Romanian Health Care Reform in the Context of Economic Crisis

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Abstract: The effects of financial crisis are strongly felt in Romania, which already face with a significant slowdown in economic growth or even economic recession. The current and international situation remains still difficult, and requires high budget constraints. Under these conditions, the health system in Romania has become one of the most inefficient in Europe, mainly characterized by lack of transparency in the allocation of funds and inefficiency in resource use. The lack of clear and coherent criteria to evaluate the performance of health institutions results in a difficult implementation of efficient managerial systems to reward the efficient manager**.**

Keywords: health systems; health economics; public management; financing

JEL Classification: A12; I10; I18

1 "Chronic" Problems of Health in Romania

Romanian health system continues to rely on hospital care as the primary method of intervention, Romania registered one of the highest rates of hospitalization from the European Union and one of the highest in the world. The access to medicines, especially for disadvantaged groups remains a perpetual problem for patients, drugs offset depletion in the early days of the month came to be regarded as a quasi-normal situation, as happens at many hospitals and otherwise. In this context it is not surprising that although the financial efforts of the Romanian state have increased considerably in 2004-2008, the feeling of deprivation in the system continues to persist and to worsen (Vlădescu, 2008).

Romanian health-care system is vulnerable through lack of transparency, monitoring and control of expenditure incurred. Funding continues to be

inappropriate and be used in an inefficient way, the health financing system in Romania remains low in a European context, especially taking into account the long period of "chronic" under-financing and lack of investment in health. Besides under-financing, we can speak about arbitrary use of resources: allocation of resources between different regions, between different types of health services, between different health care institutions is inefficient and inequitable. Cost-efficiency studies are missing or are not used for resource allocation; the allocation process is not transparent, clear criteria are missing or not constantly used. (Vlădescu, 2008)
Romania's health system is one of the most inefficient in Europe and is characterized mainly by lack of transparency in the allocation of funds and inefficiency in resource use. The management, an area crucial to the effectiveness of hospital care can be succinctly characterized by confusion and inconsistency of all health ministers since 1989 which have claimed this area as a priority, but, in their final mandate, the situation was practically unchanged. Hospital management is often characterized by confusion and incoherence. The legislation does not provide the hospital managers with the required power or authority to organize and manage resources efficiently. The managerial deficiencies, adding frequently to deficient funding, conduct to the situation when hospitals confront with stock-outs of consumables or even medicines and request patients to bring their own items that they need. The extremely low role attributed to local authorities in hospital administration explains the low support that local authorities provide in their turn; the local funds are extremely low in the hospitals total budget (Vlădescu, 2010).

Experience gained by the public managers in developed countries, the results and satisfying the public interest by considering the economic and managerial criteria is clear evidence that performance-based management is the perfect option for the public system in Romania. The health system in our country, does not apply any of the criteria based on performance management. Economic criteria, social and managerial base that should be efficiency, effectiveness, performance, actually results in a single overriding concept - economy (in the sense of inexpensive) - saving all resources regardless of consequences. Reducing at the tolerable limit of expenditure in the health system generates serious consequences: lack of medicines and sanitary materials needed to operation and to provide medical services, limiting or even banning of investments of any kind, limiting employment even whether health unit needs staff, prohibiting any increase in wages or salary supplements granted for outstanding results. Thus, a manager of public health institutions (such as tertiary credit holder) cannot exercise its powers, cannot make decisions for the purposes of performance; he is limited to execute decisions of the primary credit holders and to maintain public activity as constant as possible from existing resources.

2 The Current State of the Romanian Health System

The recent deterioration of performances in Romanian health system is due to underfunding and lack of consistent reforms, but also by the opaque and unexpected decisions of medicines pricing, higher taxation and distorted allocation of funds. These are the conclusions drawn by numerous statistical studies of companies in health economics research, nationally and internationally.

The most representative indicator of health systems is the Euro Health Consumer Index. EHCI has become a standard measurement of health systems in Europe, which include 33 countries and 38 healthcare performance sub-indicators divided into six key areas: "Patient rights and access to information", "E-health", "Waiting times for regular treatment", "Outcomes", "Range and reach of services" and "Access to pharmaceuticals". First published in 2005, the Index is a compilation from public statistics, polls and independent research conducted by the founders - analysis company "Health Consumer Powerhouse" in Brussels.

We witness with concern at the rapid deterioration of the Romanian health system performance, a phenomenon which culminated in 2009 with Romania's demotion on the penultimate place: according to 2009 report, the annual benchmarking of health systems in Europe has ranked Romania at penultimate place of 33 European countries. Romania cannot boast even with basic rights of patients or E-health, slightly improved categories; and about the results cannot even speak. The only country worse than Romania is ranked Bulgaria, the two new EU Member States, and it is surpassed by Albania, Croatia and Macedonia[1]. "*Romania has, unfortunately, poor scores in most areas of health*" says Dr. Arne Björnberg, Research Director of EHCI. "*It appears that informal payments from patients are still expected a serious problem and an obstacle to achieving a health system based on fairness"*. The ranking for 2009 emphasizes that winning states (Netherlands, Denmark, Iceland) are beginning to use information health and choice to involve patients in decision making, building a bottom-up process to improve performance. At the bottom of the league is a group of countries (Latvia, Romania, Bulgaria) blocked the old health system, hierarchical and lacking transparency. This difference poses a challenge for the principles of fairness and solidarity of the European Union.

We believe that the main cause for which our country has come in this situation is insufficient and inefficient allocation of financial resources for health. After nine years of continuous growth, the budget allocation for health has declined sharply since 2009 to an alarming percentage of only 3.2% of GDP, which is half the

[1] Health Consumer Powerhouse, Euro Health Consumer Index 2009 Report, available on site - http://www.healthpowerhouse.com/files/Report%20EHCI%202009%20091005%20final%20with%20cover.pdf

European minimum level and is so far from the European average of 8 %, and the government target set at 6%.

An analysis of health and pharmaceutical policy in Romania, conducted by the Romanian Academic Society (SAR) in November 2009 entitled "*Is Health Falling into a Coma?"*[1] reveals that the Romanian health budget in 2009 fell by almost 20% over last year and the budget 2010 is 25% lower than 2009. The result analysis shows that the Romanian system of public health is really underfinanced, beyond any other discussions, taking occidental standards into account (where 8-10% of GDP is allotted to health field) and the fact that our health indicators are much worse than other European countries, not only from EU. Theoretically, the Romanian health system has been developed as an occidental type, and the citizen's expectations follow the same track; or, it is impossible to make it work with third world country level of resources. For instance, in 2007 we used to spend under $ 500 PPP (purchasing price parity) - the least per capita for health out of all of Europe, except for Albania, to Norway ranked first with over $ 4.500 PPP (see Fig. 1).

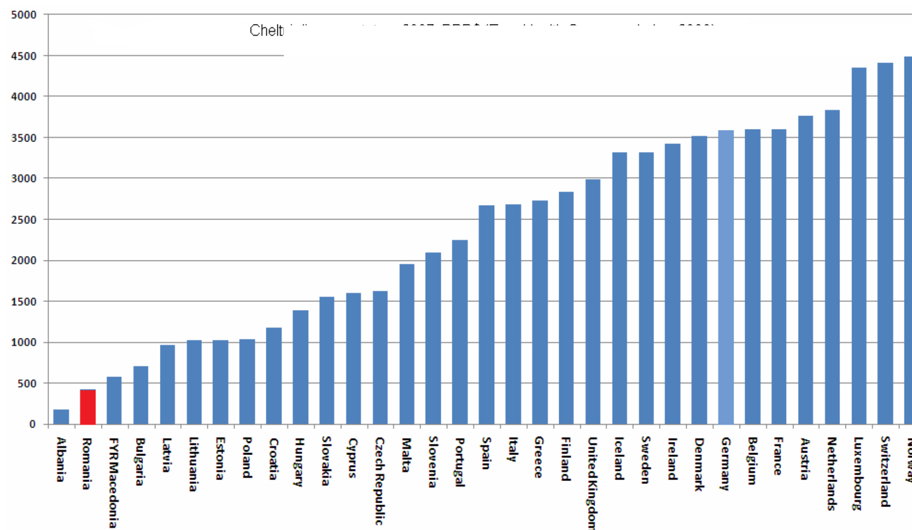

Figure 1. Total health costs in 2007, $ at PPP

Source: The Romanian Academic Society (SAR) in November 2009

[1] http://www.sar.org.ro/art/publicatii_sar/policy_briefs/intra_sanatatea_romaneasca_in_coma_-412-ro.html

3 Models for Financing and Providing Health Services

Until the advent of Law no. 145/1997 on health insurance, the health care system was centrally coordinated by the Ministry of Health through county health departments, consisting of a network of hospitals, clinics, dispensaries and other health care facilities. In addition, there were a number of hospitals, institutes and highly specialized national centres directly under the Ministry of Health, and parallel medical networks subordinated to the Ministry of Transport, Ministry of National Defence, Ministry of Interior, Ministry of Labour and Social Affairs and the Romanian Intelligence Service, which provide medical services and were responsible for health care for a particular category of people[1].

In the period 1990-1998, we used a two-tier system of the type of state budget financing, additional financing - health fund (GO no. 22/1992) and external financing - loans from World Bank (Law no. 79/1991), Phare funds and donations. The beginning of health reform involved the reorganization of health care financing system and health services. Organisational principles of the health system was significantly improved, by the free access to medical services, medical care paid for, national coverage, the transfer of responsibilities - county health departments, the Romanian College of Physicians, free choice of doctor, the emergence of the concept of family physician and emergence of the private sector.

In July 1997, Romania introduced a new health insurance system by Law no. 145 on health insurance, based on a modified version of the Bismarck-type insurance model, with compulsory health insurance based on the principle of solidarity and operating under a decentralized system. It entered into force on January 1, 1999 but there was a transition period in 1998 when the county health departments and the Ministry of Health has administered insurance funds. Accordingly, from 1 January 1999, according to the law, health insurance houses worked as a autonomous public institutions. Among the novelties introduced by Law 145/1997 on health insurance, first act which introduced the social health insurance principles, include:

- mandatory coverage of the population in a unitary system of social protection;
- free choice of doctor, health-care unit and health insurance house;
- provide a defined package of health services;
- funding through contributions and state subsidies;
- financial balance;
- decentralized operation;
- solidarity and subsidiarity in the collection and use of funds;
- fairness and accessibility in providing medical services.

[1] *National Health Insurance House (Romania), http://www.cnas.ro/despre-noi/scurt-istoric*

Since 2002, Law no. 145 on health insurance was repealed by GEO no. 150/2002 regarding the organization and functioning of health insurance system. Only in 2006 the health insurance system begins to prepare for substantial changes: the start of health reform in Romania - *the health, as a major objective social interest* - was given by Law no. 95/2006 on healthcare reform.

In all developed countries, insurance and health promotion is the responsibility of the state through its authorities. In Romania, taking several years ago policy decision of profound and sustainable change of health system, namely health care reform, it must be translated into practice, with the ultimate goal of population health improvement. In his "personal vision", Prof. Dr. Armean Petru establishes the main objectives of health reform in Romania:

- *general accessibility to health services;*
- *equity in service delivery, depending on the needs and expectations population;*
- *quality health care;*
- *increased efficiency in public spending;*
- *allocation of resources at national and regional levels.*

To achieve its goals, health policy must be uniform and multisectoral integrated, with the following strategic priorities (Armean, April 2010):

- health promotion and disease prevention;
- development of health care services;
- development of rural healthcare and for the elderly;
- development of social services and preventive medical care;
- reducing avoidable deaths, given the fact that in Romania, 15% of the deaths fall into this category, but currently are not avoided;
- influence major risk factors for health.

Health insurance is a key objective of a health system. Achieving a high level of health and equal distribution of healthcare services is an important goal of it. Each country's health system must involve respect for the individual (privacy and autonomy) and the orientation of the patient through responsive and quality amenities, so to meet people's expectations (Bârliba & Siniţchi 2008).

Health systems are defined by the dominant mode of funding, and those used in Europe are:

- The national health service - Beveridge type;
- The system of compulsory social health insurance - Bismarck type;
- The centralized system of health insurance - Semashko type;
- The private health insurance system.

A comparative analysis of the characteristics, operation, advantages and disadvantages of international health insurance systems is presented in the table. 1, in an adaptation of Bârliba & Siniţchi, 2008. It is noted in the comparative study, that world states grants priority for their health services, to one or other of the objective, depending on strategy, economic, social and ideological factors, and sacrificing other qualities of the system: either be granted universal and equal access to a specific package of medical services, either be more pronounced freedom is exercised options for beneficiaries and providers, either becomes paramount efficient use of available resources and limited. If, for example, they choose for a high freedom of choice of the beneficiaries, then the costs will be high and there is a restriction of accessibility to health services because not all patients can incur high costs. This system which stresses freedom of choice is common in the U.S., where, although the state is investing enormous health (14% of GDP, as opposed to 3.2 ÷ 4% in Romania), there are over 35 million citizens who do not have insurance and not receiving medical services (Doboş, 2006). U.S. health system is the most expensive in the world, but also the least efficient among the six major industrialized countries, said economists, authors of a study published by the Institute for Independent Studies "Commonwealth Fund". (Davis, Schoen, & Schoenbaum, May 2007) The study compares the health systems in Australia, Canada, Germany, New Zealand, UK and USA. "*U.S. health experts often assert that the U.S. system is best in the world without scientific evidence to that effect /.../ Americans looks at their mirror image, without including international comparison*" says the study's authors. In terms of quality, access, efficiency, equity and the results, the American health care system ranks last in every time between the six countries. Germany is ranked first place for access and quality health care, while Great Britain is also the first place to the criteria of equity in medical access and effectiveness of health-care.

Another type is the British model, there is increased access to health care, fairness, but accompanied by a limitation of options and of freedom choice (Tomescu, 2009). In contrast, the British system is the least expensive in the EU, but options are limited and there are long lists of waiting. Over one million patients are on waiting lists for various interventions (Vlădescu, 2004). The growth in health spending is remarkably moderate compared with trends observed in most Member States. The level of funding of UK health care, subjected to a rigorous central budgetary control, is still subject to further public and political debate. The criticism is powered especially by the scarce resources for secondary care, which appears as one of the main causes of long waiting lists in hospitals. The problem of waiting lists explains the relatively mediocre level of satisfaction with their British health system. With rare exceptions, the system works correctly for serious illnesses or emergencies, but less well for minor ailments (CNPV, 2009).

Concluding our analysis, we can say that health is considered a social right in Europe, to which all citizens should have access, unlike the U.S., where health is an individual item for which you must pay high costs.

In our country, has created a system of financing medical care consisting of public and private resources, based on equal opportunities for health services and ensuring equity in the issue of payments for services rendered. The health system in Romania is a modified revision of German Bismarck model - with compulsory health insurance based on the principle of solidarity and operating under a decentralized system - with influences from Semashko and Beveridge. The changes in recent years, in the medical services, did not solve the problems, the system at present is one hybrid, calling into question some health policy decisions on their long-term effectiveness. Following the operation of this hybrid system, some experts in the field was not considered necessary to pass the Romanian to health insurance system (Doboş, 2005). One of the reasons invoked by decision makers change was that the structure before 1989 was associated with centralized communist regime. But discontent and expectations were diffuse and they were not related to operating one way or another, but, obviously, by the poor quality of health services and doctors complaints were related to low wages and difficult working conditions in terms of lack of sanitary materials, facilities and utilities. Switching to the new financial scheme created, it seems, a new "mammoth" administrative, annual consumption of significant additional financial resources (Doboş, 2008). An example is the National Health Insurance House with 235 employees and 42 county homes with an average of 50 persons/house, whose administrative efficiency reported costs is questionable.

Switching to the new system was done without a very clear analysis of the implications of various European models in the Romanian context, in the immediate time period '89 when Romania did not have trained too many specialists in the field of healthcare management or health policy. The precarious financial resources allocated to health sector in the period 1990-2007, continued weak investment trend in the health system of the last decades in Romania. This led to lack endowment of public hospitals, with modern medical equipment and utilities performance and providing of low wage to staff in the system, compared with their status. This was reflected directly on the quality of health care enjoyed by the population. Perception of medical staff on working conditions offered by the system and its social status, combined with dissatisfaction with the low wages, legitimizes according to medical staff, demanding extra payments for the provision of medical care. This limits poor population access to services, which demanding, in turn, as required, or rooted, the additional payment (Tomescu, 2009).

Unfortunately, current economic and financial crisis, the lack of real reforms and several years of underfunding have destroyed the Romanian health system. The powerful social character of the Romanian health allows for broad segments of the

population to be included in the insurance system, without financial contribution from the person or another state body. Paradoxically, by the contributions of nearly 5 million payers, benefits, at least in theory - for free or compensated - about 21 million policyholders - potential patients. Thus, wife, husband or parents without their own income, who are dependents by a medical insured person, may have all the facilities it offers health insurance, as co-insured. Uninsured persons receive a minimum package of health services that includes medical-surgical emergencies to stabilize the patient, screening of potential endemic-epidemic diseases, family planning services. There are also certain categories of people without income or with incomes below the gross minimum wage for the country, receiving medical services without payment of contribution[1]: all children up to age 18, young people from 18 years up to age 26 years, if they are pupils or students, other categories of persons who receive gratuities by virtue of specific laws (revolutionaries, politically persecuted, war veterans, disabled persons, ill patients included in national health programs), people in leave for temporary incapacity to work following a work accident or occupational disease and persons in parental leave up to the age of 2 years, pregnant and postpartum women, pensioners for pension income up to the limit on income subject to tax, unemployed, detainees and remand prisoners, monarchical staff of recognized religions, etc.

In addition, the NHIH policy in Romania is only populist: it says gratuities everywhere, but financial limitation of these gratuities is the responsibility of medical providers (hospitals, pharmacies, medical offices, etc.) through the ceiling of compensated prescriptions / physician, the ceiling of number of admissions / hospital, the ceiling of drugs netted / pharmacy, the ceiling of number of medical tests / medical analysis laboratory (Păduraru, Radu & Pereţianu, 2000). Given the limited financial resources, therefore, have been found other ways, to limiting the number of services and hence, the costs: access to specialized services, generally more expensive, is permitted only with referral from general practitioners; laboratory investigations are allowed only correlated with diagnosis and can only be prescribed by some doctors, prescriptions compensated and free drugs are limited in number and value of drugs prescribed per prescription, etc. (Tomescu, 2009).

4 Conclusions

In light of the globalization trend, but amid the general crisis faced by most national health systems, we can say that radical reform measures are needed. In Romania it is necessary to develop a strategy based on four principles: equity, quality, accountability and focusing on patients / citizens, the principles which in fact were in varying degrees, assumed and accepted by all governments after 1990,

[1] Article 213 of Law no. 95 of 14 April 2006 on health care reform.

while being consistent with all agreements and documents to which Romania is a signatory.

It is crucial to look at expenditure on health, not only in the form of cost increases, but as an investment that will bring us future benefits - that social and economic value resulting from investment in health. Given these considerations, and current financial situation, it is necessary a continue and predictable growing of financial resources allocated to health, including the generalization of multi-annual budgets, which can lead to recovery the imbalances caused by decades of previous underfunding, compared with the rest of EU member countries. In the medium term, the gradual increase of the GDP allocated to health resources, through the multiannual budgetary cycles, should arrive by 2012 to 6% of GDP.

For increase the funds available, it should be rethought the current system of health contributions. It can consider using a method similar to that of private pensions: small percentages of the compulsory individual contribution to be redirected to a private health insurance system, along with a tax incentive scheme for those amounts.

It is also necessary to develop a system of allocating health resources based on transparent criteria and medical records. The essence of the health system must be level of service provided and not the level of funding. Therefore, the organization and financing should be made so as to ensure that funds are used in the most efficient way, to enable the provision of quality health services and appropriate patient needs. In other words, the level of funding is not only important but also, especially, how these resources are used. In allocating resources among different types of services should be considered especially those services that can contribute most, to reducing illness and decreasing avoidable death rate, with an emphasis on the allocation to primary care and preventive services and to promote health; it is vital to freeing up hospital care, intensive consuming financial resources.

On the other hand, currently, payment of most health services provided in the health sector in Romania do not take into account the performance of medical act, particularly at the level where occur most medical services (hospitals, for example). Both doctors and other medical staff are paid by salaries that take little account of the quantity and quality of medical services performed. These deficiencies should be eliminated by introducing and supporting payment mechanisms based only on efficiency and quality of medical act, and by stimulating and developing public-private partnerships, privatizations and private management in the public system.

Finally, the solution already put in place since August 2010 - organizational and decisional decentralization - is a solution for the Romanian health system reorganization. Recent events - decentralization (hospitals are subordinated to local authorities), liquidation of arrears in hospitals and for compensated and free drugs -

will lead to more efficient hospitals to stabilize the health system and will have a positive impact on environmental business in health. This will only happen if there will be a major change in the decision-making and accountability mechanisms so that decision can be taken as close to where they are provided and used health services. In this way, ensure a better match to the health needs of the population, along with direct accountability to those who take decisions in the community.

Table 1. Comparative Analysis of International Health Systems

Insurance system	Application	Features and operation mode	Advantages	Disadvantages
BEVERIDGE	• Denmark • Finland • Iceland • Norway • Sweden • Greece • Italy • Portugal • Spain • England	• source of funding through taxes, general tax (public budget) • government-controlled, government is the payer of health services • there is a private sector • access to services for all citizens • broad coverage of the population with health services • leadership by state authorities • use the role of "filter" principle-family doctors, elected freely by patients • physicians are salaried or paid by the number of patients enrolled on their lists (per capitation) • it is engaged a co-payment of part of the cost of medical services • budget (as total revenue) is split, divided by destinations, according to criteria of social importance (as education, health, defense, public order)	• positive impact on health • ensure universal coverage of population • a high degree of social equity • relatively un-onerous (not unbearable by population) • payment for services performed after administration of therapeutic act • risk groups have priority	• long waiting lists of payment for therapeutic acts and for certain categories of diseases and patients • medical staff has no incentive • high dose of bureaucracy
BISMARCK	• Austria • France • Netherlands • Germany • Belgium • Romania	• source of funding is contributions to health, which are binding on the employer and the employee • contributions are equal to a percentage set by law, but it is reflected different at taxpayers in relation with real income received • share of the institution and the employee's participation is dependent on the executive policy and economic potential (additional resources) • insurance contributions are collected and managed by Health House, an independent institution of government, that select models of health service delivery, payment models, contracts with hospitals, clinics, surgeries • health policies are set by the executive with the Ministry of Health and Insurance Houses • broad coverage, but not total (remaining uninsured persons who do not work) • contracts with health care providers based on tax per service, tax per prestation, tax per case solved	• relatively high medical performance • funds transferred, custom stable • visible cash flows on the components of the system • making effective and appropriate service delivery • health programs consistent with the public policy • Insurance House has an operational independence in relation to the executive • combining "good risks" to "bad risks" • health services allocated according to needs • remove tests • supports the rights of policyholders	• high administrative costs (the largest in Europe) • generates a high induced consum, with the possibility of emergence phenomena "perverse", such as moral risk (in a service whose price is zero, demand always exceeds supply) or "adverse selection" (expensive groups insurance are denied due to expensive high volume of consumption or the high cost of services.) • health services are for the insured persons and for disadvantaged groups • cost control for medical services, with a difficult execution
SEMASKO	• countries that had a centralized economic system in Central and Eastern Europe	• source of funding: taxes, general tax, which forms the state budget • the state has a monopoly on health services, which are its property • the controlling of the sales process - purchasing of medical services is the territorial level through centralized planning and execution in stages • medical employed staff (civil servants) • people's access to health services is generally free and seems erroneously (in the sense that is not paid by patient) • there is no private sector • medical staff do not obtain additional data through work	• general access to medical services	• lack of initiative and competition • doctors become public servants • reduced impact on health status • quality of treatment act is affected by insufficient funding (underfunded and ineffective) • competition is absent, so this system is unperformant

Insurance system	Application	Features and operation mode	Advantages	Disadvantages
PRIVATE	• USA - functional priority • Europe - voluntary, 20% of health insurance	• the patient, through the private insurance model, selects the institution, the service quality and includes a financial relationship patient - doctor • disadvantaged categories are covered by special programs	• emphasizes the freedom of options • high medical performance • efficient and quality services • cover all categories of medical services (proportional with insurance)	• health is an individual good for which must pay high costs • those with high risks of illness will be excluded from the system • those with presumptive risks will have input (adverse selection)

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