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AN ANALYSIS OF THE HEALTH SECTOR IN ROMANIA

Case study

Keywords
Public policy
Health sector
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Abstract

The paper intends to present an analysis of the efficiency and the performance of health sector in Romania. The research efforts are based on the description of the operational mechanism and analyses of the financing or underfinancing of the above system. Romania has a significant issue in terms of poverty and fairness. Among EU States, it was ranked second in 2008 in terms of the share of the population exposed the risk of poverty, with a share close to the value of 23%, Latvia, with a rate of 26 %. Given this inequality, it would be advisable for the Government to devise specific policies in plane to ensure access for the poor population to health care. Theoretically, Romania provides such protection through the exemption of those registered in the program concerning the guaranteed minimum income from the payment of contributions and of copayments. However, in practice this mechanism is insufficient.

Introduction

The present paper presents an analysis of the efficiency and of the performance of health sector in Romania. The research efforts are based on the description of the operational mechanism and analyses of the financing or underfinancing of the above system. On the other hand, there are underlined the main weak points existing within health system and there are some proposals to improve them.

The analysis of the health system is based on the functional one. The general purpose of the functional analysis consists in:

- Identifying the strengths and distortions in the present type of organization; the performance and good functioning of the Romanian health system; the proposal of some recommendations in order to repair the identified deficits
- The optimization of the dialogue between decision-makers in the finance and health areas.
- Highlighting the discrepancies between declared and assumed functions of the key agencies in health sector and their place in service supplying, funding and concrete creation of the selected health system resources such as technology, main offices and staff.
- Settling the basis for increasing the availability and use (especially the quantitative one) of the data and quality information.

Health Sector Performance

The health sector performance from Romania and not only, can be analyzed in relation with four different indicatives:

    a. Health results;
    b. Beneficiaries receptivity;
    c. Equity and financial protection;
    d. Its own financial sustainability.

The theoretical framework used within functional analysis – figure 1.

The functional analysis has identified significant problems in all four areas.

a. Health results

Given the fact that Romania has joined European Union (EU) in 2004, it is relevant to compare Romania with the other EU countries. However, it is equally important to keep in mind that Romania (with an income per capita of 7 500 USD in 2009) is considerably poorer than the EU average (with an income per capita of 38 845 USD in the same year) and that the income level of a country is linked to the health of its population. The analysis found that – even if the health results registered improvements and the gap between Romania and EU is diminishing, at some major indicators, the results achieved in the health sector in Romania remain significantly behind those in the EU Member States (Eurostat, (2012)).

It is also noted that health indicators are close to the average of countries with similar levels of income.

Over the past three decades, life expectancy in Romania increased to 69.9 years for men and 77.5 years for women. Also, there was a huge reduction of the death probability before age of 5 (down to 12 deaths per 1000) live births and maternal mortality (currently registering 21.1 maternal deaths per 100 000 live births). Within these global indicators of this summary, Romania reduces the high and still significant historical difference between this and the EU average, but its life expectancy remains significantly behind the EU average life expectancy of 76.5 years for men and 82.6 years for women (Eurostat, (2012)).

- Cardiovascular diseases are the leading cause of death in Romania, meaning that success in cardiac interventions is an important indicator of the health system success as a whole. The report concluded that this is an area in which Romania has achieved some successes. Standardized mortality rate of heart disease in Romania for

both sexes (194 per 100,000) is below the level recorded by countries with similar income levels (330-100000 inhabitants), even if the country scores limited progress in achieving the results within the EU.

- In other areas, such as the preventive medicine, Romania does not compare favorably with others. A dramatic example is provided by cervical cancer mortality which can be avoided to a large extent by detecting and treating cervical lesions. There is a high rate of cervical cancer in Romania. Even more worrying is the fact that death rate from this disease raised or was unchanged, while in most European countries it drops.

a. Responsiveness to beneficiaries

Problems related to this aspect tend to be the most often reported in the press, including long queues and patients dissatisfied because they could not get the diagnostic services and the medicines they need. Users often complain that they are humiliated when dealing with the health sector - there are few complaints due to the costs involved in this for users but also because they reflect a lack of concern for patients' rights and for suppliers' freedom to decide on the quality of services they provide to patients.

Surveys suggest that informal payments are widely perceived especially for hospital services , over 60% of hospital patients make informal payments . Receptiveness towards patients' rights is difficult to measure and to rate, but such an attempt of Euro Index of the alternatives' consumers within the system didn't exist and the providers often do not make any effort to be attractive and to meet the users (hence come the problems of lack of cleaning or maintenance) .

The provision by the private sector is reduced. Only 3% of consultations (or 6 % of households in the richest fifth) occur in a clinic & private practice. Health System 2009 ranked Romania on 32nd out of 33 European countries in this respect.

b. Equity and Financial Protection

How fair is the health care system? The latest data available are from the Survey on household budgets (GBS) in 2008. The data GBS can draw several conclusions:

- There is a big problem with access to health services, especially for the poor part of the population. Many poor people in need of medical services do not seek health care. Almost half of the poorest 20 % of the population is in this situation. This gap is particularly large in the treatment of chronic diseases, as 42 % of the poor who say they have a chronic illness do not seek care compared to 17 % of wealthy individuals. Real gap is even greater, because most poor people with chronic diseases do not realize the need for medical care. The simulations which assume the need for health care among people with chronic disease are similar among the rich and the poor categories of population and these estimate that an alarming 85% of the poor who need health care do not receive it.

- Years of economic growth have increased the access of the entire population from 61% in 1996 to 71% in 2008. However, during this period, increased access was concentrated among higher income groups. For those with increased income the access has risen from 65% to 80% while there was no increase access for the poorest.

- Government policy is to subsidize services (so that, theoretically, there is no co-payment for services) and to partially subsidize a variety of pharmaceutical products for the entire population. In addition, poor categories are

explicitly spared of payments, but the evidence available suggests that this policy is not effective in protecting the poor and other vulnerable groups face financial difficulties.

- Three out of patients are too poor for the services they receive;
- 62% of the poor people requiring medication pay for them.

While in some countries poverty diseases lead to high costs of health care incurred by patients in their own pockets, in Romania, the main problem is rather the lack of access to it than high financial costs. A study based on data of a survey for the period 1999 - 2004 measured the impact of payments for health care on poverty. In 1999, payments for medical care brought 1.2% of the population below the poverty line, while in 2004 they got 0.4 % of the population below this limit.

c. Financial Sustainability

Between 2005 and 2008, the public health sector revenues have grown quickly, with an average nominal rate of 23% per year, a growth rate much faster than the overall public revenue. Financing needs of the health sector grew at an even faster rate, due to a number of factors, including the increase of the number of eligible drugs for subsidy and the removal of ceilings for compensated medicines. When the financial crisis in 2008 forced the government to cut public spending, the health sector has been unable to control costs and, instead, the debts to suppliers of drugs and against other providers.

Subsequently, the auditors found that hospitals and pharmacies had sold their products and services, but the invoices were not recorded by the county houses insurance because they would have exceeded their budget ceilings set out in.

Health System Description

After the Revolution of 1989, Romania started a reform of its tax system centrally. The changes introduced in the first decade of the Revolution were strengthened and deepened by Health Insurance Law from 1997 and the Health Reform Law of 2006. The aim of the reform was to create a system of health insurance decentralized and pluralistic, in which citizens would contribute based on income from these funds for health insurance would purchase services from health providers a market where quality and safety should be carefully regulated by an independent entity. Even though there existed significant progress in terms of directing the system towards this vision, many of the features of the old system and still were not created some vital skills to enable the new system to work effectively.

Following the recent decentralization of hospital accountability relationships within the health system in Romania have become more complex. The managers of these hospitals must now report to the county councils and municipalities that belong to Health Ministry (HM) and CNAS. The second level of responsibility for primary care outpatient centers and the hospital is reported by the Health Ministry through county public health authorities. The conclusion is that this relationship is extremely weak. It will be crucial for the government to clarify, consolidate or redistribute responsibilities within the board, thereby increasing transparency. Such clarification should restore HM leadership policy (as opposed to its role management) and ensure the autonomy of CNAS as a purchaser of health services (as opposed to its role of simply paying), while promoting a greater clarity regarding liability CNAS and greater transparency in the Council (by publishing annual reports, audit memoranda and other technical documents) .

Strengthening financial controls

The evolution of health spending over the past years has shown that, without careful control, costs can increase in an explosive manner. Shortly, the difficulty lies in strengthening financial controls. In the long term, the difficulty lies in the

development of systems able to establish priorities regarding the use of new technologies and pharmaceuticals in accordance with available funding.

In 2009 and 2010, there have been significant expenditures in the sector, which exceeded the approved budget, particularly for pharmaceutical and hospital services. There have accumulated very important arrears and for several months, they did not know the real extent of the problem. Since then, the government, with the support of the IMF and the EU, has developed a series of measures to exercise effective control over health spending. In recent months, among them was included to reduce the number of patients admitted to hospital with 10% compared to 2010 and reduce the ceiling price paid by the government for medicine in national health programs. The Government is also implementing an ambitious information technology system within CNAS for monitoring and improving the efficiency of health spending. It will implement additional controls in the near future, which will include:

- establishing a quarterly indicative ceilings for services contracted with hospitals and physicians with incentives to physicians that they fall within the limits of prescription drugs;
- reduction of compensated and free drugs approved in 2008 in order, directing, if possible, to generics.

An unusual feature of the health sector in Romania is the existence of a massive number of national health programs. These programs have grown at a much faster rate than any other item included in the budget for the health budget is equivalent to almost a fifth of total health spending and 2.3 times the total budget for primary care.

In Romania, there is a third group of programs that consists of conditions and treatments with high costs and low incidence and they constitute the lion's share in national programs. These include cancer (31% of the total national programs), diabetes (13%), transplantation of organs and tissues (2%) and renal dialysis (23%). These programs are funded by the HM and CNAS and receive special treatment. Not only these contributed to a high budgetary priority but have been exempted from cuts during the financial crisis of 2009 (Institutul National de Statistica, (2011)).

Also, there are exempts from regulations that require co-payments by users and the practice of favoring generics and new technologies tend to involve high costs without adequate assessment of health technology. Within this functional analysis, I recommend first directing national health programs so that they focus on the prevention of non-communicable diseases and cervical cancer as well as infectious disease control and, second, the transformation of other national health programs which finances the high cost interventions and reduced incidence in a fund for catastrophic diseases, with a clear budget ceiling and transparent rules decisions

Efficiency of network health and recovery of quality control systems

Romania inherited a large hospital sector, outdated and distorted, with very few outpatient facilities and a poor regulatory quality of the old communist system. Even if there has been some progress in terms of modernization, there is still much to do, given that professional and financial incentives have continued to target direct investment and human resources to the provision of hospital services .

Efficient network would involve the remodeling of existing institutions that operate independently of one another, to turn them into networks capable of operating within the system of referrals and referral back. This would require classification of existing units providing health services and identifying the level and type of tertiary centers that could become the leader of each network

connection. It would also require the reduction of hospital care units that are no longer necessary, reorganizing and reducing singular specialization hospital beds for acute conditions up to a maximum of 4 per 1,000 inhabitants. As you reduce the supply of hospital services will be necessary to increase the supply of specialized outpatient and day (they may work in hospitals, clinics as satellite or independent facilities). Some of these actions may require updating, as appropriate, of EU-funded investment program to rehabilitate hospitals and buying medical equipment.

- Many family doctors are working only a few hours a day and is likely to increase considerably the volume of services.This is due partly to the small share of their earnings that are paid out of fees for services, but largely due to regulatory maximum ceiling on the number of visits of patients for which may charged on a daily basis.There are already plants to increase fee for the services of doctors income from 30% to 50%, but if it is deleted and the regulary ceiling, they will not be able to be responsive to such incentives.

- Similarly, the under-utilisation of specialist doctors in massive outpatients. Again, this is due to a ceiling on the number of points you can earn per working day and the absence of incentives for outpatient procedures.

- Doctors don't have any incentive to limit the references because they can be charged .

- Hospitals are paid on the basis of the Diagnostic Group (DRG) for hospitals services, wich give them an incentive to increase the number of hospitalizations. In 2006, 9 of the 20 most common DRGs observes were those who, in other countries, are usually treated as outpatient or day services. These

patients represent 15% of hospitalized patients in Romania and that could be easily treated in the outpatient procedure.

- It is assumed that the DRG stimulates competition and, however, argues that CNAS is forced to conclude contracts with all hospitals, regardless of cost or quality.

- Structurals technical units for introducing positive incentives are already largely implemented. Fees for services associated with the capital can reach a balance between the different levels of supply and to ensure access for the entire population. DRG payments, if they are properly sructured, can encourage the provision of outpatient medical care and daily hospital treatment instead.

Changing the rules so that CNAS do not pay for readmissions, which exist in the current framework agreement, constitutes a good example of such improvement, maybe adding quality indicators for improving these payments. There are numerous examples easily adjustable from other European countries. However, the constraints of the current framework agreement which, in effect, limit the volume of activity professionals' primary health care and ambulatory and quarterly recalculation of values could offset any points of potential benefits obtained from adjustment of the payment rates by itself.

Another major component of quality of the health care system is the use of international clinical guidelines, which are algorithms that provide practitioners instructions regarding diagnosis, management and treatment in specific areas of health care. Each country must adapt these clinical guidelines to fit the context of the health system, own their own referral network and resources. The guide creates what is known as the paths, which provides detailed guidance for the

management for patients suffering from specific diseases or certain periods of time, including details on the progress and the results. In this way, ways of pursuing quality care, equity, continuity and coordination of care within the health system.

In addition, we recommend that the Government establish health policies (cross-cutting programs of preventive care to the population), including through the introduction of legislation to reduce risk factors (for example, to increase the excise duty on tobacco products and the prohibition of smoking in public spaces), the national communication campaigns, preventive interventions for the population and for individuals and programs to reduce risk factors highly scattered, intensification of cancer detection, vaccination, as well the monitoring increase.

The demographic problem.
Romania's population declines and ages. Even if this trend can be observed in other countries, it is even more pronounced and more severe in Romania.

Figure 2 illustrates the speed with which the Romanian population is aging as a result of the fall in combined fertility and mortality. The world as a whole goes through this transition. In the 1950s, the global population within the categories of age, each age group was higher than that of older than him, creating the traditional pyramid of the ages. Today, this is no longer valid, since the lower age groups approaching the size of adults. It is expected that by the year 2050, this change in the age structure will become more prominent, all age ranges for adults and youth approaching the same size, this process culminating with the standardization of the pyramid.

Romania recorded an advance compared to the rest of the world during this transition. Since the 1950s, the younger age groups of population were no longer the greatest. Today, unlike the rest of the world, the majority of the population in Romania is made up of adults between the ages of 20 and 60 years of age. It is expected that by the year 2050, the largest segment of the population will consist of older persons (those aged over 60 years), and the population would take the distribution in the form of the inverted pyramid, "each age group being higher than younger than him" is this the reverse very quick and severe in Romania compared to the pace of the transition to a global level (Comisia Comunit ilor Europene, (2007)).

Figure 3 points out another core feature of demographics of Romania, namely the decrease in its population. Romania's population continues to drop steadily since 1990 and looming this fall. At its peak, the Romania's population was over 23 million inhabitants, while today it is less than 21 million. The United Nations forecasts that the total population will decrease by up to approximately 17 million by 2050, going back to the year 1950. Today, the two groups are of equal size and in the future, the number of older people will exceed the number of young people in Romania. This change, coupled with decreasing population continues, is a defining characteristic of the demographics of Romania.

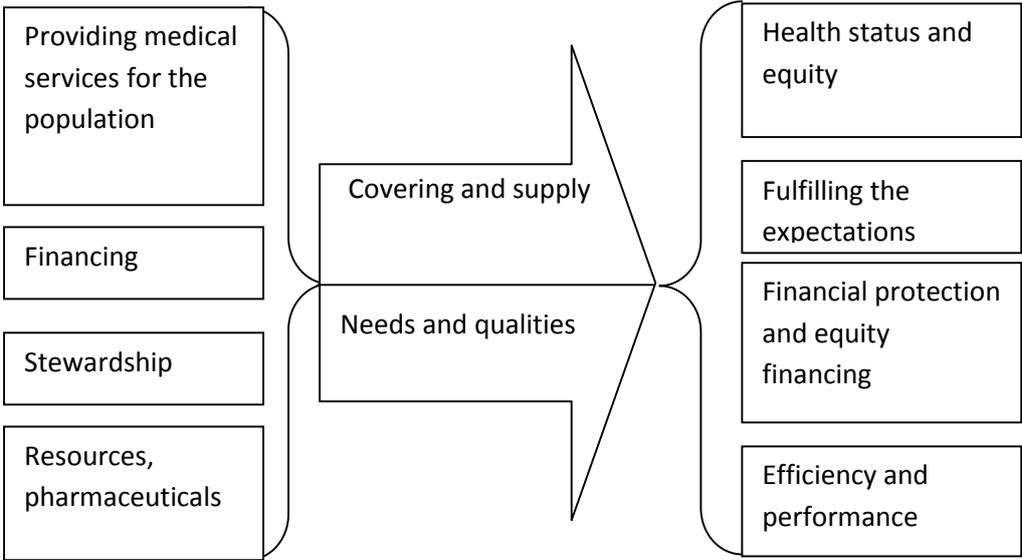**Comparison to other dimensions of health system**

Without the intention of supporting a specific grading system health within the framework of this analysis, I have taken note of the European Index of Consumer Health Care 2009. It provides scores of health systems of the 33 countries in the EU based on 38 indicators grouped into 6 categories, which included: the existence of insurance covered for liability in cases of malpractice, the speed with which computerized scans are obtained, fatal heart attack cases, the value of informal payments made to doctors and the existence of subsidies for pharmaceutical products. Data were collected from public sources and from within a study requested

a private provider. General results can be seen in Table 1.1.

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Figure 1: The theoretical framework used within functional analysis

Providing medical services for the population		Health status and equity
	Covering and supply	
Financing		Fulfilling the expectations
	Needs and qualities	Financial protection and equity financing
Stewardship		
Resources, pharmaceuticals		Efficiency and performance

Source: Adapted from Duran A, Kutzin J, Martin-Moreno JM, Travis P., 2011

Figure 2: The age structure of the population in Romania and worldwide-thousands
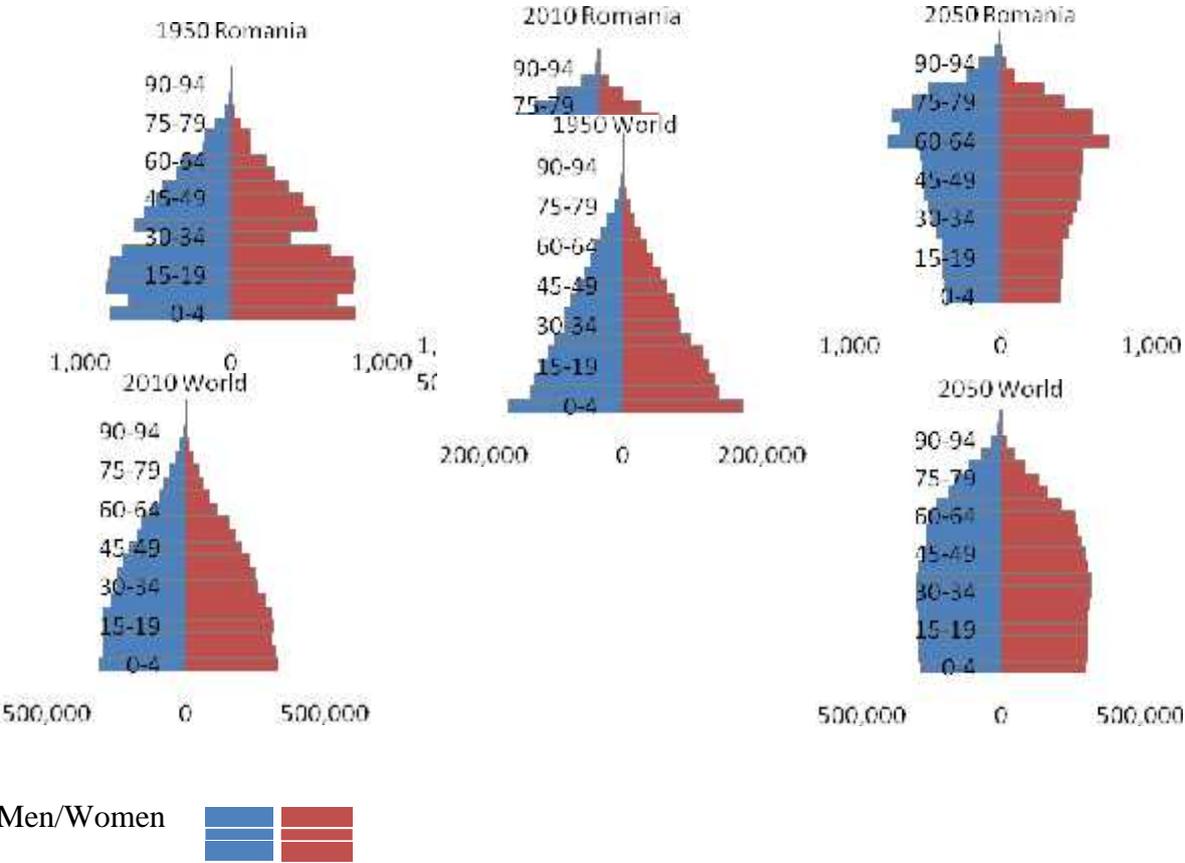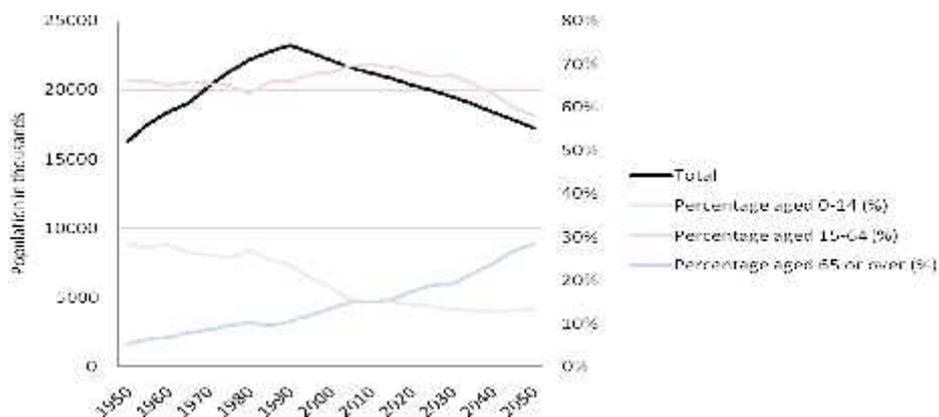

Men/Women

Figure 3: the total population of Romania and the distribution of age groups over time

Source: The Population of the Department of Economic and Social Affairs of the United Nations Secretariat, World Population Prospects: the 2008 revision.

CATEGORY	RANK
PATIENTS RIGHTS AND INFORMATION	**28**
E-HEALTH	**32**
WAITING TIMES	**16**
RESULTS	**29**
DIVERSIFICATION AND ACCESIBILITY	**30**
PHARMACEUTICAL PRODUCTS	**25**
TOTAL	**32**

Table 1: Classification Euro Index of Consumer Health Care 2009 (sub)category selected for Romania
Source: The European Index of Consumer Health Care 2009