

Public-private partnership role in increasing the quality of the health insurance services

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Abstract. *In a context in which the social politics tend to become an optimization instrument for adapting the social security system to the market's forces, and the talk of some analysts about reinventing the European social model, the partnership between the public sector and the private one in the social domain presumes, besides a tight collaboration, a combination of advantages specific to the private sector, more competitive and efficient, with the ones from the public sector, more responsible toward the society regarding the public money spending. The existence of the private health insurances cannot be tied, causally, to a social politics failure, reason for which they don't intend, usually, to replace the public insurances, but rather, to offer a complementary alternative for them. In such a context, the public-private partnership's goal regards both increasing the insurant's satisfaction and increasing his/her access degree to services, and increasing the investments profitability made by the insurant and insurer. We are facing thus a mixed competitive system that combines the peculiarities of the public and private sectors. Interesting is the fact that, although the different meanings for the quality term may generate some problems regarding implementing quality management in the two health insurance sectors, the experts in the area reckon that establishing a good relationship between public buyers and private providers of healthcare can reduce the costs of public health programs. An essential condition for operating efficiently the partnership model is defining correctly the basic medical services packet financed by the public budget. Which doesn't exclude the possibility of administrating by the private insurers, the sums of money gathered from the employees and employers contributions to the health fund, as a recently initiated project of law intends to do in Romania.*

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I. The European social model – a premise for public-private partnership approach

The “European social model” (ESM) was initially used by Jacques Delors in the middle of the 90s (Jepsen, Pasqual, 2005), to define an alternative to the American model of market pure capitalism. The fundamental idea of ESM is that economic and social progress must go together; in other words, the economic growth should be combined with social cohesion.

Although more than a decade has passed from that moment, the term continues to be debated both in an academic and a political environment, maintaining still a vague signification.

Among the most clear official definitions of the term there is the one mentioned in the European Council Presidency’s Conclusions from Nisa from December 2000, where the descriptions of the European Social Agenda stipulates: “the European social model – particularly characterized by a system that offers a high level of social security, by the importance of the social dialogue and the general services which cover the vital activities for the social cohesion – is based, despite the multitude of State Members’ social systems, on a common value foundation” (Păuna et al., 2006).

In the specialized literature (Hay et al., 1999), ESM is mentioned in different areas, able of being identified under distinct presentations that don’t, however, exclude one another.

Thus, we find ESM presented as a model which incorporates certain common characteristics (institutions, values) that are inherent to EU members’ status and that are perceived as a way to regulate the society and the competing economy.

Another set of definitions presents ESM as being included in a variety of different national models, some of them representing good examples for the others.

Most of the authors and political deciders identify ESM, though, with an European political program whose purpose is modernizing and adapting the society to the perpetual changing of economic conditions. The essence of these changes is illustrated by the specialists through the collocation “society based on knowledge/information”. From this point of view, ESM is a phenomenon occurring at a transnational level.

ESM is also presented as a cohesion instrument among the EU member countries which doesn’t exclude though the appearance of other new European social models.

Another ESM approach (Jepsen, Pasqual, 2005) presents the idea of a productive social policy applied to different social models from Europe, to promote flexibility, partnership, to gain labor force in activity, etc. Such a concept implies the orientation of social politics rather toward encouraging the individual's capability of survival in an economy that became more and more dynamic, than using the individual's capability as a reason to take action to correct the market forces.

Rather than being a market corrector, social policy becomes through this new European speech an optimization instrument to adapt the social security system to the market forces. This new ESM approach starts from the idea of a European Political Project whose goal is building a European Identity, not through institutions and common value, but more exactly through common solutions of social politics.

In conditions in which economic pressures become more and more obvious, an adaptation – favorable to activity and innovation – to a new capitalist model is imposed on. The main idea is that solidarity was so much institutionalized that it diminishes people's desire to adapt their behavior to economic requests. Thus, passing from the passive to the active support is required, for implicating people in society's modernization process. Institutions' part is to provide instruments (the ability to attract labor force on the labor market, flexibility) that allow individuals to find ways to adapt to the changing of economical and social conditions (Păuna et al., 2006).

More and more specialists opt for changing the exact rules with different post-regulatory instruments, especially to be able to face postmodern society's variety, dynamic and complexity.

An example regarding this matter – that holds popularity – is a new way of approaching the problems of the European society, with the help of the Open Method of Coordination. It is the “soft” regulating model for coordinating politics of the labor market, of pensions and of health by the EU institutions that uses rather a flexible framework than a “compulsory rigid system”, as a manifestation of Europeanization of the industrial relationships.

Among the newest methods of approach of the ESM model is the one according to which the European speech is based on a European Society Model or, in other words, on a socio-economic model, as long as the models and reforms are linked not only to the social aspects, but also to regulation, incentives and innovation system. The authors (Aiginger, Guger, 1999) of such method of approach by socio-economic model understand the society's responsibility for the individual's wellbeing. The three characteristics – responsibility,

regulation and redistribution – reflect that the European Model is more than a social model in a strict sense.

At economy's scale, Europe is trying to combine the dynamic of market economy growth with the coordination of social dialogue between collective partners. At state's scale, the European countries are not just free democracies but also redistribution states, meaning states of prosperity that are trying to help the disadvantaged persons – that have lost the ability to work from different reasons: sickness, unemployment etc. At society's scale, besides offering individual opportunities of reaching accomplishment (happiness), European societies promote solidarity between individuals which enforces, otherwise, the social cohesion. The essence of European objectives (which denote, in many specialists' opinion, the superiority of European society itself) had been majestically highlighted by Anthony Giddens, who states that “the European social model combines the economical dynamic with the social justice” (Alber, 2004).

In the globalization terms, we cannot talk about absolute virtues of the European social model. Thus, there is a series of specialists that contest or doubt the reality of the European social model. Regardless these ones, the European social model exists under different forms, and is looking for new forms of expression.

Equally true is that, presently, in Western Europe there are many voices that doubt the possibility of maintaining national social protection systems and even governing mechanisms so costly in Europe.

Many politicians and social analysts mention even the reinventing of the European social model, “by making it flexible, but without it losing elements of social solidarity”.

2. Theoretical and methodological coordinates regarding public-private partnership

With a tradition of over 20 years in the world, the partnership between the public sector and the private sector in the social domain begins to be applied in Romania also, after the year 1989, being allowed both by the suffered changes in the governing process, and the reform in the public administration. The authentic partnership assumes, at least in theory, a close collaboration and a combination of specific advantages between the private sector (more competitive and efficient) and the public sector (with responsibilities toward the society concerning public money spending) (Lambru, Mărginean, 2004).

The development of this kind of relationship between the public and private sector is due to the consequences of three factors, namely:

- The fiscal pressure governments are being exposed to;
- The interest manifested by private organizations in the social services domain;
- Developing the idea of complementarity between the two sectors, in organizing and providing such services.

From the theoretical point of view, public-private partnership is sustained by the “public choice theory”, and its functioning is conditioned by partners’ goals compatibility, by decisions coordination and by deciding to put together resources for the realization of shared common goal.

Public-private partnership (PPP) can be applied through social contracting methods, process which assumes social services auction sale by private foreign contractors. What is of extreme importance in this process is the fact that state responsibility doesn’t disappear, and social services efficiency increases.

There are although much more reserved opinions regarding PPP virtues. Thus, even if the starting point is the premise that any company is interested in maximizing its profit and will act in this direction by providing services or products of a higher quality than one that isn’t interested in obtaining a maximum profit, this principle isn’t always applicable in the PPP case for various reasons.

The main problem of PPP is that by this type of contract the active’s ownership is not transferable. Another concept’s problem is the lack of competitiveness. De facto, what happens in most cases is monopole transfer from the state to a private entity. Companies are motivated to develop their products/services quality only when there are other companies able to take over their activity by offering a better product/service. A last PPP problem is a political one. Any state asset is managed by state clerks. As long as the PPP is owned by the state, the privatization contracts in this regime will be long term instable due to the political risks.

PPP presents a set of problems also from the competition’s point of view (Vass, 2007), more exactly regarding the selection, by the public authority, of the private partnership.

Thus PPP doesn’t represent an optimal solution, but returning to the old system, in which providing social services belongs exclusively to the state, is as much a disadvantage.

Even in the European Union the PPP problem isn’t totally clarified. For this reason, the European Commission organized a series of public

consultations, completed by the Green Card of PPP, which proffer instruments made to ensure that PPP are opened to competition in a transparent legislative environment, namely:

- Clarification of concepts and approaches through an legislative instruments (procedures of private partner selection, legislative frame for works and services concessions, contractual frame and its amendment during the partnership period);
- The interpretive communication;
- Actions of improving the coordination of national level practices or good practices exchange between state members.

According to the European Commission definition, PPP is a cooperation method between public authorities and the business environment made to ensure that infrastructure projects can be realized or that services fruitful to the public can be offered. These forms of partnership can be realized in different areas of the public sector, such as: transportation, health care, education, social security, waste management, water distribution etc.

The types of PPP regulated on European level started from specific approaches on national level and they regard:

- Contractual PPP, realized exclusively based on contractual relationships;
- Institutional PPP, which assumes common participation of public and private partnership in a juridical entity with mixed capital.

The principles to be applied in all forms of public-private partnership in EU concern: transparency, equal treatment, adequacy and mutual acknowledgement.

For the PPP created for contracts qualified to be public contracts there are applied the directives which coordinate offer procedures of public contracts. Work concession is covered only by a few articles lost in the secondary legislation, because the directives concerning public contracts don't cover this area at all.

In any case, the contractual dispositions must be in accordance to relevant community rules, to the equal treatment and transparency principles, in particular. Art. 26 of the 2004/18/EC Directive gives the possibility to the contracting authorities to establish specific conditions concerning contract fulfilling, but these conditions must be compatible with community rights and be indicated in the publicity phase preceding the auction. These conditions may contain, especially, social or environmental considerations.

The European Commission highlights the optimal distribution of risks between public and private partnership, a fact considered crucial for the PPP project success.

Also, periodical performance evaluation mechanisms of the owner of PPP contract are important. In this context, the transparency principle requires that risk evaluation and distribution factors, along with performance evaluation, to be communicated through the project's descriptive documents, in the publicity phase preceding the auction.

Regarding the works and services duration period, this must be established according to the project's economical and financial stability guaranteeing need. The duration of partnership relation must be established in such a manner as not to limit the free competition more than is necessary to guarantee the regain of investment and a reasonable profit. An excessive period may break the principles governing the internal market or the CE Treaty article concerning competition.

Due to the fact that activities forming the PPP subject matter are running on a relatively long period of time, the relations in PPP must be able to evolve according to the macro-economic or technologic environment changes, as to the requirements of general interest. As much as they are compatible to the equal treatment and transparency principles, automatic adjustment clauses of the contractual conditions are permissible.

Generally, changes brought to the project's conditions of realization, during its course, which are not included in the contractual documents, influences the equal treatment principle between economic agents. Also, the community rights forbid changes made during the contract's editing, after the final selection of the private partner. Thus, these changes are acceptable only if they become necessary following some unforeseen events, or are justified by public political criteria, social security or public health.

For the institutional PPP case, direct cooperation between public and private partnership, in a juridical entity, allows the first one, thanks to its presence in the shareholding and decision making forums, to maintain a relatively high level of control on the project's realization, and to adapt it during its course, according to the circumstances. More, by cooperating with its private partner, the public partner may gain managerial and technical experience in regard to providing the respective service.

An institutional PPP may be applied, either by creating an entity commonly controlled by the public and private partner, or by the private partner's taking over control over the existent public enterprise.

The European Commission states that rules regarding public acquisitions and concessions contracts are not applied to the transactions by which it is created a public-private mixed entity. But, in case that this transaction is associated with assigning some tasks to the respective entity, an assignment that may be qualified as a public acquisitions or concession contract, it is necessary to be realized by the rules and principles mentioned in the CE Treaty and in the applicable directives.

Under such circumstances, the private partner selection, called to perform the above-mentioned tasks as part of the mixed entity, cannot be based solely on the quality of its capital contribution or on its experience, but it is necessary to acknowledge the economical advantages of its offer, from the perspective of the services that are to be provided.

Creating this mixed public-private entities must, according to the European Commission and the European Court of Justice Jurisprudence, respect the principle of non-discrimination based on nationality criteria, in general, and free capital circulation, in particular. Thus, public authorities cannot condition their participation as a shareholder in such entities by the existence of excessive principles in their favour, that doesn't drift from a normal application of trade companies' right.

If the foundation of institutional PPP is realized by changing the shareholding structure of a public entity, it must be specified that taking the enterprise from the public sector into the private sector represents an economical and political decision, over which state members have exclusive competence.

Also, it must be specified that public acquisitions community right isn't applicable, per se, to the transactions involving an investor's simple capital infusions in a company, either public or private. These transactions are governed by the CE Treaty legislation regarding free capital circulation, according to which the national measures taken must not constitute barriers to investments from other state members.

On the other hand, the Treaty's legislation concerning free establishment must be applied when a public authority decides to cease to a third party, through a capital transaction, a determined influence over a public entity providing economic services that, usually, are the state's responsibility.

3. Health insurance – from the market to the state and back to the market

Health care is not just a personal problem, aiming to reduce the discomfort, to prevent the loss of work capacity or to avoid the premature deaths. In turn, the society is interested in preserving the health status as a

support for prolonging the duration of the active life and increasing the social and economic efficiency, reason for which the increase in the citizens' life expectancy, along with the increase of labor productivity are reference points to any national strategy in the area.

Health care services and health insurances benefit of an increased interest, not only because they cover a distinct category of risks, but also because the involved sector consumes an appreciable amount of resources. A demographic reality marked by the process of population aging, based on the technological development in the domain, makes the demand of health services to present an accentuated dynamic.

The health system forms a particular type of market, whose specific characteristic differentiates it from other markets (Dragomirișteanu et al., 2003).

Health services market is far from being a perfect one. There are several reasons that lead to the considerable standstill of this market, therefore requiring government intervention. These can be structured on three dimensions, respectively: market failures, positive externalities, and medical care costs.

Market failure can be analyzed both from the demand perspective and from the perspective of health care services' offer. Most of the times, the demand of services is characterized by the consumer's ignorance. For instance, this information deficiency may be compensated by mandatory description of the prescribed medicines. Moreover, the uncertainty of the medical care moment of need and of its cost is reduced by social insurances systems that allow the access to services and financially protect the client.

Also, in the structure of the offer show up a series of distorts that may lead to the market failure, particularly with regard to the staff's competence, the used medical equipment and the monopole in the health services network.

The positive externalities refer to the potential effects of the health services on other persons than those whom they are meant for, the government intervention being of nature to expand the positive effects the individualized assistance might have. Starting from the individual evaluation of the costs and benefits in the health care services and from the effect of such services on the community, the government finances – for instance – services to promote the preventive medical assistance at the level of the entire society.

The cost of the medical care is another reason supporting the necessity for government intervention on the medical services market. If the natural option is to minimize the individual costs or, in any case, to fit into a quantum dependent on the incomes that may be allowed to this purpose, the medical system

functionality is dependent on securing a certain level of the funds allowed to this segment of activity.

In other words, the fundamental landmark on the system viability is not the total cost of the care services but the GDP percentage that is allotted to the health care system.

The increase of the salaries for the staff in the medical system, the appearance of some much more performing but more expensive equipments, procedures or medicines, raise other issues on funding the healthcare system, based exclusively on the market mechanisms. Not to mention also the influence produced by maintaining a quasi state monopole in the sanitary units network.

All these elements led to the occurrence of the mechanism based on the intervention of the third paying party who becomes the purchaser of the medical services. The principles of the solidarity are applied and, depending on the situation, of the mutuality, the individual contributions being, periodically, paid to the third party, regardless of using or not the medical services, and the services payment is done by the third party from the collected funds.

The funding by public compulsory insurance is usually imposed by law, who sets the quantum and the periodicity of the contributions, the categories of taxpayers and the margin of the medical services beneficiaries.

Applying the social solidarity principle leads to a quasi-complete covering of the population but, in the same time, induces some distorts in the contribution-benefits ratio by the fact that dimensioning the contributions is usually related to the level of the individual incomes and not to the participants' personal risk.

The advantages of the social health insurances mainly regard the following aspects:

- Increasing the system decentralization;
- Exclusively directing the accumulated funds to the expenses in the sanitary area;
- The possibility for the insurance institutions to impose quality standards for the medical activities;
- Defining, both quantitatively and qualitatively, the packages of services to be delivered to the taxpayers;
- The diversity of the medical services suppliers;
- Configuring some managerial structures closer to the private sector;
- Transparency of the financial flows dedicated to the sanitary system.

Public insurance limits and disadvantages lead to reconsidering the contribution of the private insurance. They are:

- The unbalanced ratio between the insured persons and the taxpayers, the funding of the medical services for pupils, students, unemployed and retired persons being supported by the occupied population;
- The perception of the contributions as a taxation increase (*tax on labour*) that encourages the “black labour”;
- The reduced degree of freelancers’ enrolment in the system.

The existence of the private health insurances cannot be causally tied to a failure of the social policies, reason for which they usually do not intend to replace the public insurances but rather to provide a complementary option to them.

Besides, basic medical care coverage is an exception, available only in countries where they are not provided by the public system, or as a substitute (Colombo, Tapay, 2004). In some health care systems, the private insurances increase the patients’ opportunities of access to the services delivered by hospitals, but in most of the situations they provide a possible additional source of coverage for the medical care costs.

Despite the fact it is based on a contributory system, the voluntary insurance resembles more with the system of direct payment of services by the patients, through its high transparency, a better justification of the ways to spend the funds, doubled by a higher responsibility with regard to practicing the medical act.

A simple review of the main categories of private insurances allows us to state that one of their main roles is to cover the deficit between the market demands and the public system possibilities.

In such a context, a discrepancy between desirability and feasibility can be highlighted, expressed by the public system insufficiently protecting the population through services proper for their wishes.

The demand’s characteristics and the preferences of medical services consumers, as well as the employers’ contribution to cover the costs of health insurances are, also, representative factors of profile market dimensioning.

The increase in performance, expected by the participation of the private sector to the health systems may be evaluated based on several criteria, but the distribution of the performance within the applicants for services raise, additionally, several issues aiming the equity of the health care process, starting with the reality that the private insurances are not available to all segments of

population, especially for those presenting a high risk of sickness, and, in the absence of some governmental interventions, the rights of certain categories of patients may not be put into practice.

Nevertheless, increasing the possibilities of option represent an undisputable fact and, last but not least, reducing waiting periods of time, as a result of services volume increase and the development of diagnose and treatment ability, may be appreciated as a global system performance factor, generated by the contribution of the private sector.

4. The quality of the health insurance services – a common problem of the public and private sectors

For healthcare insurance services, defining the concept of quality itself, can represent a problem, especially because, although part of the public services area, insuring health differs very much from other services alike due to the following characteristics:

- The unlimited demand of services, in conditions of limited financial resources;
- The sensitivity of health services users (clients), with a limited influence over quality;
- The presence off very well skilled specialists;
- The large influence over life quality;
- Satisfying complex needs: users' (patients) expectations and requests, contributors' (insurance companies, public financial resources) requests (Puksic, Goricanec, 2005).

If the 8402 ISO standard defined the quality as being the assembly of properties and characteristics of a product or service that confers to it the ability to satisfy explicit or implicit needs, today it manifests tendencies of enlarging the sense of quality, in a way that it doesn't only mean satisfying the clients but also the general interest.

The situation reached a point where the 9004 ISO standard considered the state should be involved in quality, because through it freedom is promoted, gives a meaning to responsibility, being in the same time an edification factor for society and civilization.

Although quality theory was applied entirely to health insurance services, there are to be noticed a series of peculiarities that drift from the specificity of medical care services.

Thus, the three periods of time of a service's lifetime namely providing, selling and using it, by manifesting simultaneously and in the presence of the provider, determines a direct link between him and the client, the latter being able to immediately analyze the quality.

A large importance has the established relations between services providers and their clients, on a long term, a fact that makes possible the appearance of characteristics like: gentleness, courtesy, honesty and respect.

Services' quality depends also on clients' behavior. As preferences can or cannot be shared, there must be the possibility of offering a series of services to satisfy them all. Assistance must be provided in case the client is ignored, supplementary information must be bestowed, advice, and so on.

As services are unable to be stored up, punctuality and promptitude in providing the service represent their qualitative characteristics, because the client doesn't wish to lose a lot of time.

These characteristics depend also on the sanitary services provider's ability to manage large varieties of request, a fact that commands an adequate design of the clients' receiving points. Thus, as characteristics there can be identified the access time, the waiting time, and the servicing time.

The intangibility of services generates a more rapid services blotting, in the beneficiary's mind remaining only certain aspects. The overall impression is the dominating one. In making an overall impression on a client over the quality of the provided medical service, there is series of factors competing such as:

- The quality of the medical act, determined by the medical personnel's professional preparation and specialization, but also by the endowment of the sanitary unit with high performance equipment;
- The quality of hotel conditions offered by the sanitary unit (food, cleaning).

In this context, the quality of the health insurance services was defined as the total satisfaction of necessities of those that need the most these services, at the lowest cost for the organization, in the limits and directives established by the hierarchically superior authorities and by the buyers (Ovretveit, 1992).

A definition that highlights the main three dimensions of the concept, these being:

- Patient/client quality;
- Professional quality (of the specialists);
- Management quality.

These three quality dimensions are determined by the three groups of interest involved in the health insurance system: the users, the professionals

(the service providers) and management. A through cooperation between these groups represents another fundamental aspect for the success of improving the health insurance services quality (Harvey, Green, 1993).

Different acceptations for the discussed notion may generate problems regarding implementing quality management in the two sectors of health insurance, public and private. We mention that, in ex-communist countries but not only, private health insurance services represent a relatively new component of activity in this domain and can contribute significantly in developing and growing the mentioned activity, exercising – in the same time – an important influence on using the resources and thus, on cost optimization.

Cost control and the impact on environment represent significant aspects regarding the differences and competitiveness between the two sectors, private and public. Capitalizing on the two types of experience and permanent education, allow forming some competitive advantages in both spheres of activity and obtaining some considerable better results than the past ones.

The biggest problem of the public-private partnership in health insurance area remains establishing business relationships between private providers and public buyers. The two parties' methods of approach are, thus, completely different.

The public sector intends to offer health services equal for the entire population, according to the accepted standards (financial and quality) and constitutional or legal rights. The main goal is a just distribution of a public good (health care).

The quality of the health insurance services regards a much larger complex of aspects of the public-private partnership, such as – for example – the ones referring to the manipulation and confidentiality of information.

The confidentiality of the medical act seems to preoccupy people more than other aspects of their private life. Health problems and medical information have a personal character, some of these being considered very sensitive by the ones involved, due to some negative social connotations.

The medical profession has a long tradition regarding the preoccupation to protect the patient's intimacy but, in our era, although the general principles that regard respecting the private life and confidentiality is further applied, the separating line between public and private becomes more and more unclear.

Thus, health insurance companies request the proof of effectuated treatments before realizing the payment, and the integrated systems' benefits of medical information electronic processing are compensated by the risks of interfering in the patients' private life, because the stored information might be

subject to other uses. In addition, medical records contain a detailed history of previous medical analyses and procedures, in the idea of making easier some positive results for future consultations (Marshall, Miller, 2005).

Another connective component of the healthcare insurance services quality problematic is the impact of the environmental factors. Besides, the use of innovating components for increasing the quality and techniques of environment's management for permanently improving the procedures, products or services provided to the clients, allows their beneficiaries a level of satisfaction as high as possible.

Creating, maintaining and improving the quality's and environment's management system, looked upon as an instrument of rational functioning, serves both at systemizing the efforts of increasing the efficiency, and at comparing the two sectors, public and private.

With the quality and environment management systems and using the informational support of economic activity, the following main activities can be done:

- Insuring and permanently improving the health services quality levels;
- Ensuring a constant growth of population's satisfaction, in its entirety, regarding providing health services;
- Optimizing the economical aspect of the health insurance activity (Kralj, Stamenković, 2006).

Not lastly, we will note the fact that one of the virtues of the public-private partnership is in the dissemination speed of the technical progress results and innovation in the health services matter, with evident benefits for the final consumer.

To the new industrial strategies, marketing strategies are superimposed, which regard both practitioners and patients. These strategies must be oriented toward information, training and publicity. Keeping in mind the competition pressure and the tendency of shortening the cycle of life of the products on the medicine market and the therapeutic techniques, a new product's success depends more and more on the business' capacity to quickly launch it on the market (Ristea et al., 2011).

5. The basic health services package – condition for achieving public-private partnership

The constraints on the resources impose a limitation – explicit or implicit – of the available medical services. In the same time, setting some limits for the given benefices in the health sector is of nature to affect the systems of

individual and social values, as well as some sectors and responsibilities of professional rank.

Consequently, it seems natural to us the preoccupation to try to identify which of the medical benefits are essential for the population and for each individual apart, and starting from such analyses, to define the basic health services package that the public service can provide.

In the states with a national health service or with a more comprehensive system of social health insurances and where – especially for political reasons – it is preferred not to define a limited package of basic services, we have to deal with the so-called passive approach, that generated long waiting lists, the decision of rationalising being left to the doctor. Characteristic for the countries in the Central and East-European areas is the frequent use of the unofficial payments as a method of priority access to health services.

The implicit rationalising was for a long period of time concealed by the medical decision and maintained as such by the lack of knowledge in the field of a large category of population. Nevertheless, the level of sanitary education and of public involvement grew during the last years, as well as the resistance of the health sector experts to assume obligations in the process of rationalising the medical services. Consequently, it appeared the need for an explicit definition of the benefices delivered by the health system, even if they do not always respond to the requirements of efficiency and equity.

In this acceptance, the basic package becomes a tool through which the population's wishes and needs are channelled through certain patterns of medical services and, lately, it reflects the citizens' priorities in relation with the types and the level of the services they expect from the health care system.

Even if all society members must have access to the entire spectre of the health services, in terms of quality and regardless of their payment capacity, as a result of the objective limitation of the funding resources of the system, a decision needs to be taken on the sustainable offer of services, concretised in the contents of the basic package.

Usually, defining it is the government's responsibility and such an approach is to be preferred, as in the decision-making) process, there are several aspects to be considered, connected to the ethics, the legality, and the quality of the services, economic and political considerations.

In the same time, considering that it is difficult to reach a consensus in the political process of defining the basic package, it is to be preferred a wider participation of all involved factors: doctors and other experts, citizens,

government, authorities from the public health sector, insurers, medical companies.

There are two approaches used for defining the basic services package, respectively the implicit method and the explicit one. Both methods have advantages and disadvantages. An explicitly defined package may generate several controversies and debates on the services comprised within. A too vague (implicit) approach will allow for subjective interpretations, which may cause significant differences between the offered benefits, selections with high social risk, the rise of the coverage costs and, in some situations, a doubtful quality of the services.

The most important factors that ultimately establish the contents of the basic benefits package concern the level of available financial resources and the number of eligible persons for covering the medical services (the covered target population). In terms of a preset budget, the lower the number of persons included in the system is, the more comprehensive the basic package becomes and vice versa.

The international experience in the field consecrated several methods, techniques and approaches out of which we are going to mention:

- Clear definition of the criteria for including or excluding the categories of eligible persons for services coverage provided by the basic package;
- Identifying a priority list of included products and services (the positive list);
- Identifying a list of excluded products and services (the negative list);
- Designing a model of implicit allowance of the resources on efficiency and efficacy criteria (implicit rationalising);
- Using some financial constraints imposed to the patients (co-payments, contributions et al.).

The criteria used for setting the priorities within the basic package concern: medical necessities, efficacy, efficiency and one's responsibility or, otherwise said, the cost, the quality and the ethical criterion.

As long as the content of the basic package is tightly related to the costs level and to the available resources, an iterative approach of the definition process is necessary. A first stage consists of setting a technical frame, meant to provide the general parameters of the benefits list, which will afterwards be submitted to public debate in order to get a wider consensus.

There are two levels of generality by which the basic services package can be defined: a higher level one, where the legislation sets the essential coordinates,

and a lower level one, where the package of benefices is defined by explicit lists of services or by systems of grouping the services depending on the funding methods. The explicit lists contain recommendations, but also inclusions or/and explicit exclusions of services. The level of detailing, the configuration of the lists and the ways of extending it varies from one country to another. It is preferable that the review of the basic services package to be made on a yearly basis, as much as possible.

The practice of exclusion varies from issuing some negative lists to establishing a national framework in this regard. Most of the countries exclude services such as aesthetic surgery, certain unusual vaccines (such as those for travelling abroad) and the non-conventional treatments (like acupuncture).

With regard to the services delivered to the hospitalised patients, it is noticed a transit from the global budgets and per day payments to the explicit positive lists or to those indirectly determined by the systems of services grouping depending on the funding. Such systems are tools of estimation on the resources consume and, in the same time, they provide the basis of remuneration of the intra-hospital services. Generally, the classification of the care period is accomplished depending on the diagnosis of the most important disease, of the associated sicknesses and of the basic surgical intervention to which it is associated a more or less homogenous consume of resources (medicines, diagnosing procedures etc). Expressing it in monetary units, on funding groups (public, co-payments, and insurances) allows establishing the level of reimbursement of the expenses to the hospital.

With regard to services provided to the non-hospitalised patients, there are used explicit positive lists, as well as the grouping systems for expenses reimbursement such as, for instance, the calculation on every sick person (per capita). Usually, the explicit benefices lists are used for direct per service payments. If doctor receive fix budgets or per capita payment, the services package is indirectly restricted to the allotted sum of money, reason for which the services package regulates also the doctor's obligation to provide those services considered to be necessary medically speaking. The specialty services, those of laboratory and the x-rays are paid in the per service system of payment, according to a detailed list of procedures, that can be assimilated to a positive explicit list, as the expenses reimbursement concerns only the procedures included in these lists. If there are established detailed lists in some countries, with all of the procedures, in others there are inserted only the complex services, leaving the setting of priorities to the doctor's choice.

Beyond the technical and methodological issues, defining the basic package is essential because it is either the boundary between the two partners in the expenses of medical services (for complementary and supplementary insurance), or the configuration support for the private substitutive insurance offer.

6. Evolution and tendencies on the Romanian market of health insurances

In Romania, the abandon of the Semaško system, practiced in the communist era and based on universal coverage, state financing, central planning and free access to health services was realized late enough.

No sooner than 1998 had a new law of social health insurances been applied that followed the Bismarck insurance model, with mandatory health insurances and was based on the solidarity principle. As a consequence, the financial resources of the health system have been modified, by significantly reducing the state budget and introducing a sole national fund for social health insurances. Today, the health budget has two sources of income: the state budget and the health insurance fund, the latter representing more than three quarters of the total.

The structural changes in financing and organizing the health services have registered slow rhythms, a fact that concluded in a chronically sub financed state and in a low efficiency system. Regardless of some worthy attempts, for a long time it was noticed the absence of an integrated national strategy for health insurance as a political engagement of the state's authorities, the modifying of real priorities remaining under the influence of economic recession and social tensions.

In 2004, Romania's government issued a decision for approving the national strategy regarding health services and the plan of action for the health sector's reform. On a long term, the strategy's desired effect was improving population's health state and, by this, the life quality. The national strategy's goal regarding health services is to increase population's access to medical-sanitary services of quality and making more efficient the way of providing the hospital's medical-sanitary services.

The most recent legislative approach on the subject is dated from the beginning of the first half of the year 2006 when the Law regarding health reform was adopted, actually a legislative package comprising institutional aspects, systems of organizing and financing, management methods and

models, as well as other technical coordinates that are to sustain the sanitary system reform.

Basically, the discussed law doesn't bring significant changes in administrating and conducting the social health insurance system, these being realized further by the National Institution of Health Insurances – a public institution, autonomous, of national interest, with judicial personality, having as a main activity goal ensuring the unitary functioning and coordinates of the social health insurance system in Romania and which subordinates districts' health insurance institutions and the Health Insurance Institution of Bucharest.

The centralized system inertness, inherited from the communist era, still generates many deficiencies, which the public system cannot overcome unless with the help of the concurrency practices imposed by the co-existence of a private system. In regard, we are looking at the following aspects:

- The infrastructure of the sanitary system is old, dimensioned incorrectly, without respecting the market needs;
- Technology and top equipment acquisition criteria are too less based on economic principles, the political factor having an unjustified influence in this regard;
- Human resources allocation is inefficient, the resources being distributed by national normative;
- Human resources management is also deficient, the number of liberty degrees being reduced enough;
- The discontent of the medical-sanitary personnel, paid insufficiently, has become chronic, parallel with the appearance of the corruption phenomenon;
- The system is rigid, immobile, adaptable with difficulty and sometimes even inadaptable to the patient's needs, thus it is incapable of answering the market's requests;
- The exaggerated centralization is doubled by the management's incapacity in exercising control and by the evaluations, which should be followed by correction measures and adapted to new standards;
- Administrative enforcement of rigid norms and standards, established at a national level, led to an inefficient mixture of abundance and waste in some regions and to chronic scarcity in others;
- The impossibility of cost control led to imposing some unrealistic costs, the small costs of some services compensating for others, that have become artificially profitable;

- Excessive taking of medication, influenced by the fact that the majority of the deciders have exclusively medical preparation, reduced a lot the chances of between sectors approaches, but also the capacity of anticipating population's needs;
- Reduced transparency when using funds is favored by a deficient informational flux, heavy and late enough, as well as by the absence of quality control systems, by specific evaluation standards and procedures.

Private health insurances have developed pretty timidly, in conditions in which the medical services providers' network was prevalingly of state, and the legal regulation framework was not facilitating the connection of the two systems.

The first legislative initiative in the domain was materialized only in 2004, through the appearance of the private health insurances Law. Regarding the comprehension the law was permissive, referring both to complementary or supplementary insurances, and the substitutive ones.

Sadly, the above mentioned law covered a series of debatable or even inoperative regulations, reason for which it could not be applied.

Two years later, the private health insurance problematic was resumed through a more ample legislative project that offers a separated title to the domain. The ruler preferred, this time, the use of the voluntary health insurance slogan, reason for which they were defined in the law as facultative insurances, compared to the Law's provisions regarding insurances and reinsurances in Romania.

Instead, out of the voluntary health insurances, the substitutive ones were excluded, the main reason being the insufficient financing of the public system, to this being added the difficulties that would have appeared in the discounting process between the budget of the health insurance institutes and the private insurers.

Under these circumstances and in terms of a deficient and imprecise definition of the basic medical services package discounted by the public system, the volume of the private health insurances registered average values compared to their potential and with the system's financial needs (less than 10 million Euros, respectively less than 0.5% of the subscribed brute primes).

Very recently, a project of law is offering to regulate a new health insurance system functioning method through private insurance institutions (actually, insurance companies authorized by the competent authority).

According to the above mentioned project, companies and employees will be further paying contributions to the National Agency of Fiscal Administration, the money being transferred afterwards through the National Institute of Health Insurance to the health insurers, pro rata with the number of registered insured people. The services required by the sick persons will be discounted by the insurers on account of the contracts signed with the medical services providers.

The project of law encloses also a first definition of the basic services package, which remains to be detailed and on account of which voluntary health insurances will be able to develop.

For family doctors the main change is represented by the possibility of signing contracts with the private institutions, while the hospitals could be transformed in foundations or commercial companies. The income and spending budget will have to be published on their own website or on the website of the supervising authority.

Although the project still presents some unclearness and controversial elements, it is appreciated that it will lead to the most profound reform in health insurance domain in Romania and perhaps one of the most radical in the entire Europe.

7. Conclusions

Even though the debates regarding the European social model are far from being concluded, it is a certainty that in order to be able to face the variety, dynamic and complexity of the postmodern society a new method of approach is needed, more pragmatic, with the main goal to modernize and adapt the social policies to the permanent changes of economic conditions.

Considering the increasing fiscal pressure the governments are being subjected to, the interest manifested by the private organizations in the social services domain is obvious and justified, considering the two sectors are complementary one to the other, in organizing and providing such services.

An analysis to the evolution of health insurance services proves that they oscillated between state and market, and in the end they settled in the concept of public-private partnership, a model in which state's responsibility does not disappear, and the efficiency of social services is increasing.

Of course the public-private partnership does not represent an ideal solution and not even an optimal one in all cases considered, but the recurrence

to the old system, where providing social services is exclusively to the state, is a lot more costing.

Interesting is the fact that exactly the characteristics of the health insurance services – especially the unlimited request of services, with limited financial resources, suggests a combining of virtues of the two sectors to satisfy complex needs that include both the expectations and users' requests, and the domain's contributors and providers requests.

The most accepted definition in the area reveals that the three quality dimensions are determined by the three groups of interest implicated in the health insurance system: users, professionals (services providers) and management, and the complete cooperation between these groups represents a fundamental aspect for the success of improving service quality.

The positioning and percentage of the private sector differs from one country to another, depending on a multitude of factors.

Starting from the Romanian example, it can be appreciated that a sub-dimensioning of its implication is made to prejudice the system from a significant volume of resources. Meanwhile, realizing an authentic partnership is conditioned by the clarification of each sector's implication, reason for which a correct definition of the basic medical services package constitutes an essential condition of the discussed relation.

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