CONSIDERATIONS UPON THE ROMANIAN HEALTH CARE SYSTEM REFORM BASED ON OTHER EUROPEAN EXPERIENCES

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Abstract
The Romanian health care system has been changed and reformed over the past decades with the declared objective of providing quality services for all citizens. However, the results have been more than modest and health indicators for Romanian population place among the last in the European Union. This papers summarizes the evolution of some of the best health care systems in Europe and in the world and emphasizes how some of the most simple and feasible actions that Romanian policymakers could have implemented as a lesson learned from these countries turned out to be just some random changes in the system which did not generate the expected results (lower expenditure on health, more income for the health sector, less unnecessary use of public health services, better coverage for the population), but only added more disorder and dissatisfaction to the system.
Keywords
health care system, management reform, policy decision

Introduction

Europe does not have a single model for a health care system, and searching for such a model to answer the particular requirements of each country is not feasible, as much as we do not have knowledge to transition a bankrupt health system to a performing one without human and financial costs. Each state is presently at liberty to configure its own health care system, contingent to its needs and particularities, yet founded on the fundamental principles for ensuring universal health.

Despite structural and ideological differences, health care systems across the world have the same interests and face the same challenges, primarily ensuring high standards of health for the entire population with minimal costs. All health care systems have their limitations and are in a state of permanent reform, its necessity further increased by the current global crisis; facing issues of financing, cost control, ineffective organizational structure, all are nevertheless bound to search for new ways to increase the quality of health care services.

Several European states have ranked among first according to the World Health Organization (WHO) and have provided valuable lessons for other health care systems in transition. Some of their successes are described in this paper with the purpose of emphasizing means of improving the Romanian health care system. The main question that arises is why cannot these good practices be adjusted to national level in order to achieve efficient reforms instead of just copy/pasting them without a thorough analysis of the cost and benefits they may generate? As shown below, for a highly effective and competitive health care system, a few steps must be completed: evaluation of the national current health situation (including population health, system funding needs, resources etc.), analysis of other health care models, identification of opportune measures that can be implemented deriving from these and adjusted implementation in national health care system.

Thus, the main scope of this paper is to emphasize some good practices from other countries health systems and how their superficial implementation in Romania did not generate positive outcome for the health system's reform.

1. Literature review

Health care systems, defined as the collection of human, material, financial and informational resources capable of delivering services with the purpose of maintaining and improving health state, are essentially dynamic entities, requiring continuous management, adequate tweaking and tuning, and effective control. The structure and functioning of a national health system seems easy to understand on the basis of its theoretical definition: an open system with known objectives and socially unstable (Mincă, 2005). The system can be thus generically componentized – inputs, processing, outputs, feedback loops, and external inter-dependencies (including the operational diagram of control and system management levers). The input-processing-output model is dependent on feedback loops to achieve the administrative and educational changes required to achieve objectives. Inputs of work (personnel time), money, information and assets are processed into outputs. The processes involved are the whole of required activities and their sequence needed to deliver the output, which is then exchanged in order to obtain profit. In health care, the output can be measured as reduction in mortality and morbidity, improvement in health state, increase in the number of cured patients, patient satisfaction with the medical services provided. Continuous monitoring, feedback loops, evaluation and change in response to new demands, are required to ensure that individual and community health needs are satisfyingly met.

The specifics of health care systems have provoked analysts to consider them as complex architectures with several sub-systems, each with its own purpose and objectives, organization, management and internal information systems; these sub-systems have to be in permanent communication between themselves, external organizations (professional bodies) and the health system as a whole.

A national health system can be economically analyzed and classified considering its financial flows, the role of the state and financing sources.

On the criterion of financing sources, three different models are used in Europe:

- the Beveridge model of a National Health System (NHS);
- the Bismarck model of Social Insurance Health System (SIS);
- the Semaşko Centralized State System (CSS).

The NHS model – introduced in UK by William Beveridge, following the Report on *Social Insurance and Associated Services* (1941), consecrated a view of the future in which a prosperous state provides universal health care and has health as a national political priority. This model is now used in Denmark, Finland, Ireland, Norway, Sweden, Greece, Italy, Portugal, Spain and the United Kingdom. The system is financed from general taxes, is controlled by public authorities, works on a state budget, and has a private component. Access is free for all citizens, with universal coverage, under state management. Medical staff is either employed on a wage or paid a per capita fee for registered patients; some services involve co-payment.

The SIS model – is the most used national program for health insurance, founded on a collection of social security and health insurance elements, implemented in Germany, Austria, Belgium, Switzerland, France, Luxembourg and Netherlands, with various national specificities. The system is financed through the mandatory contribution of employers and employees, according to income or/and as general taxes – the social insurance introduced by Otto von Bismarck. There is extended but not complete coverage, with several population segments without access. The funds are allotted and managed by state bodies or agencies. These "insurance funds" contract hospitals and general practitioners for the

services offered to the insured. General Practitioner's contracts are based on a service fee, while hospital contracts are agreed on budgets, usually global.

The CSS model – was characteristic to the former communist countries of Central and Eastern Europe and is now being transformed. It was financed by the state budget and managed by the state through central planning. The state had a complete monopoly over health services (no possibility for private practice), owned all the assets and resources, and fully employed all medical personnel. The system offered complete and universal health services. It made excessive use of medical personnel, hospital beds and clinics, favoring quantity over quality and hospital care over ambulatory care, with population-wide medical analysis programs as the main method of preventive care. The system lacked any mechanism for economic or epidemiologic analysis and was not treated as a social priority.

Each model has advantages and disadvantages, and a quick review of reforms in European countries shows convergence towards mixed systems, with state control and regulation and a "controlled market" (table 1).

Table 1: Main types of health care system by country[1]

Country	**Type of System**	**Country**	**Type of System**
Austria	Bismarck	**Hungary**	Mixed
Belgium	Bismarck	**Ireland**	Beveridge
Switzerland	Mixed	**Italy**	Beveridge
Czech Republic	Bismarck	**Luxembourg**	Bismarck
Germany	Bismarck	**Netherland**	Mixed
Denmark	Beveridge	**Norway**	Mixed
Estonia	Mixed	**Poland**	Mixed
Spain	Beveridge	**Portugal**	Beveridge
Finland	Mixed	**Sweden**	Beveridge
France	Bismarck	**Slovenia**	Bismarck
UK	Beveridge	**Slovakia**	Bismarck
Greece	Beveridge	**Ukraine**	Beveridge

Source: Citoni G. 2009. *Satisfaction of European citizens with their health care: some correlates*, Dipartimento di Medicina Sperimentale, Università "La Sapienza", Roma, available at: http://w3.uniroma1.it/citonig/

[1] Even though Romania is not part of this table, it is the authors' opinion that its health system is a mixed one as well although this mixture is still uncertain. However, in a former CSS model, the reforms after 1989 introduced elements of both the Bismarck and the Beveridge models.

For further analysis of the main characteristics of some health care models, we have chosen some of the best ranked countries in the world, according to the World Health Organization statistics (World Health Organization, 2014), with emphasis on the most efficient health measures that have determined them among world leaders in terms of health.

2. Main characteristics of some relevant European health systems

2.1 United Kingdom

The United Kingdom is one of the few European states where the national health system is decentralized at local administration levels. This unique model of health care, financed from public sources, has a major influence on other national health systems. It is extremely popular and has managed to achieve its initial objectives, continuously reformed ever since its beginnings in 1948 while surviving numerous changes of government and dominant ideologies.

The National Health Service was built over several decades, on a historical foundation of social reform – the Poverty Laws of the 18th and 19th century, the National Medical Insurance of 1891 for workers and their families; the turning points that led to its creation were the National Exceptional Health Service during the second World War and the Beveridge Report of 1942. (Dobson, 1999)

By improving efficiency in primary health care, the NHS has expenses below the EU average, allowing increased investment, development and savings, i.e. continuous economic development. Since its launch more than sixty years ago, the NHS has become the largest publicly financed health care system in the world, while at the same time being one of the most efficient, equalitarian and comprehensive. The principle of universal access regardless of wealth and income, stood at its core since the beginning and remains so today.

Undergoing a major reform during each decade, the system has accumulated precious experience in satisfying the population's health needs while adapting to changing economic conditions. It continues to provide health services to all the population, even if it failed the attempt to equalize health state across social segments.

We consider most telling of the NHS's identity Klein's statement (1993) that it is the policy sector most appreciated by the population, the true "Crown Jewels" of the British Welfare State. The reality behind this metaphor is further proven by the fact that, during the radical reduction in welfare provisioning and state expenses of the Conservative 80s and 90s, the NHS was the least affected. Even today, the WHO ranking reinforces that this is a very good NHS, despite the fact that it has such a low level of funding relative to other countries.

2.2 Germany

Germany is a federal state with a long tradition of social security policies. The German National Health Insurance System, based on Otto von Bismarck's policy for the medical insurance of low income workers, is built on mixing elements of social security and health insurance. It is primarily financed by the social security system, whose budget is made of equal contributions by employers and employees.

The weight of health as percent of GDP in Germany increased from 9.2% in 1986 to 10.6% in 1996, making the country second in the world after the United States in terms of allocated financial resources (Baggott, Forster, 2008). In 2011, total health expenditure as a percent of GDP was 11.3%; the current distribution of funding sources in Germany shows the Government contributing 19% to total medical expenses, employers and employees covering 61%, patients' direct payments 12% and private health insurance with 8% (World Health Organization, 2014).

The SIS specifically provides for the highest quality of health care, putting Germany among the first places on a global ranking. On the other hand, Health Funds don't yet have health

improvement as a primary responsibility, an increasingly frequent topic of debate considering the reforms required in keeping up with the EU's and WHO's objectives on health state.
However, the investments made by the German government offer patients and practitioners top health facilities to be treated or work in, fully equipped with the latest medical technology. It is one of the main reasons for which Germany stands as one of the top health tourism destinations in Europe, being visited annually by numerous non-German patients.

2.3 Sweden

The current structure of the Swedish health system is the result of a prolonged institutional and regulatory accumulation of experience in the sector. The Swedish model for health insurance was developed over several decades, becoming mandatory in 1955 and covering all public and private expenses for hospital and ambulatory care. Health care services are mainly state-funded, with additional input from employers and patients, the latter as direct co-payment. Health expenses were 7.5% of GDP in 1972, 9.6% in 1982 and 7.6% in 1994 (UNESCO, 2006). The primary administrative responsibility for health care management rests with regional and municipal authorities.
The Law of Medical and Health Care Services was adopted in 1982, aiming for equitable access to health services and equal health state for all citizens. This law, applied on the basis of three principles ("human dignity", "need and solidarity" and "cost-efficiency"), provided a new vision on a health care services provisioning system.
Current reforms are focused on improving primary health care and reducing the number of hospital beds. Application of this policy made Sweden one of the few countries in the world that actually reduced health expenses as a percent of GDP without diminishing the high quality of services provided and without slowing down the pace of national health indicators' improvement.
The recent reforms in Sweden have allowed the contracting of public health services, providing to the primary health care providers the best services in terms of cost efficiency. The hospitals in Sweden operate as separate business units, balancing income and expenditure under the new conditions of market economy, being in constant competition for the flow of patients. The public medical and sanitary services are competing with the private ones and, in some cases, the services are supplied by private sector. As a result, the waiting times for surgeries were reduced and those hospitals that provided an inefficient or unacceptable level of care went bankruptcy (Drăgoi, 2010).
As a country led by social democratic governments, long before and after the Second World War, Sweden is, together with other Northern countries, one of the global public health leaders. Sweden is the country which has succeeded in continuous growth of performance standard of health services in terms of significantly reducing their costs. Sweden is also the "pioneer of prevention" as it is the country for which the principle "it is better to prevent than to cure" was translated into reality (WHO, 2008). Prevention programs have started in the '80s, and the results are visible today, Sweden making prove of some of the best health indicators in the world.

2.4 Italy

Italy's health care system is a regionally based national health service (*Servizio Sanitario Nazionale* (SSN)) that provides universal coverage free of charge at the point of service. The financing of the system is public, as a combination between general taxation and health insurance. Unlike the British model, the SSN is highly decentralized: the national level is responsible for the minimum package of services that must be guaranteed throughout the country, while the implementation, planning, financing and control of the health system fall into the responsibility of the regional governments through a network of population-based

health management organizations (*azienda sanitaria locale*, 'local health enterprises' (ASLs)) and public and private accredited hospitals (Corte dei Conti, 2007).
The financing of the Italian health system is mostly public, with approx. 41% coming from health insurance contribution and 37% from general taxation. The need to ensure more income to the system generated the introduction of user co-payment, which covers up most of the rest of the health system expenditure.
The main challenges that the reforms of the Italian health care system face are providing universal coverage while reducing the discrepancies between the Northern and the Southern regions.
Therefore, the reforms that took place in the '90s and 2000s tried to set clearer delimitations among health responsibilities and better use of allocated funds, since the previous increase in health expenditure did not generate improvement of the health status of the population (Ferrera, 1995). However, even with some administrative difficulties, the health indicators of the Italian population are considered to be one of the highest in Europe (Lo Scalzo et al., 2009).
As we can see, the decentralization of the health care system has been a key issue in the development of the SSN since its inception in 1978, and especially during the last decade. This process provided the regional health departments with more autonomy in policy-making, health care administration and management, resource allocation and control.

3. Romania – evolution of the health system and measures taken as reform

The year 1989 found Romania in a deep economic, social and implicitly health crisis. The population's health was below average, health care services under-financed, staff motivation totally lacking, and overall low system efficiency. The political change of December 1989 had as its first reaction the rejection of all communist institutions, including state property and, health-wise, the principles and organization of the health system according to the Semaşko model. The primary force for change was the doctors, asking for a Bismarck type model and the development of a health private sector or private practice.
Frequent changes of government, the absence of clear strategies and properly defined objectives followed independently of political changes, all delayed and slowed down health care reform after 1990; Romania barely adopted a system of social health insurance in 1997.
After more than 15 years of reform, the Romanian health care system is still in crisis. Many of the great reform ideas designed to radically change the quality of the medical system are yet to be implemented. These include: the need to increase the volume of system resources, the need to increase transparency, to revitalize the primary health care, to recover the personnel deficit in all major specializations, to eliminate corruption, to correlate the activities of the system in order to eliminate the time-consuming nature of service delivery, the need for national programs to reduce the high incidence of some infectious and chronic diseases etc. Restructuring of the system under a massive shortage of economic resources and also the lack of vision of its social impact, has deepened the crisis already installed since the '80s (Păuna (coord.), 2006).
The most acute problems arising in primary care are: deficiency in ordering the family physicians throughout the national territory, infrastructure deficit, lack of trained personnel, lack of preventive programs and shortage of qualified personnel to assist at home.
As a response to these matters, actions for reformation have been taken chaotically, following (without taking into consideration the macroeconomic and microeconomic situation of the country) either the Bismarck model or the Beveridge system. Results have proven that introducing elements from other types of system organization without adapting them to national conjuncture does not offer the desirable outcome, but become an even

greater burden to the health system. In order to emphasize this theory, we have chosen for analysis two significant political decisions taken for the reformation of the Romanian health care system: the introduction of co-payment and the reorganization of medical units nationwide, within the process of decentralization.

Co-payment and merged hospitals

Co-payment was used in the NHS model, which as seen before was introduced in Great Britain by William Beveridge, who through the *Report of Social Insurance and Related Services* (1942) opened an opportunity of a wealthy state with an efficient national health service, and set medical assistance as one of the national political priorities (http://www.nhs.uk). Co-payment refers to patient's contribution to the costs of health care services and is meant to determine consumers not to ask for unnecessary medical services. However, it is considered to create disadvantage to lower-income citizens, chronically ill and high risk patients and discourage preventive care.

Co-payment would contribute to rationalizing health care spending and moderate the use of the system, especially for services that have the least effect on patients' health. However, the experience of other countries shows that co-payment reduces the consumption of medication and health care services, especially preventive appointments and less essential services. This might lead to less use of both valuable and less valuable health care services.

The challenge is to design a system in which the services that people stop using as much are those that are less vital to their health. Furthermore, an international comparison shows that implementing co-payment only in primary care can prompt people to use emergency room (ER) services more, a habit that could lead to an overall increase in health care costs (Mas, Cirera, Viñolas, 2011).

Introduction of co-payment in Romania did not follow any specific rules. No cost savings estimations were made, nor an evaluation of the impact co-payment would have on the use of health care services. Regardless of the valuable lessons stated above, provided by other countries, co-payment in Romania consists of a fixed sum applied at the end of the hospital stay and it is not applied to ambulatory and ER care. The income deriving from co-payment is of negligible amount and has not been thoroughly assessed and reinvested.

For a better cost reducing effect, we consider that the co-payment system should be more complex: first, lower-income population should be protected with a preferential formula, because even though the IMF and the government consider the co-payment to be a small amount, for some of the elderly for example means a few days survival budget. Second, it would be more efficient to apply a co-payment sum to ER visits than to primary care. Third, economic estimations and calculations may lead to different co-payment fees, according to the type of medical service provided – no fee or a small fee for preventive care.

Concerning the process of reorganization of the hospital system in Romania, a previous study (Drăgoi, 2011) shows that each county of Romania has either a deficit or a surplus of hospital beds, but the merger or readjustment of hospitals did not take this issue into consideration, thus generating an economically inefficient reform. Economic considerations would determine a merger between a hospital with surplus of beds and one with a deficit, medical aspects would lead to mergers to cover all medical specialties within one single medical unit, demographical issues would take into consideration the distance between population's establishments and medical units in order to ensure better access to health care. The key motivation for this radical change in the public hospital system was the hospital's inefficiency, but as other countries show, economic efficiency in public health units derives from more than just a readjustment of their functioning, it is determined by the efficient planning and operating of the health care system as a whole, doubled by substantial financing and investments at national level.

Conclusions and recommendations for improving the Romanian health care system

A very important conclusion is that regardless of the effectiveness of resource utilization, countries providing health expenditure below 4% of the GDP have an underdeveloped health care system. States that allocate 4-5% of the GDP (as is the case of Romania) may lean towards a universal medical coverage, but which is often provided with low salaries for the medical staff and old medical equipment. This is even more accentuated when resources are concentrated in the urban areas, while a rather large part of the population lives in the rural areas.

Developed countries that spend on health 6-14% of the GDP place the health of their populations among national priorities. In these countries, the salaries of the doctors are high and motivating, even in comparison with other professions.

Privatization can be a viable method for improvement, but no health care system can function exclusively on market logic and mechanisms, without state intervention. This is particularly the case in Romania, with a less developed private sector and immature capital markets. As a general rule, privatization cannot be a purpose itself, and it can become damaging if it fails to provide sufficient competition in the system. Introducing and expanding market mechanisms in the sector requires and supports flexible health management competencies and the addition of functional business knowledge and skills (finance, marketing, law etc.).

A valuable lesson from the other European countries taken into analysis is that patients' rights must be fully respected and that universal coverage is not synonym with corruption and discretionary attitudes towards patients. Therefore, in Italy for example, each medical unit is obliged to have a *Carta dei Servizi Sanitari*, which offers the possibility of suggestions and reclamations as well as information regarding the provided services, the waiting duration etc. Also, the organizational charts of the hospital include a director in charge of the public relation and an ethical committee. Moreover, there is a public compensation fund for patients that have suffered permanent lesions after vaccination or blood transfusion performed with infected medical instruments.

Sweden has shown that investments in prevention generate a long term wellbeing of the population and a substantially decrease in system expenditure. The United Kingdom offered one of the first methods of hospitals performance evaluation through and an aggregate performance index which allows rigorous fund allocation and prioritizes decision taking.

Other key issues are ensuring the transparency of funds allocation and utilization as well as diminishing excessive bureaucracy. Also, as previously seen, there is a high need of medical units in the disadvantaged areas of the country, especially in the rural zones. Refurbishment of the medical units can be achieved by introducing deductibles from taxation on profit for investments made in the health sector.

Considering the correlation between the level of economic development of a country and the quality of health care, the European average level of health expenses exerts upward pressure in the Romanian health sector. Thus, the need to match available financing is joined by the even more pressing need to improve efficiency in resource utilization, the latter actually being the more complex challenge for health policy makers. Increasing awareness of the need of efficient resource allocation based on accurate prioritization of health care demand remains an issue of fundamental interest.

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