ASSESSMENT OF THE REFORM OF THE ROMANIAN HEALTH CARE SYSTEM

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Abstract

The purpose of this introductory paper is to offer a brief description of the Public Health Care System in Romania, and to examine how it evolved, after the fall of the communist regime, from a Semashko health care system to a social health insurance system. We will explore how the regime influenced this evolution and whether we can talk about a distinct management component. It is not an exhaustive study, but rather an overview of some issues/problems that Romania has faced in the effort to modernize its health care system.

We will start by defining public health and by outlining the major characteristics of a public health system, followed by a list of objectives recommended for use by the World Health Organization, to which the paper refers in examining the current issues in Romania. After this, the major reforms will be described and analyzed trying to identify how this affected the outcomes.

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What is Public Health?

Definitions of the concept can be found as early as the 1920s. C.E.A. Winslow (Professor of Public Health at the Yale School of Medicine from 1915 to 1945) defined public health as "the science and art of preventing disease, prolonging life and promoting health through the organized efforts and informed choices of society, organizations, public and private, communities and individuals".

"Public health is what we, as a society, do collectively to assure the conditions in which people can be healthy" (Institute of Medicine, 1988, p. 7). Public health is "*the approach to medicine that is concerned with the health of the community as a whole. Public health is community health. It has been said that: Health care is vital to all of us some of the time, but public health is vital to all of us all of the time*" (http://www.medterms.com/script/ main/art.asp?articlekey=5120).

The Romanian Government defined public health as the health status of the population taking into consideration health determinants: socio-economic, biological, environmental, life-style, insurance to health services and accessibility and quality of health services provided (Law nr. 95/2006). While the first definitions highlight the importance of prevention and promotion, the Romanian Government emphasizes more the importance of certain social determinants of health. This shows that public health is a very broad field and there are different views regarding what can or cannot be included under the umbrella of public health, but also that the desired outcome is always the same: improvement of the health status of population.

The way in which a government defines public health influences the structure, organization and functioning of the whole system, and thus has a major impact on the actual outcomes. In our opinion, focusing only on a single aspect, such as the social determinants of health or prevention and promotion, is not enough. Public health should be as comprehensive as it can be and definitely should include, besides the above mentioned elements, a strong evaluation component of governmental health policies in terms of their cost effectiveness and, most of all, in terms of their efficiency. Assessments need to be conducted in order to identify in what way policies and programs achieve their goals and objectives, and to what extent they meet communities' needs.

Health Care Systems Deal with Public Health

World Health Organization (WHO) defines health systems as comprising of all organizations, institutions and resources devoted to producing actions that aim to improve health (http://www.who.int/topics/health_systems/en/). Health systems are concerned with public health. Although there are general guiding principles, such as universal and equal access to health care, better health status or achieving certain standards of quality of the services delivered, each country government has a specific point of view on how public health and health care system should be organized, leading to an abundance of approaches in the structure, organization, objectives and functions of the health care system. Some limit health care at the basic functions of the health services; others have a broader view of the concept adding along the delivery of the health services other services such as transportation or education, for example.

Consensus is usually found only at the theoretical level. However, when those objectives have to be translated into policy, every government has a unique approach to the policy process. There are a multitude of approaches all shaped by different factors like culture, tradition, political-administrative structure and economic development. All this diversity raises a series of questions regarding the best way to organize and manage a health care system in order to get the best results.

WHO identifies four major functions of any health care system (WHO Europe, 2005, p. 7-9):

1. **Stewardship** - although related to regulation, stewardship is a broader concept that includes strategic planning, regulation, implementation of policy and capacity of evaluation to ensure accountability and transparency.
2. **Resource generation** includes both short and long term approach to resource use. The system can only use the resources that rest at its disposal but it can influence this through strategic investments in human resource development or adoption of modern technology that will surely have a significant impact on performance.
3. **Service delivery** – production and delivery of health services using the inputs. Often governments identify health systems with this function alone.
4. **Financing** includes a large number of activities starting with revenue collection up to the distribution of financial resources to health care providers in order to produce the necessary health services.

But most important, health care systems are run by, and address services to *people*. Consequently, humans are probably the most important but also the most complex resource that a health system has. "An effective infrastructure is the right people in the right places. Health systems lack people who have and use the managerial competencies to match their responsibilities" (Filerman, 2003, p. 1).

Most health care systems put clinical status and medical preparation before management competencies as priorities (Filerman 2003, p. 1). This often results in poor use of the available resources, under-motivation and general lack of efficiency of the systems. Outside the system, it affects the quality of services delivered and the health status of the population. "Weak management is the enemy of fundamental public health values" (Filerman 2003, p. 1).

If we have the resources on one side, on the other we have the structure. The structure of the system represents the basic framework in which all the resources need to operate in order to produce the desired outcomes. In this sense, the most common discussion revolves around centralized vs. decentralized systems.

Centralized Health Systems are characterized by a hierarchical structure, "vertical" health programs, planning is undergone only by the central authorities, hierarchical control, rule driven management, monopoly of power and weak management capacity. The weak points of such a structure are: decision-making takes place only at the top level of the system, the communication process is weak and mostly linear (top-bottom), a low touch with reality (in most cases top level managers do not come into interaction with the day by day situations and they base most of their decisions on theory; this has a negative result on the actual impact of the services delivered by the system),

lack of creativity and initiative of the lower levels of the organization which finally translates into lack of motivation. This is a typical bureaucratic way of organization and functioning and we can talk more about administration than management.

On the other hand, Decentralized Health Systems are characterized by health programs designed horizontally, share of power, community orientation, importance of information, knowledge, accountability of results, strong management capacity and strong leadership. Consequently, the advantages of a decentralized structure are an increased efficiency, more acute sense of reality leading to a better and more prompt response to community needs, better communication, better use of information, more accountability for the actions taken. Decentralization can be seen as a managerial tool that can be used to increase the efficiency and to achieve the proposed results.

Romanian Health Care System

The Romanian health care system shifted from a centralized, closed system to a social health insurance one. During the communist regime the system was strongly centralized in terms of planning and financing (WHO, 1996). With regard to health services, primary health care was provided through dispensaries (Schneider M et all., 2000). Secondary and tertiary care was provided exclusively by state health units. As a result of the nationalized economy and the absence of the private sector, health professionals were trained in state universities and technical schools, and after graduation they were assigned to work in specific locations where they were employed as salaried civil servants (Bara, van den Heuvel, and Maarse, 2002, p. 1).

Since the 1989 Revolution, Romania has gone through a slow process of transition to a liberal-democracy, which meant a lot of changes in the structure and functioning of the public sector. Changes took place in the health care system as well. Between 1990 and 1995, the government issued a series of regulations in the field of public health, but none of them made any reference to the basic right of citizens to health care because this right was stated in the Romanian Constitution (European Observatory on Health Care Systems, 2000). The goals of the health care reform were a better health status of the population, increased efficiency (with regard to the use of resources and to the structure of the system) and a better patient-physician relationship. Starting with 1995, important laws concerning the structure and organization of the Romanian health care system were passed. The new regulations (Law no. 74/1995 regarding the organization of the College of Physicians, Law no. 145/1997 regarding the social health insurance, Law no. 100/1998 on public health assistance, Law no. 146/1999 on hospital organization) started to transform the system from a state owned, centralized system to a more decentralized social insurance type, with "contractual relationships between health insurance funds as purchasers and health care providers" (European Observatory on Health Care Systems, 2000, p. 5).

The adoption of the Law on Social Health Insurance in 1997 was a major step toward the transformation of the Romanian health care system. Key provisions of the law regulate health sector financing – revenue generation, redistribution process, and also allocation of funds. It made insurance membership mandatory and linked

it with employment, with both the employer and the employee having to pay a certain percentage of the salary for health insurance (European Observatory on Health Care Systems, 2000, p. 17). Another notable aspect was the status change of the health professionals, who switched their status from state employees to independent practitioners that run their activity based on contracts with the national or county insurance house (US Dept. of Commerce, 2001).

Since 1999, the main stakeholders involved in the health care system are: the Ministry of Public Health and the County Authorities for Public Health, the National and the County Health Insurance Houses, the National and the County Colleges of Physicians and the Colleges of Nurses and Midwives, and the health care providers. The Ministry of Public Health and its local representatives, the Authorities for Public Health, are responsible for developing the national health policy and for dealing with public health issues. The ministry's activity focuses now on policy formulation and implementation, and planning and coordination of decisions regarding the achievement of medium and long-term goals. Thus it has responsibilities regarding: budgetary allocations for health, accountability for the programs it decides to implement, managing public health programs, regulation of both the public and the private health sectors, conducting health policy research and planning, defining and improving the legal and regulatory framework for the health care system, developing a coherent human resources policy and building capacity for policy analysis and management of the health care system (European Observatory on Health Care Systems, 2000, p. 10).

In the reforming process, the responsibilities mentioned above were not doubled by consistent changes in the human resources management. The authority that regulates the medical profession is the College of Physicians (CPh), which has local semi-independent organizations at county level. The CPh is run by a board elected every four years. Membership in the CPh is mandatory for al physicians (European Observatory on Health Care Systems, 2000, p. 9).

Starting with 1999, the financing of the system is done through County Health Insurance Houses (CHIHs), which are responsible for the revenues collection and for the reimbursement of provider within their respective counties. At the central level there is a National Health Insurance House (NHIH) that sets the rules and regulations for the CHIHs and that has the right to reallocate up to 25% of the collected funds toward under-financed counties (Observatory on Health Care Systems, 2000, p. 5). The relationships between NHIH and the CPh are based on a framework contract, which sets up the benefit package to which the persons insured are entitled, and the resources allotted for different types of care. The major problem in all these years was the low governmental expenditures on health. Between 1990 and 1998 the funds allocated for health care varied between 2,4% and 4% of GDP. From 2000 there was a steady growth in absolute figures, but still they varied only between 3,6% and 4,2% of the national GDP. Below some figures regarding expenditures for health care in Romania are presented comparatively with two western countries, as well as another former communist country.

Table 1: Total Expenditures on Health in Romania compared to UK and US

Country	Total Expenditure on health as % of gross domestic product (a)	General government expenditure on health as % of total government expenditure (a)	Per Capita total expenditure on health at average exchange rate (USD) (a)
Romania	5.1	11.1	178
The United States of America	15.4	18.9	6096
The United Kingdom	8.1	15.9	2900

National health accounts: country information. Geneva, World Health Organization, 2007. (Also available at http://www.who.int/nha/country)

Table 2: Total health expenditures as % of Gross Domestic Product (GDP)

Country	1998	1999	2000	2001	2002	2003	2004
Romania	4.1	3.9	3.9	4.2	3.8	3.8	3.9
The United Kingdom	6.9	7.1	7.3	7.5	7.7	7.8	8.1
Hungary	7.1	7.2	6.9	7.2	7.6	8.3	8.1

Source: European health for all database (HFA-DB) World Health Organization Regional Office for Europe Updated: November 2007– http://data.euro.who.int/hfadb/

Table 3: Total health expenditures, PPP$ per capita, WHO estimates

Country	1998	1999	2000	2001	2002	2003	2004
Romania	331$	368$	386$	429$	491$	540$	433$
UK	1586$	1700$	1840$	2044$	2231$	2389$	2560$
Hungary	774$	819$	857$	975$	1115$	1269$	1308$

Source: European health for all database (HFA-DB) World Health Organization Regional Office for Europe Updated: November 2007– http://data.euro.who.int/hfadb/

Table 4: Public sector expenditures on health as % of total government expenditures, WHO estimates

Country	1998	1999	2000	2001	2002	2003	2004
Romania	8.1	9.6	9.9	10.3	10.5	10.9	11.1
UK	13.7	14.5	14.8	15.3	15.4	15.8	15.9
Hungary	10.1	10.7	10.6	10.5	10.4	12.1	11.6

Source: European health for all database (HFA-DB) World Health Organization Regional Office for Europe Updated: November 2007– http://data.euro.who.int/hfadb/

The figures presented above illustrate a pretty grim picture regarding the financial resources allocated for health. Health expenditures are almost double in Hungary comparatively with Romania. When looking at the expenditures per capita, the situation is even worse, with UK spending around 5 or 6 times more than Romania on health care, while Hungary 2 or 3 times.

We have to mention that besides the governmental funds, considerable external financial resources were received from international organizations such as the World Bank, EU (PHARE Funds), UNICEF and USAID.

Because the reform of the health care system was more a catchword to increase the political capital rather than a true objective, there was a constant under funding of the programs in this field, which conducted to slow changes in the system and to a low motivation of the physicians.

All these changes were accompanied by a process of decentralization in the public sector. In 1991 the Public Administration Law was passed and the public institutions from county level belonging to ministries were moved under the authority of a Prefect (the representative of the government at county level). Consequently, the County Authorities for Public Health were created to apply the policies of the ministry at local level. The heads of these institutions are directors (always physicians) appointed by the Ministry of Health with the agreement of the prefect of that county. After the introduction of the Health Insurance Law, these structures were changed into the County Public Health Directorates (which later became Public Health Authorities). "After the introduction of the health insurance regulations, delegation and privatization played a more important role in the process of decentralization. The health insurance funds took over the responsibilities for revenue generation, allocation of resources for geographical areas, levels of care and provider institutions" (European Observatory on Health Care Systems, 2000, p. 14-15)

The last important change took place after the 2004 elections, more precisely in 2005, when a package of laws was passed having the generic title "Public Health Reform" (Law no. 95/2006). The key changes that were addressed in this law regarded the following specific areas of the health care system: structure, national health programs, primary health care, hospital management, hospital financing, the organization and functioning of the National School of Public Health and Health Management.

The health care reform further aimed, in the process of decentralization, to give more autonomy to the local authorities, leaving the Ministry of Public Health to deal more with the strategic decisions. However, the ministry kept hierarchical control over the local institutions.

The County Authorities for Public Health became Local Public Health Authorities subordinated to the Ministry of Public Health. Their role is not only to implement the health policies and the national health programs developed by the ministry, but also to address the major issues in the field of public health at local level (article 17 of Law no. 95/2006 regarding the Public Health Reform).

One of the major improvements was the introduction of the National Health Programs (NHP) that are a set of different governmental policies with the purpose of evaluation, prevention, treatment and control of diseases with a major impact on the health status of the population. These programs include: evaluation programs and prophylactic programs. The Ministry of Public Health is responsible for developing, coordinating and implementing these national health programs. These programs are meant to give a larger picture regarding the possible health threats at national level and to assist public institutions in preventing possible diseases, activity which was almost inexistent before 2005.

The programs are implemented through the representatives of the ministry at local level in collaboration with the National Insurance House, which has a role in monitoring and evaluation. It reports on the level of implementation to the National Agency of Health Programs, which is a part of the Ministry of Public Health (articles 50, 52, 54 of Law no. 95/2006).

Another major change regarded the primary health. The primary health assistance is provided through the family health cabinet, which is defined as a specialized cabinet in delivering medical services in primary health assistance, organized under the provisions of the law (article 60 of Law no. 95/2006). The cabinet is run by a family physician specialized in primary health care. The cabinet is basically the first point of contact for the citizens with the public health system. Every person needs to be enrolled to a family physician (in order to get health services). Starting with 2005 family physicians need to have their residency program complete, in order to be allowed to practice. They can perform their practical stage in so called cabinets – either individual or through different forms of association between two or more family physicians. The services offered through these cabinets include: health prevention services, curative health services, home care services, palliative care, counseling, scientific research in health.

The family physicians can earn the majority of their revenues through different contracts: contracts with the County Insurance Houses based on the Framework-Contract (a standard contract from the Ministry of Public Health, which contains rules regarding financing); contracts with other local Health Care Authorities for specific services like family planning, special counseling services, homecare for terminally ill patients; contracts with private health insurance companies; contracts with health care authorities for services included in the National Health Programs (articles 80, 81 of Law no. 95/2006).

The major change brought by this law is the way in which hospitals are run. Before the introduction of the law the vast majority of hospitals were run by physicians who had no special training in health management or health economics. In order to become a manager, a person has to have at least a bachelor degree and some kind of training or special education in management or health management that is established and recognized by the Ministry of Public Health. The manager signs a 3 year contract with the Ministry of Public Health. The contract can be extended or canceled depending on the results of the annual evaluation conducted based on a series of performance criteria defined by the Ministry of Public Health. The manager is appointed after passing a public exam. After appointment, the manager signs a 3 year contract with all the head physicians. This contract can be also extended or canceled based on the results of the annual performance evaluations. The contract includes performance indicators and standards that have to be met (articles 178, 179, 184 of Law no. 95/2006). The legislators aimed to promote the measurement of the hospital management performance in order to have a clearer picture of the performance of the manager and of the hospital medical staff.

The major source of revenue for the public hospitals is the contract with the National Health Insurance House. The contract is negotiated between the manager of

the hospital and the director of the National Health Insurance House based on a set of indicators included in the framework-contract. Public hospitals can also receive funds from the Ministry of Public Health but only for certain activities clearly stated by the ministry (for example: National Health Programs, investments in infrastructure). Hospitals have another possibility for earning revenues: through sponsorships or donations, contracts with private insurance agents for delivering medical services or research grants. Another provision is that all the scientific research activities and the salaries of the personnel involved in research had to be paid by the hospital from its own funds. Only starting with January 2008, these activities are financed from the state budget (articles 189, 190, 191 of Law no. 95/2006).

Last but not least, the new law introduces provisions regarding the establishment, organization and functioning of the National School of Public Health and Health Management (NSPHHM). The main objectives of the NSPHHM are: to organize and teach courses in the field of health administration and management for the personnel involved in the health system in order to have a more professional human resource especially at the upper levels; to develop research activities in the field of public health and health management; to provide technical assistance in public health and health management; other activities in the field of public health, such as promoting public health, evaluation of the health system, analysis of the reform process and so on. The NSPHHM should also develop and teach courses in the field of public health and health management, and administration for the personnel working in the public health system.

Although the name suggests a stand-alone educational institution, NSPHHM is only a department of the Ministry of Public Health, covering the continuous education of the already existing management staff. This department has no accreditation whatsoever from the Ministry of Education and Research, and is not able to offer undergraduate or postgraduate programs. Most of the courses offered are through collaborations with different NGO's or universities. In 2008, Romania still does not have an actual School of Public Health, educating public health specialists (not physicians), and able to design and implement programs.

Conclusions and recommendations

A steady evolution of the Romanian health system can be observed, from a centralized to a decentralized insurance based system. Is it enough? Surely not. The latest provisions are in our opinion just the starting point for a modern health system that can handle in an efficient way all the health issues of the population. One important step forward is the introduction of certain provisions like those regarding the hospital management or the establishment of the National School of Public Health and Health Management, which surely try to give a more important role to the management component and to introduce new management principles like efficiency, value for money or resource rationalizing.

Creating the National School of Public Health and Health Management is the first step toward creating a special category of public health professionals who will manage the system – hospital managers and managers of other public health authorities. Until

now the only solution for those willing to follow a career in health management was to study abroad. This is reflected in the education of the majority of hospital managers who are in the best case economists - the majority being physicians. A health manager is a person who has to work in a changing context, with scarce resources – most of the times – and to be able to motivate other people to share his vision and to feel the need to follow him. Such skills and abilities can be acquired trough special training courses, but only up recently managers across Romania have this possibility.

The National Health Programs are another important change in the health care system, aiming to give a broader and clearer view with regard to the population health status and the major health threats. Starting with September 2007 the National Program for the Evaluation of the Population Health Status is underway, and it is due to finish in September 2008. Its purpose is to identify the major health concerns among the population and to take action accordingly. For 2008 there are a series of other National Health Programs scheduled to be implemented that include: National Prophylactic Program, National Mental Health Program, National Program regarding Diabetes and other Nutritional Diseases.

Another strong aspect of the management of the health system is the introduction of performance indicators for the managers and for the medical staff. Without performance based measurement indicators, it is difficult, if not impossible, to evaluate the activity of a hospital. We have to take into account that hospitals are public institutions and they do not work for profit. This situation led to a rigid and outdated system in which things were done more by inertia than by motivation. At this moment, the first evaluation process for the 2007 activity is underway and there are signs that some managers could lose their jobs and be replaced with more qualified people, because of lack of performance.

One approach to get better managers is the action learning approach (Kerrigan and Luke, 1987). The action learning approach combines formal training with on the job problem solving (Kerrigan and Luke, 1987). Action learning is an approach to the development of people within organizations that use real-life tasks as the vehicle for learning. It is based on the premise that there is no learning without action and no sober and deliberate action without learning. It is the most complex approach and it is best used for acquiring knowledge, understanding concepts, understanding techniques, acquiring skills in use of techniques, skills in analysis of organization problem, and skills in developing and implementing action plans.

But such an approach needs a strong commitment from the political heads of the Ministry of Public Health in order to be introduced in the National School of Public Health and Health Management curricula. Nevertheless, the latest changes brought a new approach to health care delivery by introducing a stronger management component.

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