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PATTERNS OF DELIVERY, FINANCING AND CONTROL FOR HEALTH SYSTEMS[1]

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Abstract: *In this article, I analyse different types of health systems, in terms of funding, control, supply schemes and level of social redistribution. I show that the state plays a central role in determining the coverage and the nature of benefits, choices of financing the health systemand the structure of servicesin every European health system. Two major types are ideal in terms of funding, supply and control in Europe: Health insurance system (German type) and The National Health System (British type). A private insurance system is met in The USA. Private insurance does not play an important role in European Union countries, as in The USA or Australia. The governments of UE countries act according to the principles of state-funded health care or social security available to all citizens. This model leads to health systems characterized by almost full covering.*

Keywords: *health services, systems, patterns, European Union, financing, supply of health care*

Introduction

In its current form, health care is part of the welfare state, as aresult of a historical process which has begun in the late nineteenth century and has developed in various different stages over a period of more than a century (Zamfir, 1995; Cace, 2004). Therefore, welfare stateis a cornerstone of structuring European public health systems and way of supply and funding in health systems are based on howwelfare states function.

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Provision of benefits in the welfare state is based on the concept of social citizenship, solidarity and redistribution. The main mechanism of operation is the collection of taxes and insurance premiums based on primary incomes. Differences between the mechanisms adopted by various countries appear based on historical, national values, the power of social class, trade unions and so on. Some common structural elements are found in all European welfare states: social security (pension, unemployment benefit), social welfare, maternal support and public education, health services. Changes in the level of expenditures in welfare states are to be determined by economic factors, political institutions, in power political parties' doctrine.

Among social functions of the welfare state, according to Zamfir, are the following ones (Zamfir, 1995):

- The function to coagulate the structures of national states and to promote national cohesion. The state's ability to collect taxes is of great importance, from this point of view.The state offers welfare to the citizens, through systems of social insurance and universal public services as health care and education, strengthening citizen's motivation to pay taxes.
- The function to relax social tensions caused by capitalism. Capitalist society brings social problems: poverty, the risk of unmployment. There are required balancing mechanisms of capital/labour ratio and reducing the social pressure, in order to prevent to be expressed in social movements in the future.The state also offers services of health care and education, in order to accomplish this function.
- The function of ensuring satisfaction of collective needs and absorbing social risks. Setting up a system of individual and collective risk absorption and redistribution of resources underlies the philosophy of the welfare state. Vertical redistribution is designed to reduce material inequalities, in order to secure equal access to services (education, health, social protection). Horizontal redistribution is designed to offset market failure situations and social risks of the modern world.(Zamfir, 1995). Most European states assure mechanisms of reducings disparities in accesing health care between the rich and the poor, the healthy and the ill, the young and the earderly.

In the bottom article, I try to analyse different types of health systems, in terms of funding schemes, control and supply schemes and the level of social redistribution. The obstacles encountered in this approach may be related, as James F. draws attention (Jameset al., 2011), to measuring health services provided to patients in different systems. This can be difficult when patients see providers across multiple health systems (public/private) and all visits are rarely captured in a single data source covering all systems where patients receive care. "*Combining data across systems and comparing utilization patterns across health systems creates complications for both aggregation and accuracy because data-generating processes tend to vary across systems.* " (Jameset al., 2011: 239). The further analyses will take into account these limits.

On the other hand, we can ask ourselves, why typologies for welfare states and health care systems.As Cace S. shows: *"It is the classical solution, the Weberian one, in most institutional analysis, analyzing of typologies. Typological analysis is a way to group characteristics that usually occur together or, is moving logicallytoward one another in groups that are granted with some*

status teoretic. These groups - ideal types - can be used either as dependent variables (types whose apparition and logic are not neccesssary to be explained) or as independent variables (types that cause societal effects in some areas). (…) Weber's method is based on some historical analysis and a lot of "logical intuition". The welfare state theory, typological analysisbecame theory of the welfare regime. It begins with the distinction made by R. Titmuss between universal welfare states, rezidual onesand industrial in achieving performance"(Cace, 2004: 86)

Comparing health systems in terms of funding, supply and control

As Crieson shows, currently, in any European health system, the state plays a central role in determining the coverage and the nature of benefits, choices of financing the health system, including the type of charging, allocation and distribution of resources and the structure and organization of services.In Europe, two major types are ideal in terms of funding, supply and control: Health insurance system and The National Health System. One of the major ways to differentiatethem is following three criteria: financing, service delivery/supply and control.

The systems are often described on basis of generatingfundes, rather then on basison how resources are allocated. These include direct or indirect, national or local taxation, national health insurance, private insurance, co-payments. In practice, the systems of most countries operate through a mix of funding, including various items of charge.Basics of funding schemes are on a continuum, on one end there are systems dominated by state, as the UK system, predominantly funded through general taxation and at the other end of the continuum there are market dominated systems, based on private insurance, the typical one being US system.This type of dividing can be misleading, in the sense that the state's role in both types of systems remains, but it behaves differently.(Crieson I., 2010)

Tabel 1: Funding, service delivery/supply and control

Ideal type	Funding	Service delivery/ supply	Control	Systems
National Health System	Direct (income taxes), indirect forms of public tax (through consume, for instance)	Public supplyers	Top down Control and command achieved by state through birocracy	Great Britain, Sweden, Finland Italy (since 1978) Spain (since 1986)
Health insurancesys tem	Public contributions based on income	Public and private supplyers	Corporatist model of negociation between supplyers and buyers	France, Germany Austria, Begium Netherlands

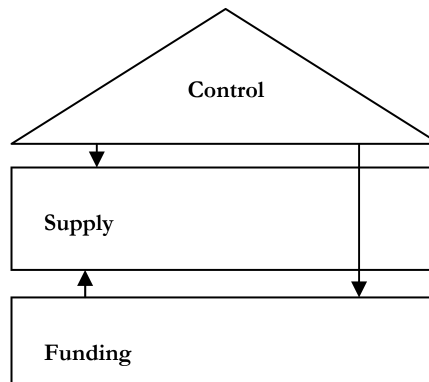
Source: apud Crieson I., 2010

Different types of services can be found on a continuum from total public to private, and the state's role extends far beyond the role of finance, more or less involved in the provision of health services in EU states.

Most OECD countries have a large proportion of expenditures in hospital area, with in-patients. Preference for hospital care, based on admissions is a constant in all developed countries. This model was one of the reasons why environmental and social factors that influence health were not properly considered.This led to lower costs with prevention programs, public health; out-patient services and home services for patients have been neglected in comparison with hospitals funding.

Generally speaking, insurance-based systems offer the choice of electing hospital or doctor while national systems based on charging use general practitioner as "guardian of the gates" filter, limiting choices. But you cannot say that limiting election is specific for the national systems. For example, in the 90s, Sweden (a national system based on taxation) left the choice of electing any doctor and institution, while the Netherlands, for example, had limited options.

Graphic 1: *Comparing health systems in terms of funding, supply and control*



Source: Crieson I., 2010

Management of relationships that exist between organizational actors in the system is a second level of analysis. There are several models. A firstform is binding rules through a strong top down control of the state. A second form is incentives for competition in a market for health or building organizational networks that become mutually dependent on each other.

The history of state's regulation begins in the late 19th, when regulatory agencies were created for factory workers, public health, fire safety etc. State regulation developed

after the Second World War, when it was extended to consumer rights, environmental protection, rights against discrimination, urban planning, and so on.There are several explanations for widespread use of regulations in healthcare systems: well established obiectivesthat cannot be kept out of reach of local managers, who would have the authority to impose;the need for networking. As the health systems are large organizations with complex bureaucratic structures, it is necessary for them to work in a network. (Crieson, 2010)

There are a variety of forms of regulation in Europe, reflecting the different relationships between financial bodies, providers of services and those who use the services. In many countries, in the center of triangulation is the medical profession, represented by associations, profesionalunions. In Great Britain, after the war, for example, medical professionals were a strong class which has laid down determination of needs, funding priorities in the system. The need for care was traditionally controlled by the medical specialists. In the last two decades, this power was subject to constraints, because there were new local and national regulatory powers. There is a convergence of systems and one of the common points is public contract.

Comparing systems in terms of financing

In all EU countries, governments are involved in financing of care and many Member States use a combined system between social security and taxation, through income taxes and direct government funding of health. The role of optional private insurance differ greatly from country to country, but generally they are a supplement, rather than a substitute for primary health system. (Mosialles et al., 2002; Vlădescu, 2001)

Financing for health care can be made in six basic ways:

- Financing through taxation (in the case of National Systems);
- Mandatory Social Insurance;
- Private individual insurance (most often optional);
- Private insurance related to work groups (Houses of professional associations);
- State funding (usually of specific Health Programms: Public Health);
- Payment out of pocket.

Health systems are great resource consuming in the last 30-40 years and there was a continuous increase in the level of resources needed, mainly due to increase in aging population, more efficient drug discovery and advanced but expensive technologies, increasing number of beneficiaries, receiving medical assistance.

Theoretically, financial support can be improved through a number of measures: limiting access to services, reducing services' quality or increasing the share of private funding (which in turn has consequences related to limiting access to services). But none of them is desirable from social point of view.From the perspective of social protection, the best way of improving financial support is to increase health system

efficiency. Efficiency here refers to lowering costs, while maintaining the same levels of quantity and quality, achieved by preventing over-consumption of health services and allocating sufficient resources for programs of prevention and health maintenance, in order to reduce any potential future expenses. Comparison made between different international experiences on the expenditure/results may costitute a useful guide on efficiency.(Mosialles et al., 2002; Vlădescu, 2001)

In a simplified presentation, the defining elements of financing health systemsare: a) parts between which funds are transferred (which usually are: government, health insurance funds, medical units, beneficiaries) and b)payment mechanism (the most used are: payment service, the payment per capita and wages). In payment flowing, the relationship between the providers and beneficiaries of health services can be direct or mediated by a third part, e.g. the Health Insurance House. (Mossialos et al., 2002). Therefore, the health care system can be represented in terms of its functional parts: who provides the funding sources, which are the mechanisms for gathering and which are the collecting agencies?

The funds come mainly from the public (individuals or corporations), collection mechanisms include taxes, social security contributions, private insurance premiums, household savings, payments made directly by patients (out of pocket), grants, loans. The collectors can be public or private (for-profit or non-profitagents) and taxes can be direct (paid by individuals, families, companies) or indirect (transactions). Taxes are collected by the government, while mandatory insurance contributions are collected by an independent or semi-independent agent. Health insurance contributions are paid by both employer and employee, and usually depends on level of income.

Private health insurance premiums are paid either by individuals or by employers and employees together or only by employer. Insurance premiums can be calculated based on the individual risk, individual health evaluation or depending on conditions related to community or group to which the individual belongs. The collectors in this case are private organizations, for-profit insurance or non-profit companies.Individual savings accounts for health are intended for health care expenses. These payments may be perceived as co-payments, additional insurance and even the collective agent is offering the service: doctor, hospital orpharmacist. (Elias Mossialos et al., 2002)

There are two basic alternatives for the allocation of funds: oriented towards those who provide medical services (in this case the finance goes to them, but not necessarily to the beneficiaries; for example, in rural areas the number of those offering health is lower) and oriented towards beneficiaries (in this case, the payment is made to the beneficiaries, so that those who offer the service receives money if the patient is treated, wherever the place that helds medical care).

Where there is an intermediary, who has responsibility for financing services for a certain category of the population, certain rules on the funds allocation need to be develop. Generally speaking, in European countries these rules are given both by the principles of the free market and by technocratic principles. The latter are designed to reduce unintended consequences arising from market or social/regional inequalities,

also to diminish factors as limited information to patients, incentives, moral hazard and so on.

As Vlădescu shows, resource allocation to beneficiaries can be realized by taking into account several factors; depending on these factors, it is obtained the following typology (Vlădescu C. et al., 2001):

1) Financial allocation thatisbased on population needs. The aim of this type is to increase the equity between different categories of people in terms of access to health services and increase the level of funding where the needs are greatest. In order to determine needs, health indicators are used that measure health status and factors that influence the health of a particular category compared to the total population.

2) Financial allocation that isbased on efficiency. The challenge facing all healthcare systems is the most effective use of limited resources available in the context of the continuous increase of costs. In this respect, better cost control can be achieved by allocating financial resources to the services with best cost - efficiency ratio. The method has been used very little due to difficulties in obtaining reliable data on the cost – effeciency ratio in interventions. 3.)Financial alocation that are based on public priorities.

Social Health Insurance Systems

Funding based on health insurance has some common elements beyond diversity of systems. First of all, it is part of the social protection system and based on principle of solidarity. Secondly, there is agovernance system alternative to the state, that controls the system. So the state has another role than in countries where there is the national system, based on direct taxation, meaning that funding and service provision is controlled by an alternative form (such as National Health Insurance House/Houses, for example) and the state is the guardian of structures . This does not mean that the state has a weaker role, but just a different one. The state is the one who takes decisions regarding the types of benefits, the rules for contracting, as well as ways of calculating contributions.Refering to costs, there is no evidence that the insurance-based systems are more or less efficient in terms of costs than national systems.(Mosialles et al., 2002; Vlădescu, 2001)

Contributions are independent to risk and transparent. They are linked only by income levels, not to health status as in case of private insurance. Contributions are different from other taxes, so they are transparent to individuals.Payment of health contribution is made towards purchasers of services. The insurance is collected either by Sickness Funds (Germany, France, Austria, and Switzerland) or a Fund / Central House (Netherlands, Luxembourg). All Funds are independent organizations run by a board and are non profit. Contributions are used to conclude collective agreements with care providers: be it private (for profit or non profit) or public.

There isthe same package of benefits for all members, based on the same security.. The system covers 63% of the population for example in the Netherlands and 100% in

France. In countries where participation in the scheme is compulsory, one cannot leave scheme or only those who earn high incomes can leave compulsory scheme and pass on a private scheme (as in Germany, for example, over a certain upper income level).

There is a pluralism in the organizational structure. There are several health funds according to the professional group, region, religion etc. All public and private hospitals and family doctors have contracts with the Funds.There is a corporate model of negotiating. It ensures uniformity of results and lower transaction costs. The process requires openness from the government for all organizational actors to participate in decision-making.

Individual choices are permitted. In general, fund members can choose hospital and doctor. Health insurance contributions are established related to income, and their payment is split between employer and employee. There are however differences between EU countries regarding: uniformity and variability of rate distribution between employer and employee, the existence of an upper limit of contribution, existence of other types of contributions beside the salary.Contribution rates vary between European countries from 14-13.5% to a minimum of 6-7% of wage. In most EU Member States, the distribution between employer and employee is significant in favour of the employee; the employer pays between 70-90% of the contribution. However, in countries like Romania, Austria and Belgium the distribution of employee/ employer is almost equal. (Mossialos et al., 2002)

German health care system

The German is the typical model of health insurance. The insurance system is founded by Bismarck since 1883. Social insurance has been a subject of political debate for a long timein Germany. At the timeof German unification, there was a shortage of health care which pressured the national economy till rebalance, as restoring balance was a priority. The German system is currently among the most successful in Europe.Since establishment, it has not undergone major transformations, being reformed only in order to improve cost efficiency. It is a decentralized system, the central government's role is limited to determine the legislative framework; executive responsibilities enter in the duty of Federal Districts (Landuri). (Vlădescu, 2001).

Health care reform is a topic on the agenda in Germany and most of the approaches focus on equitable distribution of the budget. The 2004 reform aimed at reducing contributions paid by employees, by introducing payment system related on diagnostic groups (DRGs) in order to standardize prices and stimulate competition within the system and call for greater co-payments from insured person. The government tried to make hospitals competitive and reduce the costs of state insurance.

Under the 2007 reform, health insurance became compulsory for German nationals. The contribution to the fund is 50:50 to employer and employee, regardless state or private insurance. A percentage of 85% of the population is insured in the public scheme and a percentage of 15% has private insurance. Minimum insurance cover access to a hospital, to ambulatory system and treatment for pregnant women.

Private services sector is well developed; private service providers are paid per service. The same payment model is used for primary care, which encourages doctors to take as many cases, to the benefit of expanding access to primary care population.Despite efforts to limit costs, health costs have increased to 10.7% of GDP in 2005, while the number of doctors per thousand population is the largest in Europe: 3.3 per thousand inhabitans.Co-payment was introduced in the '80s to prevent excessive use of medical services. The mean duration of hospitalization has decreased in recent years from 14 to 9 days, yet longer than in the US, for instance, where it is 5-6 days. (Mossialos et al., 2002)

In 2011, health insurance contributions paid by employers and employees grew from 14.9% to 15.5% of gross salary, according to the new reform. It has also been approved a law, limiting pharmaceutical companies to set prices in the market. Through the new measures, the government intended to bring to health budget two billion euros.

Basically, in terms of cost, Bismarck-type systems, as German one, are more focused on the range of services offered to patients and professional recognition, but do not provide good cost control, risking oversupply of care services. Beveridge systems, about which I shall talk in the following chapter, are more efficient in terms of cost management, but does not cover so many services. (Vlădescu, 2001)

The National Health System: UK

NHS pattern is known as the "Beveridge model" and is used in the UK, Italy, Greece, Finland, Spain, Norway and Sweden.The main features related to the financial aspect of this model are:

- People have access to health services based on binding tax revenue, so there is a high degree of social equity.
- The financial resources come from income tax collection, and the system is managed by the state.
- Those who provide medical outpatient services are employees of the state.
- Payments to suppliers is made through salary and depending on the number of patients.
- Providers of secondary health care services have available a general budget.

The British model is the typical pattern of a National Health System, based on the tax and is among the most efficient systems, operating since 1948. Each state of Great Britain has its own system, which are functioning independently. The whole system remains in the state's management, but is completely decentralized. It was reformed in the 90s, while attempting to delineate the district authorities to funds management.

The services offered to the public are currently managed by 10 Strategic Health Authorities and 150 subordinate local bodies, called Primary Care Trusts. The latter determine local needs and negotiate with medical facilities. It was developed a private party of the system, but considerably lower than the public one, offering services under

private insurance. There is therefore optional freedom to choose private extra insurance. In 2003, 15% of the population had private insurance in UK, but not for access to National Health Service.

The role of voluntary health insurance in health systems

Private insurance does not play an important role in European Union countries, as in the US or Australia. The governments of UEcountries act according to the principles of state-funded health care or social security, available to all citizens, regardless of their ability to pay. This model leads to health systems characterized by high public spending, almost fullcovering; accordingly, voluntary insurance plays a marginal role.

Typically, in EU countries, voluntary health insurance provides additional support, for covering the partly uncovered services, by social care. On the other hand, they can provide a faster access to some services and/or a more abundant offer. (Mossialos et al., 2002)

Common is that all European countries have legislation allowing purchase of private voluntary health insurance, alongside with compulsory insurance or public funding. Mandatory public insurance are dominant in European countries. Therefore, voluntary insurance market is marked by regulations of the mandatory part of the system. Voluntary insurance can be either complementary, suplimentary or substitute ones.

In Great Britain, Spain, Poland, voluntary insurance are suplimentary, therefore it covers a supplement for services that are under the public insurance package, offering some advantages: avoiding waiting lists, taking advantage of better conditions in lounge hospitalization, so on. Complementary insurance cover services that are not covered by public insurance: access to private health system, reimbursement of co-payment for services in the public system. This type of insurance may include a significant part of the costs of primary care, medications, tests, specialists, transport, and maternity period. The reimbursement varies from country to country and is depending on the insurance package chosen. They can be found in Denmark, the Netherlands or Hungary. (Olsavszky& Butu, 2009)

Under the Romanian law, voluntary insurance in Romania may be complementary or suplimentary, depending on the services covered by insurance. In fact, in practice, voluntary insurances in Romania are complementary in anoverwhelming percentage. The susbstitutive voluntary insurance offer coverage for people who are not included in the mandatory insurance system (Estonia) or for those for which public insurance is not mandatory, because are above a threshold of income (Germany).

Keeping public compulsory insurance in European developed countries, as main source of insurance, voluntary insurance being marginal, lead to more easily achievement ofhealth policies' goals: protection of disadvantaged, equity in access, wide access to care. On the other hand, European systems offered through compulsory insurance a good package of services, which has made voluntary insurance market to marginallyintervene. The voluntary insurances remain for social classes with a certain standard of living and not for poor groups.

Supplementary insurances can cover reimbursements of co-payments. In France, 95% of the population is included in the social insurance system and 90% contribute to supplementary insurance. Also, according to the laws in 2000, low-income people are included without paying in supplementary insurance system. Insurance policies focused on groups are preferred to individual policies due to the costs involved.(Olsavszky& Butu, 2009)

Systems centered on private insurance, based on types of employers

Providing healthcare works differently in the United States in contrast to Europe. Insurance is not compulsory in the US, as it in European countries and this leads to a very large proportion, 47 million people uninsured in 2000, although health expenditure per capita as a percentage of GDP is much higher in US than in Europe. Many of the uninsured come from either unemployed or low-wage population, people with fluctuating income, debts or large family to sustain and therefore they postpone insurance, focusing on urgent payments.(Mossialos et al., 2002)

There are two types of insurance in the US: individual private insurance and private insurance based on the types of employers.

Individual private insurance has following components: Individual–Insurance premium-Insurer-Refinancing -Provider. History of regulating health care in the US is different. In Europe, mutual societies, guilds appeared in the nineteenth century. In exchange for a monthly amount, citizens receive assistance in case of illness. In the US, in the early twentieth century, European immigrants arriving performed small charities offering sickness benefits for members. During this period, there are two commercial insurance companies: Metropolitan Life and Prudential, who collected 10 to 25 cents each week from workers for expenses in case of serious, fatal illness. The policies were weekly paid, so customers were weekly visitedby agencies. Administration costs were very high. Currently, individual private insurance system remained marginal in the US, covering only 5% of the population. (Crieson, 2010)

In case of private insurance based on types of employers, the scheme include: Employee plus Employer-Insurance premium-Insurer-Refinancing-Provider. Intro-ducing insurance was generated by finding ways to cover the necessary costs of hospitals. In the twentieth century, hospitals have started to become places where people went to heal, not just places where one is going to die. Many patients could not afford the cost out of pocket for hospitalization. In 1929, Baylor University Hospital has insured 1, 500 teachers for 21 days hospitalization for a fee of $ 6 per person per year. In the 30s, due to the financial crisis, the Great Depression, hospitalization decreased to 60%, because people could not afford to go to hospital.In this context, insurance plans arose, but they applied only to a particular hospital. You were insured for a hospital. American Association of Hospitals soon intervenes and performs an assurance that one could have access to any hospital in the state, by Blue Cross insurance plan. Already in 1940, there were 6 million policyholders. Also in the 40s, a second insurance plan appears, called Blue Shild and it is expanding nationally. The two

planes were controlled by State medical societies. Thus, we can say that contrary to the European trend, where insurance development was driven by consumers through pressure on the government, in the US it was triggered by providers seeking a stable source of income. During the Second World War, in the USA, companies have started to offer insurance to employees, due to weak labour employment. After the war, the unions have continued this trend and negotiated health benefits. Insurance beneficiaries increased from 12 million in 1940, to 142 million inhabitants in 1988. (Crieson, 2010)

The US remains among modern industrialized states with the lowest coverage of patients. In 2000, a total of 47 million had no insurance and are not beneficiaries of the scheme. Among them, there are not only unemployed people Three quarters of the employed are uninsured, as American official statistics show. Therefore, in the US, lack of insurance is not only a problem of the poor, but also a middle class phenomenon.

On the other hand, packages that are provided for insurance do not include any type of service. For a certain sum assured, one can receive a certain package, which may include certain kind of analysis, a limited number of days of hospitalization, a ceiling for a maximum amount for drugs, access to certain types of hospitals. In 2005, 20% of adults under 60 years had difficulties in paying medical bills for services or medication that exceed the insured amounts. However, expenditure on health per capita are much higher in the US than in Western European countries and the quality of services for those who receive them is very high. In counterpoint, access to the system in Romania is easy, but the services are of lower quality, because the system cannot afford more from financial perspective, in addition it has dysfunctions that hamper spending the most effective way of scarce resources.Returning to the case of the USA, private insurance scheme by employers is the most common form. Employers pay an insurance premium which purchase services. Flow sphere is not yet so simple: the federal government sees these premiums as deductible tax on income profit. Insurance premiums are not seen as part of the employee's income. Therefore, the government offers subsidies to employers. They were of $ 200 billion in 2006.(Crieson, 2010; Mossialos et al., 2012)

Once commercial insurance companies penetrated the market, to compete with the two Blue (Blue Cross and Blue shied), things changed. There were thus two types of rating for the size of the insurance premium: based on individual experience (experience rating), and based on the community of which the individual belongs (community rating). In the rating based on experience, insurance premiums are consistent with the experience of each group in using health services. Therefore, premium is smaller for a group of young bankers (age, good social status), higher for a group of middle-aged skilled workers, and higher for a group of miners close to retirement, who accumulated a number of diseases.

In the community-based rating, all community members pay the same, be they bankers, skilled workers, miners, etc. Blue Cross had started using rating-based community. This rating ensures a redistribution from the healthy to the sick and from the rich to the poor. Such redistribution was within each group on the one hand, sick getting more than the healthy ones, but also between different social status groups.

Rating based on experience is less redistributive because the redistribution is established only between the healthy and the sick ones and not between different social status groups. Once commercial insurers emerged, in order to attract customers, they used the experience rating and Blue Cross wasgetting into a crisis and itought to pass to the same type of rating. Healthy and customers wanted to pay less money and therefore directed to commercial insurers who used rating based on experience. Blue Cross began to have fewer customers, most of them poor, sick, old, losing customers from middle status, young healthy who ment lower costs with services. In order to survive, Blue Cross ought to attract young, healthy groups and lower the taxes for these groups, using rating-based on experience. Withdrawal of rating based on community primarily affected elderly and the sick, some of them having not afforded the insurance or were insured only for a limited package at a discount price.(Crieson, 2010; Mossialos et al., 2012)

From these groups' point of view of, the poors, the elder people, the sick people, the functioning only on the market basis is tough and discriminatory. On the other hand, the healthy could make the following argument: why pay more as long as you do not use that service. The answer that may be given is related to the unpredictability of health needs. Health status may turn into one of disease even for young people. Secondly, it comes to social values and social solidarityand to definition of access to health care in that society, as it is in European countries.

In Europe, access to health is considered a citizen's right and there is the obligation ofentrying into the scheme of those who work. Those who do not work, enter in a social security scheme, which includes access to health services in most European states. US Experience, with the free market acting, led to a situation in which rating based social community although desirable, could not work in a private competitive/marketsystem.

Therefore, as Eliassenshows, *"health disparities in the United States have declined little over the past century despite far-reaching technological advances and, especially since the 1980s, heightened consciousness of the problem. Their persistence can be explained in large part by their usefulness to those who hold and seek to consolidate power. Among other things, health disparities help in bolstering master-subservient relationships; shoring up the ideology of rugged individualism; maintaining bureaucratic structures and jobs; providing plausible public enemies; monitoring upstream social ills; and sustaining a flow of research funding. Conditions likely necessary for ameliorating health disparities include open and mutual recognition of several often veiled realities concerning power relations: money equals power; power translates into access to resources; those who hold power are reluctant to part with it; those who lack power serve as convenient scapegoats; and institutions evolve so as to ensure their own survival."*(Eliassen, 2013: 3)

Insurance has introduced the possibility for those with health problems to be able to afford costs based on a monthly/annual premium (in comparison with out of pocket spendin) and assured a steady flow of financial resources to medical units. The negative aspect upon the health system is that making insurance resulted in a lower control on costs (and the costs increased). When payment is made out of pocket, this adjusts the prices and quantity of services. A well-insured patient who presents himself to medical unit without a serious illness, usually uses more services than he needs. If those services

would have to be paid out of pocket, this would reduce cosume of services. At the same time, suppliers increase more easily the prices, because there is a third entity that is willing to pay. Insurance schemes with low levels of co-financing have higher values of insurance premiums. Government is responsible for providing support to vulnerable groups: the elderly, people with low incomes.

A typology of medical systems, based on Gosta Esping – Andersen's typology of welfare states.

One of the most popular typology of the welfare states is that of Gosta Esping - Andersen. This makes a complex typology of states in Western Europe alongside USA, Canada, Australia, Japan (including a total of 18 capitalist democratic states). It defines three types of welfare states/regimes: liberal, conservative and social democratic (socialist).

The author uses the following criteria in classifying these arrangements. It is primarily aboutthe decomodification degree in granting benefits (the degree of universal access to benefits): to what extent are services available to citizens free of charge, without reliance on means-testing and insurance contributions/therefore work. The second criterion is the social stratification, the extent of distributive impact, of services and benefits and to what extent the effect of taxes and benefits system has led to inequality, maintaining social stratification, to what extent was achieved a redistribution of goods and services towards equalization.The third criterion is the state-market relationship and more specifically granting state pensions-private mix. To what extent, pension entitlement is dependent on the state, on the employment structures or on the market." (Esping-Andersen, 1991)

The 3 types of arrangements have therefore three important factors as causal forces: „*the nature of class mobilization (especially of the working class), the structure of the coalition between the political classes and the historic institutional heritage of the regim*" (Esping-Andersen G., 1991: 29). More specifically, it is about presence to governance of left parties (representing the working class) and the historical tradition of the country regarding catholicism and absolutism (authoritarianism).

Gosta Esping-Andersen characterizes the 3 patterns of welfare states in the following terms: In the liberal pattern (Australia, Canada, Japan, Switzerland, and U.S.A), means-tested assistance predominatesand universal transfersare modest. The focus is on those with low incomes (especially the working class), the benefits are modest and stigmatizingin order that people would't choose benefits from the state, instead of work. The state encourages the market: passive (by guaranteeing minimum) and actively (by encouraging private welfare systems). Decomodification effect is minimized. There is a strong stratification. (Esping-Andersen, 1991)

In the conservative corporatist regimes (Austria, Belgium, France, Germany, Italy), keeping differences between social layers is strong. The private insurance and occupational benefits have a marginal role. Redistributive impact is negligible, going on preserving the status differences. Church plays an important role, also preserving of traditional family values (hence policies to encourage maternity, social security including

housewives). State intervenes when family's ability to help its members is exhausted. (Esping-Andersen, 1991)

Social Democrat type is characteristic for countries like Denmark, Finland, Netherlands, Norwayand Sweden, having features as follows. Universalism and decomodification are extensive (even for new middle class). It seeks equalization at a high standard, not the bare minimum (the workers have the same rights for example as"white collars" and officials). Insurance system is universal, yet the benefits are based on income. There is a universal solidarity in favour of the welfare state (all benefit, all contribute). The objective is not to maximize dependence to family, but the ability of individual independence. Family-state relationship is characterized by: a) state assure services forchildren, elderly and helpless; b) the state allows women to choose work, instead of household, by facilitation work (part time, for example); c) State responde to family needs through multiple services. There is a fusion between work and welfare. (Esping-Andersen, 1991)

The state is involved in full employment; the right to work is on a par equal with the right to be socially helped. To minimize social tensions and thus maximize solidarity, employment is considered a necessarypolicy. Social democratic parties and mobilizing of workers are strong.

From the point of view of the application of these schemes of welfare to healthcare, Charles F.A. makes the following characterization of systems. (Charles, 1998). Entreprenorial liberal model of health provision is based on the liberal, pro-market values. Efficiency is a priority over equal access or treatment. The support is for decentralization, competitive marketsand minimizedstate interference. Market meets the needs and preferences; providers and consumers of health services have an extensive freedom. Private system managers make decisions based on cost-benefit analysis. Doctors and hospital staff have clinical autonomy in treating patients. Citizens assume personal responsibility for individual health needs. Funding is mainly through private health insurance. While the healthy pay lower insurance premiums, sick or high risk pay higher premiums. State benefits is based on means testing and targeting the low income persons.

Canada and particularly the United States have adopted this system. The system is decentralized, federal, pluralist extensively, based on private market economy. Despite the similarities, Canada and the US have divergent health policies pursued since the 60s. Canada has provided universal, comprehensive, generous benefits. It combines entreprenoriat with some socio-democratic practices. The United States is the business/market model; corporations are profit-oriented insurance. (Charles, 1998).

The German model is the corporatist, organicmodel. German corporatism is combined with market model. The Swedish model is the socio-democratic one. Corporatist Swedishtradition shaped health policies. Although both England and Sweden are national state health systems, the concept of market began to be increasingly important.French corporatism is weaker and combine with liberalism, manifested in the clinical autonomy of doctors. Dutch system is extensively pluralist, based on all three

models. Japan is mixing corporatism with private sector entrepreneurship. (Charles, 1998)

Other criteria for system classification

It is important how medical institutions exercise their function of health, promoting social values and their relationships with other institutions. Institutions in the health system are in a procees of modifying, influenced by a number of factors such as: increasing the quality of medical knowledge and technologies, increasing demands for care, population aging. Health policy is influenced by traditions and historical experiences, economic, ideological, cultural factors. (Rădulescu, 2002).

Mark Field (Field, in Rădulescu, 2002) argues that institutional health systems are defined by following:

- Functionalist orientation, in order to maintain and promote health at social level. It is about the conservation, rehabilitation and capacity of individuals to exercise their social roles. The disease is seen as a dysfunction and health care becomes a social attitude with functional implications.
- Difference in functions of different health units, part of the systems. System's units have functions of prevention, diagnosis, treatment, recovery or medical education, in relation to various aspects of the disease: disease, discomfort, disability etc.
- The existence of some structural supports for the effective exercise of all medical services and system components: personnel, means and resources required.

From here, there can be detected three types of systems:

1. Pluralistic systems (public authorities, private, voluntary);
2. Systems with mixed authority (public or voluntary);
3. National Systems (controlled and managed by state): UK, communist countries before 1989.

William Cockerham (Cockerham, in Rădulescu, 2002) speaks of three types of systems:

1. Systems based on forms of socialized medicine (Canada, England, Sweden)

   Providing health takes place in the form of state support of the consumer. The state directly controls the funding and health care, pais directly to providers, has most medical facilities in property, guarantees equal access to services, allow private services to be solely responsible for managing their own expenses.

2. Decentralized systems. (Japan, Germany, France, Mexico)

   There is a different type of control, anindirect control exercised by the state. The state no longer regulates the functioning of the services and does not operate in them. It has only the role of coordinator and mediator between health providers and organizations involved in financing. The state indirectly controls the way of financing

and organization of health, regulates payment methods for health providers, owns medical facilities, guarantees equal access to health.

3. Centralized systems (communist countries before 1989).

   State directly controls, finances and distributes care, ensuring free servicesto their citizens. There are not insurance companies that come between suppliers and consumers. The state pays the salaries of employees in the system and there are not private forms of healthcare. So, state controls the care financing and distribution, paid directly to providers, has all medical facilities/units in posesion, guarantees access to careto all citizens; private physicians/private medical units are prohibited. (Rădulescu, 2002)

Conclusions

Provision of benefits in the welfare state is based on the concept of social citizenship, solidarity and redistribution. The main mechanism of operation is the collection of taxes and insurance premiums based on primary incomes. Some common structural elements are found in all European welfare states: social security (pension, unemployment benefit), social welfare, maternal support and public education, health services. Differences between the mechanisms adopted by various countries appear based on historical, national values, the power of social class, trade unions, economic factors, political institutions, in power political parties' doctrine.

The systems of most countries operate through a mix of funding, including various items of charge.Basics of funding schemes are on a continuum, on one end there are systems dominated by state, as the UK system, predominantly funded through general taxation and at the other end of the continuum there are market dominated systems, based on private insurance, the typical one being US system.This type of dividing can be misleading, in the sense that the state's role in both types of systems remains, but it behaves differently.In European health system, the state plays a central role in determining the coverage and the nature of benefits, choices of financing the health system, including the type of charging, allocation and distribution of resources and the structure and organization of services. In Europe, two major types are ideal in terms of funding, supply and control: Health insurance system and The National Health System. One of the major ways to differentiatethem is following three criteria: financing, service delivery/supply and control. Also, there are a variety of forms of regulation in Europe, reflecting the different relationships between financial bodies, providers of services and those who use the services. In many countries, in the center of triangulation is the medical profession, represented by associations, profesional unions.

Theoretically, financial support for European health systems can be improved through a number of measures: limiting access to services, reducing services' quality or increasing the share of private funding (which in turn has consequences related to limiting access to services). But none of them is desirable from social point of view. From the perspective of social protection, the best way of improving financial support is to increase health system efficiency. Efficiency here refers to lowering costs, while maintaining the same levels of quantity and quality, achieved by preventing over-

consumption of health services and allocating sufficient resources for programs of prevention and health maintenance, in order to reduce any potential future expenses. But, as Stanciu M. shows: "*recent evolutions in the field of European public health demand the review of European and national regulations and the definition of a new strategic approach. This approach must address demographic changes within each European country, demographic ageing, and the development of new pathological patterns that put pressure on old national health systems whose parameters have been designed for different dimensions of the social needs."*The establishment of necessary conditions for a healthy ageing of the European population presumes lifelong promotion of health and narrowing the inequities in the field of public health generated by social, economic and environmental factors. (Stanciu, Jawad, 2013)

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