage of this type of system is linked to the political pressures it is subject to. These affect resource distribution, as well as the way of payment of the medical services providers. On the other hand, politicians can promise, in exchange of electoral support, packages of unrealistic services, which, on the background of aging population and continual increase of the costs in the sanitary field, will constitute a heavy burden for the generations to come. Such health insurance systems are in the countries of South America.

3. Social health insurance administered by public or private health insurance companies (Bismark model)

Within this type of system, the role of the government is to declare compulsory insurance for all eligible people. The citizens have the freedom to choose between several insurance funds, public or private. In many countries these funds are named "illness funds" and can be organized by the big industrial consortia or unions.

The organization of healthcare may vary according to various social insurance schemes. For instance, in Japan, most of the tertiary assistance specialists are hospital employees while in Germany and France payments are made separately for physicians, respectively hospitals, by the insurance funds. This leads to a reduced integration of hospital services as well as to a poor collaboration between physicians and hospital management, resulting in a decrease in efficiency.

The advantages of this type of system, in contrast with the one of social health insurances administered by the government are the following:

- ✧ lack of political involvement;
- ✧ reduction of bureaucracy;
- ✧ competition between insurance funds leading to an increase in the quality of the medical activity.

However, the problems facing this system are related to the occurrence of adverse selection, insurance funds trying to attract healthy people to the detriment of the sick, the young instead of elderly people . Examples of social health insurance system type Bismarck are seen in Germany, France, Japan, Benelux, Austria, and recently in Romania.

Private health insurance is offered by insurance companies non-profit or for profit, on individual or group basis. In terms of individual private insurance, the premium is actuarial, based on their risk of disease. Size contribution also depends on the package to be provided, to which adds administrative costs, and profit margin. The last two are about 40-50% of the values of the insurance premium. High administrative costs are mainly due to very high marketing costs needed to sell insurance to as many individuals as possible.

Private insurance may be offered to groups of people, usually employees of the same employer, or members of unions. To minimize adverse selection, insurance companies often require a minimum number of individuals (75%) to get insurance.

But the most important aspects are related to the role of government. Its most important task is to establish the legal framework without which insurance company cannot operate. Also executive may engage in a series of questions such as: establishment of reserve funds for insurance companies, similar to those of the banking system in order to prevent any fraud. The question is whether authorities should exercise any control over relations between private insurers and health

providers, concerning the rules they follow in establishing the premium, or if they should get involved in combating the phenomenon of risk selection? What is certainly clear is that private insurance option does not relieve the responsibility of government involvement in financing health system. On the contrary, private insurance raises additional legislation and management issues. As a conclusion we can say that private insurance is really an additional source of revenue for health. Yet they raise questions about the high administrative costs, and issues of equity.

The implementations of private insurance require specific regulations, accompanied by close and constant supervision, requirements that many countries are not able to comply.

There are several types of direct payment:

- ✧ full payment for services
- ✧ co-payment (a fixed amount for each medical examination)
- ✧ Co-insurance (a certain percentage of the cost of medical visit)

The full payment for the medical services is usually done in the private sector, while co-payments and co-insurance are common especially in the public sector of health services. Positive effects of these methods of payment may be: to reduce non-necessary services by empowering both patients and medical doctors; the increase of service quality; the increase of allocate efficiency.

Problems that arise are related to the fact that the poor people or the elders, main beneficiary of medical services, could reduce the consumption of care required due to inability to pay. Despite the optimistic appearances, studies have shown that the introduction of direct methods of payment has not led to a significant increase in funds for health, growth estimated at less than 10%. Moreover, no evidence of any visible improvement in the quality of services provided. In conclusion, although lately notice we remark a trend of introducing the direct payment, there are many possible negative effects in this method of financing.

Community financing is a method which can be applied generally to rural communities. It requires that the members of a community to pay in advance a contribution in order to obtain a package of medical services, when they will be needed. Contribution usually covers part of costs, the remainder being subsidized by the government. Community financing is based on two principles: cooperation and trust between community members. Recognizing health care as a basic necessity, and that joint efforts can be achieve economic and social welfare of the community members, they are mobilized in order to finance, organize and management of health care. Community financing can be supported and encouraged by the government through legislative initiatives, technical and financial assistance. Yet the ideal is that Community funding organization to be independent of local or central authorities

4. Health Insurance System in Romania

To the emergence of the Social Health Insurance law no.145/1997, the health care system was conducted in a centralized way by the Ministry of Health through the 41 county health directions and the health department of Bucharest, consisting of a network of hospitals, clinics, dispensaries and other medical units. In addition there were also a number of hospitals, institutes and highly specialized national centers directly under the Ministry of Health, and also parallel medical networks under the Ministry of Transport, National Defense Ministry, Internal Affairs, Labor and Social Protection Ministry and Romanian Information Service, which were providing medical services and were responsible for a certain category of population. During 1990-1998 a dualistic system was used such as financing from the state budget, complementary financing - special health fund, and foreign financing, loans from World Bank, PHARE funds and donations. The beginning of health reform involved the reorganization of health services and of the financing system of health care. The principles of organization of the health system have significantly improved by free access to medical services, paid medical assistance, national coverage, the transfer of responsibilities- district health directions the College of physicians of Romania, free choice of doctor, the appearance of the notion family doctors and the appearance private sector.

In July 1997 was adopted by the Romanian Parliament and promulgated by the President, the Social Health Insurance Law-law no 145/1997. This law followed the Bismarck model of insurance, with compulsory health insurance based on solidarity principle, and operating in a decentralized system. It came into force, with all prevision since 1 January 1999 but there was a transition period in 1998 when county health directorates and the Ministry of Health have administered the insurance funds. In consequence since 1 January 1999, according to the law the insurance houses functioned as independent public institutions, led by the representatives of the insured and employers thought administration boards, and the national health insurance house. Social health insurance law no.145/2002,first introduced legislation that principles of social health insurance came with new features and democratic(includes mandatory population, free choice of doctor, health unit and home health insurance, granting defined package of health services covered by the framework contract, financing through contributions and state subsidies, financial balance, decentralized operation, solidarity and subsidiary in the collection and use of funds, equity, accessibility in providing medical services).

During 1997-2001, Law Social health insurance no.145/1997 was changed successively by the Emergency Ordinance of Government no.30/1998, EOG no.72/1998, EOG no.180/2000. Since 20 November 2002 (date of occurrence in the Official Gazette), Law Social health insurance was abrogated by the Government Emergency Ordinance no. 150/2002 on organization and functioning of social health insurance system.

By 17 November 2005, Emergency Ordinance no. 158/2005 was published on medical leaves of social health insurance, so CNAS took over from 01.01.2006, a task that for years belonged to the National House of Pensions and Insurance. The appearance of the Order no. 60/32/2006 for approval of the Normas for the application of Government Emergency Ordinance no. 158/2005 on medical leaves of social health insurance is a logical step forward. Since 2006 the health insurance system is preparing for significant changes, the Romanian Parliament approved the package of laws on healthcare reform, Law no. 95/2006. With a health budgets at a minimum the last nine years, only 3,2% of GDP, down 20% over last year, Romanian health system is comparable only to that of the poorest countries of the word and the collapse seems to be imminent in 2010, without additional funding, says a report of the Romanian Academic Society.

Health in Romania are likely to fail next year, if they will not find money to cover five quarters, and this because the last three months they have received future budget for the year, although not yet know the percentage og GDP will receive health. The 2,8billion allocated in September to cover health costs in the fourth quarter of 2009 will be deducted from the budget next year is not likely to receive more than 3% of GDP.

The pharmaceutical sector, although it means less than 25% of the entire health system outgoings, is one of the most affected, 2009 being the first year the market has fallen, both in volume and treated patients. A Romanian citizen spends, in average, 100 euro for drugs / year, 4 times less than the European average (cca.430 euro / year). Consumption of drugs is almost the lowest in Europe, only the Bulgarians spending less: 85euro/year.

In addition, the drugs producers are facing other difficulties, beyond the stint of the consumption. Pricing free an compensated medicines according to an exchange rate lower than real, extending deadlines up to 210 days, a bad collection of trade debtors and also the new income fee, make the producers to have lower incomes. Since the majority of the pharmacies have incomes lower than 30.000 euro, the costs became unsupportable, so in present almost 10% of the Romanian pharmacies are being brought to trial for default, and are being declared bankrupt. For half of the 1.200 pharmacies in rural areas the insolvency seems to be the only outcome. On the other hand, the pharmacies are bound by contract to continue the delivery of free and compensated medicines till the end of this year and maybe also till January 2010, meanwhile the arrears to the producers are increasing.

5. Health Insurance System in Europe

In Europe, there are two models of health care systems:

1. national health service model (S.N.S) ;
 2. model of social health insurance system (S.A.S); type Bismarck ;
1. The National Health Service (S.N.S): imagined by the British, works in Denmark, Finland, Iceland, Norway, Sweden, Greece, Italy, Portugal, Spain, England.

Features:

- ✧ Funding source: general taxes ;
- ✧ Controlled by the government ;
- ✧ Dispose of state budget ;
- ✧ There is a private sector too ;
- ✧ Free access to services for all citizens ;
- ✧ General coverage of the population with health services ;
- ✧ Leadership by state authorities ;
- ✧ Doctors are: employees or paid depending on the number of patients enrolled on their lists (capitation) ;
- ✧ There is co-payment of some parts of the cost of benefits ;

Advantages:

- ✧ Positive impact on the health status;
- ✧ Relatively non onerous (it is not difficult to support by the population)

Disadvantages:

- ✧ Long waiting lists for some medical papers ;
- ✧ Doctors with lack of incentives ;
- ✧ High dose of bureaucracy ;

2. Social health insurance system (S.A.S): works in countries like Austria, France, Finland, Germany, Belgium.

Features:

- ✧ Funded, in general, from the compulsory contribution of employees and employers (dues) depending on income and from general taxes ;
- ✧ Wide coverage, but not total (remain uninsured the persons who do not work) ;
- ✧ The management of funds is done by agencies ;
- ✧ Agencies contracts with hospitals and family physicians or general practitioners, services to be provided to the insured ;
- ✧ Contracts with practitioners are based on tax/service, tax/benefits, and with hospitals through global budgets ;

Advantages:

- ✧ Relatively high medical performances ;

Disadvantages:

- ✧ Expenses-the largest in Europe ;
- ✧ Its administration costs are high ;

Generates high induced consumption; with the possibility of perverse phenomena such as: Moral hazard (in a service whose price is 0, the demand always exceeds supply) ; Opposite selection (refusing insurance of costly groups by high volume of consumption and the high cost of benefits) .

Social health insurance system in Austria - Austria has one of the best health services in the European Union, including approximately 99% of the population in health care. The whole concept of the health system is based on the desire of prevention, not treatment. It is structured like the German model, in four major categories: health insurance, accident insurance, life insurance and unemployment insurance. Differences from the German system refer to the direct provision of services and the possibility of negotiating fees by regional Chambers of physicians or by medical associations.

Health policy refers equally to improve hospital services system and to revive the role of primary

or ambulatory medicine. Using the example of Austria, this country has one of the lowest unemployment contributions, about 1.7%. Percentage of population younger than 20 years, was, according to a survey conducted several years ago, only 23.7%. Meanwhile, the percentage of population over 65 was 14.6% and the population older than 75, was 6%, Austria with having one of the greatest life expectancy in Europe, that is 80.2 years women and 73, 9 years men. In these conditions, financing the health system is based primarily on security in the event of illness, 59%, 24% taxation, private insurance with only 7.5%. Austrian Ministry of Health is limited to the formulation of health policy framework.

In terms of hospitals, doctors are paid here on a salary and on fees that are set according to the seriousness of the disease. These fees are determined based on a Framework Convention concluded between the Sickness Funds and and Regional Chambers of Physicians.

For dental offices these are established at federal level. Contributions for the diseases are funded by the employer or the employee. Because health promotion and disease prevention measures are the main concern of health authorities, since 1992, these prevention measures have been incorporated into the social security system and efforts for early detection of diseases such as cardio-vascular affections, cancer, diabetes have become more and more supported.

To this end, the focus is on preventing diseases, which is included in a national plan, besides the already known programs that are being developed, where requested, a number of new programs. An important aspect is that preventive actions have involved a particular effort on information and documentation regarding health status and health of the population.

There is therefore no surprise that 50.3% of 63.35% insured are satisfied with the health system and life expectancy is so high. The differences compared to our health system is huge (to be well understood, the differences are not related to personal training doctors or nurses), so I guess I can not draw any conclusion.

6. Conclusions

Recognizing health care as a basic necessity, and that joint efforts can be achieve economic and social welfare of the community members, they are mobilized in order to finance, organize and management of health care. Community financing can be supported and encouraged by the government through legislative initiatives, technical and financial assistance.

In conclusion, we recommend following:

- ✧ It must be invested approximately 6% of PIB for health sector in order to maintain a decent functioning with a realistic budget, witch will create the context needed for building long-term programs.
- ✧ Building a system for collecting and processing data from the health sector in order to produce relevant information on the priorities of the system.
- ✧ Adequate definition of "package to be provided" for the insured people, considered to be too generous for the existing funding, without priorities and unsustainable.
- ✧ Efficient allocation of public resources between medical services and treatments (most used for expensive services and less for services provided by family physicians or outpatient treatments).
- ✧ Separation from regulatory activity factors (Ministry of Health), from funding system (National House of Health Insurance) and service providers.

Worldwide, occur changes in health systems, changes which follow to eliminate and reduce dysfunction occurred both in democratic countries with stable economies and in countries that had an economy based on state monopoly of production factors with a centralized planning system, rigid and on demand.

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