

Chapter 3

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ROMANIA HEALTH CARE ANALYSIS

Abstract: Chapter shows analysis health care in Romania and attempt to evaluate its situation. It was stated that hospitals not fulfilling the classification criteria because of major deficiencies can be transformed into health care centres functioning as branches of municipal hospitals

Key words: health care, Romania, quality.

3.1. Introduction

The beginning of the healthcare reform in Romania meant the reorganization of health services and a new financing system.

Primary care was organized as permitted by law (Emergency Government Ordinance nr. 124/1998) in individual practice, associated practice, civil medical societies and limited responsibility societies. Most of the GPs chose individual practice. They employed nurses and paid for all the expenses of the practice. Doctors had to fulfill the contract with the DHIH but they were subordinated also to the District Health Directory (DHD) for coordination and control. Also the DHD's were the owners of the buildings in which GP worked. A new GP office or a

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change in an old one (like retiring of a GP) was made through DHD and a GP had to sustain an exam at the local DHD to enter in the system.

Since Romania adopted a mandatory social health insurance system in 1998, the roles of the main participants in the health system have changed, the relationships between different organizations have become more complex and the number of participants involved has increased (Fig. 3.1). The system is organized at two main levels: national/central and district (judet). The national level is responsible for attaining general objectives and ensuring the fundamental principles of the government health policy. The district level is responsible for ensuring service provision according to the rules set by the central units. **Main institutions:**

The Ministry of Public Health is the state's institution responsible for ensuring the health of the nation. It does so through the definition of policies and strategies, and planning, coordinating and evaluating outcomes. Since 1 January 1999, the Ministry of Public Health ceased to have direct control over the financing of a large part of its network of service providers. Responsibilities consist of:

- Stewardship role in engaging main stakeholders in different types and different stages of health policies and strategies formulation, implementation and evaluation.
- Defining and improving the legal environment in the context of wide public circulation that includes views of stakeholders and of patients.
- Ensuring increased transparency in managing the state's budgetary allocation for health. The Ministry of Public Health retains responsibility for financing and managing the national public health programmes, selected specialty services and investments in buildings and high-technology medical equipment.
- Regulating both the public and the private health sectors, and their interface.
- Ensuring leadership in conducting research and developing policy and planning in relation to developing reform policies and monitoring their impact; monitoring the impact of financing reforms; monitoring

the need to upgrade buildings, major repairs and high-technology medical equipment; and monitoring the emergence of the private health sector.

Fig. 2.1 Organizational chart of the statutory health system

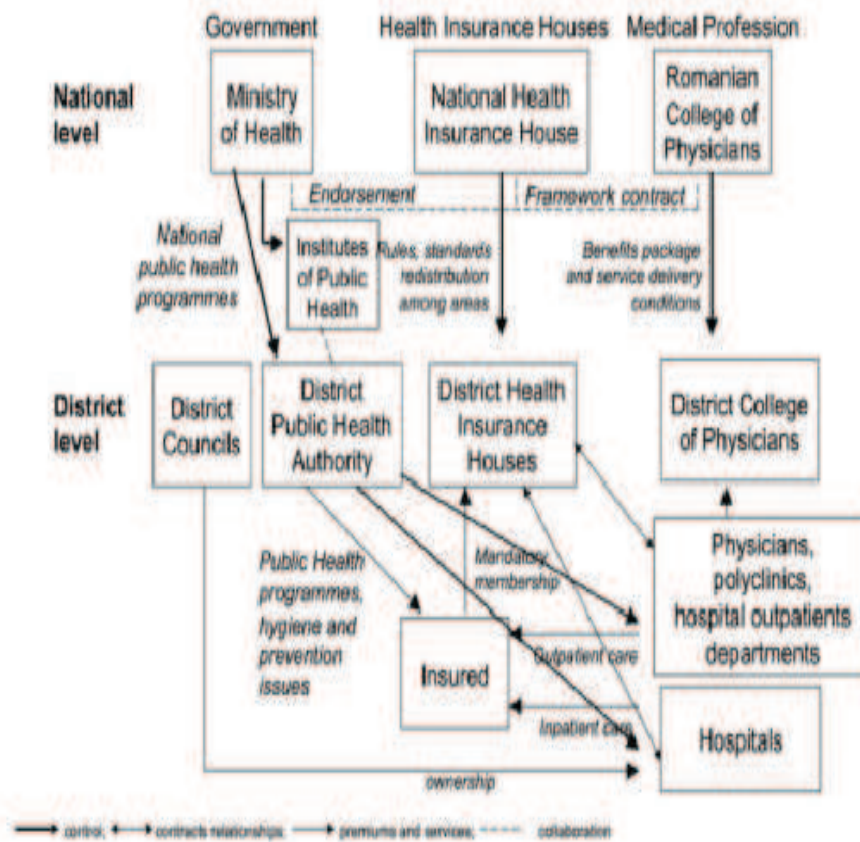


Fig. 3.1. Health care organization.

Source: Own study

- Defining and improving the legal and regulatory framework for the health care system. This includes regulation of the pharmaceutical sector as well as public health policies and services, the sanitary inspection and the framework contract.
- Developing a coherent human resources policy and for building capacity for policy analysis and management of the health care system.

The National Health Insurance House –an autonomous public institution that administrates and regulates the social health insurance system. Between 2002 and 2005, the NHIF was under the coordination of the Ministry of Public Health. In 2005, the NHIF regained its independent status and is currently mainly responsible for:

- developing the strategy of the social health insurance system.
- coordinating and supervising the activity of the Districts Health Insurance Fund.
- Elaborating the framework contract, which together with the accompanying norms sets up the benefit package to which the insured are entitled, and the provider payment mechanisms
- Deciding on the resource allocation to the Districts Health Insurance Fund.
- Deciding on the resources allotted between types of care

At present, according to the Health Reform Law (95/2006), the Council of Administration consists of 17 members with the following composition:

- five representatives of the government: one each appointed by the Minister of Public Health, the Minister of Labour, Social Solidarity and Family, the Minister of Public Finances, the Minister of Justice and the Romanian President.
- Five representatives of trade unions.
- Five representatives of employers' associations.
- Two members appointed by the prime minister upon consultation with the National Council of the Elderly.

The president of the NHIF is appointed by the prime minister. The Council of Administration has two vice-presidents, elected by Council members.

The Ministry of Public Finances. This ministry plays a key role in decisions involving health sector reform measures. Since reform tends to involve changes in public finances, Finance Ministry approval is required. Therefore, reforms need the signature of the Minister of Finance (together with the Minister of Public Health and the Minister of Labour and Social Protection). Any policy document that involves the expenditure of public money requires the technical approval of the Minister of Finance; therefore, this minister has an important role in shaping health policy reform.

Other ministries. Others with competence in health matters include the Ministry of Labour and Social Solidarity and Family, which provides funds for health insurance contributions for people on unemployment or social benefit; the Ministry of Transport; the Ministry of Defence; the Ministry of Interior and Administrative Reform; the Ministry of Justice; and the Romanian Intelligence Agency, which all own and operate their own parallel health systems consisting of separate health care facilities (hospitals, polyclinics, dispensaries)

The College of Physicians – this is a disciplinary organism with attributions in the field of medical accreditation. It also evaluates the malpraxis cases. In the same category there is also The College of Pharmacists which is taking care of the politics of drug deliveries.

The Romanian Medical Association and the Society of General Practitioners. The Romanian Medical Association is the successor of the single professional association that existed before 1989 during the communist regime. Today, the association has limited its activities to scientific concerns, professional issues being dealt by the College of Physicians. The Society of General Practitioners was established initially as a purely scientific society. However, gradually it has started to be involved also in matters of the profession, since General Practitioners felt that the College of Physicians does not deal properly enough with their

profession, the management being dominated by specialist physicians coming mainly from hospitals.

3.2. Hospitals divided in Romania

Hospitals in Romania are divided following (ROSAK-SZYROCKA J. NASTA R., TIRAU 2012):

- 1. *First class – maximum performance*** - The highest class include hospitals which have 34 sections of different kinds. Basically, a first class institution should have all the specialties covered. In addition, might have guard lines and clinics in all these 34 sections, with skillful doctors. First class institution might have a minimum medical equipment: digital radiology, computed tomography, magnetic resonance and to conduct scientific research. The number of patients from other counties should be higher or equal with 30%, and readmissions and patients transfer will be in the smaller proportions.
- 2. *Second class – the best county hospitals*** - The institution from this class might have in their own structure 21 sections and labs, including general surgery and infectious diseases. Guard lines will cover every department and specialty doctors might assure the healthcare 24 h/day in 11 departments. The most performing equipment requested for the second class are: computer-tomography and magnetic resonance device. Institution is required to conduct scientific research and hospitalized patients from other counties at least 5%.
- 3. *Third class – the most county hospitals*** - The third class institutions have 21 sections, from anesthesia and intensive care to oncology and general surgery. The specialty doctors will be present non-stop only in 10 from all 21 sections. A third class hospital will have a computer-tomography. The institutions doesn't have conditions for hospitalized patients from other counties.
- 4. *Fourth class – Municipal units*** - The fourth class includes especially municipal hospitals which have 7 sections required, including

anesthesia, intensive care and general surgery. Gynecology have at least a maternity. The institution have only 2 guard lines. Shouldn't miss the ultrasound and radiology equipment.

5. **Fifth class – Chronic hospitals** - The last category includes hospital for chronic diseases, mostly in rural areas. In these are hospitalized patients having some chronically diseases of some kind like: neurology, psychiatry and rehabilitation. The equipment is just for treating patients with those diseases.

In the Figure 3.2 it was showed number of hospital with taking into consideration classes.

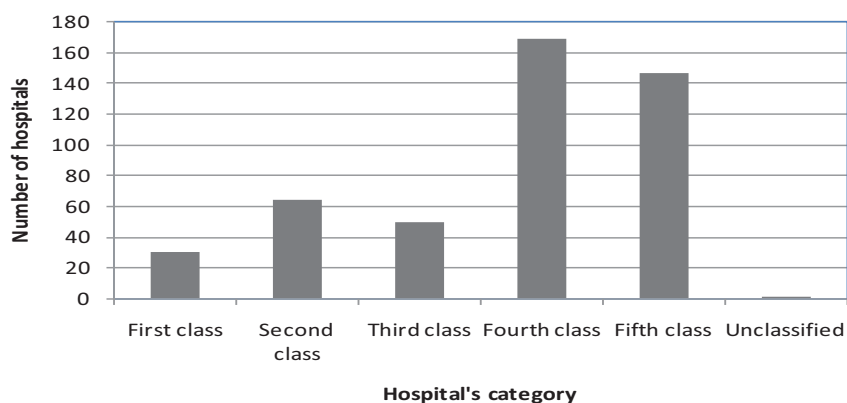


Fig. 3.2. Number of hospital with taking into consideration classes.

Source: Own study

It can be seen from the Figure 3.2 that the highest number of hospitals in Romania occurs in case of fourth class –municipal units 169 hospitals after then there is fifth class – chronic hospitals are posing 147 hospitals.

The components of the health care system in Romania is represented by:

Primary health care – Since 1998, patients are allowed to choose their dispensary or family doctor or general practitioner, and can change after a minimum of three months after initial registration. In parallel, general practitioner changed from being state employees to independent

practitioner, contracted by Health Insurance House, privately operating their medical offices. In order to cover the preventive and curative care, dispensaries provide prenatal and postnatal care, some public health care and health promotion and health education. After a survey carried on in 1998 the conclusion indicated that primary health services are generally speaking of poor quality and require continued reform attention.

Secondary health care – delivered by a network of hospitals, centres of diagnosis and treatment, office-based specialists. In the same time, private outpatient services may be accredited for all specialists, including outpatient surgery. Big part of the physicians practice privately as well as publicly.

From the point of view of the ownership, with the exception of a few small hospitals, all hospitals are publicly owned and under the state administration. The hospitals are led by a council board with a general director who holds executive power. In Romania, the existence of the Semasko health services system facilitated the development of an illegal practice: offering money or presents to the medical staff in exchange for their services. This practice is generally called “under the table payment”. The “under the table payment” was developed due to the extremely low financing of the health system that of course affected the staff salaries. Because of this, the “under the table payment” has become a current practice (continued even today), although the communist propaganda claimed that the medical services are completely free. In the Figure 3.3 was showed the total number of hospitals in 2008-2011. It can be seen that in 2010 the number of hospitals was the largest (503 hospitals) while the smallest was in 2008 (458). Health care services are delivered free of charge to the whole population on the basis of registration with a family doctor. Dental care is free for all persons up to 18 years of age; above this limit, between 40% and 60% is covered by the National Health Insurance Fund. The drugs’ coverage depends on the category to which they belong. Currently, there are three distinct lists of drugs: A, where the coverage is 90% of the reference price; B, covered at 50% rate; C, fully covered by the social security. Excepting the emergency situations, the admission to

hospital is possible only on the basis of a prescription from the family doctor. No fees are charged during hospitalization, unless the patient wants higher standards of medical services and accommodation.

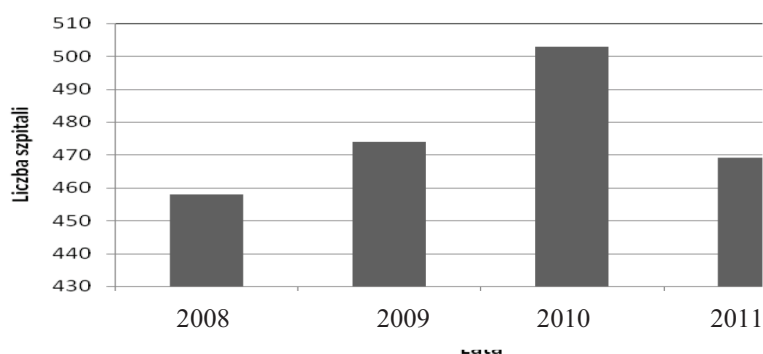


Fig. 3.3. Number of hospitals in 2008-2011.

Source: Own study

The reforms of the sector in 2011 concerned the continuation of hospitals reorganization, the adoption of the law on the introduction of a co-payment mechanism for medical services, and the submission to public debate of a new law on health care. By 2012 healthcare spending per head is forecasted to be more than 80% higher as compared to 2007, as Romania attempts to align to the EU requirements. Further growth will be fuelled by the rise of the disposable incomes, the development of the private health insurance and the increase of the medicine consumption. Informal payments in state-owned healthcare facilities are deemed to stimulate the development of the private medical services, as the latter represent a better alternative to the poor state-owned services. The reorganization of hospitals is based on a classification system that divides the 347 units concerned by the process into five categories, ranging from highest competence (category I) to the lowest one (category V). The majority of hospitals are already classified; because of various organizational problems, 87 of them received from the Ministry of Health a temporary classification until the end of 2011. This deadline was

insufficient, and consequently the delay was extended for one more year. There are only 28 hospitals in the first category, the largest number of them (201) being placed in the fourth and fifth categories, which group medical units with limited and very limited level of competence. In 2011, sanitary system had 52.6 thou physicians (dentists excluded), 13.4 thou physicians dentists, 14.6 thou pharmaceutical chemists and 126.6 thou ancillary medical staff. In 2011, for every physician (excluding dentists) there were 407 inhabitants (428 inhabitants in 2008). For every dentist there were 1602 inhabitants, 205 inhabitants less than in 2008, and for every pharmaceutical chemist there were 1470 inhabitants, 367 less than in 2008. In 2011, per 1000 inhabitants there were: 24.6 physicians, 6.2 dentists, 6.8 pharmaceutical chemists and 59.1 ancillary medical staff.

3.3. Summary

Medical staff of Romania complies with the provisions of the Code of Medical Ethics. The doctors' obligation are to protect human physical and mental health, in the ease suffering, in the respect life and human dignity, without discrimination based on age, sex, race, ethnicity, religion, nationality, social, political ideology or any another reason, in the peacetime and in wartime. The hospitals not fulfilling the classification criteria because of major deficiencies can be transformed into health care centres functioning as branches of municipal hospitals but their effective destination and role is not yet clearly defined. Another proof that the system it's not working very well it's the number of beds. If in 2008 the total number of beds were 138184 in 2011 become 128136 (WWW.HOPE.BE).

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