The Organization of Health Sector Financing in the Member States of the European Union and Health Policies*

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Abstract

The elaboration of the present paper starts from the idea of the interdependence between the state of health of the population and the economy of a state, namely, that, on the one hand, the financial resources existing in the health sector can improve the health of the population and, on the other hand, healthy people will have labour, an aspect that contributes to economic growth. Thus, the main hypothesis on which the work is based is that a way of efficiently financing the healthcare sector can lead, in the long run, to improving the health of the population. The main purpose of this article is to analyse the financing modalities of the health sector in the EU Member States as well as the percentage contribution of each form of funding to the types of services provided to the population; the analysis of this aspect is useful given that the way in which the health sector finances directly influences the range and quality of health services provided to the population. The research methodology used combines the qualitative and quantitative method; the qualitative method supports the revision of the specialized literature, which is based on a series of largely conceptual studies, international studies, which present a fundamental theoretical orientation related to the concept, policies and financing modalities of the health sector. The quantitative method is based on grouping method, comparison method, indicator method, data analysis methods using statistical techniques such as graphs and tables; the data required for quantitative analysis were collected from official sources, www.ec.europa.eu. Health system financing accounts for more than 10% of GDP in the most developed countries, so one of the conclusions is that the choice of funding method determines the type of organization of the health system, who has access to health care, the cost of such care, productive efficiency and, last but not least, the quality of the services offered.

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Introduction

The global concern for reducing serious health problems has always existed and persists, and the search for solutions to common health problems has been undertaken by nations with very different approaches to policy development and implementation, taking into account modeled methods. by socio-political, economic and historical environments; However, the conclusion is unique, namely that health policies have a beneficial role in the population, on efficient and equitable medical care. Thus, the consequences of these aspects directly influence the development of national health policies, and the achievement of public health objectives is a difficulty. The adequacy of health policies is often based on the availability of financial resources, the ability of citizens to pay out of pocket, or by assessing the real or potential discrepancies that result from implementation; In this regard, financial resources are a determining factor in the development and implementation of health policies.

The health status of a nation correlates with multiple dimensions of quality of life: income, job, housing and utilities, equity and quality of health and education services and more. According to the definitions of the World Health Organization, adopted over the last 30 years, a man's health should not be limited only to a lack of disease, but to a state of physical, mental and social prosperity. (WHO, 2008, p. 12). By this modern definition, the health of the individual is closely linked to the concept of quality of life, more than ever. Starting from this vision, in the developed countries the offer of health services is successfully combined, at present, with psychological counseling or social assistance services, with services at the patient's home or efficient medico-social services, for persons with disabilities or persons with other types of medical and social problems at the same time. The policies in the health field combine, efficiently, with other types of social policy, for the most adequate investment in the recovery of the human capital of the respective community.

Research Methodology

The research methodology of this study involves both qualitative and quantitative research; qualitative research supported the stage of knowledge by studying the specialized literature, respectively books, and articles relevant in the field. Quantitative research has supported research, through the method of graphs, classification, and comparison, through the possibility of monitoring government spending on health (%), social health insurance (%),

voluntary health insurance (%), household out-of-pocket payments (%) the data needed for the quantitative analysis were collected from official sources, respectively www.ec.europa.eu.

Literature Review

The financing of the health sector has proved to be an important topic since the 1970s when numerous researches began to emphasize the need for financial support for the health of the population. Among the authors who have studied the concept, as well as the importance of financing health services, from 1970 to 1990, are Kleiman (1974), Newhouse (1977, 1987), Culyer and Jonsson (1986), Donaldson and Dunlop (1986), Parkin et al. (1987), Culyer (1989), Milne and Molana (1991), Getzen and Poullier (1991), Gerdtham and Jonsson (1991), Hitiris and Posnett (1992), who demonstrated the existence of a positive correlation between the efficiency of public spending and health. and population health, in most OECD countries; thus, an increased financing of this sector and the increase of its efficiency support the general health of the population. More recent research has also focused on assessing the importance of the correlation between the volume of public spending with health, the health of the population and the growth of GDP, respectively Murthy and Ukpolo (1994), Hansen and King (1996), Di Matteo and Di Matteo (1998), Di Matteo (2005), Gruen and Howarth (2005).

Edelman (1985) stated, since 1985, that health policies are elaborated based on economic and governmental conditions, but also based on organizational ideologies and interests, which can aim to improve the health of the population by expanding health units and institutions. Twaddle (1996) considers in the article "Health system reforms - Toward a framework for international comparisons", based on a well-founded theory, that the implementation of health policies is the basis of the evolution of states, an aspect also supported by Graig (1999) and Waitzkin et al. (2005). Putnam (2000) considers that health policies cannot be implemented without the existence of resources such as education, technology, health system infrastructure, financial resources, labor force, and a pleasant environment; thus, the author considers it essential to develop the states in order to be able to implement health policies; also, the achievement of cooperation between states is considered participatory and of common interest and culminates in the creation of cooperative and collaborative policies. As a result, there are researches, Kreuter and Lezin (1998), Bossert and Beavais (2002), which indicate that proactive community involvement can lead to favorable outcomes for health policy implementation.

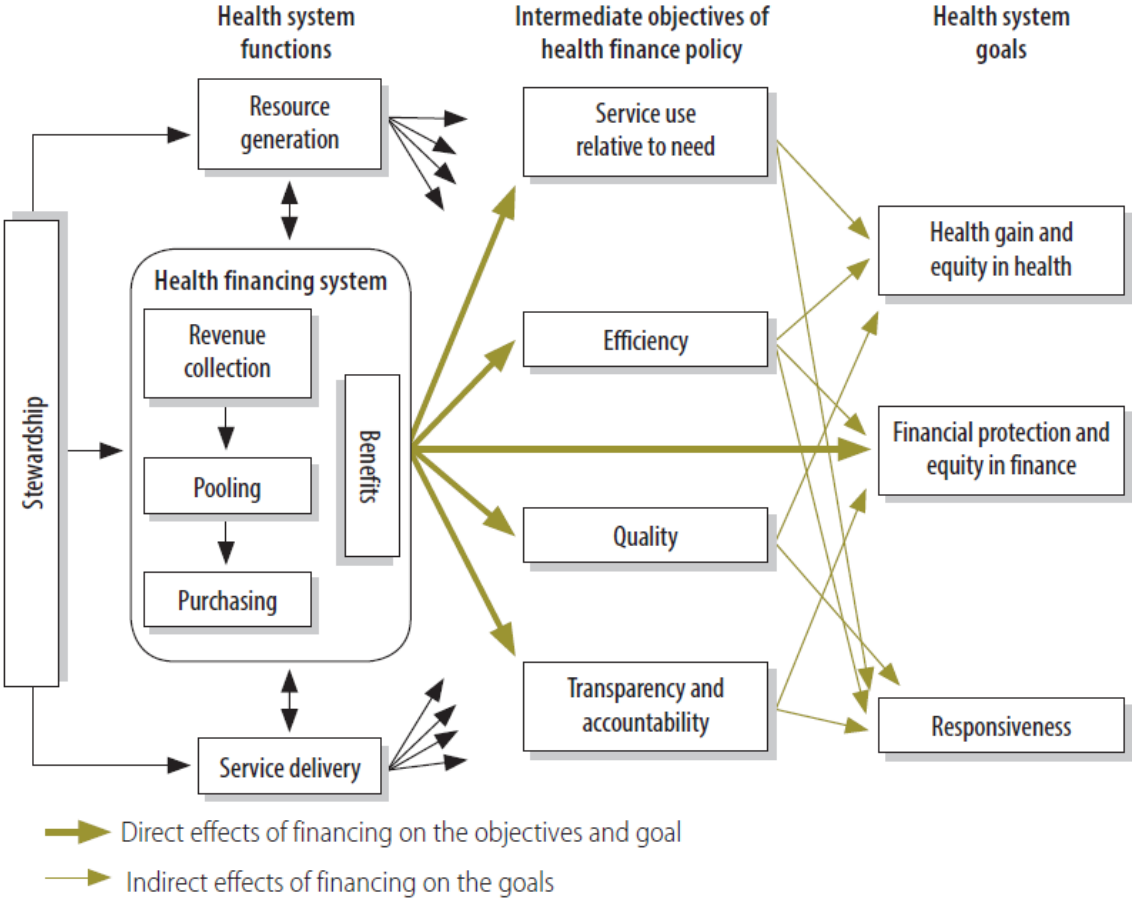
Policy for Financing Health Care

About health policy, this is a set of priorities and directions of development in the field of health, which aim at strengthening the population's health, achieving adequate living standards and creating optimal conditions for the maximum realization of the health potential of each person. throughout life. Of course, these goals are valid for all countries in general, and each country, depending on its degree of development, will implement them.

According to Tobin (2015), health decision-makers face four problems that make decisions difficult, respectively: (1) a slowdown in the economy; (2) state of health constrained by the existing budget for care; (3) the rising costs of medical services and (4) the high expectations of the population. (Tobin, C., 2015, p. 456). The economic factors of the state are at the basis of the decision-makers, an aspect on which, to a large extent, most decisions depend on the actions taken in the health environment.

According to the studies, the public policy in the field of healthcare determines the financing policy of this sector; however, a policy of financing health care for insured persons causes relative decreases in the expenses of the hospital units for the provision of medical care. (Munoz, E., et al., 1989, pp. 174). In terms of globalization, economic cooperation in the field of health, facilitated by international trade agreements, has strengthened the promotion and implementation of public policy initiatives in this field. Thus, Waitzkin et al. (2005), using qualitative research methods, studies several governmental organizations, international health organizations, multinational corporations, proving that different ideologies and organizational interests influence the application of health policies and also the financing policies of the health sector. Policy for Financing Health Care is imported into both developed and least developed countries, contributing, decisively, to improving the health of the population, which directly influences the economy of the states.

Figure 1. Health System Goals and Health Financing Policy Objectives



Source: Kutzin, J., 2013, p. 603

The link between health financing policy and health financing policy objectives (Figure 1) is an important one, highlighting how health financing can affect the intermediate and final objectives of health financing policies. Coordinated policy and implementation across health system functions are essential for making progress on the desired objectives, such as improving the quality of care. Many countries, moreover, face problems with physical access to health services and human resource supply, and again, financing policy alone cannot address these problems. These other health system functions exert an important influence on the goals, but examining this influence is beyond the scope of this paper, which is focused on health financing policy. The way health financing arrangements are organized often affects other social goals. Although they are not the focus of this paper, these effects are important for public policy. In particular, health financing mechanisms can influence individual choices and options with regard to employment. In countries that have a national system of coverage with a unified set of

entitlements, as in most of western Europe, people are free to change jobs without fear of losing their health coverage. (Kutzin, J., 2013, p. 603).

Ways of financing the health sector

According to Carrin (2008), the main options for financing health care (ranged along a continuum from private to public) are as follows: (1) private payment (out of pocket), including partial private payment, i.e., co-payments; (2) voluntary private insurance, including partial versions; (3) statutory private insurance regulated by the state (including partial versions such as substitutive insurance, meaning – in this option – mandatory private contributions by certain categories of citizen (generally the better-off) toward core rather than supplementary or optional health services. That is, everyone is covered, but the better-off pay a form of insurance that is obligatory; (4) community pooling; (5) public/social insurance; (6) hypothecated (earmarked) health taxation; (7) general taxation. (Carrin, G., 2008, pp. 10- 11).

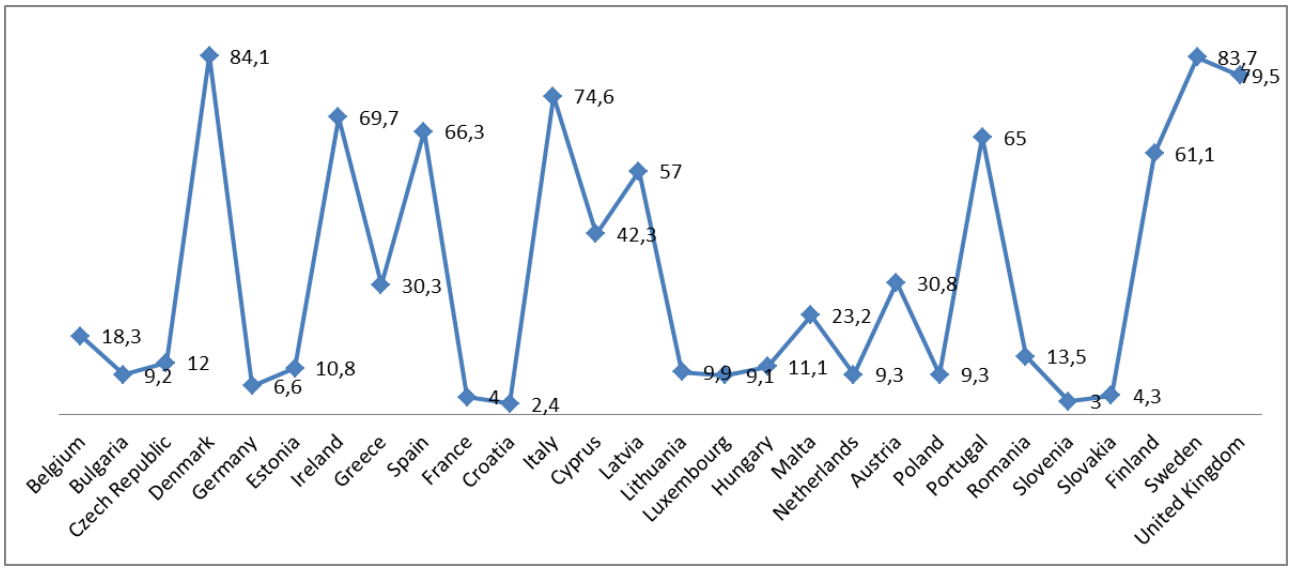
Financing from the state budget

Within this financing mode there are several sources of funds: (1) general taxes; (2) taxes with special destination for health; (3) other budget revenues; (4) external donations and loans. (WHO, 1978, pp. 1 - 44). This modality is most commonly found in developed, sustained and well-managed Western countries, which collect and manage tax revenues, argue Fried and Gaydos (2002), who, when analyzing the sources of financing of the health sector, consider that financing from the budget of state is one of the safest ways to cover the population of a country with medical assistance. (Fried, B. & Gaydos, L., 2002, p. 56). In developing countries, however, Lee and Mills (1984) and Green (2007) consider, the basis of tax revenues is often narrow and consists largely of general taxes, which is not always strong support for this sector.

The financing of health services from the state budget presents a number of advantages and disadvantages; among the advantages of this method of financing, we mention: (1) budget allocated for programs that contribute to the prevention of certain conditions (diabetes, etc.); (2) comprehensive coverage of the population with health services; (3) reduced financial risk for people with health conditions or who may develop such problems; (4) budget allocated for actions to reduce the disease index for certain conditions (eg diabetes, stroke, etc.);

disadvantages include (1) insufficient funds to fully cover the needs of the population; (2) determines the range of basic services included in the social health insurance package; (3) quality degree of questionable health services; (4) the possibility to redirect funds for purposes other than those foreseen. (Goldberg, A., 2016, pp. 478 - 479).

Figure 2: Government Spending On Health (%) In E.U., 2017



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In terms of government spending on health, this aspect differs from country to country, not necessarily in terms of the degree of development of the state, but in terms of how the health system is financed. Thus, in Romania, the government expenditure for health care represents a 13.5% percentage, insufficient to cover all the needs of the population in this segment. The lowest percentage of this type of expenditure is found in Croatia, respectively 2.4%, followed by Slovenia with 3%, France 4.0% and Slovakia 4.3%. The highest percentage of government spending on health is in Denmark, respectively 84.1%, followed by Sweden with 83.7%. Government spending on health is important for increasing the coverage of the population with health services, as well as for expanding the range of health services that the population benefits from.

Tax financing

In the case of financing of health through general taxation, the types of taxes are direct and/or indirect, the levels of variable administration, locally and centrally, and the amounts are general or with a special purpose. Choosing the type of taxation for financing the health sector has implications both in terms of social equity and the efficiency of the system. For example, in the UK, the health system is financed in a high proportion through direct taxes; in France and Italy, special purpose taxes and levies make an important contribution to health financing; local taxes have a significant share in the financial resources of the health sector and Bulgaria, Denmark, Finland, Norway, Sweden, and Italy. (Garber, A. & Phelps, C., 1997, pp. 1 - 31).

Public funding of the health sector includes all sources of government funding for health services. In countries where most health care institutions rely on this type of funding, decision-makers must allocate a substantial amount of financial resources in this regard. Through this method of financing, the funds are collected in the state budget, are then allocated to the health sector. The coverage of the population in general, the people contributing according to income and not according to the individual risk of illness.

Funding through donations

Donations can be in the form of money, equipment, buildings or medical assistance from partners, multinationals, international organizations or individuals and/or legal entities who wish to contribute to the financing of health services. The donations of these groups cover several categories and have evolved over the years, from the funds granted for certain projects, to what is called budget support. Scheiber et al. (2006) think that external support represents about 7% of total health spending in low-income countries and does not represent a significant source of funding for health in developed countries. (Schieber, G., et al., 2006, pp. 224-225). However, according to WHO (2008), in some African countries, external support plays an important role in financing the health sector, with charitable donations accounting for 40% of health financing between 1993 and 2004. (WHO, 2008, pp. 5 - 17).

Financing through social health insurance

Another type of public financing is social insurance, where the state is responsible for managing this modality. Social health insurance is the most important source of financing for the health sector in most countries in Europe. According to Wagstaff and Doorslaer (1992), social health insurance is a form of financing and managing healthcare based on risk-sharing. (Wagstaff, A. & Doorslaer, E., 1992, pp. 361 - 387). Vogel (1988) explains that social insurance is an advance payment mechanism, where the funds are grouped "in a basket", to cover certain "losses", health deficiencies. (Vogel, R., 1988, pp. 35-37).

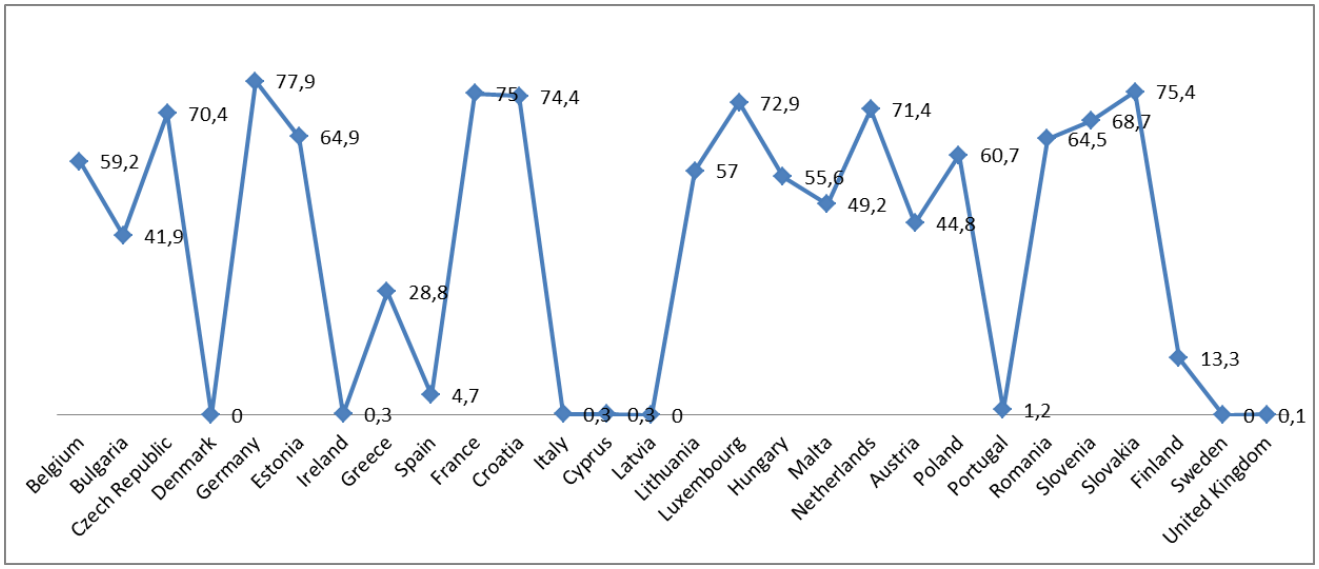
The financing of the health insurance system is made through compulsory contributions, according to the income of the insured persons, and is supported by both the employee and the employer. To include also persons working outside the official sector, the contribution can be calculated as a percentage of the overall income of the respective persons, for example, in the case of farmers. Within the social health insurance system, the government contributes funds from the state budget to finance specific objectives that are not supported by insurance, such as health programs of national interest, construction, and rehabilitation in the health sector, endowment with high-performance equipment, etc. The government must also manage the health care of disadvantaged groups, which are not included in social health insurance.

The financing of health care through social insurance represents about 2% of the total health financing in low-income countries, about 15% in middle-income countries and 30% in countries with higher-middle-income and high-income countries. (OECD/ European Union, 2018, p. 144). In sub-Saharan Africa, only 2% of total public spending on health is provided by social insurance, and in South Asia, they account for 8% of total health spending. (White, A., et al., 2006, p. 116). According to Carrin et al. (2005), financing for health through the development of social insurance is generally recognized as a sustainable method to obtain universal coverage, with adequate financial protection, for most of the population of a country. (Carrin, G., et al., 2005, pp. 799-811). In general, insurances play two important roles, respectively, on the one hand, they sum up the individual risks of a large number of people, each of them having a probability of an unwanted health event; on the other hand, it offers the possibility for each insured person to transfer the financial risk to the insurance company by paying a sum, on whose account the insurer agrees to pay certain benefits when an unwanted event occurs, which is provided in the insurance policy . The main disadvantages of the health

insurance system are related to the higher labor costs that they generate, which can reduce the economic competitiveness of a country internationally. Also, it can create, under certain conditions, social inequity.

Social insurance is compulsory, and each person in the eligible group must pay the corresponding amount, which, together with the expected benefits, is established by the legislation in force. Social health insurance differs from other ways of financing health services by criteria such as (1) social insurance is not a right of all citizens, but only of those who are eligible and pay the contribution; (2) the insured perceive that they pay a sum of money in exchange for the services that they could benefit at one point, so they become aware that "health costs"; (3) the contributions are intended for the social health insurance fund, being thus separated from other funds obtained through taxes and fees, which means the impossibility of these funds being used for a different destination than the one for which they were collected; (4) the value of the insurance amounts, as well as the services package provided, cannot be changed by a unilateral decision of the executive; these provisions can be modified only through the legislation, which implies the agreement of all interested parties; (5) the social health insurance system is obliged to maintain its solvency by its own means. From fund management, there are two types of social health insurance, respectively (1) social health insurance administered by the government, through government agencies; (2) social health insurance managed by public or private insurance houses. (Mihalache, I., et al., 2018, pp. 211 – 224).

Figure 3: Social health insurance (%) in E.U., 2017



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The percentage of health financing from social health insurance differs from state to state, because of the different ways of financing this system. Thus, in Romania, social health insurance represents 64.5% of the total financing of health services; a higher percentage in this regard is found in Germany, respectively 77.9%, followed by Slovakia with 75.4%. In countries such as Denmark, Latvia or Sweden, the percentage of financing for health services through social insurance is 0%, followed by the United Kingdom with 0.1% and Ireland, Cyprus, and Latvia with 0.3%. These states are based on the financing of health through private health insurance, direct payments, government payments, etc.

Private, voluntary health insurance

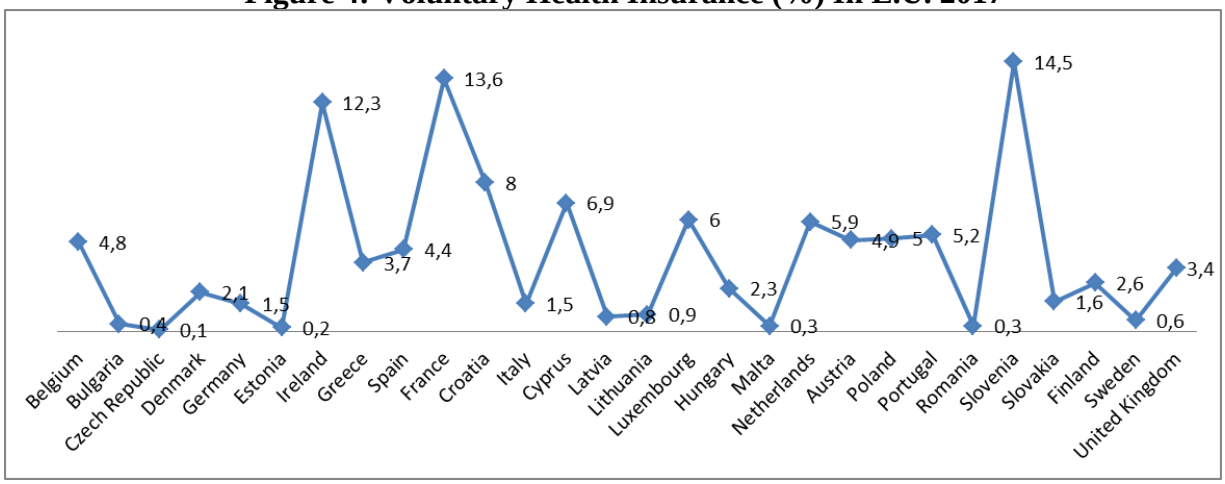
The main source of private financing for health services is represented by private health insurance, respectively optional health insurance, which people can access. The amounts for private health insurance can be paid by individuals, can be divided between employees and employer, or can be paid in full by the employer. The package of medical services within this system depends on the amount of the amount paid by the insured; the amount of insurance depends, in turn, on the predisposition of the insured for illness. Sekhir and Savedoff (2005) support access to private health insurance even by the middle-income categories, as it offers an

opportunity to avoid situations that require high costs and provides financial protection. (Sekhir, N. & Savedoff, W., 2005, pp. 127 - 134). Private health insurance tends to play a different role, depending on the wealth and economic development of a country. Many debates on health policy tend to focus on the lack of resources to provide public health services, an issue that encourages access to private insurance. Thus, in recent years, worldwide, there has been an increase in interest in private insurance, seen as a way of increasing health incomes (eg France, Belgium, Slovenia, Germany, etc.).

Private health insurance can be provided by non-profit or non-profit insurance companies, based on individual or group insurance. Regarding individual private insurance, the amount owed is calculated based on the actual risk of the disease. The amount of the contribution also depends on the package of services that will be provided, to which are added the administrative expenses as well as, in some cases, the profit of the insurance company, the last two aspects representing about 40-50% of the value of the insurance premium. The high administrative costs are mainly explained by the very high marketing costs necessary to sell the insurance to as many people as possible. Private insurance can also be offered to groups of people, usual employees of the same employer, or members of trade unions. (Murgea, M., 2016, p. 320).

The advantages of this type of system, compared to that of social health insurance, are represented by (1) the protection of the financial risk, according to the option of each person; (2) the limited role of the policy; (3) reducing bureaucracy; (4) competition between the insurance funds, thus leading to an increase in the quality of the medical act. However, for the population, one of the main problems they face in accessing this type of insurance is related to the emergence of the selection, the insurance companies intending to attract healthy people to the detriment of the sick.

Figure 4: Voluntary Health Insurance (%) In E.U. 2017



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Voluntary health insurance is, for many states, an important source of funding for health services. In Romania, the percentage of financing of health services by this method is 0.3%, as is Malta. A lower percentage is found in the Czech Republic, respectively 0.1%, followed by Estonia with 0.2% and Bulgaria with 0.4%. The largest number of voluntary or private health insurance is found in Slovenia, respectively 14.5%, followed by France with 13.6% and Ireland with 12.3%.

Financing through direct payments

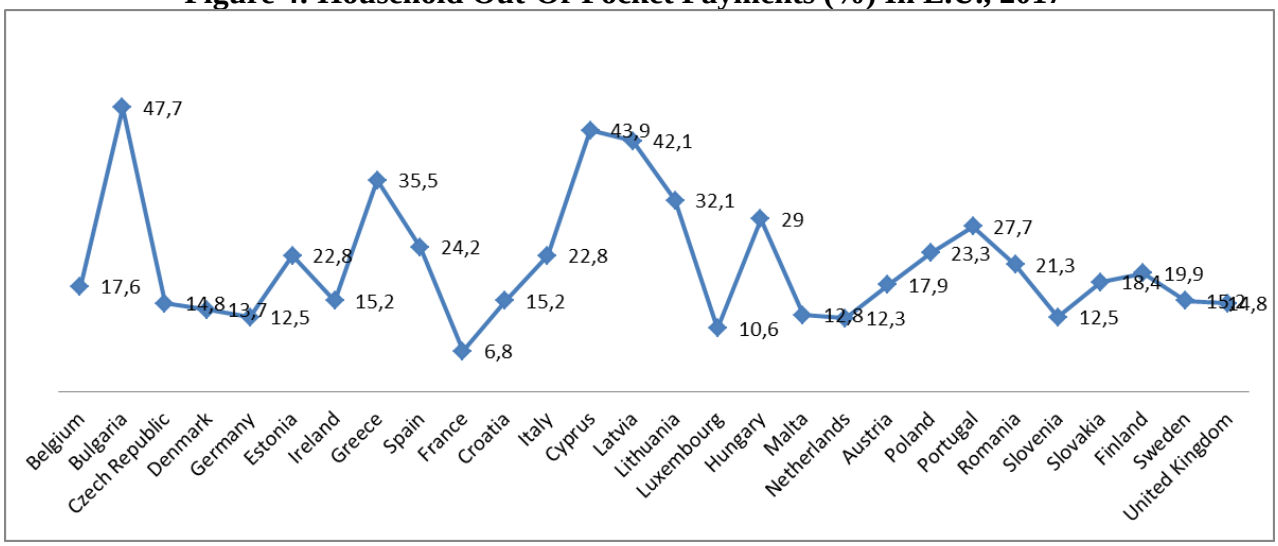
There are several types of direct payment, respectively: (1) the total payment of the health services by the patient; (2) co-payment, meaning a fixed amount for each medical service; (3) co-insurance, meaning a certain percentage of the cost of the medical service. Direct payment, in full, of medical services, is usually done in the private sector, while co-payment and co-insurance are met, especially, in the public sector of the provision of medical services, or the association of private hospital units with those public; for example, in the case of medical analyzes, the patient can perform them in the private sanitary fittings that are in collaboration with the National Health Insurance House, and the difference between the cost of the service and the part settled by the CNAS through the social health insurance, will be paid, by direct payment, by the patient, meaning co-payment. (Waitzkin, H. et. al., 2005, pp. 893 – 906). For example, in Bulgaria, the services provided by doctors who have no contract with the health insurance

company, by specialist doctors without having a referral from the general practitioner, certain types of medicines, dental services, the visit of a specialist doctor are not covered. then is the normal schedule or special conditions for hospitalization or plastic surgery, etc. In Slovakia, the rates are charged for certain outpatient primary care services (vaccinations, medical examinations requested by the employer, etc.) or various laboratory diagnoses (CT, x-rays, etc.). In the Netherlands, they apply to certain medical providers (pharmacies, dentists, physiotherapists). (WHO, 2008, pp. 22- 25).

Direct payments are a way of financing health care, which comes in support of public health services, in the sense that this system is no longer over-demanded. Positive effects of direct payment can be felt in: (1) diminishing the overload of public health services; (2) reducing the waiting time for patients; (3) increasing the quality of services; (4) increasing the allocation efficiency. The main negative effect is related to the fact that the population with low incomes, or the elderly, in fact, the main beneficiary of the medical services, could have access to health care because of the impossibility to pay. The direct payments made by the patients make an important contribution to the total of the expenses for the health. The main reasons for promoting this type of modality as a source of financing of health expenses were: (1) reducing the risk that the population will abuse medical services that are not necessarily needed and (2) the need to attract additional resources into the system. However, direct payments are criticized as affecting access to health services for low-income people or leading to increased population costs for health care. (Mihalache, I., et al., 2019, pp. 563 – 574).

The modality of the direct payment of health services is necessary to be adopted according to the specific economic context of each country. Contrary to the optimistic appearances, studies conducted by the OECD (2018) show that the introduction of direct payment methods has not led to a significant increase in health funds; thus, in five countries of the US, namely Malta, Greece, Latvia, Bulgaria, and Cyprus, in 2016, the estimated increase is 10% and no visible improvement in the quality of the services provided was observed. (OECD, 2018, p. 142). Schieber et al. (2006) show that, in low-income countries, direct payments represent 60% of total health spending, while in high-income countries, direct payments represent 20% of total health spending. (Schieber, G., et al., 2006, pp. 225-226).

Figure 4: Household Out-Of-Pocket Payments (%) In E.U., 2017



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In Romania, Household out-of-pocket payments recorded a percentage of 21.3% in 2017; this percentage differs from state to state, depending on the degree of development, as well as the way of financing the health services. For Romania, given the fact that social health insurance is obligatory, and health services are financing, for the most part, from these contributions, the 21.3% percentage of payments out of pocket is an increased one. Higher percentages are found, most often, in more developed states and where social health insurance is not mandatory; In Bulgaria, the percentage of out-of-pocket direct payments for health services is 47.7%, in Cyprus, 43.9%, Latvia, 42.1% and Greece 35.3%. The lowest percentages in this regard are found in France, respectively 6.8%, Luxembourg 10.6%, Holland 12.3%.

The provision and financing of health services can be regarded as a transfer of resources between providers, patients, and third parties. The simplest form of transaction for obtaining a good or service is the direct payment, paid by the beneficiary directly to the supplier in exchange for the purchased good/service. However, due to the high costs of many medical treatments, modern health systems have been developed by interposing a third party between the beneficiary and the service provider, with the role of taking over the financial risk associated with the illness. Third parties may be public and/or private institutions, which are financed both by direct and indirect contributions, from a group of beneficiaries that they protect against risk through a mechanism for allocating resources to service providers, medicines and medical devices. The

most common organizations in this regard are those that offer health insurance; In Romania, private health insurance represents 0.3% of the total financing of this sector, and social health insurance represents 64.5%, according to the OECD / E.U. (2018).

Conclusions

Given that health policies aim to maintain a balanced population health status, they will be directly influenced, on the one hand, by the factors that lead to the occurrence of certain diseases and, on the other, by the incidence of the diseases. The financing policies of the health services are necessary to seek both the coverage of a larger number of people with this type of services, as well as the possibility that the population will benefit from a wider range of health care services. In this regard, we consider it necessary for policies in this sector to focus on prevention, which is less expensive compared to treating illnesses.

It is difficult to find a way to finance the healthcare system that covers all population levels in this segment, but managing the existing financial resources according to priorities could support the access of the population to a wider range of services. For the right to health care to materialize in equity, quality and accessibility, the choice of the financing system, as well as the reimbursement and payment mechanisms bring important determinants, such as (1) the collection of financial resources, (2) the management with transparency and efficiency of the available resources, (3) establishing the population's health as a priority, (4) developing prevention programs for certain diseases, etc. Thus, financial mechanisms are required to promote cost-effective healthcare. It is necessary that the financing of the health system be effective through the capacity of managing the existing funds, so as to ensure the coverage of the requests of the patients, the increase of the safety and the quality of the care process, the acquisition of progressive technologies, the diminution of the existing disparities in accessing these services.

Health is important for the well-being of people and society, but a healthy population is also a prerequisite for a high level of economic productivity and prosperity. Thus, spending on health is not just a cost, but an investment. Expenditure on health can be seen as an economic burden, but the direct costs of the company for health services may be lower compared to the indirect costs, determined by the increased disease index of the population.

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