CURRENT ECONOMIC AND MEDICAL REFORMS IN THE ROMANIAN HEALTH CARE SYSTEM (1)

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The "issue" of health has always been, both in social reality and in academia and research, a sensitive topic considering the relationship each individual has with his own health and the health care system as a public policy. At public opinion levels and not only, health care is the most important sector demanding the outmost attention, considering that individual health is the fundamental prerequisite for well-being, happiness and a satisfying life. The ever present research and practical question is on the optimal financing of the health care system. Any answer to this question is also a political decision, reflecting the social-economic value of health for a particular country. The size of the resource pool and the criteria and methods for resource allocation are the central economic problems for any health system. This paper takes into consideration the limited resources of the national health care system (the rationalization of health services), the common methods of health financing, the specificity of health services market (the health market being highly asymmetric, with health professionals knowing most if not all of the relevant information, such as diagnosis, treatment options and costs and consumers fully dependent on the information provided in each case) and the performance of all hospitals in Romania, in order to assess the latest strategic decisions (introduction of co-payment and merging and reconversion of hospitals) taken within the Romanian health care system and their social and economic implications. The main finding show that, even though the intention of reforming and transforming the Romanian health care system into a more efficient one is obvious, the lack of economic and demographic analysis may results into greater discrepancies nationwide. This paper is aimed to renew the necessity of joint collaboration between the economic and medical field, since the relationship between health and economic development runs both ways. (This paper was co-financed by the European Social Fund through the Operational Programme of Human Resources Development 2007-2013, POSDRU/1.5/S/59184 „Performance and excellence in the economic science postdoctoral research in Romania" coordinated by the Bucharest Academy of Economic Studies; my postdoctoral research period lasts from Nov. 2010 to Mar. 2013)

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I. Introduction

The end of 1989 found Romania in a deep economic, social and obviously, sanitary crisis. The health of the population was quite poor, partly due to the lack of finance for the health services, of positive factors to motivate the staff and internal inefficiency of the system. **The political changes since December 1989** generated a replacement of the old structure – part of a totalitarian system – and in the health field the principles and organization of a socialist health system, such as Semaşko. Physicians fought to introduce a new Bismarck model (***health insurance system***) and to develop the private sector or private practice in public services.Under the context of changes since December 1989, in terms of reforms, the health care system has set up the following goals: reconstitution of the legislative and organizational framework; introduction of the health insurance system; payment of services on the basis of the medical act efficiency and quality; facility of a better access to health services; improvement of medical

service quality; replacement of traditional medical service with ambulatory care, in terms of health care services; decentralization of the health system by increasing the role of the local authorities, financing institutions, communities. Frequent changes of government and ministers, the lack of clear strategy and defined objectives to be pursued rigorously and independently of political changes slowed down the health reform process after 1990; only after 1997, Romania adopted a social insurance health system. But the main strategic decision was the start of a process of management training for new executives appointed after the revolution, which had to manage crisis and lead change. The main difficulties in the early years of reform, not completely cleared until today, were the exact definition of the future roadmap, identifying priority issues specific to the whole system, as well as to each phase and area, inability of absorption of medical aid and financial management, serious shortcomings in communication science, negotiation and stimulation of all "actors"' participation in the process of change.

II. Rationalization of the medical services

The analysis of countries with representative health care systems shows that there is a determined relation between the objectives of health systems, their structure and health policies. (Drăgoi 2010: 128). Basically, health policies that lead to a certain structure of the health system are affected and respond to the objectives that policy makers intend to achieve in terms of public health care. It is impossible to set up a sanitary policy and a health system that should ensure universal access for a large number of people, to high quality services and that should decrease costs at both macro-systemic and micro-systemic level. This can be translated through the impossibility of universality and equity regarding the access to welfare services and low costs. As a consequence to the mechanisms used when establishing the policies of allocating resources in the health system, one should highlight the fact that in all countries where the payment for the medical services is not made directly, **the phenomenon of medical services rationalization** appears (Klein 1993: 308). The configuration of a medical service package was regarded as an option of facing up the discrepancy between the available public resources and the related requirements.

In the national systems such as the one of Great Britain, the rationalization process was achieved by streamlining the implicit and less explicit mechanisms; doctors used to send to specialist services only certain patients, and in terms of specialized, ambulatory or hospital care, the issue itself was a matter of waiting lists. Following the reforms taking place in Britain, these decisions tend to be explicit, through negotiated contracts between health care providers and payers, establishing more clearly the number of patients that can be treated, the quality and the volume of services involved. The rationalization phenomenon is also present in health systems that are based on public or private health insurances. In such cases, rationalization has often been explicitly approached, detailed contracts between the insurance house and health care providers, which specify what services are covered by the insurance policy, including criteria under which those services to be rendered (quality, waiting time, additional costs etc.). When the right to medical services is not explicitly stated and the system is theoretically comprehensive, it is the buyers who decide (e.g. insurance funds) thus undermining equity of access. In situations where there is a defined package of health services, buyers are free to provide more benefits (services). This is quite rare in Central and Eastern European countries.

III. Decentralization of the health care systems

Decentralization of health services, considered a key concept in reforming health systems in many countries, including Romania, conceived and applied with responsibility, can be an effective means of stimulating local and individual initiative to facilitate a better resource allocation according to the health needs, leading through the community involvement, to a more

efficient decision-making process and a reduced inequity in health care. Decentralization should not be viewed as a saving solution to structural problems of a system as, at the same time, it should not be omitted its disadvantages (fragmentation and duplication of services, increased costs). Traditional forms of decentralization in health services were defined by analysis of the role of public administration, focusing on how a national political structure relates to the distribution of authority and responsibility for health services at the local level. The initial elements of decentralization were introduced in the early years of the new regime. Local Administration Act in 1992 sets a new decentralized government structure defining the organizational context in which the public health care system should operate.

According to the experts' opinion (Vlădescu 2004: 64), decentralization may envisage four major forms:

- ***deconcentration*** – refers to a partial transfer of central administration authority towards the local segment;
- ***devolution*** – involves the creation or strengthening of the autonomous sub-national administrative level, which should have greater independence from the national one, the authorities concerned being elected locally rather than appointed by the centre;
- ***delegation*** or ***functional decentralization*** – relies on the transfer of management responsibilities that belong to a number of well-defined positions, a specific organization, outside the central administrative structure, which is indirectly controlled by the late one;
- ***privatization*** – use a price system as a set of "signals" that consumers and producers can use to make decisions.

The study on the decentralization of health facilities and services as well as introduction of some elements of market economy has been experienced in Romania with World Bank support in four and then eight pilot counties. Strategies and objectives at the county level have been identified for the pilot, with emphasis on primary health services, performance and motivation of human resources, improving hospital management and integration, community involvement and strengthening the role of county health departments. Until the introduction of social health insurance system, decentralization of health care organization was limited by rigid hierarchical reporting system. So far, decentralization has manifested itself just as deconcentration. After entering the law on health insurance, delegation and privatization began to play an important role in the decentralization process. Thus, the National Health Insurance has taken over responsibility for revenue collection, allocation of resources considering the geographical areas, levels of care assistance and health care institutions. Under the new legislation, part of the Ministry of Health responsibilities has been delegated to the College of Physicians and Pharmacists respectively. These include rules on work, planning the number of medical staff (together with the Ministry of Health) and physician' representation towards the third party payer.

Given that the health care system in our country (but the phenomenon is present in many other countries) is not efficient enough in terms of both health care accessibility and quality of services, people look for alternative sources on the private market, privatization and competition occurring in response to these pressures. The so often invoked privatization, which some authors (Collins 1996 in Vlădescu 2004: 62) even contested as specific form of decentralization of health services, should not be regarded as an objective itself but rather as a means of achieving pre-set objectives. This has important implications in defining ways of introducing private health care practice, since the achievement of different types of objectives can lead to acceptance of certain modes of privatization at the expense of others. For example, co-payments may be brought to increase access to certain services, which are applied in excess, or to reduce the demand for them. Also, privatization may increase or reduce funding priority for the health sector. Essentially, privatization can be a means to a default goal, when you want to achieve a coherent strategy, and as a general rule, privatization that does not provide competition may be more harmful than no

privatization at all. And this is one reason why more and more countries choose the public/private mix against the total privatization.

IV. Current decisions in the Romanian medical system

IV.1. Co-payment

The allocation of financial resources requires a comprehensive and thorough planning process to balance the costs of various sectors of the health field and the adequate level of equity between regions and social groups. In this respect, the World Health Organization (http://www.who.int), focusing on efficient use of resources as vital element of health development, recommended preferential allocation of resources to primary and intermediate care services, particularly for health services coverage of social disadvantaged groups.

The financing methods of medical- sanitary assistance refer mainly to (Ashworth et al. 2005: 259-262): ***general fees*** – collected at the state budget and then distributed to the sanitary sector, in accordance with the approved budget; ***compulsory insurance*** – cover the entire population, regardless of the health status of those who pay; ***voluntary insurance (optional)*** – related to health or the insured person's illness risk; ***direct "out of pocket" payment*** – rarely in the western countries, usually as part of co-payment.

Co-payment was used in the *national health service model*, 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). The system has the general taxation as a funding source, which is controlled by public authority, as well as a budget; there is also the private sector. In this model, there is free access for all citizens, the coverage is general and administration is supplied by state authorities. Physicians are either employees or paid for the number of patients enrolled on their lists (capitation method), co-payment of a portion of the cost of some service being practiced to some extent (Dobson 1999: 19). Therefore, co-payment involves patient's contribution to the costs of health care assistance, which is co-participation. The argument is that using this method stimulates consumers not to use unnecessary medical services. Its opponents consider this method to affect disproportionately poor people and discourage preventive care.

From the perspective of classical economic theory, the individual is regarded as the best expert of its needs and, therefore, decides what to buy (consumer sovereignty). In healthcare, this means that the patient looks for health services based on price and quality, as anybody does when buying any other product. However, the medical services market does not work the same way as other markets, displaying certain specificity. As it is well known, only if the market functions properly, it becomes efficient and its customers have sufficient information to choose correctly, too. Market transactions are problematic because of **information asymmetry** between providers, consumers and health care financers. Information asymmetry is high: most doctors are informed (by the nature of their profession), which can thus induce the behavior of consumers (patients). The consumers of medical services find very difficult to be properly informed, mainly because of the high cost of information. Most often, they are unable to determine whether their symptoms are severe or do not know the type and form of therapy required, and generally, there is little information about the effectiveness of all existing treatments. Consequently, if the doctors and hospitals operate in a free market by seeking to maximize profits, is unlikely to lower price of health services due to competition. In a situation of tacit cooperation between physicians and hospitals, due to the setting of standard prices and the protection of their income, one can hardly speak of a fair competition. Even if the doctors would compete freely, it is unlikely that patients should be informed so as they may choose the best medical service quality and the lowest price. The question is whether or not all health services could be allocated through market mechanisms

just like any other goods or services. But there are a number of fundamental constraints (uncertainty about the anticipated medical needs, lack of complete information and patient ignorance, unfettered access to medical services determined by income, oligopolistic situation.), which, making it impossible to allocate all resources through free-market health, helps to shape context frame that makes health care market be typical example of **market failure**. The constraints that make a free market mechanism fail in the allocation of health resources do not stand for an argument that government intervention and free medical services offer would be the best alternative. Most often, the free market failure takes the form of government intervention which subsidizes the consumption of medical services, regulating the behavior of producers of medical services (doctors, hospitals) or imposes taxes on consumption, such as co-payment.

IV.2. Merged Hospitals

Ministry of Health has recently made public **the list of merged hospitals**, a process that is part of **the reorganization of the hospital system**. In accordance with the project implemented by the **Ministry of Health**, of the 435 **hospitals** with beds that currently exist, 182 units are proposed to remain unincorporated and to **get reorganized** as outer sections. Of 182 **hospitals**, a number of 111 **sanitary units** will be merged (http://www.ms.ro/. http://www.sanatateatv.ro/stiri-medicale/spitale-comasate/). This decision of the Ministry is based on arguments such as:

- profile change of certain hospital will lead to a more stable sanitary system;
- hospitals that are not able to meet certain conditions, finally will not benefit from the contract with the National Health Insurance House (prof. dr. V. Astărăstoae, http://www.ziaruldeiasi.ro/local/comasarea-spitalelor-pro-si-contra~ni724q), thus being excluded the reimbursement of the medical services belonging to some unprofitable units;
- merging process will cut health care system bureaucracy, considering that patients will be treated for different diseases within the same hospital;
- reduction of management positions – the hospitals that are merged are to have only one manager and a single administrative body.

But there are several arguments against that deserve to be taken into account. On one hand, opponents of mergers argue that the Health Ministry should not condition hospitals' classification and funding from this point of view. Starting from certain hospitals inefficiency argument put forward by policymakers in health care, based on National Center for Statistics and Public Health, I analyzed the performance of hospitals in Romania through the following parameters: average number of hospital beds, the average use rate, the rate of their optimum utilization and the resultant of the two or the demand or the surplus of beds in each of the 435 hospitals. Centralized data shows the following:

- within each county, (including Bucharest) there are both units recording a surplus of hospital beds (in relation to optimal utilization rate) and hospitals with beds deficit;
- nationally, totaling the excess of beds needed, the figures show that there is a surplus of hospital beds, according to table no. 1. In the light of these indicators, merger or readjustment of certain hospitals is justified, but a closer analysis shows that hospitals list for such restructuring do not fully comply with any economic considerations (merging a hospital with a surplus of beds with one with a deficit), not even the medical terms or merging hospitals to cover other necessities) and, not least, the context regarding patients or medical staff (which regards hospitals located in different places at considerable distance between them – for example, to get an approval from the manager of the hospital, the employee of the medical sector could be forced to go to another town).

Table no. 1 – Demand/surplus of beds in Romanian hospitals (the average of 2007-2009)

County	Demand/surplus of beds	County	Demand/surplus of beds	County	Demand/surplus of beds
Alba	59	Covasna	-208	Neamţ	-24
Arad	-41	Dâmboviţa	-216	Olt	-53
Argeş	-48	Dolj	-105	Prahova	-51
Bacău	-104	Galaţi	-164	Satu Mare	-178
Bihor	30	Giurgiu	-82	Sălaj	-224
Bistriţa Năsăud	-281	Gorj	-10	Sibiu	-161
Botoşani	-68	Harghita	-346	Suceava	-359
Braşov	-111	Hunedoara	-279	Teleorman	-178
Brăila	-61	Ialomiţa	-55	Timiş	-445
Buzău	41	Iaşi	-46	Tulcea	-238
Caraş-Severin	-146	Ilfov	3	Vaslui	62
Călăraşi	-119	Maramureş	-235	Vâlcea	166
Cluj	-145	Mehedinţi	-147	Vrancea	-99
Constanţa	-173	Mureş	-277	Bucureşti	514
Total	**- 4602**				
Note: sign „-" stands for a surplus of bed; sign „+" stands for a demand of beds					

Source: achieved by author on the basis of data offered by the National Center of Statistics and Information in Public Health

V. Conclusions

If the picture of the past health care system has had rather a documentary value, the current and future image cannot be indifferent to us, especially since the transition has prolonged excessively, overlapping global crisis. The reasons for which the health reform, in Romania, has generated, at best, partial results are manifold, but they can be mainly summarized as follows:

- ignorance of tradition and evolution of public health concepts in Romania by physicians in general, and decision makers, in particular, seems to be the most serious deficiency, which adversely affected the cooperation with foreign experts;
- contradictions between the views of public health experts and their acquisition by public policymakers in implementing the reform;
- democratic deficit in health system planning (at the implementation of laws);
- excessive politicization of the health system, form the minister up in all health units;
- a general lack of public health managers in the ministry structure that does not change with each government or minister;
- absence of implementing the primary health care programs;
- inability to prioritize system as a major imperative in terms of transition to a market system with mechanisms different from the previous total and limited resources;
- excessive bureaucratization of business at the expense of medical care itself.

In this context, to accelerate the process of reforming the health system certain priorities should be established with utmost responsibility, that can be achieved with available resources and potential so as the primary health care programs may become reality. It is also necessary to reinvent the College of Physicians and Pharmacists functions to restore public respect for the doctor, not just through professional attire, but also by behavior and attitude (common sense, morality, decency, dignity). Another tool for optimization of the reform process is voluntary health insurance market (private insurance). The advantages of this type of medical insurance are designed to introduce elements of competition between health providers as well as the encouragement of loyalty towards employers. For the first time in Romania, voluntary health insurance creates a legal remedy that allows medical personal income growth in line with quality, value their work and its social importance, creating prerequisites for decreasing the "informal payments". Also, the relationship between health care providers in the budgetary network and insurance companies will induce greater discipline in the public system through indirect control that insurance companies exercise over the expenses incurred by their customers in this system.

As for the Romanian context, I consider that the experiences of certain European countries can be taken as a basis for developing an efficient health system. In addition to the national interest, it appears as a necessity in terms of European integration and "health globalization".

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