An Economic Approach to Health Insurance

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Abstract: Financing the healthcare sector, which directly affects the health of the population, has become a topic of major importance at a global level because even developed countries face difficulties in sustaining the financial sustainability of these services. In most countries, such as the Netherlands, Croatia, France, Slovakia, Romania, etc., the financing of health care through health insurance is the basis for its financing. This article proposes an analysis of the financing of the health sector through health insurance in order to emphasize the need to increase the percentage of GDP in this sector for comprehensive coverage of the population with health services and to improve access to health care. In this respect, Romania is being analyzed in the context of the EU, because a comparative criterion is needed to form an overview of the way and level of financing of health services in Romania. The objective of this article is to highlight the impact of health sector financing on the access of the population to health care and the financing of health insurance as a percentage of the total expenditures of this sector. The motivation for approaching the theme comes from the fact that the health care activity has an important influence on the development of the national economy because, at the macroeconomic level, the health condition contributes to the labor force and to the general well-being. Making a radiograph of the health insurance system in Romania is necessary and timely at the same time as it is a topical issue because the health condition has profound implications on social-economic life.

Keywords: *economy; health financing; social health insurance; development; Bismarck.*

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1. Introduction

Health is important for the welfare of individuals and society, and a healthy population is a prerequisite for economic productivity and prosperity. In this respect, the financing of the health systems of the EU Member States has become a constant concern of the European Commission because it is necessary to cope with increased disease index and permanent cost increase. Thus, promoting public health as a means of economic growth and sustainable development is increasingly supported, the first such action to take place in the framework of the Lisbon Strategy in 2005; Healthy Life Years (HLY) was included as an indicator directly proportional to the life expectancy of the population, which is "a key factor for the growth of the economy." (European Commission, 2008, pp. 6 - 7). In this sense, the social health insurance system is one of the most important economic and social systems for protecting the health of the population and thus has been adopted in time by most EU member states.

As far as the importance of social health insurance is concerned, there are several economic arguments in favor of it, namely the lower administrative costs, the reduction of the financial risk associated with the health conditions, the comprehensive coverage. However, social health insurance fails to ensure universal coverage, does not provide a wide range of services, and also people without income can only benefit from emergency medical care. This type of insurance is mandatory in Romania, and their function is to support the health of the population through access to the national health system. Thus, the social health insurance system outlined the need to protect people and the need to create a legal framework to support this objective, providing the real opportunity for the population to benefit from health care.

2. Methodology

The research methodology of this study is based on qualitative and quantitative research; Qualitative research of data includes (1) identifying specialized literature, (2) selecting it, (3) corroborating studies and summarizing them. In order to identify the impact of health insurance on the state of health of the population, we sought to identify, on the one hand, the percentage of government expenditures and compulsory insurance as a proportion of total health expenditures and, on the other hand, visited a specialist in 2017. The percentage of GDP allocated to the health sector determines the financing of health care and thus the population's access to

these services. The quantitative data required for quantitative analysis were collected from official sources, www.insse.ro, www.ec.europa.eu.

3. Literature review

Newhouse's statement in 1977 that health was a luxury asset because of the high spending it involved has led to more than 20 years of empirical research to identify factors that have led to a steady increase in health care spending. Among the authors who studied this aspect, we mention: Clark et al. (1994), Di Matteo (2005), Hansen and King (1996), Hartwig, (2008), Parkhurst (2008), Kemp et al. (2010), Kleiman (1974), Scott et al. (1979), Younis et al. (2010).

One of the main sources of health care financing is represented by health insurance, which means a necessity for comprehensive care of the population's health. Adoption by more and more states within the U.E. is also due to the fact that insurance is a way to protect the population against unexpected financial risks (Kimball, 1960) so that social health insurance signifies a "risk-free society." (Aharoni, 1981, pp. 22 - 23) aspects supported by Epple and Romano (1996). Vogel (1988) explains that social insurance is a prepayment mechanism where funds are grouped "in a basket" to cover certain "losses", health deficiencies. (Vogel, 1988, pp. 35-37). According to Wagstaff and Doorslaer (1992), health insurance is a form of risk-based financing and management of healthcare. (Wagstaff & Doorslaer, 1992, pp. 361-387). Health care insurance, quoted by William Henry Beveridge, quoted by van Gerven (2005), should be understood to mean cash payments made as mandatory contributions, lodged by the insured person in his own name. Public assistance should be understood as state payments in the amount of the interest and resources available to it at a given time. (van Gerven, 2005, p. 195). Among the authors who studied the importance of financial support for health insurance for economic welfare, we mention: Baltagi and Moscone (2010), Breyer (1995), Carrin (2002), Monheit and Cantor (2004), Kerssens and Groenewegen 2005), Pütz and Hagist (2006), Rimlinger (1963), Rushing (1986), Rossignol (2008), Zweifel (2007).

4. Financing the health sector through social health insurance

Social Health Insurance (SHI) is a health financing model where the right of a person to health care depends on employment and the payment of contributions to the system. (Wagstaff, 2010, pp. 503-517). Funding of the health insurance system is made through mandatory contributions, depending on the income of the insured and is borne by both the employee

and the employer. Many countries that have largely relied on general or tax revenues to finance their health systems (Slovakia, Slovenia, Romania, and other former socialist countries) have introduced SHI or are thinking about doing so (Denmark, Ireland, Cyprus); countries with a developing SHI scheme are also stepping up their efforts to expand coverage (Finland, Portugal). Thus, according to Carrin et al. (2005), funding for health through the development of social security is generally recognized as a sustainable way to achieve universal coverage with adequate financial protection for much of a country's population (Carrin et al., 2005, pp. 799- 811).

Financing health care through social security accounts for about 2% of total health financing in low-income countries, around 15% in middle-income countries and 30% in middle-income and high-income countries (OECD, 2018, p. 144). In sub-Saharan Africa, only 2% of total public health spending comes from social security, and in South Asia, it accounts for 8% of total health spending. (White et al., 2006, p. 116).

Financing through health insurance is important because it influences the basic package of health services benefiting the insured population. Social health insurance has a major role to play in financing health services: in two-thirds of the Member States, more than 70% of health expenditure is funded by them. (Rossignol, 2008, pp. 387-401). This situation risks jeopardizing the sustainability of public finances, especially in the context of an aging population, which is why the percentage of GDP allocated to health is becoming increasingly important for sound financial support for health services.

Figure 1. Health Insurance Expenditure as a Percentage of Total Expenditures, the Year 2017

Source: Authors' elaboration based on data from OECD/ E.U. (2018)

Social health insurance should cover the general coverage of the population with medical services, as well as the reduction of the financial risk associated with the costs of health care. These represent (Figure 1) one of the most used and consistent ways of financing the health sector in most EU Member States. In countries such as Slovakia (75.4%), Slovenia (68.7%), Romania (64.5%), Poland (60.7%), Netherlands (71.4%), Luxembourg (72.9%), Croatia (74.4), Germany (77.9%), Czech Republic (70.4%), health insurance represents the highest share of financial resources in this sector. Countries that do not rely on this way to fund the healthcare sector support people's access to health services by allocating a higher percentage of GDP

to this objective or relying on private health insurance. Social security funding is an important source of financial resources for this sector, but the percentage of GDP is also needed to be substantial. Thus, developed countries, such as Germany, France, Luxembourg, also rely on health insurance, but also allocate a higher percentage of GDP in the sector, which leads to increased accessibility of these services to the population.

Figure 2. Percentage of people who did not visit a specialist in 2017
 Source: authors' elaboration based on data from Eurostat (2017)

The percentage of people who did not visit a specialist in 2017 is an increase, mainly in Romania (42.9% general medicine, 81.7% dentist, 87.8% general surgery); (60.4% general medicine, 74.7% dentist and 73% general surgery), Bulgaria (52.3% general medicine, 78, 5% dentist, 67.8% general surgery), Hungary (28.9% general medicine, 74.4% dentist and 55.7% general surgery). The lowest percentage in this respect is found in the Czech Republic (14.2% general medicine, 18.4% dentist, 26.1 general surgery), Luxembourg (11.8% general medicine, 19.4% dentist and 28, 1% General Surgery). The reason why these sectors of the medical system were not accessed was not the lack of necessity but, most frequently, the lack of possibilities. It is known that people require a routine dental consultation every 6 months and that 81.7% of the Romanian population did not access this type of consultation (Figure 2) is certainly due to the lack of financial resources. The reasons why the population of Romania does not frequently access the general health services are the lack of financial resources, on the one hand, and, on the other hand, the lack of sanitary units and medical staff in rural areas, which makes access to health care.

The low percentage of GDP allocated by Romania to this sector does not encourage people's access to health care. Under-funding of the healthcare system has an effect on the health status of the population through (1) the reduced number of health professionals working in the national healthcare system; (2) a questionable quality level of these services; (3) less comprehensive coverage of the population with free and/or compensated medical services; (4) inequalities in access to health care; (5) increase the level of direct payments or from the patient's pocket to health services.

Figure 3. Percentage of GDP allocated to healthcare in EU countries
Source: Authors' elaboration based on data from Eurostat (2018)

During the analyzed period it can be noticed that Romania allocates the lowest percentage of GDP to the health sector, namely 5.2% in 2017, 5.0% in 2016, 4.5% in 2015 and 5.3% in 2014. Countries such as Germany (11.3% in 2017, 2016 and 2014 and 8.7% in 2015), France (11.5% in 2017, 11.0% in 2016, 9.0% in 2015), Luxembourg (6.1% in 2017, 6.3% in 2016), Netherlands (10.1% in 2017, 10.5% in 2016) allocates an increased percentage of GDP to health services, this sector being a national priority. Although France allocates a higher percentage of GDP to the health sector (11.5%), this amounts to USD 4,026.15 per capita allocated to health compared to the Netherlands, which allocates a lower percentage of GDP (10.1%), but it means USD 4,746.01 per capita spent on health. This also applies to the Luxembourg state, which, although allocating 6.1% of GDP to the health sector, means USD 6,236.00 per capita spent on health.

5. The Economic Model for Financing Health Services in Romania: The Bismarck Model

Romania, as well as other former socialist countries, such as Albania, Bulgaria, Slovakia, Slovenia, Lithuania, had a healthcare system based on the Semashko model. The fall of communism meant a set of reforms designed to bring Romania's health system closer to the German model, namely the Bismarck model, and also to implement an alternative to the public health sector, a private health system.

At the end of 1989, the Romanian medical system was structured according to the Semashko model, which operated under precarious conditions. In Romania, until 1991, the only source of funding for national health services was represented by the state budget. With Law no. 145/1997 of the health insurance, the medical system became predominantly of the Bismarck type, through the mandatory insurance rates paid by the taxpayers, fixed according to their income. Thus, the law on social health insurance, which represents the main system of health protection of the population, came into force. This system implies that health insurance funds consist of the contribution of insured persons, natural and legal persons employing salaried employees, subsidies from the state budget, as well as from other sources; health insurance is also mandatory and decentralized, based on the principle of solidarity and subsidiarity in the collection and use of funds, as well as the right of free choice by physicians, health care providers, and health insurers. (Law no. 145/1997). However, according to statistics, there are a large number of people who can't access the medical services they need, the main reason being the lack of financial resources.

Currently, the Romanian health system represents the revised Bismarck model, with the Semasko and Beveridge models influenced. Private health insurance is a voluntary system in addition to that of compulsory health insurance, supporting the organization and functioning of the supplementary or substitute health insurance system.

Table 1. The characteristics, advantages and disadvantages of the Bismarck model

Bismarck Model
Characteristics
<ul style="list-style-type: none">– the source of funding is the contribution to health, which is mandatory both from the employer and from the employee;– contributions established by law are equal in percentage, but are reflected differently among taxpayers, in relation to the actual income

obtained;

- contributions established by law are equal in percentage, but are reflected differently among taxpayers, in relation to the actual income obtained;
- political changes can influence the funding of the system by modifying the percentage contributed;
- the financing of the medical system is related to the level of each person's income;
- the participation share of the institution and the employee is dependent on executive politics and economic potential;
- insurance contributions are collected by insurance houses, a government-independent institution;
- health policies are set by the executive with the Ministry of Health and the insurance houses;
- insurance houses select healthcare delivery patterns, payment methods, conclude contracts with hospitals, polyclinics, medical offices;

Advantages

- transparency of system contributions and benefits;
- the high coverage of the population with health services;
- institutions managing health insurance funds are nonprofit institutions;
- the activity of the institutions administering health insurance funds is carefully monitored at the public level;
- health programs are in line with policies in the field;
- The National Health Insurance House presents functional independence in relation to the executive, but their activity is established by strict regulations;
- the allocation of health services is according to needs;
- clear definition of the package of health services to be provided to the population;
- supports the rights of policyholders;
- the qualitative level of healthcare can be increased, taking into account the fact that paying bodies can impose certain quality standards that are required to be met by physicians who are in a contractual relationship with insurance companies;
- existence among providers may also lead to an increase in the quality of the medical act;

Disadvantages

- reducing the taxpayer base during the period when the unemployment level is increased;
 - funding is strongly linked to the level of employment;
-

- the need to cover from other funds people who are not paid, unemployed, pupils, retirees, which may lead to the need for massive subsidies from the state budget;
- difficulty in establishing the contributions to be paid by self-employed persons, given that these contributions depend on earnings;
- high costs for economic agents;
- the most equitable redistribution of resources is not achieved;
- health services for disadvantaged groups are limited;
- waiting lists;
- relatively high administrative costs;
- reduced efficiency in providing medical services in terms of waiting times for patients;
- doubtful qualitative level;
- insufficient funding for a comprehensive range of basic health services;

Source: authors' elaboration, based on Mihalache et al. (2018, pp. 211 – 224)

6. Conclusions

The Romanian health system still responds ineffectively to the major health problems of Romanians, with the current model focusing on curative and preponderant care in the hospital, over ambulatory and primary care. Some critical considerations regarding the current health care system in Romania are: (1) underfunding the health system; (2) inefficient management of resources; (3) lack of prioritization of health services; (4) poor management of health information; (5) the lack of a viable quality assurance system for health services. When the potential macroeconomic and economic effects (ie health and economic efficiency at the national level) of health insurance are not visible or difficult to measure, it is also difficult to justify the importance of spending on this kind of insurance health. Little evidence shows that health increases with increasing health insurance. However, we consider that the idea that social health insurance contributes to the growth of the national economy is based on the assumption that health insurance supports the increase of the health efficiency, which supports the economic growth through the national productivity.

Health is important for the well-being of individuals and society, but a healthy population is also a prerequisite for economic productivity and prosperity. Thus, health spending is not just a cost but an investment. Health expenditures can be seen as an economic burden, but direct healthcare company costs may be lower compared to indirect costs due to the increased sickness index of the population.

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