

## NEW OPTIONS OF FINANCING THE HEALTH INSURANCE SYSTEM IN ROMANIA

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### 1. Introduction

Romania's health insurance market is stuttering into life, but is restricted by the financial crisis, a lack of comprehensive private medical providers and an absence of long-term Government policy.

Healthcare in Romania suffers from a massive budget shortfall. There are fewer than five million contributors and more than 20 million beneficiaries. There is a poor quality state service, which is plagued by bribes between patients and medical staff. Many have fought for health insurance to be fully deductible from all the social taxes. The hope is that a minority who take out health insurance for private care will lift the burden on the state system. Although this will mean less cash to the state, the capitalist argument is that the private system can use the money in a more efficient way.

Overall reform is needed in the health market. Therapeutic guidelines are not followed. Health costs are rising and the income from taxes is low. The state system is not well-managed and there is little competition.

### 2. Shortcomings in financing the public health insurance system

The public health insurance system in Romania has been struggling with a massive deficit during the last years. Informal payments in the health sector in Romania have emerged as a fundamental aspect of health care financing and a serious impediment to health care reform.

Informal payments can be defined both as payments to individual and institutional providers, in kind or in cash, that are made outside official payment channels and purchases that are meant to be covered by the health care system. The former encompass "envelope" payments to physicians and "contributions" to hospitals, and the latter the value of medical supplies purchased by patients and drugs obtained from private pharmacies that should be provided by government-financed health care services. Voluntary purchases from private providers are not considered informal payments, but a market transaction at the discretion of the consumer.

Such patient fees may have the virtue of making providers accountable to their patients, but they ultimately result in greater attention being given to those able and willing to pay for services.

The need for intervention in health care is premised on the assumption that health care market failure stems from asymmetric information — physicians have good information about diagnosis and treatment, the government knows its options as far as private financing sources are concerned, but patients have very little information or understanding of either—and externalities. The unexpected nature of ill health makes risk pooling a valuable means of sharing risk and of dealing equitably with the consequences of illness. In addition, communicable diseases such as tuberculosis, AIDS, or meningitis require aggressive prevention to contain their spread, a function that markets do not

address effectively. While these reasons underlie the rationale for a government role in health care delivery and finance, they do not necessarily imply that the public sector should be the direct provider or payer of all health care. They do, however, support the case that government should guarantee access to health care and that it should protect consumers and regulate the health industry. Governments, however, often fail to fulfill their roles as protector of patients and as insurer through which risks are pooled. While market failure requires government involvement in health care, government involvement without accountability is no panacea.

In developing countries, where salaries are low and infrastructure is weak, wage bills are generally met. In the Eastern European Region, resources are simply insufficient to keep the oversized health care systems operating, leading to a range of measures that undermine the basic operation of health care. Without serious restructuring of the organization of care and reductions in the size of personnel rosters, there is little likelihood of improvement. The discretionary authority of health providers is also extensive, particularly of physicians who make medical decisions with minimal supervision. Hospital directors, while they are often audited on public expenditures, are not evaluated on performance or quality of services. The lack of accountability to a higher authority—to the ministry of health, hospital director, the general public, or patients—is limited, as performance is rarely, if ever, the basis for reward or penalty. This again contributes to the emergence of corruption.

Requiring payments from patients restricts access to health care to those who can pay, makes payment levels and terms arbitrary, and can render essential services unaffordable. One of the primary reasons for government involvement in financing health care is to pool the risk of illness

across the population and to therefore pool resources to ensure equity both across the healthy and the sick, and among those who cannot afford health care. The present arrangement undermines those objectives, producing what is effectively a private, unregulated system operating within a public shell. Without the government regulations that in a formal private system ensure standards and the financial solvency of insurance, there can be neither fairness nor fiscal responsibility, and this is the case with a system based on informal payments. Both quantitative and qualitative studies suggest that the poor as well as the nonpoor may be disadvantaged from using the public system as they are unable to pay. However, the burden falls more heavily on the poor, given their more limited ability to pay. The informal nature of “envelope” payments reduces the role of public policy and the likelihood that resource allocation decisions will be made in the public interest. Since payments are set with virtually no involvement of the system sponsor—the government—it is patient ability and willingness to pay that determines where resources flow into the system. Priority expenditures, such as maternity care, are not necessarily realized, as investment decisions are determined by the market, driven by provider decisions as to whom should benefit from services, rather than by general need. In short, government objectives become marginalized.

For years, Romania’s health care system has struggled to cope with underfunding. Most hospitals in the country are in debt and even large university hospitals often lack basic supplies, such as surgical gloves and antibiotics, forcing patients to pay for such amenities out of pocket. Many buildings are in serious need of repair and sanitization. The conditions are fodder for the media.

The fact remains that for a European Union country in the 21st

century that has managed advances in many other sectors of the economy and society, health care continues to lag significantly behind.

The country has had a mandatory health insurance scheme covering all citizens since 1998, administered by a National Insurance House that contracts services from providers. But it is chronically underfunded and notoriously inefficient in allocation of resources. According to the available data<sup>1</sup>, we note that the National Fund of Health Insurance is at a shortage of funds, with its' deficit positioned on an upward trend. Although current forecasts and projections for the current year show an optimistic scenario, with the purpose of presenting a balanced budget, it is unlikely that under the influence of the global financial crisis and low collection level to CNAS, predicted values are to be achieved. (See Table no. 1)

Compounding the problem is the medical brain drain faced by Romania, which now has one of the lowest ratios of physicians per population in Europe. The Romanian College of Physicians reported that more than 4000 doctors — mostly junior doctors — have emigrated since 2007, representing almost 10% of doctors in the country (See Table no. 2).

The brain drain has been fuelled by demand for physicians in many Western European countries, particularly Germany, France and several Nordic nations. Romania's entry into the European Union in 2007 made it easier for those countries to import Romanian doctors willing to relocate. In October 2009, Bucharest held a medical job fair during which more than 2000 jobs from around the world were up for grabs.

Complicating matters are informal payments to physicians for their services, which a market and social research institute, the Bucharest-based Centre for Urban and Regional

Sociology, pegged at 0.3% of Romania's gross domestic product in a 2008 survey.

Doctors find the compensation attractive because of low salaries. But the payments have had a dramatic impact on equity of access to services and the public image of doctors. Thus far, though, the government has not taken action to quash the practice.

In the face of such developments within the troubled public health care system, there has been significant growth in a parallel, private system.

That's been primarily driven by clinic chains that were created with corporate sponsorship, primarily in Bucharest. They've since expanded to other cities and serve individuals, along with corporations. Many find the clinics attractive because they offer medical services at a level comparable to those in developed Western countries.

But such clinics tend to focus on more profitable segments or outpatient services such as gynecology, dermatology and some surgeries, and leaving more complex and costly therapies to the public sector. Left in the wake of such developments are the patients, who face ever-poorer health outcomes.

### **3. Private health insurance - a long – term solution -**

The Romanian health system reform is urgently needed in order to improve the health care financing system. Besides the public health insurance system that provides financing for a package of basic health services, while respecting the principles of solidarity and obligation of every citizen participation, a vital need for alternative options is needed through voluntary insurance, providing additional benefits in return of related premiums. This system is expected to influence current management practices of funds in hospitals and health insurance funds with the principles and values of the private

<sup>1</sup> [www.cnas.ro/](http://www.cnas.ro/) Budget execution Section

system, contributing to good use the amounts collected.

In 2010, the Romanian private healthcare market is expected to develop by around 13% to €373 million, according to estimates included in the report “Private healthcare market in Romania 2010. Development forecasts for 2010-2012” by PMR, a research and consulting company. At the same time, the medical subscriptions market could stagnate, because of reductions in the number of company employees, whereas the health insurance market is expected to develop relatively rapidly, driven by individual insurance purchased by those dissatisfied with the deteriorating quality of public healthcare. It is also assumed that clients will be poached from private healthcare providers.

Growth is expected to continue on the private medical services market in Romania in 2010 despite the unfavourable economic conditions. All leading medical chains in the country expect their sales to increase this year by 10-50%. “According to PMR forecasts, in 2010 the market, which consists of out-of-pocket payments for medical services, medical subscriptions (along with occupational healthcare services) and health insurance, will grow by 13% and develop even more rapidly in 2011 and 2012” says Monika Stefanczyk, PMR’s Head Pharmaceutical Market Analyst and the report’s coordinator.

Against a background of difficulties in public healthcare, private spending on healthcare has grown constantly in recent years, and this is expected to continue. Compulsory health insurance almost covers payment for treatment at public clinics in full, but Romanians, in general, complain about the quality of service in the public system and also the lack of special sophisticated treatments which are available at private hospitals. Another important matter pertaining to customer choice is the fact that private healthcare chains attract the best doctors, by offering them higher

salaries. At public hospitals doctors can earn around €200-350, whereas salaries at private facilities are several times this amount.

In 2010 difficulties with public healthcare funding are expected, and this will affect quality of service at public hospitals and encourage more customers to migrate to private clinics. With improvements in quality of life and increasing affluence, Romanians are no longer willing to tolerate bad management, an unprofessional appearance and a lack of individual care and courtesy at public clinics. Another important reason for the progress of private healthcare is the prevalence of bribery in the public healthcare system. People give bribes to doctors for quality of treatment and attention, and the total costs of treatment at public and private clinics are often comparable.

In anticipation of this trend, leading private suppliers of medical services are planning to invest more than €200 million within two or three years in hospitals alone to meet growing demand, according to our estimates. Although the private healthcare services market in Romania is not highly saturated, key players are expecting tough price competition in 2010, particularly with regard to corporate users.

Because there were, for many years, no legal provisions aimed at helping the private health insurance market to take off in Romania, the country has, over the past five years, seen a booming subscription market which has been acting as a substitute for insurance plans. The medical subscription market in Romania has been driven by mandatory occupational medical services, introduced in 2002, when the Health Ministry adopted a directive which forced both public and private employers to offer their staff medical examinations on a regular basis.

Subscriptions to private medical services became a standard offer in the

employee packages of large companies in Romania.

In total, according to data gathered by PMR, in 2009 there were approximately 380,000 subscribers to private medical services in Romania. Subscriptions usually guarantee a minimum set of services, and it is necessary to pay additional fees for more expensive treatment.

In 2010 providers of medical chains expect stagnation on the corporate market and a boom in retail. Private medical companies have reported that the fees-for-services arena was already booming in 2009.

Most medical subscriptions developed in the fields of dental services, laboratory diagnostics, maternity and gynaecology. Providers usually operate as a clinic. There are only two companies which have hospitals in their organisations: Unirea Medical Center and MedLife.

In 2010 most of the operators expect consolidation of the supply of medical services. Large chains of clinics already have a network of smaller partners which are expected to be acquired.

In 2009 investment funds paid more attention to private healthcare and acquired, for example, MedLife (taken over in late 2009 by Societe Generale Asset Management).

The health insurance market has developed relatively slowly in the absence of legal provisions which would redefine the basic package of services and fiscal incentives. At present, the package covers a wide range of services, which prevents private insurers from creating comprehensive and more sophisticated offers for their clients. At the same time, the poor condition of medical facilities in Romania has discouraged patients from purchasing such products.

Development of health insurance is expected to take place in the next few years and to begin to take clients from

private healthcare providers in the short term. The corporate subscription market is believed to have reached saturation, and some customers might switch in future years to private health insurance, which is believed to be more comprehensive than the services offered by a network of medical facilities. However, this will depend largely on the expansion of private healthcare facilities in the country.

According to private medical companies operating in Romania, the market has a total potential of €400 million, but only about 12% of this can be achieved by 2012, according to the most optimistic scenarios.

#### 4. Conclusions

The Romanian health care reforms are intended to follow some principles as accessibility, universality, solidarity in funding health services, incentives for effectiveness and efficiency as well as providing service delivery linked to health care needs. But, little is known about what the people think about the reality covered by these principles. One of the major issues that should concern policymakers and service providers is the effect of reform on weaker population groups such as the poor, chronically ill and elderly. Having an impact on people's health status and with consequences readily visible to the affected publics the outcome of reforms of the Romanian health care system may be largely determined by societal reaction.

The most affected categories of people by reforms, the elderly and other deprived group, may respond to policy change with reactions varying from minor reactions, to reactions that make implementation of the new policy questionable and eventually in reversing the policy decisions.

At present, Romanian reforms of health care are being implemented. In the literature, implementation is seen as

the most crucial aspect of the policy process. It is also known that the outcomes of implementation efforts are highly variable (ranging from successful to unsuccessful). The range of outcomes results from the fact that implementation is an interactive and ongoing process of decision making by policy elites and managers in response to actual or anticipated reactions to reformist initiatives. Usually when reforms are implemented, there are some categories of people who are better off and some who are worse off than before. But involvement of the population in health care reforms may mean that changes are more easily accepted, therefore, there is a better chance that reforms are successfully implemented. When co-payments will become common, it is essential that patients and doctors are willing to cooperate with it. If not, the utilization pattern may be changed and/or other ways of rescription/referral will be developed.

The Romanian situation of non-involvement of the population in reforms of the health care system, either technical or political, and some of the political measures which created in the people's opinion less quality and less accessibility may result in the population's distrust in reforms. At least, it may be expected that elderly and vulnerable groups have more problems in getting adequate care in the reformed system since the costs involved in getting proper care (medicines, co-payment, access) are increasing. In the implementation process and evaluation of the results, the policy makers and those who implement health care reforms may consider the categories with a critical view as barriers and even as opponents, therefore, they have to find solutions for the problems these people are confronted with. In the same time, the highly educated people, who have the most positive opinion about the changes in the health care system, may become the supporters of these reforms.

Table no. 1. **EXECUTION OF THE NATIONAL FUND OF HEALTH INSURANCE BUDGET** (million lei)

Relevant indicators	Year						
	2004	2005	2006	2007	2008	2009 <sup>2</sup>	2010 <sup>3</sup>
Revenues - total	6.877,4	8.474,4	10.038,7	13.080,6	15.780,5	15.458,7	15.865,3
Expenditure - total	7.001,4	9.157,4	10.046,8	12.859,1	16.636,2	15.439,7	15.725,4
Reserve fund	68,1	82,0	101,4	118,9	148,3	136,3	139,9
Surplus (+)/ Deficit (-)	-192,1	- 765,0	- 109,5	- 102,6	- 1003,7	- 117,3	0

Source: The National Health Insurance House (CNAS)

Table no. 2 **MEDICAL SANITARY STAFF** (end of year)

Year	1999	2000	2001	2002	2003	2004	2005	2006	2007
Physicians	46238	45786	46773	45805	46919	48150	47388	49936	48199
Population per physician	486	490	479	476	463	450	456	460	447

Source.: Institutul Național de statistică, Anuarul Statistic al României, 2008, pg.355

<sup>2</sup> Preliminary execution

<sup>3</sup> Programmed values

## REFERENCES

Matei, G., Mihart B.	<i>Asigurări și protecție socială</i> , Editura Universitaria, Craiova, 2010
Saltman, R.B.	<i>Social health insurance systems in estern Europe</i> , Berkshire, England 2004
Busse R., Figueras J.	
*****	<i>"Private healthcare market in Romania 2010. Development forecasts for 2010-2012,,</i> Report, March 2010
*****	<a href="http://www.cnas.ro">www.cnas.ro</a>
*****	<a href="http://www.euro.who.int">http://www.euro.who.int</a> .
*****	<a href="http://www.euro.who.int">http://www.euro.who.int</a> .
*****	<a href="http://www.insse.ro/cms/files/pdf/ro/cap21.pdf">http://www.insse.ro/cms/files/pdf/ro/cap21.pdf</a>