COMPARATIVE STUDY ON HEALTH SYSTEMS FROM THE NETHERLANDS AND ROMANIA

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The paper contains a presentation and a summary analysis on the health services in Romania and the Netherlands. The research goal is to provide a more complete picture of how each country is providing these services, and how well they satisfy the public interest. The coordinates for the analysis were: how the health services are organized in each country, how they operate, how they ensure patient care, the way that they ensures the quality of services offered, and how they are succeeding to maintain the costs of work carried out.

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1. Changes in Public Health Services from Romania

Romania in 1990 had an exclusively public health system, highly centralized, supported financially by the state and coordinated by the Ministry of Health and its health inspectors county. Services were offered to the population, officially without any costs, but the serious financing problems of the system for a long period of time resulted in lower quality services provided and the transfer of a part of the cost to the public.

Many hospitals and polyclinics were in damaged buildings, without proper technical equipment, medicines and materials, Romanian health system did not cover demand in the health units and the imported medicines, new and effective, were inaccessible to most people. Thus, part of the costs of treatment were transferred, directly or indirectly, to the recipient, including through informal payments to medical personnel, in this way limiting access to segments of the population to medical services.

Reduced quality of services and gaps in the system, due to low budget, required for decisions in order to improve public health care in Romania. Switching to a model-based health insurance has been evaluated by the decision persons, at the time, the optimal solution for many of the system problems. As a result, the principles of organizing, financing and providing the public services of public health have been amended since 1996 in terms of legislation, and in terms of actual and real transformation since 1999.[213]

Health services are thus currently granted on the basis of contribution to health insurance fund. Insured benefit, based on this contribution, free of charge of a package of services defined as vital and which are legal regulated.

Primary health care is currently provided by the family doctor, whishing to emphasis the role of a primary service, as the first filter to solve problems. Access to assistance and outpatient hospital and access to free medicines and offset is made by your family doctor. Doctors no longer have the status of employees of state, but are healthcare providers who enter into a contract with Home Health Insurance, the new coordinator of the system. The average health staff is employed by these service providers (doctors and hospitals). Ministry of Health retains only the role of funding and coordination of national public health programmes. Also, the new model resulted in an access reduction of the population to health services by some people who can not qualify for medical assistance (outside the emergency minimum), having no health insurance.

After 1990, were made changes in the positive direction, in providing health care. Some of polyclinics and hospitals in the public sector today provides services improved and diversified compared to over 19 years now, and on the market now you can find new and effective medicines, including imports. There is also a private system of granting medical services, adjacent to the public system and a wide network of private pharmacies. Meanwhile, in the context population poverty, a large segment of it, although assured, can not afford the cost of treatment, accessing to hospitals performing services outside the locality of residence or the offices of the private system as an alternative to the public health system.[214]

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213 Plumb I., Androniceanu A., Abăluţă O., Management of public services, ASE Printing House, Bucharest, 2003.
214 www.insse.ro.

2. Synthesis analysis on the health system of Romania

A large proportion of the Romania population has at present a shortage of health education and family planning, including lack of awareness of the role of prevention and habits of consultation, in the case of a problem, elements that demonstrate the reduced role that the health programs have for health education and prevention among the population. As a result, in Romania there are the highest values (the European) for incidence of diseases of the circulatory, the TB and other infectious or parasitic diseases. Infant and maternal mortality are relevant indicators of the access problems of mothers and children newborns to health care, the reduced quality of services they receive and the degree of insufficient information on methods of preventing diseases and maintaining health. Despite the decreasing trend since 1990, infant mortality rate in Romania is three times higher than the average European Union countries and two times higher than in Eastern Europe.[215]

Population appreciation regarding quality practices of family doctors reflects the current problems in medical equipment, in the state office building housing, the toilet and cleaning facilities. If some problems are related to poor financial resources, others, such as cleanliness or solicitude for the medical problems could be solved much easier. Negative public perception of the quality of services and physician-patient relationship may be a demotivator factor in the call of the doctor. Pending, for the benefit of consultation is another problem reported by the population, reflecting, in some areas, shortages of doctors and health units. On the other hand, legal regulations require periodic renewal of a recipe by a doctor, where long-term treatment is needed, leading to congestion of these people at the door the doctor, increasing waiting time. This system is putting the doctor in a situation of losing a part of the time filling out papers to the detriment of providing advice.

High rate of admission in hospitals shows that patients are admitted to the hospital without having a high outpatient care (70.3% of all admissions are an emergency admission), showing primary and secondary health care deficiencies, and reduced access by the sick persons of these services from the first symptoms of the disease.[216]

Product market liberalization and reduced domestic production of medicines have exaggerated increased the prices of pharmaceutical products. Thus, the increased cost of drugs has diminished access to this type of consumption for poor families, even with regard to vital treatments, mandatory.

Current financial crisis caused the inability of the population to access the public services to which they were entitled, such as: basic medical tests offered by laboratories, compensated or free drugs in the case of children or serious illnesses. One of the serious problems of the Romanian health care system is insufficient public health preventive programs and their inefficiency.

Low standard of living in Romania and the conditions offered by the Romanian health system in recent decades have led gradually to a polarization in terms of access to health services, with long-term consequences on the population health and in contradiction with the principles of social equity stated by the law of health. While a segment of the population has access to advanced services provided by specialized assistance from academic centers, to private health care and cost effective medicines, another segment of the population has problems in accessing health and quality of medication and what is worse even in accessing primary care (including dental care).

The main weaknesses of the Romanian health care system identified are: poor funding of public health, poor information of population on health insurance, a low number of buildings for health services, equipment, medical personnel, use of old technical Medical Investigation in most hospitals in Romania, which do not meet a correct diagnosis or a completely treatment for a sick person, expensive medical services, the precarious situation of public health in rural areas, insufficient information or lack of it for population on the methods of preventing disease and maintenance of sanitary hygiene, lack of motivation for employees in the medical system, the existence of a relatively large number of unqualified staff in health facilities and lack of improvement of medical staff, in Romania there are the highest values of the incidence of circulatory diseases, TB and other infectious and parasitic diseases.

3. Overview of the health system in the Netherlands

Before moving to the presentation of the current Netherlands health system it has to be noted the fact that the Netherlands has registrated major problems in health care system, but has managed to improve it through good strategies and effective planning.

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In the Netherlands, the government is not responsible for the management of daily health. Private health providers are responsible for the provision of services. Government is responsible for providing and ensuring access and quality of healthcare. The main characteristics of Dutch health care system are: complete coverage of all residents,

215 www.iccv.ro.
216 www.ipp.ro.

attention to primary care, providing primary care by specialists trained in family medicine, all other medical specialists are in place in hospitals (private or state), increasingly important role of nurses.[217]

Who is insured? Since 1 January 2006 there is a new system of health insurance in the Netherlands. In the past there was a difference between the public and private healthcare services. But it was removed, and now everyone must purchase the basic package of health insurance.

Before 2006, people with incomes higher than € 30,000 per year and those in their care (about 35% of the population) were excluded from the coverage area supported by public funds of the disease and could get coverage from private insurance companies. This form of substitution of private health insurance has been regulated by the government to ensure access to appropriate health care for the elderly and poor people and compensation of insurance public health from the state budget. Over time, increasing dissatisfaction with this dual system of public and private coverage has led to reforms in 2006.

Basic package. Government created the basic package that offers the same features as the previous system. The health insurance companies are required by law to provide at least the basic package and they can not refuse anyone who wants to apply for it. Standard health insurance is financed by a mix of income derived from contributions paid from wages and insurance premiums. The contribution of salary is fixed at 6.5% for wages not exceeding € 30,000 in annual taxable income. Employers must reimburse employees for their contribution and the employee must pay tax on the refund. For those who do not have an employer and receive no unemployment benefits, the income is 4.4%. The contribution of self-employed person is assessed individually by Tax Department. With the basic package, beneficiaries are offered the following medical services: medical care, hospitalization, dental care (until 18 yearsold, to 18 years or older are only offered care services and false teeth), various medical devices, various drugs, antenatal care, patient transport (eg, ambulance), paramedical care. Insured people may decide to purchase additional insurance which are not included in the basic package. **However, in this case, insurance companies may refuse the request and have the right to set a higher price.**

The basic package price. Fees for the basic package of health insurance is set annually by insurance ealth companies and are normally around 95 € per month. Although the Ministry of Health establishes the first standard insurance, insurance companies clearly establish a tax on the additional insured will pay in the end, being inserted in the monthly rate and in claims. Through these extra charges insurance companies maintain competition between them. Taxes of insurance varies from one company to another, and therefore it is advisable to compare prices. Children under the age of 18 should not pay health insurance and they are insured for free through the basic package.[218]

The assured pays an initial lump sum (determined by insurance companies) to the private health insurer. All people who have the same nsurance pay the same insurance premium. In 2006, an insured person was chosen for a refund of 255 €, if he did not have any medical care costs. If the policyholder has taken care expenses, but under 255 €, it will receive the difference back to the end of the year. Thise system "no claims, you get a bonus" was abolished in 2007 following a change of government and has been replaced by the exemption from income tax.

Those with low incomes are entitled to so-called "care allowance" up to a maximum of 330 € per year. Now each insured person over the age of 18 years have to pay the premium for health insurance of 150 € in a year. In 2006, the average annual premium was € 1050 ($ 1513).

How is the system of granting medical insurance organized? *Funds for health insurance:* private insurers are regulated by private law. Are allowed to be grouped in companies that pursue profits. They must be registered by the Insurance Supervisory Health (CSAS) to check if the supplies are in accordance with the Act Health Insurance and can contribute to payments for the equalization fund in case of risk. Policyholder has the free to choose the insurers, and the insurer must accept every resident in their area of coverage (although most already operate at national level). A system of equalization in cases of risk is used to prevent direct or indirect risk selection policy by insurance companies. *Doctors*: they work directly or indirectly, in contracts negotiated with insurance private health companies. Doctors are paid for each patient on their practice list, and receive a premium for each consultation. Additional revenue can be negotiated for additional services, the practice nurses, for difficult locations, etc. *Hospitals*: Most hospitals are private non-profit organisations. Hospital budgets are developed using a formula that pays a fixed amount per bed, for the patientnumber, and the number of licensed professionals, and other factors. Additional funds are provided for capital investment, although hospitals are increasingly encouraged to obtain private capital through the private market.

At the level of health system, **the quality of health care** is ensured by law in performance training, service quality health care, patients' rights and the technologies used in medicine. National Health Inspectorate is responsible for monitoring the quality of all activities. The main methods used to ensure quality in institutions include accreditation and certification, mandatory and voluntary assessments based on performance indicators and national quality improvement method based Progress - "Breakthrough" (Sneller beter).[219]

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217 http://www.tandarts.nl/ http://www.minvws.nl/.
218 http://www.actiz.nl/home/home.do.
219 http://www.civitas.org.uk.

How is effectiveness of care provided? The main approach for improving efficiency in the Dutch health system is based on regulation of competition between insurers combined with significant attention paid to performance and transparency in the results obtained by the use of performance indicators.

4. Brief analysis of the health system in the Netherlands

The main problems of public health in the Netherlands *before the year 2006* were: a rigid two-tier system of private medical insurance for the rich and assurance standard for the rest of the population, which has highlighted inequalities of health services, a system of risk equalization to resolve problem of discrimination in private insurance, an inefficient bureaucracy that highlights increased costs, dependence on the employer; multiple types of insurance (health insurance, private health insurance for civil servants, etc.), ineffective or non-competitive incentives for insurers, too little pressure or the lack of it on providers to achieve better performance, and inaccurate initial effects thereof.

After the year 2006 were identified the following problems: limited accessibility for people with low incomes to the new health system; increase of the nominal first medical assurance from 320 € in 2005 to 1038 € in 2006, although this was offset by the decreased level of contributions from income; increase in the costs of healthcare sport for the consumers.

Top rated increased. However, charges on loans and the Health Insurance ensures that the system still serves the public interest and in terms of international standards of health costs are still relatively low, add the administrative costs of the identification for the individuals who have not made payments for the first binding. Currently is discussing the possibility to investigate such "bad payers"

CONCLUSIONS

In the end of the paper we want to point out some issues relating to the organization and functioning of health system in the Netherlands that could be takeing into consideration in reforming health services system in Romania and, where possible, to adapt a number of practices of the Netherlands health system.

Few coordinates to consider the change management of health services in Romania are briefly presented below.

A) Efficiency in the program due to technical and political complexity: The first issue is a clear indication of the objectives of health services in Romania, modalities of action and a realistic timetable for their implementation. The initial reform plan for implemetation was 4 years. A more realistic timetable would reflect a period of at least 15-20 years. Such a program built on a sensitive issue both from a political point of view such as health (financing) is hardly implemented by a cabinet appointed for a period of only 4 years.

B) Elimination of free medical services: A second aspect is that the Dutch proposal for health insurance market is not a free one. A free market for health insurance would have side effects, which are considered by most companies as undesirable. In a market of health services free of charge, most people with low income and chronically ill people should have access to all medical care they need because of financial factor.

C) Monitoring of the health services. It is important to note that the Dutch government has formulated a proposal for regulating competition. Instead of direct government control over volume, price and production capacity, the Government should create conditions necessary to prevent undesirable effects of free markets and to enable the market to satisfy the public interest as regards health care. Access to good quality care for the entire population is an important objective.

D) Establishing the package of the mandatory health insurance. Therefore the government will focus on regulating the first health insurance mandatory for everyone, subsidized risk premium adjusted for insurers, anti-cartel measures, quality control and information disclosure. Therefore it is better for the Dutch health reforms to be considered "rules" instead of "deregulation".

E) Prevention of "disadvanteges customers with limited access to additional services": Last issue aims prevent this trend and is a necessary condition to reap the benefits of competition rules inserted in the health insurance market. This disadvantage means that selection occurs when insurers prefer profitable costumers over the unprofitable ones.

BIBLIOGRAPHY

1. Plumb I., Androniceanu A., Abăluţă O., Management of public services, ASE Printing House, Bucharest, 2003
2. http://www.civitas.org.uk
3. http://www.actiz.nl/home/home.do
4. http://www.tandarts.nl/ http://www.minvws.nl/
5. http://www.insse.ro/
6. http://www.iccv.ro/
7. http://www.ipp.ro/