

## THE FUTURE AND PERSPECTIVES OF FINANCING THE HEALTHCARE SYSTEM

**Prof. Gheorghe MATEI, PhD**  
**Bianca MIHART, PhD student**  
**University of Craiova**

### 1. General characteristics of the healthcare systems

Health care can generally be financed in four different ways:

- social insurance, which is based on tax-like contributions and managed or regulated by the state,
- a health system, which is completely financed from tax revenues and other government resources,
- private direct payments (out of pocket),
- private health insurance.

These groups are not mutually exclusive; in fact, all health systems depict a mixture of various elements. Similarly, the distinction between private and social insurance is not as clear-cut as indicated in the previous typology; i.e., most health insurance systems are somewhere in-between the extreme ends of either category.

Private health insurance may be a tool to eventually achieve universal public insurance. Similarly, PHI-based health systems often contain cost sharing (e.g., user fees, co-payments, or deductibles) in order to restrain household demand and consumption of health care. Finally, out of pocket spending may become the starting point of an insurance-based system if resources are redirected for prepayments. Several studies derive a willingness and ability to pay for health insurance based on the large OOP (out-of-pocket) spending on health in low- and middle-income countries. As argued in

several studies, even the poor may be willing to pay for health insurance.

Out-of-pocket spending constitutes a large and very important source of health care financing in developing countries. Payments are not made beforehand but when care is needed. This can have catastrophic outcomes, especially for low-income families:

- individuals may not be able to pay for needed care and thus risk a grave deterioration of their health condition,
- individuals may be reluctant to pay for needed care and thus fail to get therapy when it is still effective,
- individuals may pay for needed care by using a large portion of their resources and thus risk impoverishment.

Despite these perils that are extremely critical for the health situation but also the overall economic performance in low- and middle-income countries, OOP is particularly important in the developing world. Some low income countries meet more than 2/3 of their total health care spending through OOP.

Unlike Social Insurance, PHI is usually (but not always) voluntary, which may leave the risk-pool relatively small. This has certain consequences that may be problematic from a policy maker's point of view. In risk-rated schemes, premiums are primarily based on individual health risks and not on a person's income. In community- or group-rated schemes, on the other hand, the relatively small pool will make cross-

subsidization between different risk-groups more difficult than in social insurance schemes (issue of equity). Furthermore, providers of PHI have an incentive to be selective concerning whom to insure. Beyond raising premiums for bad-risk individuals providers can simply refuse to insure high-risk/high-treatment patients (issue of discrimination). This cream-skimming is difficult to prevent. Sometimes, public regulation may even deteriorate market outcomes; i.e., in the case of community-rated schemes, general enrolment obligations for insurance providers will mainly attract bad-risk individuals. This will lead to premiums escalation, which further discourages good-risks from joining the scheme (adverse selection). Health risks are not shared in a large risk pool, but are spread among few individuals or across time. Without efficient management PHI may thus run the risk of going bankrupt. On the positive side, PHI will offer personalized insurance packages and competitive premiums to its clientele, particularly to good-risk individuals. Due to small company sizes and reduced bureaucratic processes, PHI can also work more efficiently than social insurance schemes, although insurers may face higher administrative costs due to product development as well as advertising and distribution activities. Alternative ways of premium collection may furthermore expand coverage beyond formal sector employment. Especially the non-profit PHI sector offers room for innovation to include individuals who would otherwise be left outside insurance based programs.

## **2. Private Health Insurance in Eastern Europe**

Private health insurance in Eastern Europe is still in its infancy. In many countries, private insurers only recently entered the market as part of the general reform process toward market

based systems. Measured as total insurance premium volume, the health and accident insurance industry is most significant in Russia, Slovenia, Poland, the Czech Republic, and Croatia. Except for Slovenia, which, as a high income country, will not be considered in the analysis, PHI does not play a significant role for health care financing in Eastern Europe. In Romania, PHI is offered by large firms for their employees (primarily multi national organizations operating in Romania) or it is used by Romanian residents travelling abroad as such services are not covered through compulsory social insurance.

Since its first appearance in the 1990s, PHI has not been able to become a major pillar of the health care financing system in Eastern Europe. As document for many countries, private risk sharing programs are either restricted to a very small and exclusive part of the population; or the schemes are only rudimentarily developed while coverage is limited to very basic services.

Over the past two decades the main trends in the healthcare systems in the region have been:

- a shift from central budgetary control to a mandatory health insurance based system
- the gradual introduction of market rules and practices governing relations between healthcare providers and insurance fund payers
- continuous underfunding of the public system, which has led to a search for complementary sources of private funding
- increasing involvement of employers in providing health products and support for their staff
- increasing demand from the public for a more modern and affordable system
- increasing life expectancy to levels closer to western European countries likely to lead to significant

The experience from Eastern Europe clearly underlines that a

successful implementation of PHI demands more political and regulatory will than merely opening markets for private providers. Beyond financial constraints of the state that could foster the development of private insurance markets, it is, of course, a political decision whether or not PHI should gain a more prominent role than in Eastern Europe.

### **3. The Romanian Health – Care System**

At present, Romania's healthcare system is still dominated by the public healthcare system, being funded by a combination of employer and employee contributions to the National Health Insurance Fund (NHIF) and of direct allocations from the state budget. Romania has a mandatory insurance-based financing model for healthcare, involving contributions from employers (5.2% of the gross wage) and employees (5.5% of the gross wage). The health insurance system is administrated and regulated by NHIF, a central quasi-autonomous body.

The system is organized at two main levels: national/central and district (judet). The Ministry of Public Health responsibilities consist of developing national health policy, regulating the health sector, setting organizational and functional standards, and improving public health.

The private healthcare sector is in an incipient phase but growing at a high-speed. An increasing number of private clinics have been opened and have been well received by those in the middle and upper income segments. Private health insurance services are usually offered by private companies to their employees, as part of the benefits package. In theory, insurance coverage is almost comprehensive. Exclusions comprise certain dental services and high-technology treatments.

As in most countries, Romania has a mix of compulsory and voluntary elements of finance, but the dominant contribution mechanism is the social insurance. Health funds derive primarily from the population, the most part through third party payment mechanisms (social health insurance contributions and taxation) but also by out-of-pocket payments (co-payments for goods and services not covered by the insurance scheme or direct payments to private or public providers for services outside of the yearly framework contract).

In 2004, the social health insurance contributed to 82.7% of the total expenditure, whereas taxes from the state budget represented 15.8%. As the state budget holds responsibility for funding public health services, capital investments, preventive activities and some treatments under the national health programs (e.g., for the treatment of diabetes, transplant and oncology), taxes continue to be an important contribution mechanism to finance healthcare. Other sources of health financing are out-of-pocket payments, external financing and donations. In 2006, a new tax on cigarettes and alcohol called "the tax on vices" was introduced at the request of the Ministry of Public Health. Substantial funds were collected and an important share is used by the Ministry of Public Health on strategic health programs (health promotion and prevention) and capital investment. As a result of increase in the taxes weight to the total health funding, in 2007, the social health insurance share in the total expenditure decreased to 75% (World Health Organization data).

The share of the state budget earmarked for recurrent and capital expenditure in the health sector is decided annually by the Parliament. The overall public health budget (including the NHIF budget) is annually set by the government and approved by the Parliament through the Budget State Law. Total healthcare expenditure is

difficult to measure because of the incomplete records of private expenditure (especially direct payments charged by private providers and informal payments in the public sector). Public figures on health expenditures include mainly those of the NHIF and Ministry of Public Health for medicines, health services, preventive services, medical equipment and capital investments, whereas the level of private spending is most probably underestimated. The data available so far suggest that from 2000 to 2008, the share of GDP spent on health had increased from 4.1% to 4.7%. Despite this increase and the limited comparability with international figures, the healthcare spending remains considerably lower than in most EU countries.

Annual spending on healthcare is however expected to rise gradually to about 5.4% of GDP by 2012, still remaining below the average forecasted levels in CEE (7% of GDP), but reducing the gap. By 2012 healthcare spending per head is forecasted to be more than 80% higher as compared to 2008, as Romania attempts to align to the EU requirements. Further growth will be fuelled by the rise of the disposable incomes, the development of the private health insurance and the increase of the medicine consumption. Informal payments in state-owned healthcare facilities are deemed to stimulate the development of the private medical services, as the latter represent a better alternative to the poor state-owned services.

The Romanian private medical services market emerged in the mid 90s, as an alternative to the poor condition of the public health system, long queues and the artificially created bottlenecks that were addressed through various “gifts” and informal payments. Initially, local entrepreneurs opened small medical practices in order to address the deficiencies of the public ambulatory health system. Furthermore, the

increasing demand for better quality services led to the emersion of the first outpatient clinics. The sector attracted foreign investors with operations in Central and Eastern European markets, Medsana and Medicover being among the first foreign names to enter the market.

The private clinics offer mainly three types of medical services to their clients: fee-for-service (for each consultation, investigation or laboratory test the beneficiary pays a fee), prepaid medical services (for a monthly subscription, an individual benefits of a certain package of services) and occupational health services (medical check for employees, at sign-up date and on an annual basis thereafter, paid on a fee-for-service basis or as a monthly subscription).

The prepaid medical services are usually part of the compensation package offered by the employer (the corporate client) to its employees as a method of personnel incentive and retention.

The next natural step which is expected is the establishment of private health insurance. Market players anticipate that this type of insurance will become interesting in the near future, as the specific regulation in this field will be developed. The expansion of the private health insurance contracts will produce a new and important stream of revenues for the providers of medical services. Moreover, the further development of private hospitals is conditional on the boosting of this type of insurance contracts. In 2008, the emerging market of private health insurance was estimated at some only EUR 9 mn and 14,000 clients, being currently offered by some of the international insurance companies which operate on the local market.

The Romanian private medical services market accounted for some EUR 250-300 mn in 2008, deemed to reach some EUR 300-350 mn in 2009. The private healthcare market in

Romania is quite small – considering the healthcare spending of some EUR 5 bn. The outlook for the sector looks promising – the private medical services market is estimated to grow at a CAGR of over 30% in the next four to five years, up to EUR 1 bn.

The Romanian private medical services market is estimated to continue its double digit growth over the next years. In 2010, the market is seen to reach EUR 400 mn, tempering its growth pattern to 15-20% y/y, on the back of the unfavourable economic context. According to the main players in the field, the international financial crisis could trigger the postponement of some investments in the private medical services industry, budget reviews, and freeze the increase in prices of services.

For the second part of the year, as the economy may suffer more severely because of the international context, the increase in the level of corporate contracts could face a slowdown. The raise in the unemployment rate would reduce contribution to the social insurance, which would also impact the value of contracts with the National Insurance House and could trigger delays in the collection of receivables for the corresponding segment of services. Additional pressure would result from the potential raise in taxes, in the interest level for loans and leasing contracts, as well as increases in medical devices prices and consumables due to foreign exchange volatility. On the other hand, some players foresee a decline in the staff turnover and a drop off in the financial claims, especially for the managerial positions. As the overall picture of the economy worsen, the decline in the population' purchasing power is likely to affect the patients' ability to access more private medical services. Alternatively, the deterioration of the public health services due to potentially lower amounts of resources allocated to the Ministry of Health for

2010 might result in an opposite trend, that of directing patients towards the private clinics and hospitals. Overall, in the absence of a viable substitute, the demand for private medical services is expected to remain strong. In this situation, the battle for market share and customers in the private healthcare industry is expected to tighten.

#### 4. Conclusion

An analysis of the Romanian health system, both private and public, reveals the advantages and prospects, as well as the vulnerabilities in need of improvement.

As far as the first point is concerned, the following could be mentioned:

- a sustainable economic growth of recent years and good prospects for future growth of demand, due to the lack of a viable substitute;
- a better management capacity in the private sector, mainly the consequence of foreign investments, corporations with a wider experience in management and cost control;
- heavy investments of the past now take the form of benefits;
- interest from financial investors, which could result in attracting foreign direct investment by acquiring local players;
- development of private health insurance market entails direct investment, such as private hospitals.

The aspects in need of improvement, as well as the main threats, are:

- poor regulation of National Health Insurance System;
- the existence of a fragmented market, currently in its early years;
- insufficient medical resources;
- a limited number of doctors specializing in profitable areas (eg specialties such as oncology - large-scale, expensive treatment involving and expertise demanding specialization that

can not be easily developed in the private sector);

- the migration of health professionals in EU countries where GDP per capita is higher;
- migration of patients with higher incomes and expectations in the direction of other EU countries;
- significant delays in the collecting of debts for contracts with The National Health Insurance House;
- increasing prices of pharmaceuticals and medical equipment;
- unstable economic environment that may reduce public access to private medical services.

On a long run, the private medical services market remains one of the few domains with a promising outlook, attracting the interest of most of the financial investors which are looking to invest in sectors resilient to the international turmoil and with good prospect of growth. Furthermore, the strategic international operators are expected to attempt to make their way into the Romanian market, through either acquisitions or Greenfield projects, enhancing the level of foreign investments which are vital to sustain growth and to increase access to modern and complex healthcare services.

To some extent, the situation in Eastern Europe is comparable to Asian countries. The future development of PHI depends above all on a political decision as to what role private risk-sharing arrangements should play in the health

care systems of Eastern Europe. If the state continues to provide health care (as before the market reforms) or offers efficient social insurance, PHI will hardly extend beyond people from upper income percentiles who are willing and able to pay the high premiums. Thus far, private schemes are mostly a supplement to obligatory public health insurance, covering extra services and superior treatment. Many countries have not yet reached a clear political decision as to the extent and domain that should be covered by PHI. Naturally, such uncertainties hamper the development of the private insurance industry. In some cases, The development has even reversed as pilot projects did not have the desired effect on the local health care system.

Another aspect that will influence the development of the Eastern European health insurance industry is the general economic performance in each country. Especially due to the pro-profit nature of most insurance schemes in Eastern Europe, PHI primarily addresses to high income percentiles or foreign employees in each respective country. Depending on the general economic development, more people may be able to afford private insurance premiums or high inflows of foreign employees could drive market demand; where the insurance industry is expected to grow economy will continue to grow.

## REFERENCES

Bara AC, van den Heuvel WJA, Maarse JAM Ionescu, T.

*Reforms of health care system in Romania*. Croatian Medical Journal 2002;

Lambrou M., Chirițoiu B., Gregoire J.

*Chronic Diseases Public Health Priority in Romania*. 2001. Ministry of Health. National Centre for Health Statistics. Bucharest. Romania (In Romanian);

*Sistemul românesc de asigurări sociale și aderarea la Uniunea Europeană*, Institutul European Român, Bucuresti 2003;

European Observatory on Health Care System	<i>Health Care Systems in Transition - Romania</i> . 2000. European Observatory on Health Care System. WHO Regional Office for Europe;
*****	<a href="http://ec.europa.eu/employment_social/spsi/docs/social_inclusion/2008/nap/romania_en.pdf">http://ec.europa.eu/employment_social/spsi/docs/social_inclusion/2008/nap/romania_en.pdf</a> ;
*****	<a href="http://ec.europa.eu/employment_social/spsi/docs/social_inclusion/2009/country_profiles_en.pdf">http://ec.europa.eu/employment_social/spsi/docs/social_inclusion/2009/country_profiles_en.pdf</a> ;
*****	<a href="http://www.pmrpublications.com">www.pmrpublications.com</a> .