THE FINANCIAL CRISIS AND THE CRISIS WITHIN EUROPEAN HEALTH INSURANCE SYSTEMS

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1. Sustainability of health insurance systems

The current financial recession substantially affects almost all countries and, unlike previous similar situations, the current economic crisis which broke out in late 2008, begun in the developed countries, and subsequently spread to the rest of the states. Its effects on developing countries are still felt longer, and resume the upward economic trend is expected to not show in the near future, despite the optimistic forecasts.

In terms of the impact of the economic downturn on health insurance systems, an analysis is required, in order to understand the concept of sustainability. In this regard, the specific terminology[1] defines two concepts which are often missunderstood: fiscal sustainability and economic sustainability.

Economic sustainability refers to the growth of health spendings as a percentage of the GDP. Expenditure in healthcare is considered effective to the point where the cost exceeds the value obtained. When the level of spending of health s systems negatively impacts other vital sectors of the economy, health expenditures are perceived as being, in economic terms, unsustainable.

Fiscal sustainability of a health system refers to the level of public spending on health. A health system can be sustainable in economic terms, but fiscally unsustainable, where public revenues are insufficient to cover expenses.

Under the impact of the items listed above, the need for sustainability in the health sector is often seen as an objective in itself, independent and superior to any other frequently used in order to achieve efficiency or effectiveness. Although this approach has the advantage of simplifying the fiscal measures (if increasing the funds allocated to health is neither possible nor desirable, a viable option will take the form of reduced expenditure), the disadvantages are numerous.

Firstly, the sustainability of health insurance systems can not become a goal in itself, independent of the principles imposed on them (universal access, equity, efficiency). Secondly, achieving financial balance can be based on arrangements with a negative impact on policyholders. For example, the reduction of spendings could lead to a diminish of health coverage, while an increase of funds can only be achieved by increasing contributions. Thirdly, the sustainability of health insurance systems may be influenced by other factors such as the effective usage of funds.

In order to address the issues of fiscal sustainability with regard to health systems, there are three basic approaches to be considered[2]:

- increasing revenues to the point where public expenditure of health care systems can be covered;

[1] Thomson S. et. al. — Addressing financial sustainability in health systems", Organizația Mondială a Sănătății, Czech Republic, 2009, p. 5

[2] Thomson S. et. al. –op. cit. p. 27

- proportional reduction in the number of services provided by the health insurance system so that it can be covered by existing (or estimated) revenues;
- improving system efficiency.

The option of increasing public revenues, especially on account of tax levies and social security contributions, is facing a number of problems which could threaten economic sustainability by creating the premises for unfair competition between private insurers and the public systems. Moreover, any cut-backs of services provided by the public health insurance systems, would lead to a reduction in coverage which could help ensure fiscal sustainability, but would undermine the four values listed by the Council of the European Union

2. The impact of recession on the health sector and health insurance systems in European countries

In an environment affected by funding constraints, health systems within Europe are facing increased pressure in terms of an effective and universal access to health services. In order to counteract the effect of the recession, many states were forced to access financial support thus ensuring sustainability of their health systems.

Income cuts and the increasing unemployment rate have reduced tax levies and contributions to social health insurance with a major impact on the funds allocated to health insurance systems. The immediate response of the countries took the form of wide-ranging reforms designed to influence the previously used funding methods. Some reforms, already under discussion or on the verge of implementation, have been accelerated, while others were imposed in response to the financial constraints.

Since medical care and all other medical services are usually the major source of costs in the industry, all adopted measures aimed at reducing costs and increasing efficiency. In addition to these measures, the main goal was set to be increased productivity in providing a constant quantity of service based on a lower amount of resources.

Some countries decided on slowing down health spending by setting maximum limits, while other countries reduced operational costs, prices paid to suppliers for services provided on behalf of health insurance, spendings on pharmaceuticals and also procurement of goods, services and tangible assets for hospitals. A short-term measure has been implemented, aiming at decreasing the amount health services provided to all insured.

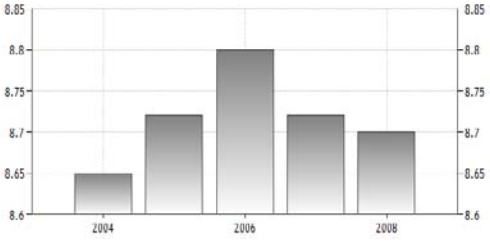
With regard to medical personnel, the effects og the recession have been felt in the field of employment, meaning that governments have promoted policies aimed at dismissing or not replacing retired staff. An additional package of measures was ment to reduce wages, a common trend for the entire public sector. The reduction of wages in some countries, up to 25%, as is the case of Romania, generated a real exodus of health professionals ultimately favoring developed countries through terms of accessing low-cost labor.

Economic reforms imposed by the financial crisis affected, in some countries, both patients and insured as a whole. Thus, some countries have rethought the entire health insurance system, modifying procedures on services provided, the quantity of services that could be accessed in a period of time and amount of money paid as contributions to health insurance. As a result, hospital costs increased significantly, while new co-payment amounts have been imposed.

The French health insurance system is based on compulsory insurance paid by employers and employees, thus, under the impact of the economic recession, the increase of the unemployment rate declined available resources by 1,3% in 2009, to a level

,comparable to that recorded after the Second World War'[3]. As shown in Graph no. 1, total health expenditure in France showed a downward trend since 2007 from a level of 8.8% of GDP in 2006 to 8.7% of GDP in 2008.

Graph 1 ***Total health expenditure in France between the years 2004-2008(% of GDP)***



Source: Tradingeconomics.com/France

The deficit of health insurance funds reached 20,3[4] billion euros in 2009, doubling the figure recorded in 2008. The direct consequences of the crisis are visible especially through the reductions planned for 2011. Thus, savings of 2.4 billion euros from streamlining health services and materials provided by health insurance are expected. Of this total amount, 40% (or the equivalent of 860 million euros) should come from pharmaceutical and medical device industries, as well as from certain activities in the field of biology and radiology, 50% (the equivalent of 1.200 million euros), are expected to be saved on the basis of improving efficiency, while 10% (330 million euros) are to be obtained from imposing a compulsory health insurance with a complementary role[5]. Also, for 2011, health spending growth is limited to only 3%[6].

In the long run, the mandatory supplementary health insurance may adversely affect the premiums charged by insurers. Besides this, the government decision from September and December of 2010 aimed to reduce compensation for medicines and medical supplies[7] by 5% and then 10%, is to increase the individual financial effort of the insured.

Moreover, starting from May 2010 hospitals have been required to reduce their, while a maximum annual increase of 2.8% of funds has been imposed. This policy is expected to generate savings of around 150 million euros[8] by the end of 2011.

Another measure adopted in the year 2010 preset charges for hospital care. Since the calculation was based on raw figgures, public hospitals have not received sufficient funds so that the deficit reduction measure could be achieved. Moreover, the impact was felt by healthcare professionals as layoffs and salary caps.

In Germany for instance, the total health expenditures in 2009 totaled 250 billion euros when, despite the health insurance reform which increased contributions to 15,5%, the actual contribution was reduced by 0.6% in July, in order to reduce the financial effort of employees and employers[9]. This was made possible by an increase in federal transfers, to offset a deficit of 3.9 billion euros[10]. Because of these measures until the beginning of the year 2011 there was no negative impact on the german

[3] Bandelow N., Hassenteufel P. – „*Structural Financial Crisis and the Strengthening of the Regulatory State Health Care Governance Reforms in France and Germany"*, International Political Science Association, Research Committee: Structure and Organization of Government **"CRISIS AS OPPORTUNITY"** Berlin Hertie School of Governance 4-5 November 2010, p. 8

[4] Rodwin V. G. – „*Universal Health Insurance in France. How Sustainable?"*, The Office of Health and Social Affairs, Embassy of France in Washington, DC, 2009, p. 101

[5] Rodwin V. G. Op. cit. p. 123

[6] Tradingfeconomic.com/France

[7] Bandelow N., Hassenteufel P. – op.cit., p. 11

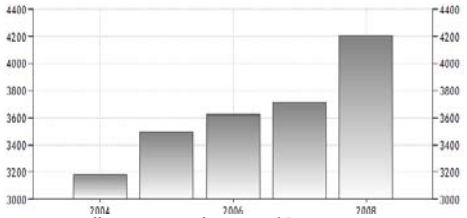
[8] Tradingfeconomic.com/France

[9] Federal Ministry of Health, Statistical Data, available at: https://www.bundesgesundheitsministerium.de

[10] Greß S. – *„Sustainability of health care financing – lessons learned from Germany*", Panel on financing, sustainability, and governance at the 2010 CAHSPR conference, Toronto, 12 May 2010, http://www.stefan-gress.eu/mediapool/40/403223/data/Financing_Germany.pdf

budget for the health sector, so the level of health expenditure per capita in Germany continued to grow during the recession, as shown in Graph no. 2.

Graph 2. ***Total health expenditure in Germany between the years 2004-2008 (US Dollars)***



Source: Tradingeconomics.com/Germany

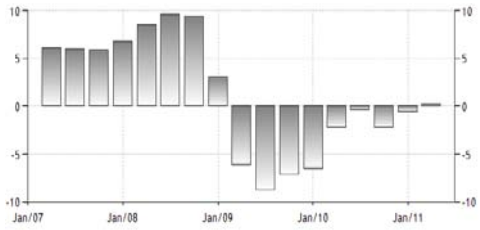
For 2011, however, a deficit of 11 billion has been projected, due to lower receipts from contributions; the immediate counter measure raised the current level of contributions to health insurance to its initial level of 15,5%, 8,2% borne by the employee and 7,3% by the employer[11]. In addition to that, the funds collected will be supplemented with 2 billion euros[12] from proceeds tax.

The health insurance reform of 2010 has also affected hospitals, meaning that they are expected to generate their own funds worth 500 million euros in 2011 and 600 million euros in 2012[13]. However, between the years 2009 and 2010 positive effect of the crisis had been felt: all regions have supplemented the funds for health infrastructure, investing a total of 1,5 billion euros[14] in hospitals. For the year 2011 however, service providers will have to take part in the medical savings measures promoted by the federal government by reducing the cost of services, medicines and sanitary materials. In addition to that, hospital will have to pay 30% of the costs of in-hospital medical services exceeding the agreed package of basic services under health insurance. This measure at promoting competition between public services and those provided on private basis, in order to eventually enhance public health funds by 150 million euro.

In the end, this set of sometimes complementary measures should lead to savings of around 500 million euros for the German health insurance system[15].

Under the impact of financial crisis, the situation in Romania has proved more difficult than that of Western European countries with similar health insurance systems. Due to a decrease of 7,1% in GDP, as shown in Graph no. 3, Romania was forced to seek external financial support, along with implementing a comprehensive program of economic policies aimed not only at balancing fiscal and external imbalances, but also structural bottlenecks that limited progress in terms of competitiveness and convergence.

Graph 3. ***Gross Domestic Product in Romania between the years 2007-2011 (%) - 2006=100%***



Source: Tradingeconomics.com/Romania

Public debt reached 23,9% of the GDP in the year 2009, increasing from 13,4% in 2008[16], up to a recorded level

[11] Federal Ministry of Health, Statistical Data, available at: https://www.bundesgesundheitsministerium.de

[12] „Country profile Germany" Report, Library of Congress, Federal Research Division, April 2008, p. 9

[13] Grunow, M. et al. – *„Public and Private Health Insurance in Germany: The Ignored Risk Selection Problem, 2010"*, http://ideas.repec.org/p/aug/augsbe.html, p. 3

[14] Rischatsch, M., Trottmann, M. – *„Physician dispensing and the choice between generic and brand-name drugs* –", 2009, p. 15

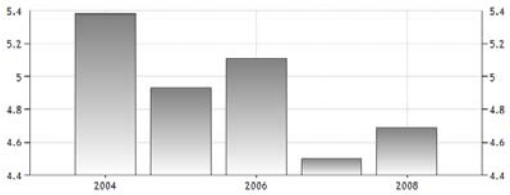
[15] Zweifel, P., et al – *„Preferences for Health Insurance in Germany and the Netherlands – A Tale of Two Countries"*, Socioeconomic Institute Zurich Working Paper No. 1002, 2010 pag. 8

[16] Tradingeconomics.com/Romania

of 37,75% of GDP in 2010. The budget deficit recorded in 2009 rose to 8,6% of the GDP, from the 5,7% level recorded in 2008[17], only to decrease to 6,6% of GDP in 2010, below the maximum requirements set by The Monetary Fund. This largely reflects the impact of the recession on public resources and is mainly caused by a reduction in receipts from Value Added Tax and social security contributions. In addition these aspects, the absorption rate of European funds and non-tax receipts were below the expected value. In the year 2009, great efforts have been made in order to limit deficit growth, including restructuring of public structures and reducing public expenditure on goods and services.

Healthcare spending in Romania as percent of the GDP is below the EU average. In 2010, only 3,6% of GDP was spent on health care, after previous values of 4,5% of GDP in 2007 and 4,7% of GDP in 2008, according to Graph no. 4.

Graph. 4. ***Total health expenditure in Romania between the years 2004-2008(% of GDP)***



Source: Tradingeconomics.com/Romania

Total resources coming from contributions to health insurance has dropped by 18%[18], mainly due to higher unemployment. In order to balance the budget of the health sector, the International Monetary Fund urged the Romanian government to pay about 446 million euros arrears to the health sector before allocating new funds for 2010.

The Ministry of Health has launched measures aiming at restructuring and decentralization of health institutions, by imposing management layoffs and by reductions of 9,000 available beds. In addition to that, healthcare workers' salaries were reduced by 25%, which eventually led to a new wave of exodus of healthcare professionals, estimated to some 2,500 in the year 2010[19].

Starting from 1 July 2011, co-paywill become operational and it is to be paid by all persons, wheather they are insured or not. The total annual amount will be of around 150 euros[20] for medical services provided within hospital area and outpatient clinics, with a tariff of 13 euros per day of hospitalization and 2,5 euros per doctor visit.

From a strategic point of view, the Ministry of Health is in the final phase of achieving a rationalization of health facilities. The main objectives of the reform are: developing a legal and institutional framework for the Romanian health system, increasing access to preventive and curative health services, improving decision making, organizational decentralization and reducing red tape, cost reduction for hospital care, increase patient care capacity, improve patient access to modern medical devices and implementing and strengthening a unified Emergency and First Aid healthcare system.

In order to provide and supplement resources to facilitate access to health care, the fallowing measures have been taken:

- increasing contribuion base by increasing the number of contributors;
- Implementing a private health insurance system (complementary role)

[17] Idem 16

[18] Lombardi G., Garel P. – *„The Crisis, Hospitals and Healthcare”*, HOPE - European Hospital and Healthcare Federation , 2011, p. 84

[19] Ibidem, p.85

[20] Legea Nr. 95 din 14 aprilie 2006 actualizată, www.ms.gov.ro/documente/lege%20%20coplata_334_725.doc

in order to diversify resources and competition within the system;

- introduction and completion of the co-payment reform and basic services package;
- further involvement of the private sector in providing health services.

Under the impact of global economic recession, many of the objectives set for health insurance schemes have been amended or supplemented. Thus, the improvement of efficiency and effectiveness is now matched by the need to cap spending growth, while maintaining non-discriminatory access to the health insirance system. Member states must continue to consider healthcare spendings as a main priority, because they are, in the end, investments in wealth and welfare not just a consumption of Gross Domestic Product.

3. Conclusions

In regard to the economic recession, the Organisation for Economic Cooperation and Development states that ‚the crisis is not in itself a threat to public health, although it indeed generates effects for the health sector, but rather a threat for the financing arrangements being used'[21]. Countries will need to adjust their public expenditure and ensure long-term control. Reactive strategies, such as reducing wages, prices adjustments for pharmaceutical goods and reduction in the basic package of services, proved to be more economically efficient than proactive; they tend to improve the quality of health care services but will not help reduce costs. In order to ensure sustainability of the overall existing health insurance systems worldwide, the World Health Organization has issued several recommendations:

- achieving cost and risk sharing using the principles of solidarity and equity;
- maintain previous levels of funding allocated as financial assistance for health so that the sustainability of health insurance systems is to be ensured;
- protecting social/ public health care systems and services;
- facilitating access to a health insurance system for all populations(in its absence there is a need for its implementation);
- promotion of health care prevention measures, the only long-term measures which are able to help reduce costs of health care systems;
- each country has to take responsibility for the insufficient number of health professionals and find means to overcome that aspect. Despite the recession and the economic downturn as a whole, it is recommended that countries maintain, protect and stimulate health professionals.

Health is regarded as perhaps ‚the most important condition for welfare and productivity'[22] so constant and sustained investment in healthcare and health insurance are extremely important. I therefore consider that efforts should be made to address the current need of reducing funds allocated to health, and even increase budgets in future years. Moreover, under the likely future effects of the recession in many countries, I believe that implementing a social aid health insurance system would be an appropriate measure, designed to help long-term, overall economic welfare of each state.

[21] Monterrey Consensus –Monterrey Agreement – Finance for Development- , 18-22 Mai 2002, „Report of the International Conference for Development Financing", chapter 1, resolution 1, appendix 1

[22] European Comission –*„Economic Crisis in Europe: Causes, Consequences and Repsonses", European Economy,* nr. 7/2009, http://ec.europa.eu/economy_finance/publications/publication15887_en.pdf, pag. 33

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