SOCIAL RESEARCH REPORTS

ISSN: 2066-6861 (print), ISSN: 2067-5941 (electronic)

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Social Research Reports, 2013, vol. 23, pp. 19-25

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ETHICAL ISSUES IN FINANCING HEALTH CARE IN ROMANIA

Sorin Gabriel ANTON[1], Cristina GAVRILOVICI[2], Liviu OPREA[3]

Abstract

The allocation of financial resources in accordance with population health care needs represents a complex task, with practical and ethical dilemmas. The decisions regarding resource allocation are made at macro, mezzo and micro levels. Legislative authorities and government decide how to allocate limited resources based on cost effectiveness criteria. Managing directors of hospitals and research institutes take mezzo decisions, while doctors and researchers in healthcare area are responsible to make micro decisions. The aim of this paper is to assess the use of equity criteria for resource allocation in Romanian public hospitals. We found that resource allocation within the Romanian health system increases the inequalities among individuals and groups.

Keywords: equity; hospital health care finance; access to health services.

Introduction

World Health Organization (WHO) considers that the main objectives of a health care system are (Clements, Coady, and Gupta, 2012) to: improve the population health by providing financial protection against the costs of ill-health; and by responding to people's expectations. An additional objective is to provide equitable health care access. Considering the equity concern, the first goal of the health systems should be to maximize the aggregate population health and, at the same time, to mitigate the social inequalities in health. In the last years, the member states of the WHO have made efforts to attain universal insurance coverage, considered to be the first step in achieving the objectives of a healthcare

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system. Universal coverage implies that "all people to have access to needed health services - prevention, promotion, treatment and rehabilitation - without the risk of financial hardship associated with accessing services" (World Health Organisation, 2010).

Only a few emerging market economies have achieved universal coverage. To provide universal coverage at an affordable cost, each country can use a tax-financed system (Beveridge system), a social insurance system (Bismarck system), private insurance, or a mixed system. The most important barriers to universal coverage are the lack of financial and real health resources (hospital beds per 100,000, practicing physicians per 100,000, pharmacists and so on), political stability, a strong institutional and policy environment, a well-educated population, and political commitment. In the 2010 annual WHO report - Health Systems Financing: The Path to Universal Coverage - offers some recommendations on how to improve the financing of health care to attain universal coverage.

The income differences, ethnicity, employment status, area of residence (urban versus rural areas) should not prevent any individual in reaching health care when he/she needs. Health is considered by the Romanian constitution a fundamental individual right for everyone. However, there are important barriers in accessing health services, especially in rural areas. The main factors that hindered the access to health services are unpaid contribution to the insurance fund, low incomes, and lack of health services in the area of residence or limited number of health units or hours of operation. These are the results of the insufficient financial resources allocated to the health sector, as well as of the inequality in the distribution of incomes. The aim of this paper is to perform an overview on the resource allocation in the Romanian health system in an attempt to establish if this allocation improves the equity of health services in Romania.

Defining and Measuring Equity in Health Services

The term "equity" in health care has been defined in several ways in the literature. The common feature of most definitions is that health inequalities (or health differences) are unfair or unjust if they are the consequence of social arrangements rather than of individual actions. Vertical equity refers to preferential treatment for those with greater health needs, while horizontal equity, the main subject of published literature, implies equal treatment for similar needs (Macinko & Starfield, 2002). Various researchers have proposed different methodologies for measuring health equity. Macinko & Starfield (2002) provide a review of main papers on equity in health. Some studies (Health Consumer Powerhouse, 2012) measure the equity of healthcare systems using the simple indicator "What percentage of total healthcare spent is public?". According to the latest Euro Health Consumer Index 2012 Report, a level of public healthcare expenditures as percentage from total healthcare expenditures higher than 80% represents a sign of equity, while a level lower as 70% indicate a significant influence of financial (private) constraint on the access to health care.

In health care services, the focus on equity goes on the distribution of health care across different categories of persons: the geographic distribution of resources, the utilization of services by those in equal needs across different socio-economic groups. Macro equity is concerned with programs rather than with patients and with decision leading to the distribution of resources among different groups. At the micro level, it is doctor's obligation to use the available resources in ways deemed best for patients within the requirements.

It has also been debated to what extent "the merit", should also be considered another determinant of equity. The merits of individuals are based on the judgments about their contribution to society, for example, whether their economic contribution is unusually significant or whether they are at a stage at which they are supporting young children or elderly persons. Horizontal equity requires equal treatments for those of equal merit and vertical equity requires more favorable treatment of those with greater merit. The ethical question here is whether health care is one of the goods and services within the "reward system" or not. Most evidence shows that most countries have rejected the "rewards" approach to health care. However, the second version of the merit argument (number of dependents) is more frequent, and there is evidence that people attach special significance to the health care needs of those with dependent children (Culyer, 2001).

Who Benefits from Health Services in Romania?

There are two fundamental questions in relation to equitable resource allocation: who benefits of the health services and who pays for these services? The first question relates to the provision of health services. The second question is concerned with the financing mechanism of health care. The main issue of the Romanian health system is the mismatch between the number of fee payers and the number of beneficiaries. In 2010, the number of persons that paid contributions to the fund was 6.7 million, while 21.5 million people used health services. Starting with 2011, the number of payroll taxpayers has increased to 8.7 million, while 21.5 million people benefited of health services to the same extent. In accordance with the data provided by WHO Regional Office for Europe, in Romania the health care is mainly financed from public resources (around 78.1%). All Romanian citizens who have mandatory health insurance and individuals excepted from paying the contributions to the Social Health Insurance Fund have the right to free health services. In the second category, there are retired people, students and children. All these categories of citizens can benefit from free health services in the boundaries of the monthly funds allocated by National Health Insurance House to each health provider.

When analyzing the level of resources allocated to public hospitals in Romania in 2011, we found large inequalities in hospital financing that significantly impacted on the availability and quality of health services - both between and within counties. In the most developed Romanian counties, where usually there are large

and performing hospitals, the level of resources allocated to hospital related to number of citizens is higher compared with the hospital resources in less developed counties. Even if we admit that inequities between counties are acceptable as long as many patients migrates from less developed areas to university cities to get better health care services, the amplitude of these differences remains high. While in Bucharest, the capital of Romania, the level of funds allocated to hospital is 930 lei per inhabitant, in Giurgiu one of the poorest counties in Romania, this ratio is ten times lower.

There are also important health care inequities within the same county. A person living in the rural area has a lower access to pharmacies, hospitals, and health centers than inhabitants of municipalities. Furthermore, the number of practicing physicians is five times lower than in the urban areas in the same county.

Significant differences also appear in access to health services determined by ethnicity. For example, only 47% of Roma women and 50% of Roma men said they had health insurance compared to 84% and 80% of total population (Sava & Menon, 2007). Another important source of inequalities comes from the high level of informal payments. Empirical evidence suggests that in Romania the level of informal payments in the hospital sector is very high. According to Jakab (2007), informal payments for health care services disproportionately burden the lower-income groups.

Who Finance the Health Services in Romania?

The Romanian healthcare system presents the characteristics of Bismarck healthcare systems. It is based on social insurance and one stated-owned insurance organization (National Health Insurance House) manages the funds collected from taxpayers. Employees and employers pay mandatory health insurance contributions (10.2% of total incomes) to the Social Health Insurance Fund. The national Insurance House, the main insurance company, is organizationally separated from healthcare providers. Currently, public and some private hospitals are financed through a contract between the healthcare providers and the insurance company. In accordance with this contract, the expenses with health services, wages, and utilities are reimbursed.

The consumers cannot choose between different insurance providers, but they can buy private insurance policies for a very limited number of health services. Until 2012, the CNAS has not discriminated between providers who are private for-profit, non-profit or public. In accordance with the new budgetary philosophy, the Romanian government wants to channel resources to public hospital and to reduce/to stop the contract with private hospitals (Health Ministry, 2013). For middle-income social groups, this new rule decreases the possibility to access health care services provided by private hospitals and settled partially by National Health Insurance House.

The first question that arises is the following: is it health care in Romania a real priority for the authorities? Romania has spent on average about 5.41 percent of its GDP on health care during the period 2000-2010, which is lower than any of the EU countries. The EU average for health care for the same period was 8.94% of GDP. High-income countries from EU spent between 9.5-11.92% of GDP on health in 2010, while middle-income and low-income countries spent between 6% and 8% of GDP. These figures suggest that health care was not a priority for authorities in the last decade. The government decided how to allocate scarce resources based on political motivation rather than by using cost effectiveness and equity criteria. Several studies have found that the efficiency of health expenditures in Romania is lower as compared to other CEE countries (Anton & Onofrei, 2012).

The Romanian public hospitals are financed from five sources: the contract with National Health Insurance House (CNAS); the national budget; their own revenues and taxes on luxury goods; local budgets; and other revenues (donations and sponsorships) (P‘rvu, 2008). The contract with the National Insurance House is the main source of financing, representing on average 66% of total revenues. Allocation from the national budget represents on average 14.60% of total revenues, with significant differences from one county to another (eg 32% in Bihor county and only 7.01% in Arges county).

The problems of the hospital sector in Romania identified by the situational analysis performed by the Presidential Commission could be grouped in three main categories: lack of a coherent classification of the hospital services that determines, among others, high and, very often, unjustified expenditures; poor management, centralized, with extremely limited involvement of local authorities; lack of mechanisms to ensure the quality of health services and the continuity of care (Vlădescu, Astărăstoae, & Sc‘ntee, 2010). Furthermore, the capacity of public hospitals to finance from their own revenues is low. Decentralization in health system implied an increasing role of local authorities in the governance and financing of public hospitals with the aim of improving the quality of health care services. After two years of implementation we can state that the decentralization did not improve the allocation of resources in the health system. The differences between the amounts from local budget transferred to the public hospitals are high. The local authorities proved to be unable to finance investments in public hospitals especially in the case of small cities. The underfinancing of public hospital will have significant influence on the level of investments and, consequently, on the qualification obtained at national assessment.

The financing of health care in Romania is plagued by severe ethical constraints. This fact is recognized even by the authorities. In 2010, the Health Ministry stated that “Currently, in Romania, the financing of hospitals is somehow incorrect, suffering from some impropriety, hospitals with the same degree of competence, but in different areas, receiving different funds”.

The solutions recommended by the Presidential Commission, for improving the hospital services were (Vlădescu, Pascu, and Astărăstoae, 2008): (1) restructuring and reorganization of hospital services; (2) hospital management

decentralization and establishment of county hospital agencies to ensure the coordination of hospital services at county level; (3) diversification and use of new hospital services financing methods based on performance and quality of services provided to the patients; (4) development of new management models for ensuring the continuity of care under therapeutic efficacy and economic efficiency.

Conclusions

The objective of any health care system is to ensure equitable access to cost-effective health services. Despite the significant improvements in health care in Romania after 1990, as evidenced by sizeable improvements in life expectancy, there are geographical areas and socio-economic groups that (completely) lack access to health units/health care services. Inequalities in health care are largely driven by the way the funds are allocated and by socioeconomic factors, such as income, education, and occupation. We found that the allocation of resources within the Romanian health system is not based on equity concerns or efficiency criteria. As a result, the financing system is increasing the inequalities among individuals and groups. Further research is needed in order to find the financing mechanisms that reduce the health inequalities and improve the health outcomes.

Acknowledgements

This paper is supported by the European Social Fund through Sectorial Operational Program Human Resources Development 2007-2013, under the project "Postdoctoral Studies in the Field of Health Policy Ethics", implemented by "Gr. T. Popa" University of Medicine and Pharmacy, Iaºi, Romania, contract number POSDRU/89/1.5/S/61879. This paper does not represent the official opinion of the European Union or Romanian Government.

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