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Financial management within the health system

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ABSTRACT
The financial management within the medical management plays a very important role considering the fact that health care costs a lot of money. The health care system is greatly influenced by the allocated funds so that there are types of health care systems depending on the allocation and collection of funds and depending on the payments of the services providers. There are several mechanisms for financing the health care system of which the most important are represented by the state budget funding and voluntary health insurance. In terms of financial management, is a reform within the Romanian health care system mainly focused on reducing the number of hospitals and restructuring the County Health Houses.

Keywords: financial management, health system, insurance system

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Introduction

In the last 20-25 years, within the scientific and specialist literature problems concerning the organization, administration and management of non-commercial organizations in general, and in particular those who provide services were highlighted and discussed. Therefore to have an efficient management, the healthcare organizations must be known and understood, and the mechanisms underlying their operation should be harmonized with the regulatory framework, with the ways of human resources selection and motivation and other features of the external environment, with impact on organizations.

It would be good if the medical management will become a part of the national management certainly with democratic economic changes towards a market economy and healthcare market. We believe that medical management is part of the general management, thus been respected and used principles and methods of classical management, taking into

account the particularities of the health system.

Regarding the health system management objective premises have appeared which cross the administrative style of command to the democratic style. Gradually, it is formed the healthcare market and its infrastructure.

These changes require the emergence of new specialties in medicine and public health and especially a medical manager.

The medical manager should be familiar with marketing problems, the medical and pharmaceutical market research, should know the relationship bid / offer, the pricing process of providing services and medical goods. A separate section is the knowledge of medical legislation, the labor code, tax laws, taxes, etc.

Qualitative and quantitative structure of the population healthcare is determined by its request. Choosing the method of treatment depends on the doctor who usually is not interested in the economic consequences of its activity.

The liability for economic status lies on the administration of the medical institution. To efficiently lead, the manager must be familiar with methods of management. Application of systematic analysis within the health care institutions was justified in the past and in the present. The system is a structure in which it is periodically introduced material, energetic, information factors etc..

The second part of the system is the operations and processes which are subject to business factors, components or materials introduced into the system. Thus, if the system input (curative institution) is the patient, towards him it is taken a series of actions (operations) by the medical personnel.

The factors entered into the system are called input conditions, which are considered by the actions of revolt (signals, stimulus) or consumer factors and output of the system are called output measures or final product, namely healthcare provision.

Income funds of the health care systems

The healthcare services, unlike other services, are required by a large number of people, but, in generally, health care costs a lot of money.

If every individual should be left free to decide on their healthcare consumption and pay for it, the medical supplies would be very different from one individual to another, with equal conditions of disease, depending on the ability to pay for them. Due to reasons of equity, in most countries there is a national health policy that sets out how to make access to health care consumption and who bear the expenses derived.

The health financing schemes, whether public or private, affects the state budget, the cost of production factor, the labor and, hence, the employment, the imports, the exports and the competitiveness of a country.

The funding mechanism is the needed instrument in order to implement this policy.

This mechanism includes:

- The collection of resources for the payment of health care;
- Their allocation (regional or by different health care providers);
- Payment of inputs (in particular, medical and health).

Collecting funds intended for health services

This issue refers to the way in which the financial resources can be collected for payment of medical services. Financial resources may be collected in several ways:

- By direct payment of the services by the patients;
- Voluntary contributions to facultative health insurance;

- The social contributions paid by employees and economic agents;
- Budgetary resources;
- By setting up deposits with special destination to health;

The way of raising funds is determined by the typology of health systems. Thus we may meet:

- National health systems financed from the state budget;
- Social security schemes financed by mandatory contributions to health insurance;
- Private insurance systems financed by voluntary insurance premiums;
- Free market systems financed by direct payment made by the consumer

The allocation of funds to health care providers

The financial resources are directly allocated to the health healthcare sectors (primary, secondary and tertiary) and to health care providers (hospitals, dispensaries, clinics, private practices).

Allocation to regions can be made on historical base or based on an allocation formula that takes into account the needs of the population in a given region, and the allocation to assistance sector is made based on the health policy objectives. At the microeconomic level, the allocation takes place based on the criteria by which the funds are granted to the health care providers.

The mechanism of funds allocation to providers includes:

- Prepay by anticipated casuistry (payment is given for each treated case, according to a predetermined cost).
- Budget of expenditure categories (principal elements volume is determined by expenditure: personnel, medicines, food).
- Overall budget (it is allocated a global sum to achieve a predetermined volume of activity).
- Budget of practice (a group of general doctors can obtain a budget for providing medical assistance to a certain number of patients).

The payment of the production factors

The mode of remuneration of medical personnel can be diverse. If the medical staff, in general, is remunerated by salary, doctors may be remunerated by several ways:

- The salary payment per service (for each service shall be fixed a rate or a score, which then turns into monetary equivalent);
- Payment per capita (for each patient cared during a period, it receives a tariff score);
- Payment according to a relative value scale (each doctor is paid according to its position occupied in a relative value scale, established on the basis of years of training, specialty difficulty, risk and cost of practice).

The mode of payment of doctors affects the total cost of health care. It was noted that countries using payment per service, as a payment method experienced a large increase of health costs. Choosing a particular payment mechanism is a compromise between the interests of doctors (who prefer a certain kind of payment) and government interests (which aims to limit costs).

The combination of the three funding aspects is different from one healthcare system to another. In a private system, the consumer pays the cost of health services in place, overlapping the resources generation with their allocation and providers payment. However, most often we are faced with a combination of two or three aspects of the remuneration of medical personnel.

State intervenes, most often, in resource generation (in case of funding from the state budget

or insurance), but is also present in their allocation, establishing rules for the remuneration of production factors.

Mechanisms of financing the health care system. Worldwide practices

The health systems of European Union countries are very different from each other, even for developed countries. There are also large differences in the level of resources allocation in this field and in the health status, both between countries with similar development levels as well as in the same state. The common key feature to all health systems is concerning the political factors regarding the accelerated growth of costs and sustained awareness concerning their control trough streamlining processes and improving outcomes, including the increase satisfaction both of the patient and medical staff.

Health care systems can be funded from multiple sources, both public and private. Funds collected from these sources can be managed by public institutions (ministries, public insurance funds) and private (private house insurance, employers' organizations and trade unions, non-profit organizations) and can be spent on medical services for public and private institutions.

We will further analyze financing arrangements. Revenue accruing from:

1) the taxes collected from the state budget;
2) facultative health insurance;
3) health insurance;
4) direct payment of patients.

For choosing between different ways of financing the health system, criteria to rank them according to the achieved performance are necessary.

The main criteria aimed for the sustainability and revenue generation, efficiency and the level of medical services, the health status evolution are:

1) Revenue generation
2) Provision of services
3) Health Status

Financing from the he State Budget

Health financing from budgetary sources are a feature of health systems such as "national health system". Such systems exists in countries like UK, Italy, Spain, and Denmark

The assessment criteria:

- Economic efficiency: the tax system should not interfere with the efficient allocation of resources.
- Fairness: the tax system should treat all individuals equally.
- Easy management: the tax system should be run easily and inexpensively.

Economic efficiency

Whenever the government uses progressive or proportional taxation to get income from the private sector, there is an economic cost that decreases the effectiveness of the revenue collected. This additional cost is known as the cost of efficiency or excess burden of taxation.

Taxes distort the firm's decisions in connection with the production, exchange and investment and consumer decisions in relation to the consumption and savings.

Branches taxpayers will face an increase in costs and will reduce the production of goods taxed and increase their price corresponding to the situation where there would not be taxes. Consumers will respond to higher prices by reducing consumption. The result is suboptimal because only part of the consumer and producer surplus is collected by the state, and by the inhibitory effect on the production, part of the excess is lost. From an economic perspective, it should be deducted from the resources collected through taxes.

Here fits the taxes or fixed amount duties, such as stamp duty, local taxes, sanitation taxes etc. Most

taxes are dependent on the level of production or the sales or revenue, so are generating cost efficiency. They are used, in spite of a positive economic argument, as they can ensure the principles of fairness.

This explains the chronic insufficiency of health financing in Romania: insufficient resources, delays in knowing the availability of the resources for the next year (adopting the budget law was made often in the spring of the current year), the accumulation of large debts during the year due to delays in revenue collecting, allocated revenues congestion from the budget to year-end, when they cannot make expenditures or are no longer meets the criteria of efficiency.

Facultative health insurance

In a facultative insurance scheme, citizens voluntarily opt to pay an insurance premium set according to individual or a group risk. In such countries like the U.S. and Switzerland, private health insurance is the main source of funding contributions curative.

The term "insurance" can be treated in several ways. Insurance can be defined as a mechanism that ensures protection against risks or as an actuarial mechanism. The first defines insurance in terms of objectives, the second – a method by which objectives can be achieved.

Even when we are not talking about a defined insurance, we use the term of insurance, whether it protects individuals against risks (such as social security).

If an individual is a risk adversary, the "uncertainty" may cause negative utility. "Certainty" is the stuff that produces positive marginal utility and for which the individual, a risk opponent, is willing to pay a positive price. The price of insurance (first actuarial insurance) in a market mechanism is given by:

$$P = p \times L + T \quad (1)$$

where: p - the probability of the risk to occur, L - loss caused by the risk size, T - Transaction costs (administrative costs plus normal profit), P - ensuring a competitive market price.

Conditions for the optional insurance:

The probability of an insured event for an individual to be independent of the others.

This condition is necessary because the security is based on the existence, in a period of a predictable number of individuals who win and a predictable number of individuals who lose. If the probabilities would be related, when a person suffers a loss, the same will happen to all the others. This explains why, for example, inflation is not an event that could be insured.

The probability should be smaller than 1.

Otherwise, equation (1) becomes: $P = L + T > L$ (2)

and the first actuarial loss exceeds the insured. In this case, there is no possibility of spreading the risks and no private insurance company will cover such a risk. The chronic or congenital diseases for which no private insurance company o will provide insurance due to the fact that the probability of requiring treatment is almost certainly equal to one.

Insurance houses are most concerned with combating moral hazard. They combat the phenomenon of capping the consumption of medical services and by placing a financial cost to the insured at the time of consumption (medical consumption rate). Even public health systems tend to use such measures obliging the consumer to bear part of the cost. Arguments in favor of establishing the obligation for consumers to bear part of the cost when using services are: 1) awareness of the cost of those services and greater accountability to patients, 2) reducing demand, 3) attracting additional sources in the system

A number of studies on the use of tariffs on consumption have demonstrated the effectiveness of this method is much lower compared to the initial expectations created by the theoretical model. A major experiment, conducted in the U.S. showed that a tariff on the consumption of medical care leads people to give up, in the same measure, to needed services, as well as the unneeded ones.

Because people not have enough information to make rational decisions about medical supplies, it is possible for people to give up more easily to preventive or primary care services, when they have to pay a price for them.

On the other hand, the rates of consumption may be reduced, primarily, the consumption of those individuals who are sensitive affected if they have to pay the price for health care services. It was noted that the imposition of a certain tariff on consumption has a significant impact, particularly on those with low incomes.

Critics argue that using consumption rates, even if this means reducing the unnecessary demand, the individuals who bear, ultimately, the cost of such measures are the truly sick and who indeed need healthcare. The rate on health services consumption becomes a disease tax.

A health system based entirely on facultative insurance does not exist in any country precisely because of the shortcomings noted above. Even in the U.S., where private health insurance is the most developed, 37 million people under 65 years do not have health care insurance (the elderly and poor who receive coverage through two public programs: Medicare and Medicaid are not included) . For people categories that do not want to ensure in a private system, or cannot afford, or are rejected by private companies, most of the times, the state steps to ensure the access to the medical treatments.

Issues previously addressed generate inefficient allocation of resources and inequality and make impossible the operation of a private health insurance market. In such circumstances it is justified the government intervention in the form of public financing, production and organization of social insurance or in the form or private insurance regulation.

In Romania

Currently, the health system is organized on the basis of mandatory social insurance, which is the main mode of financing and is operating under the following principles:

1) free choice of health insurance house;

2) solidarity and subsidiarity in the collection and use of funds;

3) free choice of the service provider;

4) payment of the mandatory participation in health insurance

Going back to present, the current legislation (Law 95/2006) has 800 initial articles and over 1,000 subsequent amendments, so it is impossible to have a minimal coherent considering that on average each article was rewritten again. That legislation failed to address major issues related to quality, cost and accessibility of health care, despite the significant increase of financial resources which have entered into the system. All mechanisms that provided the state with multiple roles such as financier, regulator, owner, service provider, etc. have not been successful.

The new health law has as philosophy strengthening the state's role in limited areas such as control and regulation, introducing regulated competition elements leading to the possibility of increasing the patient's choice depending on the offered services. Its dissatisfaction turns directly into loss of insured people form the private homes, which does not happen in the current system. In principle, the law makes more responsible those who inefficiently spend public funds, the first penalty being the loss of income.

It is necessary to analyze the organizational characteristics and managers in the Romanian health system, this being more important given that the annual funding of the health system is about 4% of GDP, being much lower than some East European countries.

Based on the arguments (too little money allocated to health per capita, health expenditure per capita declined in last few years, from 353 euros

in 2008 to 310 Euro in 2009; for 2012 is estimated 250 euro expenses per capita) is obviously required reform in Romania, but still it is necessary to have any law to be enforced, to be political will.

Moreover, it is trying to increase the amount of contributions by growing the mass of contributors as well by participation of the state budget to pay contributions for certain categories of persons who are currently exempted from the payment. The problem is the application rate of 5.2% paid by the employer will be reported to the average gross salary and will have a great impact on the budgets of companies, whether public or private. We still have an unemployment rate quite high and I do not think that this measure would solve the problems of the healthcare fund. The effect would be the increase of the number of unemployed individuals, so indirect the burden returns to the state because the state will pay the health contributions from the unemployment budget.

The State has proposed for the next two years to restructure hospitals, the health professionals to not have budgetary status so they can negotiate their salary, to reduce the number health county houses which means also a decrease of costs in the system, which will subsequently supposed to change their status in mutual health insurance companies. It remains to be seen to what extent they will be able to meet solvency criteria stipulated by the legislation in force.

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