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A WELL-FUNDED PUBLIC HEALTH SYSTEM FOR A HEALTHY NATIONAL ECONOMY

Theoretical article

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Abstract

The article focuses on the healthcare financing analysis in Romania in the European context, trying to capture the revenue and the expenses trends over the last years. All time health system was the most important domain for a national economy. It is known that a domestic economy works if it has a good health system. This is the reason for which I took as an example to be followed Netherlands health system that I would recommend to be used even in Romania in order to get the best results.

Introduction

One of the most important policies that has to be developed and continuously improved within a country is the health policy, because a state is healthy if its individuals are healthy.

Generally, as any other policy, health policy can be defined as a set of decisions well interconnected regarding choosing the objectives, the ways and the resources necessary to meet them at a given moment.

The policies depends on the level of development of the country, also a health system is healthy if state allocates and uses efficiently an important share from GDP for it.

In an economy, the health expenses, just like the educational ones, represent an accurate indicator of the development level. The countries with advanced economies allocate important resources to finance the health sector as a prerequisite for a long-term sustainable development - Graph 1.

In the EU, the share of health expenses in gross domestic product (GDP) has grown in recent decades, the average increasing from 6.4% to 9.9% between 1980 and2009.Romania is in this regard in the last place, with a level of 5.6% of gross domestic product (GDP) spent on health in 2009.In the period 2003-2009, the total health expenses growth was a marginally one, from 5.2% to 5.6%.

Financing the health expenses is mainly performed by the public sector and in addition by the private sector. In Romania, the balance is overwhelmingly tilted by the public sector, with 79% in 2009.In the other European Union countries, the participation of the private sector is at a slightly higher level, respective 27%.In this context, the health expenditure funding growth from private sources appears as a normal and viable solution for solving (partially) the existing structural problems.

Health system – comparative analysis in EU countries

In Romania, the current health insurance contributions are insufficient to fund the demand for services and drugs.

In Romania, the total resources allocated to health, 80% are public and 20% private. About those public (in 2011 was a total of 21,1 billion lei), most - 85% - are managed by the Single National Health Insurance (FNUASS).In the case of the private ones, the majority comes from direct payments, respectively co-payments or charges for services. The main public revenue for health insurance contributions are paid by employers and employees / pensioners / freelancers. In 2011 it totaled 15 billion, which represents 2.6% of the GDP.

In addition to the social health insurance, the public health system also benefits from the tobacco and alcoholic beverages taxes (informally called "vice tax" - vice tax is applied to cigarettes, tobacco, alcoholic beverages (except beer and wine) and tobacco and alcohol advertising) and income tax for manufacturers, importers and marketing authorization holders from selling medicines whose payment is wholly or partly supported by FNUASS (known as the "clawback tax "). In 2011, the vice tax generated revenues of 1.2 billion lei and 0.24 billion lei from the clawback tax, both to the Ministry of Health (it's about clawback tax as regulated by Ordinance No. 104/2009 in order to amending and supplementing Law no. 95/2006 on healthcare reform).

Except form the revenues with a special purpose, the system receives subsidies from the state budget, namely from general taxation. In 2010 and 2011 they were essential to cover the FNUASS deficit, totaling 5.5 billion lei, or 15% of the total revenue - Graph 2.

In the Western European countries, the health financing reforms that took place in the last two decades have led to the replacement of the mechanism based on the percentage of revenue contributions (mechanism implemented by the countries of Central and Eastern Europe especially in the 90s) with eclectic solutions having diverse objectives. For example, in France, in order to broaden the coverage of health funding base and to reduce the dependence on such income fluctuations and of those related to the wage employment, there has been implemented a general social contribution based on the total income and not just salaries. In this way, the employer still pays 13.1% of salary, while the employee contributions fell from 6.8% to 0.85% of gross revenues in 2010.On the other hand, there were other contributions: 8.2% from capital gains, 9.5% from gambling activities, 6.6% from the pension and 6.2% from the social benefits. Moreover, the pharmaceutical industry contributes with 1% of turnover, a tax on advertising, a tax on the sale of medicines and an additional fee if the turnover exceeds a certain threshold. There is also a tax on polluting companies work and a fee of 0.03% tax paid by all companies recorded a turnover of more than EUR 760,000.

In the Netherlands, the mechanism of collection is distinguished by two components: the basic health insurance and the extraordinary medical expenses (Exceptional Medical Expenses relate to long term care, exceeding 12 months, psychiatric care and social services nature).In the first case, the annual premium of insurance is determined by the insurers being depending on the risk which has to be covered. On average this amount was 1100 euros (in 2008), representing about 6% of the average income. To ensure the exceptional medical expenses there is asked for a

contribution of 12.15% of salary but capped at an annual amount of 3,838 euro (figure for 2008).

In Italy there is required a regional tax applied to the value added produced by companies (4.25%) and the salaries of public sector employees (8.5%).If the regional budgets of the health insurance record deficits it is allowed to increase by 1 percentage the value quoted. The health financing is also performed by a regional tax which is added t the income tax of the physical persons, through taxes on motor vehicles and other excise taxes to the petroleum products (0.13 euro / liter), the regions may increasing the amount with another 0.026 euro / liter.

The mechanisms for resource allocation in the health system suffered frequent changes, many reforms being implemented in the last decades in order to streamline the allocation of resources to health. However, some patterns can be identified which are visible in several European countries. To finance the primary health care, the most commonly used solutions are the capitation payment system based on the number of patients per physician lists (e.g. Bulgaria and Italy) and a combination of capitation system and based on rates on medical services (e.g. Slovenia , the Netherlands and Slovakia).

The capitation system has proven to be beneficial to the health insurance companies because they can control costs (knowing in advance how much will be payment effort), but it doesn't motivates the generalist doctors to perform more expensive medical procedures. In some countries, the capitation system is integrated in an operational framework which diminished the mentioned effects. Thus, in Italy, the payment level, the maximum number of patients, the general practitioners' responsibilities and the obligations of the doctors are stipulated in a collective agreement signed every three years (i.e., the contract signed in 2009 provides a fixed payment for each policyholder in the amount of 40.05 euros and additionally may be a variable payment depending on the number of patients and physician age in the industry).

The financing of the specialist ambulatory health system in most cases is based on the medical service fee provided (e.g. Slovenia, Slovakia, Bulgaria, Holland, etc.).In Slovakia, every medical procedure has attached a number of points and the insurance company negotiates rate for 1 point with the health care providers (most health insurance companies negotiate a maximum amount of points that are paid to avoid potential waste in the medical act).In the Netherlands, the Ministry of Health and Medical Specialists Association established a uniform tariff within a certain range. Within this interval, the hospitals and the medical specialists can negotiate. This tariff was EUR 132.5 ± 6 euro (since 2007). In France, the prices are agreed at national level. In Italy, since 1999, the funding has been shifted from the medical service charge criteria to the casuistry criterion.

The effect on health financing reforms was felt most strongly in the financing of hospitals. Currently, the most commonly used implemented solution seems to be the one based on the case and it has already proven to have some drawbacks that most likely will report further reforms in the future.

In Slovakia, before 2000, the hospital services were paid according to the number of bed days' prospective contract. Subsequently the payment model on case law was implemented, which encouraged hospitals to reduce patient length of stay because the price paid per case remained unchanged, regardless of the period of hospitalization. The law does not distinguish between the severities of casuistry to the same type of intervention, the hospitalization of less serious cases has been indirectly promoted, outsourcing paper of more complicated cases and their readmissions. In 2003 there was introduced a new model that determines the whole procedure of caring for a patient, which requires greater administrative and operational efforts, but solves previous problems. The costs per case were taken from a similar Australian model.

In the Netherlands, in 2005, we implemented a system based on diagnosis-treatment combinations requiring hospitals to provide a total cost of each treatment. The Ministry of Health, together with hospitals, specialists and insurers established treatment options and the costs associated with each diagnosis. These costs include the costs of specialist treatment and use of medical equipment and indirect costs of education, research and emergency treatment. This system was considered closer to patient care needs, but practical application has been disappointing and is drafting a reform of this mechanism. Regarding the treatment of long-term, the funding mechanism was changed in 2009 in terms of number of beds available for patients criterion based on the intensity and complexity of the treatment offered.

In Bulgaria, hospitals receive funding in particular the criterion casuistry. The average per case was set at 189 euro equivalent in 2003 and was determined on the cost of the medical activities, the auxiliary services provided to 2 ambulatory examinations offered after discharge.

In France, until 2004, state hospitals and the private ones non-profitable by nature were financed by the global budgets criterion, and those private profit-oriented based on a daily rate and a tariff covering hospital medical service. Currently, the funding takes place after the casuistry criterion, each patient being classified in one of the 2200 group.

A final example is the Italian one where, until 1978, hospitals were funded by the criterion day-bed hospital, which increased the number of beds and the period of hospitalization, no counterweight on the efficiency of care. Subsequently, the funding system was replaced by one based on a fixed budget, and through the reform of 1978, hospitals have been recorded in the financial responsibility of local authorities. Since 1995, the entire funding of hospitals has taken place after the case work criterion (with some exceptions: emergency medicine, prevention schemes, transplant activity and chronic disease management). Recent reviews financing mechanism based on case law in Italy have shown that the system: (i) did not lead to increased competition, but the more attention in the planning and management of budgets, (ii) promoted a trend towards specialization of private hospitals and (iii) has developed the information technology for the management of registrations for hospital activity.

Case study - health insurance system in the Netherlands

Most of the information in this section and references to the Netherlands from the wording of the report are taken from the Health Systems in Transition, The Netherlands: Health system review, The European Observatory on Health Systems and Policies, Vol. No. 12 in January 2010.

Why I have chosen Netherlands for case study? Because it can be considered a successful case when talking about health system and many EU countries, including Romania, can follow its pattern.

According to OECD standards, Netherlands spends currently approximately the equivalent of 9% of GDP on health, of which 81.5% are public expenditure (in the compulsory health insurance system) - the amount does not include the Exceptional Medical Expenses.

In the last decade the total expenditure on health has increased by almost 40% in real terms after a broad process of restructuring and new efficiency both of the public and private sector health. The first profound reform proposals were made in 1987; the implementation was impossible then, but gradually there were made small steps that have established the extensive reform from 2006 (Decision-making in the health insurance system is characterized by consultation and consensus, the important role of consultative bodies and set out in laws and regulations (Medical Council, the Council for Public Health and Medical, Health Insurance Board)). The objective of the 2006 reform was the introduction of market mechanisms to achieve organizational efficiency and cost control.

The current health system care is structured in three parts:

• The health insurance market
• The market for health care providers
• The health care purchasing market.

The Dutch social health insurance system has three main components:

1. The based health insurance, which account for about 59% of total contributions, works on two collection mechanisms. Policyholders pay premiums directly to private insurers with whom they contract, and employers contribute to the Health Insurance Fund (FAS) to balance the insurers. The insurance contracts may be individual or collective at the level of employer or patients' organization. Premiums paid by beneficiaries are unitary for the insurer and services. In order not to accumulate too much risk in the portfolio, the cuts applied by insurers are limited to 10%. The disadvantaged social categories receive state periodic health allowance in order to pay the premium.

2. Compulsory insurance for exceptional medical expenses - treatment / long-term care (chronically ill, disabled, psychiatry) - which accounts for about 41% of all health insurance contributions paid by the insured.

3. Complementary/ voluntary health insurance covering services not included in the first two categories. Most private insurers offer voluntary insurance policies next to the compulsory ones; the insurers are free to set the price of voluntary insurance premiums depending on individual risk and refuse certain beneficiaries.

In terms of paying the cost of care, private insurers offer three options:

1. Services in nature provided by contracted providers, settled directly by the insurer - 40% from the policyholders;

2. Reimbursed services of the insured, no mattering who the provider is (according to the market prices and tariffs of the providers which are not contracted) - 25% of the policyholders;

3. Combinations of the first two options - 35% of the insured.

The revenues for the basic health insurances come from policyholders through insurance premiums, and FAS through the employers' contribution:

• The average price for a basic insurance policy health was 1100 euros in 2008 (about 6% of the net income of the reference population) and in 2009 it varied between 933 and 1150 euros;

• FAS employers' contribution is 6.9% of taxable income for employees, retirees and beneficiaries of other social insurance rights, with a maximum of 2233 euros / year. The contributions are collected by the Tax Administration and they are subsequently transferred to FAS, where they are

allocated to private insurers depending on the specific risk of each portfolio for sure.

The distribution of FAS funds to the private insurers is made by taking into account the characteristics of the insured portfolio relative to total population insured:

1. Gender and age

2. Type of income (wages, income from self-employment, pensions, unemployment)

3. Geographical area - segmentation based on income level, disease prevalence, mortality, etc.).

4. Necessary medicines for groups of patients with chronic diseases - 20 groups (up to 20,000 euros per insured)

5. Patients with chronic illnesses treated in hospital - 13 diagnostic groups (exceeding 50,000 euros per insured). The amount allocated by FAS to each insurer is calculated as the difference between the estimated costs based on the model described above and the estimated revenue from premium income based on the use of a unique benchmark for policy. The most efficient insurers which fail to achieve a surplus (revenues> expenses) can reduce the premium. If the actual costs exceed the initial expectations, there are a number of ex-post mechanisms compensation insurers in FAS.

In the basic insurance system there is implemented a copayment form designed to prevent the use of essential health services. This is paid by the insured to the insurer and it applies to all medical services reimbursed by the insurer, except for services related GP visits, childbirth and dentistry (for those aged under 22 years). In 2009 the amount of the copayment was 155 euro per year. Since 2009, the insured may opt to renounce at the co-payment if:

• They go to health care providers indicated by the insurer;

• They use drugs or medical devices preferred by the insurer;

•they participate in programs to prevent diabetes, cardiovascular or respiratory diseases, depression and overweight.

Certain categories of chronically ill receive compensation from the state for copayment. For policyholders who estimate that they will not need care it is possible to opt for a voluntary co-payment up to € 500 in return for a discount on the price of the insurance policy.

For hospitals (most of the 141 private hospitals are organized in a hybrid form, i.e. non-profit corporation), the price of services is determined on the basis of a "diagnosis-treatment combinations" (DBC), which includes approximately 30,000 different combinations fall into two categories:

• With fixed price set by the Netherlands Health Authority;

• With negotiable prices between insurers and providers (about 34% of DBC). The capital costs of hospitals are included in the price of services.

DBC system is very complex and volatile which delays contracting health care providers by insurers. Since 2010, for example, it has been working to reduce the number of combinations DBC 3,000 positions.

Hospital budgets are developed on a base of the ability of hospitals and medical specialization, subsequently being separate on the two components of the DBC (i) fixed prices and (ii) negotiable prices. At the end of the year, budget of the fixed price component shall be settled by the Dutch Health Authority. The negotiable price component budget is limitless.

Family physicians act as first filter for most patients, being the main point of access to health care. Family doctors are paid according to rates per capita and per service; maximum charges for services are set by negotiation between the national association of family doctors, insurers and the Ministry of Health.

Specialty physicians are paid based on an hourly rate system DBC (hourly rate is unique: euro 132.5 +/- 6 euro and the variable is the normalized number of hours for each treatment), or as employees of a hospital. In the first case the hourly rate includes the cost of medical infrastructure and costs associated with medical practice. Even if there is a maximum gains, in practice the limits have been exceeded, indicating a deficiency of functioning of the DBC.

The pharmacists' income derives from two sources:

• dispensing fee (up to 7.28 euro in 2009)

• Reimbursement of drugs by insurers. On the second category of income there is a clawback charge of about 6.82% (2009), but it can vary if there is a contract with the insurer.

Conclusions and proposals

The conclusions that are the direct results of the success of the health system within Netherlands can be proposals for Romanian decisional factors directly involved in health system. Also, they can be considered proposals for the government when discussing abouth health system and health policies.

After the first year of implementation of health reform can draw the following conclusions:

1. In the early years, the private insurers have set relatively low prices to insurance policies in order to attract customers, which led to the accumulation of casualties. In this context it is expected that insurance premiums to rise in the coming years;

2. Patient mobility was important in the first year (2006 +21%) and has significantly decreased thereafter (<5%);

3. for safeguarding the public interests (quality, access, and cost), the competition among service providers has been regulated;

4. In the case of physicians, after entering the service charge, the number of consultations and declared that implied settlement surprisingly grew;

5. For the Hospitals case, the funding system was changed so that the money follows the patient; after two years of implementation, the DBC system has been evaluated and there were found moderate positive developments in the increase of the quality and of the access to services and cost optimization. Contracting medical providers to insurers based on quality of service is not yet a standard in the industry - 50% of private insurers have not provided any criteria related to quality of service contracts with health care providers;

6. There has been encouraged the creation of multidisciplinary clinics or specialized treatment centers that provide outpatient services, with lower costs than hospitals;

7. Generally, the waiting lists were reduced through financial incentives subject to diminishing the number of waiting patients;

8. The liberalization of the health system generated vertical consolidation trends, some insurers acquiring clinics, pharmacies and hospitals.

This set of eight conclusions, if they will be considered by decisional factors, they can lead to the success of the health system even within Romania.

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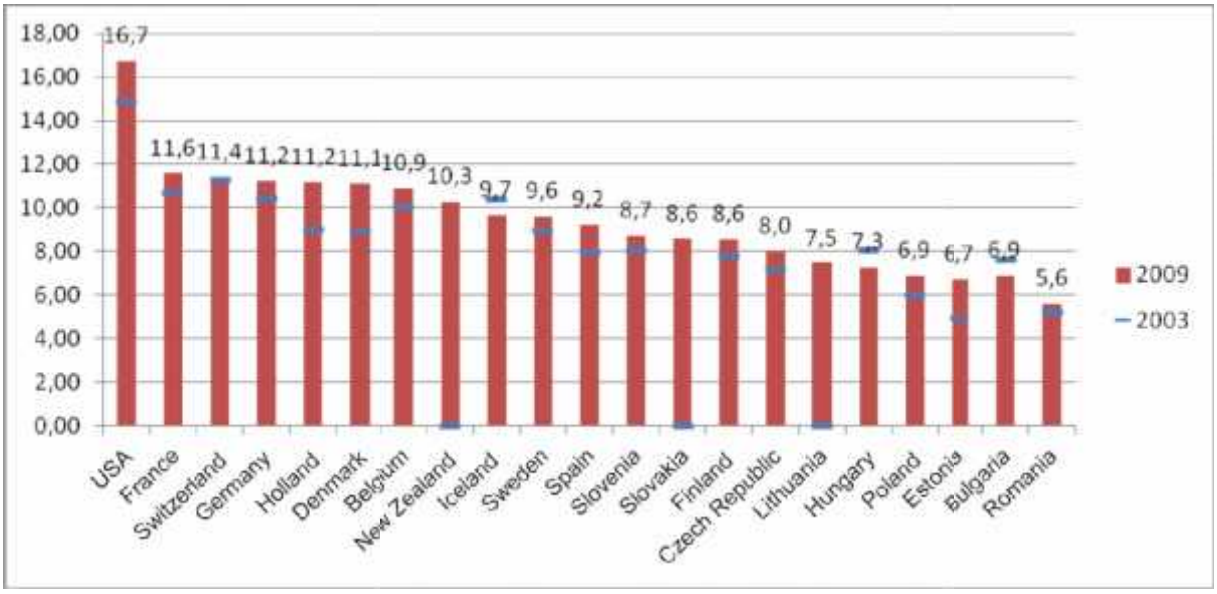
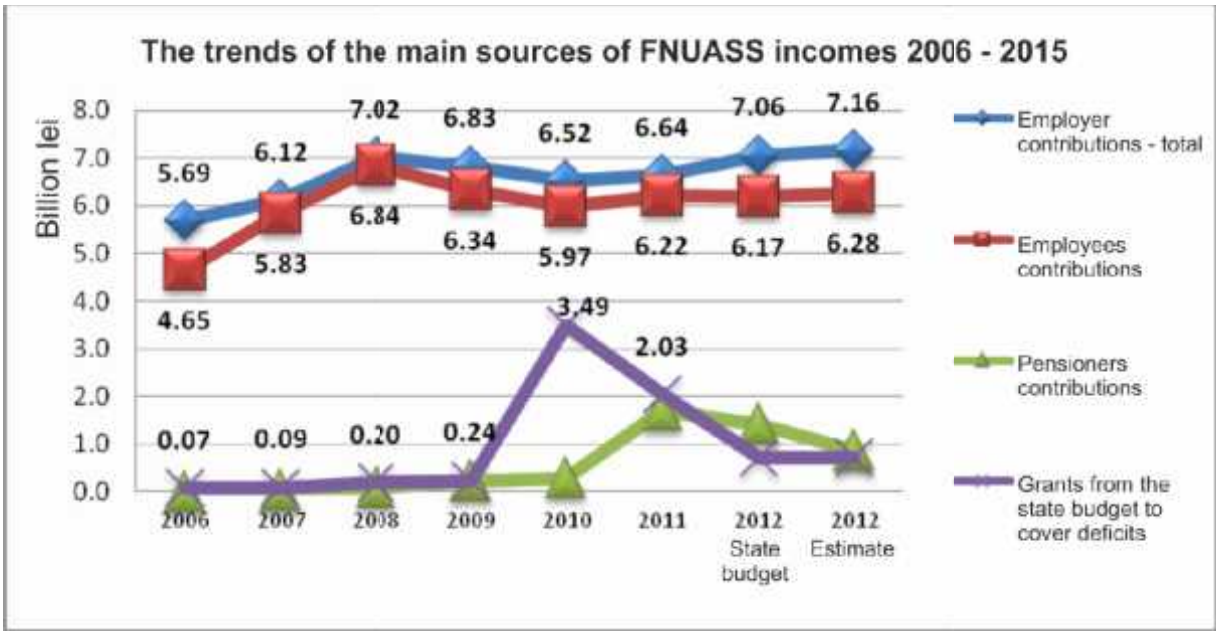
Graph 1 – Financing health system (% GDP) in different EU countries (2003-2009)



Source:Eurostat, MIND Research & Rating

Graph 2 – The trends of the mains sources of FNUASS incomes 2006-2015



Sursa:CNAS,MINDResearch& Rating