

# A HEALTH SYSTEM FOCUSED ON CITIZEN'S NEEDS. ROMANIA SITUATION ANALYSIS (I)

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## **Abstract**

*The Presidential Commission for Romanian Public Health Policies Analysis and Development established in 2007 by the President of Romania has performed an analysis of the population health status and the health system in the view of making policy recommendations for the improvement of health system performance. The driving forces that lead to the need for change are: the poor health status of the population, the discontent of both health workers and the population, and the low rating of health system performance, as they are revealed in the international statistics. The Commission has identified 6 major intervention areas in order to address the dysfunctions of the health system: health system financing, health system organization, hospital care, drug policy, primary care, and human resources. The dysfunctions identified within the 6 areas lead to the violation of one of the most elementary patient rights: the right to quality care and medical treatment in accordance to their needs, including preventive and health promotion services.*

**Key words:** *health strategy, health care, health system performance, health status.*

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## Introduction

On December 2007 the President of Romania, Mr. Traian Băsescu, established the Presidential Commission for Romanian Public Health Policies Analysis and Development with the main role of analyzing the current state of the health system and recommending policies that will improve health system performance and will lead to better population health.

The current situation of the health system was assessed by reviewing and comparing the main documents on public health policies from Romania and from abroad, by analyzing the official statistics (published in the Romanian Yearbook of Health Statistics and WHO database "Health for All"), by reviewing the existing legislation and the sector strategies, and by performing a stakeholder analysis [8].

Through a Consultative Forum, there have been chosen 9 specific topics which were assigned as specific research areas for 9 working groups: *funding, delivery systems, drug policy, hospital care, primary care, human resources, population health, quality and patient rights*. After 11 months a draft report was launched for public debate [8].

The Report of the Presidential Commission, as further introduced, was approved in 2008 by the Romanian President and presents an intervention strategy with 6 main priority areas:

- Health system financing
- Health system organization
- Hospital services
- Drug policy
- Primary care
- Human resources

## The driving forces

Health reforms are initiated by three major factors: poor health status of the

population, discontent of health system actors, and low rating of health system performance, as revealed in international statistics. Following the European Union (EU) accession, the health status of the population and the health services from the other EU Member States (EU MS) became the reference framework for comparison of our country.

### *Snapshots on health status of Romanians*

Health status analysis shows that Romania still ranks among the last places in Europe. Thus, a child born in Romania in 2007 has a 6 times higher probability to die before 1 year of age than a Swedish child and about 3 times higher than a Hungarian child [7]. Figure 1 shows the discrepancy between Romania and EU MS when comparing the infant mortality indicators.

The main causes of death in Romania in 2007 were: cardiovascular diseases, followed by cancer, digestive diseases, respiratory diseases and accidents, injuries and poisonings. If in EU countries there has been a decreasing trend of the mortality due to the diseases of circulatory system for the last three decades, the situation in Romania has not registered too much improvement, which increased the gap between our country and EU MS (Figure 2).

Overall mortality by tumors is smaller than the EU average, but there is a high number of avoidable deaths on specific cancers. For example, the standard death rate (SDR) due to neoplasm of cervix uteri, 0-64 years, is 5 times EU average and SDR due to neoplasm of trachea/bronchus/lung is about 20% higher [3]. The risk of death due to cancer of cervix is 10 times higher in Romania than in France or Finland and

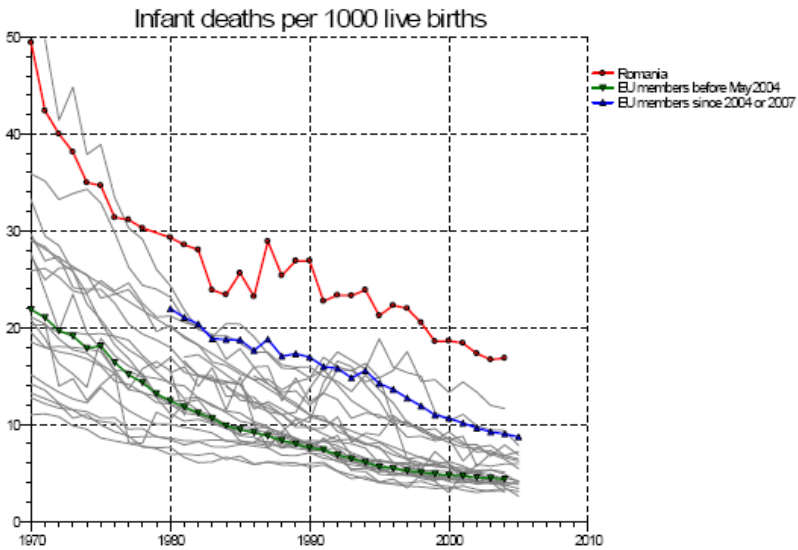


Fig. 1 Infant deaths per 1000 live births, 1970-2005, Romania, EU MS before May 2004, EU MS after 2004

Source: Vlădescu et al, 2008

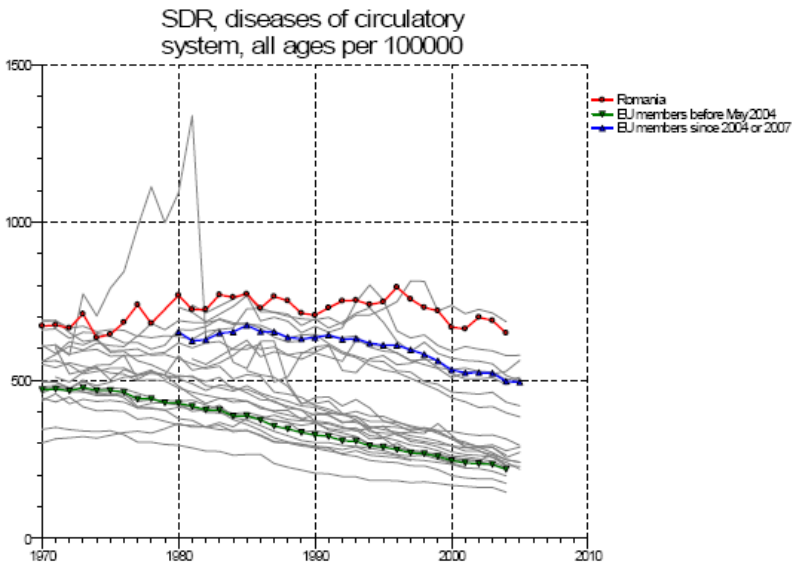


Fig. 2 Standard death rate for diseases of circulatory system, all ages per 100000, 1970-2005, Romania, EU MS before May 2004, EU MS after 2004

Source: Vlădescu et al, 2008

3-4 times higher than in Slovakia or Czech Republic despite the fact that, nowadays, this disease is easily preventable or curable by early detection [7].

Avoidable deaths – indicator directly correlated with the health system

performance, ranks Romania on the first place in EU, both for males and females (Figure 3); furthermore, the trend in this field has a marked decrease in all EU countries, while in Romania the decreasing trend is reduced in females or rather stable in males [7].

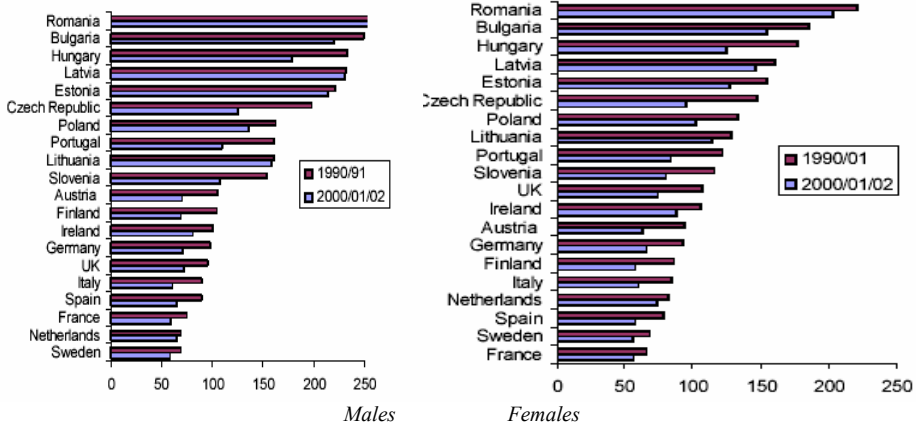


Fig. 3 Avoidable mortality in male and female, as age standardized deaths per 100000 population, 1990/91 vs. 2000-2002 in selected EU countries

Source: Newey et al. 2003

About half of the deaths in males and more than one third in females could be avoided in Romania [2]. In other words, more than 60, 000 people die each year by avoidable causes due to the dysfunctions of the Romanian health system; each year Romania is losing an equivalent population of a city of the size of Slobozia or Giurgiu [7].

As well, easy preventable diseases which are almost eradicated in EU are still present in Romania, affecting a big number of people. To give some examples: Hepatitis B incidence is double in Romania than the EU average and Romania has the highest TB incidence rate among EU MS [7].

#### Discontent with the health system

All latest studies reveal the dissatisfaction of health staff and population. The survey on population opinion on health reform conducted by the Center for Health Policies and Services in January 2005 has shown that in comparison to the previous years the population perception on health services got even worse than before: 31% (vs. 23% in 2003) considered that the health system was as bad as it would require major reforms. The population was unsatisfied mainly with hospital services (37%), but also with family doctor services (19%), ambulatory services (9%) and emergency services (7%) [5].

One explanation is the critical

situation in terms of human resources. In 2006, Romania had 192 physicians per 100 000 population, while the average for the EU was of 315 physicians per 100 000 population, with high geographical and rural/urban disparities.

The present model of care, relying mainly on hospital curative services, creates accessibility problems in rural areas where hospital density is quite low. The same applies to the population access to drugs, the number of pharmacies in the rural areas being much reduced in comparison with urban areas.

All these aspects, together with the freedom of movement following the EU accession, caused the emigration of more than 4% of the physicians (over 1000

physicians) which results in decreasing the population access to health care services [7].

*Health system performance*

WHO developed the concept of health system performance as relying on three main pillars: (1) the health status of the population, (2) the capacity to meet the expectations of population (3) the fairness concerning the financial contribution. When analyzed with regard to the achievement of these three main goals, it can be noticed that Romania is ranking the 99<sup>th</sup> in the world, behind countries like Albania (55), Slovakia (62), Hungary (66), Turkey (70), Estonia (77), as shown in Table 1 (WHO, 2000).

*Table 1 The performance of selected health systems*

RANK	COUNTRY	RANK	COUNTRY
1	FRANCE	48	CZECH REPUBLIC
2	ITALY	50	POLAND
5	MALTA	58	SOUTH KOREA
9	AUSTRIA	55	ALBANIA
14	GREECE	62	SLOVAKIA
17	The NETHERLANDS	66	HUNGARY
18	UK	70	TURKEY
25	GERMANY	77	ESTONIA
30	CANADA	99	ROMANIA
34	DENMARK	102	BULGARIA
37	USA	130	RUSSIAN FEDERATION
38	SLOVENIA	144	CHINA
43	CROATIA	167	NORTH KOREA
		191	SIERRA LEONE

Source: WHO, 2000

**The main areas that need intervention**

Health is determined by four main groups of factors: biological, individual lifestyle, social and community networks and general socio-economic, cultural and environmental conditions (see Figure 4).

As shown in Figure 4, the achievement of the full health potential depends not only by the provision of health services, but of a broad range of factors.

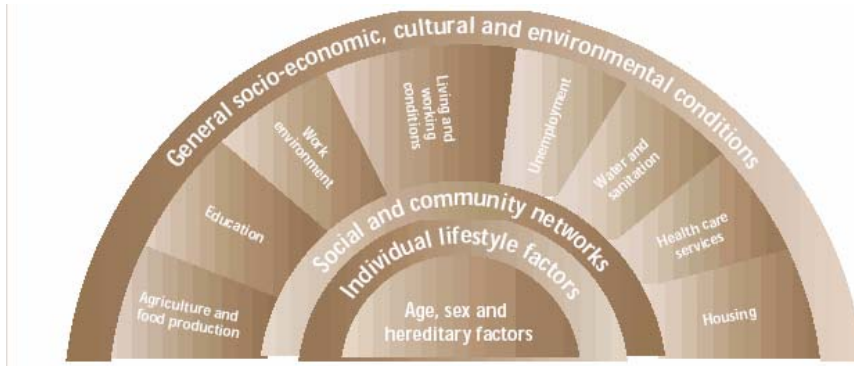


Fig. 4 Determinants of health

Source: Department for Health and Children, MoH Ireland, 2010

A multidimensional approach to the improvement of population health requires the involvement of all socio-economic sectors with impact on health and can be implemented in a very long timeframe. So, the Presidential Commission decided to select and focus on those intervention areas which could display the outcomes on medium term, and also on those areas that are mainly under the influence of the health authorities. Thus, the Commission has identified 6 major intervention areas in order to address the dysfunctions of the health system: health system financing, health system organization, hospital care, drug policy, primary care, and human resources.

#### *Health system financing*

Despite the increase of the share of total health expenditures from GDP in the last years (from 3.3% in 2006 to 4.1% in 2008), Romania continues to occupy one of the last places in EU regarding the resources allocated for health. Low level of financing is worrying especially taking into consideration: the long period of “chronic” under-financing with lack of investments in Romanian health system, the demographic trends of population

ageing and the precarious state of health of Romanian population [6].

The main funding source of the health system is the National Unique Fund for Social Health Insurance (75% in 2007). The contributions to the National Unique Fund for Social Health Insurance decreased progressively from 14% in 2001 to 11% in 2008. In the same time, the number of direct contributors decreased significantly in the same period of time, with about 4 million persons compared with 2000, so that only 5 million people are contributing to the funding of a system to which 22 million citizens should equally benefit. This situation is due to excluding from payment different population categories, without allocating in the same time equivalent funds to compensate for these exemptions from paying the contribution to health [7].

Besides under-financing, the health system is experiencing an arbitrary, inefficient and inequitable use of resources. 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. This situation, together with 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 managers [7].

#### *Health system organization*

The previous health reforms in Romania were concentrated mainly on financial and managerial aspects. There was not too much done for the organizational level. The health system is built around the central administration, and subsidiary to the medical staff. The patient or his/her representatives lack basically any power to influence the system that they finance. The single major change was the purchaser/provider split by the introduction of the health insurance system. Still, the system remained extremely centralized, with the Ministry of Health (MoH) maintaining control over the local structures and even over the National Health Insurance House (NHIH) that has a reduced degree of autonomy and unclear and overlapping roles with other institutions [7].

The Ministry of Health maintains a local and central organizational structure that has feeble connection with the population health needs and doesn't has the structures to cover the areas that consume most of the resources and provide most of the medical services, i. e. the hospitals (there is no directorate for hospital care).

Essential sections for the efficient functioning of a modern health care system, such as: quality assurance, patient safety or risk management, are not developed in any of the MoH structures.

Health information management is poor. There are several parallel health information systems coordinated and controlled by different institutions (MoH and its subordinated units, NHIH,

research and education institutes, etc.), with no data processing and analysis capacity [7].

The lack of integration of health services in order to assure the continuity of care represents another major problem of the health system. Primary care has no functional links with the hospital care, while the health promotion and prevention are not connected to the curative care. The present model of care that is based on specialization of services and the shortage of interdisciplinary teams is also contributing to the lack of an integrated approach. Cross-sector cooperation is very reduced, and health impact assessment of the policies developed by another sectors, even if highly recommended by EU, is not a common tool in Romania [7].

#### *Hospital care*

The hospitals in Romania spend almost 2/3 of the health budget, while having the highest admission rate in EU. Besides the high admission rates, there is no coherent classification of the types of care that can be provided and, after that, reimbursed from public money at the level of different hospitals. In this way, high performance and costly tertiary hospitals carry out common operations that can be done without risks in hospitals with basic equipment and competency, leading to the inefficient use of some already scarce resources [7].

The lack of monitoring of the introduction of DRG payment system has led to serious dysfunctions of this mechanism, so many times there are big differences between the reimbursed costs and the provided services.

The situation is even worse in regard of resource allocation for investments from MoH, where practically there are no clear and transparent allocation criteria, other than the ones established ad hoc

and in most of the cases on strictly subjective basis [7].

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 [7].

Another sphere with serious problems is the quality assurance in the hospital system. The quality norms and standards, the clinical guidelines and protocols are in incipient phases of development, and services provision and results obtained are not properly evaluated and monitored, hospitals activity being scarcely audited and clinically evaluated. Hospital accreditation is not applied in practice despite the existence of the legal provisions back from 1999 [7].

#### *Drug policy*

On the Romanian pharmaceutical market, the consumption increased from under 300 million USD in 1998 to about 2 billion Euros in 2008, under the circumstances of the Romanian residents reduction with more than 1 million individuals. Population benefited in an un-equitable manner of this increase, since approximately 50% of the Romanians live in the rural area where less than 30% of the pharmacists and only 20% of the physicians work. Among the first 20 medicines given on

prescription, there are many very new biological products, extremely expensive, with only an extreme reduced number of individual benefiting of them, while the others are expensive brands, which might be replaced with generic products, much cheaper and with same therapeutic results. All these aspects suggest that the manufacturers marketing is one of the most important factors in raising the medicines consumption, and this is not necessarily overlapping with the health related needs of the population [7].

Ambiguity and sometimes the inconsistency of the regulations in the area clear the path to abuse and corruption. The decisions are made in a manner lacking transparency and predictability, without systematic assessment regarding the impact of the decisions on the public health or on the financial sustainability of the system. The pharmaceutical-economic analysis and the impact analysis are quasi-non-existent, the only available data being those provided by the pharmaceutical companies which promote their own products [7].

Other sensitive areas that determine dysfunctions within the medicine market and inefficient use of resources refer to the manner of establishing the prices of medicines and to the distribution and release of medicines to the population. Thus, a vicious mechanism consists of discounts offered by the manufacturers to distributors, who offer bonuses to the pharmacies with closed circuit in order to promote specific medicines, even if they are more expensive [7].

Giving up the medicine prescription based on INN (International Nonproprietary Names) in 2007 led to the limitation of the patient's right of choosing the desired medication and also to the increase of patient financial burden. The lack of therapeutic guides

causes dysfunctions on the pharmaceutical market, and induces the use of non-standardized practices for similar pathologies [7].

#### *Primary care*

Resources allocated to primary care were permanently below the EU average, the budget allotted by National Health Insurance House to this sector more frequently being about 5% of the total expenditures. Primary care is confronted with a personnel deficit, especially in rural areas, almost 100 villages not having a physician. At national level, the number of inhabitants per family doctor, in rural area, is more than 6 times bigger than in urban areas. There are also important regional imbalances: while in South and South-East regions there are 773 and respective 655 inhabitants per family doctor, in the North-East region there are 2778 inhabitants per family doctor [7].

The infrastructure corresponding to the primary care is underdeveloped, with no coherent investment policy. As well, the financing method does not stimulate the team work (which might reduce, by concentrating the resources, the impact of financial shortcomings).

At the primary care level there is an insufficient capacity of health promotion and health education of the population. This is due to the present medical education system that offers only sporadically knowledge and skills in this area. As well, there is insufficient qualified personnel in a series of key areas such as: midwives, social workers, sanitary mediators, nutritionists and dieticians, speech therapists, pharmacists, psychologists, dentists, specialists in communication, specialists in public health, etc. Family doctors are completely isolated, not only to the hospital care, but also to most of the

community services. The role and the implication of local authorities in supporting the primary care are very low [7].

#### *Human resources*

The analysis of the physicians' density in the WHO European Region reveals that Romania is ranking the 31<sup>st</sup> out of 33 countries, with a rate of 1.9 physicians per 1000 inhabitants, only Albania and Bosnia-Herzegovina having lower rates. Romania is ranking among the last also for nurses (3.89 per 1000 inhabitants), dentists (0.22 per 1000 inhabitants) and pharmacists (0.06 per 1000 inhabitants), confirming the critical circumstances. This situation is even worsening due to the freedom of movement of health workers gained after EU accession. In addition to the low number of health personnel, there are also important geographic disparities [7].

The educational process offers limited information about certain topics with major impact on patients health (i.e. quality of health services or the economic consequences of the medical decision) and does not allow students to develop critical analysis skills, further used for practicing an evidence based medicine. The existing training system is rather inhibiting the team work and interdisciplinary cooperation, with a direct effect on the limited range of services offered to patients and population [7].

There is no appropriate system to motivate the health personnel, resulting in the decrease of the health system attractiveness on one hand, and in the increase of people leaving the system on the other hand. The incomes of health personnel are low, they have poor working conditions, subjective and unclear promotion criteria and limited career development opportunities [7].

There is no coherent human resources for health policy. The human resources planning is mainly based on the educational capacity of the medical schools and less on the population health needs that are supposed to be met by the health personnel. The planning and training of the health personnel fall under the responsibility of several institutions that do not have coordinated policies [7].

The shortcomings of the Romanian health system lead to the violation of one of the most elementary patient rights: the right to quality care and medical treatment in accordance to their needs,

including preventive and health promotion services [1]. The access to health care is many times difficult, either as a result of financial limits or the lack of available technology and human resources. In many cases health care is not continuous and does not have a multidisciplinary approach.

Based on the above mentioned findings, the Presidential Commission drafted recommendations for coping with the major dysfunctions of the health system that directly impact the health status of the population.

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