ECONOMIC AND MANAGERIAL APPROACH OF HEALTH INSURANCES

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Abstract: *The paper represents an analysis in the domain of the social insurances for health care. It emphasizes the necessity and the opportunity of creating in Romania a medical service market based on the competing system. In Romania, the social insurances for health care are at their very beginning. The development of the domain of the private insurances for health care is prevented even by its legislation, due to the lack of a normative act that may regulate the management of the private insurances for health care.*

The establishment of the legislation related to the optional insurances for health care might lead to some activity norms for the companies which carry out optional insurances for health care. The change of the legislation is made in order to create normative and financial opportunities for the development of the optional medical insurances.

This change, as part of the social protection of people, will positively influence the development of the medical insurance system. The extension of the segment of the optional insurances into the medical insurance segment increases the health protection budget with the value of the financial sources which do not belong to the budgetary funds.

Keywords: Health social insurances, subsidiary principle, medical system, social security system

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Introduction

The social insurance system became in time very complex. It is the most important economical and social system for protecting the health of people and it can say that these processes were transformed from an individual process in an organized process.

Health social insurances are obligatory and its function is to support solidarity and subsidiary principle for collecting and using the funds involved. The people who have insurance can choose medicine and the society that gave the medical services.

Social health insurance was born from necessity to protect people and for that it was necessary to create a legal frame for the organization. The existence of this frame gives the real possibility to people to product social goods and services.

In the domain of health social insurance it can be identified essential particularities that influence any way to monitor regulation and costs, such as:

- The nature of consumption and production is based on the bipolar relation between person and physician. This relation is essential for cove and society because it gives the possibility to access the consumption of goods and services;
- The request of health services is unlimited because of different values in function of patient and specific medical consumption;
- The stiffness of the request according to the price, the elasticity of requests according the offer.
- The importance of quantity argument and political-administrate decisions.
- The high level of uncertainty in health services means other essential particularities in the domain of sanitary economic medicine.

The consequence of the uncertainty in health services favours the undesirable strategic behaviour taht made in the same time difficult to introduce some mechanisms for decisions coordination:

- The uncertainty on the risk and the labour costs are at the origin of health insurance system;
- The uncertainty from the physician and the beneficiary generate the excess of settlement;
- The uncertainty may limit the concurrence on the quality that at its turn will limit the health performance services;

- The uncertainty at the origin of actual impossibility for punishing/rewarding the performances and more to evaluate health services efficacy.

Economical and social co-ordinates

In many countries the medical system through insurance supports successfully the activity of medical institutions and everyone has access to the medical services. The insurance founds are formed, usually of 3 sources: government allocations, taxes paid by patron and taxed from employments salaries.

In most modern States, the population is dissatisfied with their health systems care and it is evident that the measures that are undertaken for permanent changes and improvements; their problems are similar in most of the countries. Their content differ only by the amount of money needed to solve, with less importance on how the country spends on health - 14% or only 1% of gross domestic product.

There are two main categories of economic problems faced by different countries: under-investment and over-investment and better said - the irrational allocation of health resources in medicine. Since 1993, world development report stated: "Investing in the health of the World Bank have been dealt with the most common health problems affecting in particular the health systems of developing countries. In this report it was found that health is an irrevocable condition for economic growth and that the allocation of limited resources for costly services and relatively unproductive expenditure, such as for the armed forces, that prevent countries to meet basic health needs of the population.

At present, we can track the formation of a new system of organization of medicine by insurance - the European Community. Integrating current process requires the integration and reform of social programs in the states. The model that develops, it provides a unique concept of social policy in all states. Dominant idea of this concept is that the control of the state not only affects economic development, but also the social one. This postulated lead to the revision of the state's role in the social sphere, particularly in countries where this role is traditionally strong. It performs social diversion programs from their universality at the individual level, which leads to reducing costs and increasing efficiency, because aid is more individualized and effective for those who really need it.

Resources of all companies are limited. Rational use of them requires the establishment of priority areas. This choice reflects the attitude of the political power towards health and must be based on objective evaluation of costs and benefits of the available options. Using financial and human resources, all are linked to a

particular health program, which is designed to produce health benefits or utilities. Health benefits can be expressed directly by reducing morbidity and mortality or by increasing labour productivity and quality of life.

Models in health systems

In past years, there are discussed in the increasingly need to establish a regulatory framework for private health insurance. The arguments that this action causes, concern especially better meet the public/individual interest, improve the quality of medical act.

When discussing the choice of a health-care system it must take into account the role of the state, through various levels or bodies. A uniform system, operated entirely by the state or fully privatized, does not exist. There are liberal health systems (United States), nationalized systems and systems to date.

Basically, depending on funding sources and historical traditions in the field of health policies, three types of systems coexist:

- the social security system for health premiums based on compulsory insurance, dependent on income and not the health of the insured;
- national health system, financed by taxes;
- voluntary insurance system, typical private health market, private financing, insurance premiums are correlated with the risk policyholders.

What it seems to us very important is that no country finances its health services exclusively through a single mechanism, but only one of the following mechanisms is predominantly at a time: from the public budget, based on levied taxes, social health insurance, private health insurance, and direct payment services to patients.

For example, the financing of the Austrian health system based on private insurance at the rate of 7.5%, Ireland has, since 1994, a well-defined legal framework on private health insurance, the profile is based in Holland and the social security health insurance and private one, but it has a share of 31%, compared to only 3% in Sweden, also in France, the whole system is the result of a complex combination between the public sector and the private one; the UK, system is characterized by universal population having access to medical assistance, an organizational structure that governs the access to specialist and a majority of the funding state taxes, along with the operating system and the private one, profit-oriented, in an assurance plan, and the health benefits.

Health care systems in Europe are seen in three models:

1. national health service (SNS) model - type Beveridge;
2. social security system for health model (SAS) - Bismark type;
3. the centralized model of the state (SCS) - Semaşko type.

They are added to the model that works in the U.S. and is based on private insurance. The model of National Health Service operates in Denmark, Finland, Iceland, Norway, Sweden, Greece, Italy, Portugal, Spain and England. The system is a source of financing general charges, and it is controlled by the government which has a budget and a private sector.

The centralized model of the state is passing in Albania and Bulgaria. The system is financed from the state budget; the state has the monopoly of health services. Countries such as the United Kingdom, the Netherlands, and Germany brought and it will always bring improvements to existing systems without replacing them.

Comparative aspects of social health insurance in the European context

In Romania, social health insurance is still at the last top. The development area for private health insurance is hindered even in the legislative field, practically there is no legislation at this time to govern the management of private health insurance, insurance that would be voluntary and, therefore, the additional requirements established by the Government Emergency nr.150/2002, which provides and regulates the social security health system as a public binding.

Romanian Reform health should not import weaknesses and dysfunction of other systems. It requires monitoring projects' directories from the social insurance for health, especially those on decentralization, the contractual and independent medical practice. It becomes the appropriate criteria for selecting competent and moral managers, developing the medical and health management, conducting the dialogue between the partners involved in the medical-health and others.

Additional health insurance are the result of signing a contract between the insured person and an insurance company, covering the difference between the cost of medical services offered through social insurance and health charges by service providers in the field. The insurance company must specify all the conditions in the policy-related insurance schemes, all medical institutions, medical staff or the public and private nurses will provide the insured person the rights provided by the policy.

One of the main features of voluntary health insurance (MPA) is the dependence of the guarantees provision of the medical services in appropriate volume and quality over the value of premiums paid. The level of performance guarantees a complex package and sufficient quality of medical services that depend on the cost of the purchased policy.

In the case of mandatory medical insurance (AMO), this relationship does not exist. The volume and quality of medical services to the insured person does not depend on the financial benefits of its insurance funds. This is the most important difference between the MPA and AMO.

Table 1

Fundamental distinctions between the AMO and MPA

Nr.	**The awards**	**Insurance**	**Voluntary insurance**
1.	Legislative	By the effect of the law	Through the voluntary law
2.	Coverage	Population majority	Individual solvent layer
3.	Status	Part of the social protection system	Commercial activity
	Motivation	Defending the social interests of citizens, state and employer	Defending the citizens and state's social interests
4.	Authorizing finances	Multi-state insurance company, non-profit	Commercial insurance company
5.	The volume of services	It is set annually by the Government and is limited by the Single Package	Conditions and insurance programs are developed by insurance companies and the volume is limited by the amount of insurance
6.	The financial acquittal	Current funding needs other policyholders	Deferred financing individual needs
7.	The coverage	Universal for all	It is done individually, or family group
8:	Equivalence	For all population	Only for similar groups
9.	Insurers	Employers, employees and state	Natural or legal persons
10.	Tariffs	Shall be regulated by law	It is established contractual

11.	It is established contractual	Sources unused in the current year is used to increase the volume Single Package	Revenues are owned insurance company
12.	Prices of medical services	Shall be determined by the Government	It is sold

In European Union countries distinguish the following types of voluntary health insurance:

Private insurance-type **complement** (Austria, Belgium, Ireland, Spain, Italy, etc.) supports total or partial payment services excluded from the basic package, including co-payments as appropriate.

Private insurance type **additional** support, in whole or in part, paying for services that exceed the package of basic services in the social health insurance system, provision of a comfort level, fast access to medical services where waiting lists, special medical services abroad and other services.

Private insurance type **substitute** full or partial payment for any services, including those provided.

It is stressed that the border between additional and complementary is not always well defined.

AFS market presence depends on 3 conditions:

1. Demand positive (some people are outside risk)
2. The presence in the medical and health services medical fee
3. The possibility of granting technical insurance services.

Private health insurance is an operation whereby the insurer, on the mutual principle, an insurance fund contributing a number of policyholders exposed to certain risks and produce them and pay those that resort to the use of additional package of medical services on behalf of the fund composed of collected premiums and other revenue on account resulting from the activities.

Assurer takes a number of risks expenses that occur as a result of inefficient use of methods of treatment, loss of body function or a body part that decrease the ability of employment, death. All have a financial expression and placed under the grading of risks that can be taken in insurance.

In this way, the object of the AFS may be:

- Medical services are not included in the unique program.
- Providing medical services through alternative technologies (high technologies, costly) over the unique medical services.
- Medical Services (internment, investigations) outside the waiting lists.
- The supply the medicine of last generation.
- Comfortable conditions.

One combination of AOS and AFS:

1) AFS that complement the AOS - AFS programs include medical services over the volume of services included in AOS.

2) AFS as a partial replacement AOS - AFS programs include services that complement AOS services, and services are included in the AOS. AFS programs, which include the volume of services included in the AOS and over it. Holders of such programs are also insured for medical services provided by AOS.

3) Health insurance with multiple levels of optional insurance, with additional spending of citizens for medical services under the program AOS.

4) Health insurance with multiple levels of insurance with additional medical services in the AOS.

Today's activity in Romania, an insurer in the AFS is targeted initially for those individuals that require medical care. Regardless of the fact that most people and procure insurance policy AFS suffering from chronic diseases, they are what make us demonstrates the social aspect of the AFS.

One of the key strategies that can be applied in Romania in order work AOS and AFS is revising the volume of medical services covered by AOS for different categories of the population. It is the transfer provision of medical services in the category of medical services fee for a certain class of citizens or the introduction of co-payments, when granting medical services. Thus it would extend the field of services AFS.

Variants most often used by the MPA in Romania are:

1. MPA forms a compensation which provides insurance but does not depend on the cost of the insured person’s treatment:

- insurance in case of determining the diagnosis;
- insurance in the event of sickness as a result of suffered trauma;
- insurance in case of loss of income due to illness;
- allowances for the period of hospitalization.

2. MPA forms of which provide compensation to cover expenses for treatment:

- insurance expenses for treatment in the outpatient;
- insurance expenses for stationary treatment;
- insurance costs for surgery;
- insurance costs for treatment and postoperative care;
- providing complex medical expenses.

Conclusion

Conclusions concerning social security for health in Romania and efficiency of the health concerns three fundamental issues:

- apparently contradictory relationship between the economic and medical health system, about what may be reduced at dialogue between economists and doctors, dialogue difficult because of the relatively limited areas of their work;
- opposition of the resources allocated to medical and health, efficiency and capital investment requirements to ensure social health - increasing demand for health services in relation to the limited capacity of securing financial resources;
- existence of ethics issues, morality and vulnerability activities in health, limited procedures for the funds control allocated to health and the recognition risks and accidents event. Therapeutic (dualism interpretation of the positions of physician-economist).

Regarding the voluntary health insurance propose:

1. Finalizing the legal framework on voluntary health insurance would create certain standards of companies that provide AFS. Changing the law, in creating regulatory and financial facilities for voluntary health insurance, as part of the population social protection, it will positively influence the development of medical insurance. Expanding the share of voluntary insurance in the health insurance budget, it increases health care with the financial sources that have a different origin than the budget.

2. Quality medical services in the AFS should include more items. Evaluation of resource materials in the provision of medical services for insured AFS organization and agenda for making medical-economic expertise covers:

- Detecting flaws and arguments, medical errors and other factors that negatively affect the quality and effectiveness of medical services;
- Developing recommendations for manager's medical institutions, which aim to prevent medical terms and would contribute to raising the effectiveness of medical services;
- Assessing the potential health institution to ensure an appropriate level of medical services (in relation to market demand);
- Fairness of the application of the tariff (price) for services rendered and corresponds to the accounts presented for redemption.
- Monitoring the compliance with the contractual terms. It is necessary that every medical institution to be introduced a special service, which would include specialists in the field of studying the market, price policy, the advertisement.

With the passage of the medicine by insurance, it is necessary to form a single body control, independent, to evaluate the quality of medical services in the AOS and AFS. It is necessary to review standards of medical services and the volume of services included in the program unique, with the aim of creating conditions for insurance with several levels.

3. Application of the medical insurance in health care provides a number of changes in the management of health, relations between medical institutions and patients.

4. Medical insurance programs should be implemented in compliance with the technologies developed for serving patients, using market segmentation of medical services and calculate insurance premiums according to the most modern formula.

5. MPA must be consistent with AMO, in order not to interrupt the continuity of technological service to the patient.

6. World practice in the field of modern technologies serving patients demonstrated efficacy specialised supervising service to the patient in medical institutions. This management has positive effects not only on the quality of service, but also the financial aspect. Following the exclusion of medical services that are unnecessary or duplicated would save considerable sources. Creating a centre for routing the care granting for patients in our country currently has a vital importance.

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