CO-FINANCING MECHANISMS
An interview with the General Director of Euroclinic Hospital, Bucharest Mr. Cătălin POPA

Rezumat: In the last time, we are talking more about the introduction in Romania of copayments mechanism for some medical services. Until July 1st 2009, the Ministry of Health will elaborate the minimum services package and will define exactly what copayment means; the package will be implemented starting with September 1st and is preceded by an information campaign both among doctors and population. In the new strategy of the Ministry of Health, copayment is considered an optimal solution of the healthcare system reform, but also a way to legalize informal payments and to supplement the budget. Also, the Minister of Health believes that by introducing the copayments in hospitals the pressure on the medical units will decrease.

Mister Cătălin POPA is currently the General Director of Euroclinic Hospital where he has been working as Chief Operation Officer since 2005; during 2000-2004 period he worked at Mayo Clinic Scottsdale Phoenix, USA, as operations manager.
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Reporter: Mr. Popa, what is the experience in the USA with mechanisms of health insurance co-financing?
Cătălin Popa: Over the past 40 years, various forms of co-financing have shown up throughout the insurance industry in the USA. These mechanisms present themselves in several forms, most frequently known as copayments, co-insurance, and deductibles. Copayments are the oldest of these, dating back to before the 1970s.

R: How are they accepted by the population at large?
CP: Overall, since they have been around for quite some time now, I can say that these forms are understood reasonably well and accepted as a way of life by most individuals. In fact it has almost become unheard of to not have some form of co-financing built into most insurance plans. Even some of the more expensive plans now have some sort of copayment, co-insurance or deductible.

R: What is the reason for the existence of such alternative forms of financing?
CP: These mechanisms came into being as a result of needing to find a way to influence the utilization of
heath services. Because of the increasing healthcare costs, insurance companies, as well as the federal government, found themselves incurring high costs due to improper utilization of health services by both patients and providers.

So, the primary focus is not the additional money paid by patients at the time of service, but rather the additional savings earned from reducing improper utilization. Just so I can be more specific, let me share with you this example: If in the era before co-financing patients had no reason to avoid going to the doctor for a simple headache, once they were required to pay something out of pocket to see a doctor, they thought again before making an appointment.

Similarly, if patients were used to go to the emergency room for minor aches or cold symptoms, a totally inappropriate utilization of emergency room services, once a copayment comes into play, they are much more likely to avoid going to the emergency room and wait until the next morning when they could see a doctor in an outpatient ambulatory setting.

One could say that these mechanisms of co-financing provide a disincentive to improper utilization of medical services; they make one think twice when and where they go for medical care.

R: How and for what services are copayments used?
CP: Copayments are used for pretty much everything covered by insurance policies. There are copayments for consultations, for pharmaceuticals, for day hospital, for surgeries, for hospitalization and for emergency care. Copayments vary according to the expected cost of the service provided. For example, a copayment for an ambulatory consultation is significantly lower than a copayment for an emergency room visit. The concept is that applying a larger copayment for the more expensive areas of the healthcare delivery chain will redirect the patient to the less expensive ambulatory areas. Therefore, emergency room visits will have a copayment between $50 to $100, whereas an ambulatory consultation will have a copayment set at between $5 to $25.

One can easily see that a patient without an absolute need to seek emergency room care will likely opt for receiving care in an ambulatory setting in order to not have to pay so much. When considering the very long waiting times in emergency rooms and the relatively high cost of delivery emergency room services, it makes not only economic sense, but also moral sense since this enables the emergency room staff to focus on true emergencies rather than minor health issues that can wait for treatment in the ambulatory setting.

R: Who decides the amount of the copayment, the co-insurance or the deductible?
CP: Considering the diversity of health insurance plans, both private and governmental, for profit and not for profit, in the end it is the payer that decides the amount. In most cases, it is the subscriber that selects between a number of insurance plans with various copayment levels, co-insurance values and/or deductibles. The role of the issuer of the policy, either a private institution or the government, is to make available to the client its best offers so that there is selection based on a competitive model. If the subscriber purchases the insurance directly, then s/he will decide what the best policy is according to own budgetary limits. It can be said that insurance plans with lower co-financing values will have higher premiums, while the opposite is also true. In the race to provide options to subscribers, even the government, which for the longest time had the fewest options, in the last 15 years introduced various insurance plans that citizens can take into account. It is important to keep in mind that state and federal governments are responsible to offering health insurance plans to the elderly, those considered with low income, and its own employees.

R: So, if this is the case, how has the implementation of copayments affected the attitude of patients and medical staff?
CP: It is important to remark that the implementation of co-payments has affected not only the behavior of patients, but also that of practitioners and healthcare institutions. If, for example, a patient needs medical attention after normal business hours or on weekends, how is a patient to obtain the needed care without going to the emergency room? The early adapters to the intended purpose of copayment application were the patients since they were directly affected and disincentivised. They then started applying pressure on healthcare institutions to provide extended hours and weekend care to avoid emergency room visits.

If in the past doctors used to recommend a patient to seek care at the emergency room, they also became much more discerning when making such recommendations. Similar examples can offered as well for inpatient
treatment. The key principle is that co-participation in the financing of health services has had the effect of making the patients more responsible in the seeking of healthcare and the provider in the offering of healthcare.

*R: What have been some of the downfalls of co-financing mechanisms? Has the overall health status of the population decreased as a result of this?

*CP: Ever since the famous Rand experiment in the 1970s, numerous studies since then have consistently shown that while introduction of copayments have not decreased the health status of the average citizen not considered to be low-income or in poor health, chronic illnesses and/or general poor health, those in the latter groups suffered a decline in health status as a result of avoiding needed effective care. There are some classic examples of states that decided to introduce copayments for consultations and pharmaceuticals in the state-subsidized plans for those in the low-income bracket, and which were forced to revert the decision as a result of noticing a sharp increase in the utilization of emergency services and hospitalizations. It turned out that these low-income patients were unable to afford the copayment for needed care and experienced a worsening in health status due to not receiving timely medical care or needed pharmaceutical treatments. Another group likely to risk not receiving medical care when needed are the children of low-income families. Consequently, while co-financing provides an effective tool for correcting and guiding utilization of healthcare without affecting the health status of participants, there are important considerations to be taken into account in regards to those in the lower socio-economic classes.

*Noted by Marius Ciutan, MD*