

HiT summary

Romania

Introduction

Government and recent political history

Romania had a Communist government until the revolution of 1989 which set up a Republic led by a President and governed by a two-chamber parliament, the Senate and the Chamber of Deputies.

Population

Estimated population is 22.81 million (1992 census). The percentage of the population in absolute poverty is among the highest in the European Region (World Health Report 1999). The working population dropped by over 13% between 1989 and 1995; the number of wage earners fell by over 27%. Unemployment is high, and rose to 8.8% in 1997.

From the 1960s to the 1990s, the health status in Romania steadily declined in some respects and a tendency of relative and absolute decline prevailed.

Average life expectancy and infant/maternal mortality

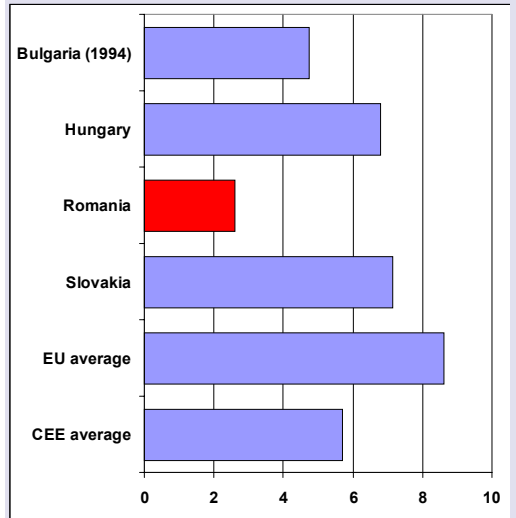
The average life expectancy is 65.3 years for men and 73.4 years for women (1997) (the lowest in central and eastern Europe). Geographic variation is prominent, with 4 years difference in life expectancy between Bucharest (1.5 years above national average) and Tulcea (about 2.5 years below national average) in the east.

Infant mortality and maternal mortality are among the highest in the European Region, despite a large decline in maternal mortality since 1990.

Leading causes of death

Cardiovascular disease, cancer and respiratory disease (1998).

Fig. 1 Total health care expenditure as % of GDP, comparing Romania, selected countries, CEE and EU average, 1998



Source: WHO Regional Office for Europe health for all database
Note: CEE = central and eastern Europe, EU = European Union

Recent history of the health care system

For four decades, from 1949 to 1989, there was a Semashko health system. Major reforms began in 1989, and by 1995 they had transformed the centralized, tax-based system into a decentralized and pluralistic social health insurance system, with contractual relationships between health insurance funds as purchasers and health care providers.

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Reform trends

The Health Insurance Law is in the third year of implementation and parts of it still need to be adapted to the changing political, social and economic context. Main changes are occurring in the primary health sector, where general practitioners are becoming independent providers.

Health expenditure and GDP

Public expenditure was 3.9% of GDP in 1999, but data on total expenditure is limited because private expenditure is not accurately calculated even though it plays a significant role. The country still has a low proportion of its GDP spent on health.

Overview

The health care system has undergone – and is still undergoing – rapid transformation, and health sector reform is part of the country's broader transition to political pluralism and a market style economy. It is still early to judge the success of the reform, but Romania's history plays a role in many of the problems that still exist. Little is spent on health per capita, equity remains of concern, social care is limited and there is still overuse of hospital care. However, lessons learned so far have led to positive changes in reforms, pointing to the country's flexibility and ability to adapt.

Organizational structure and management

The system is insurance-based with mandatory membership, linked to employment, and contributions are a percentage of income paid in equal proportions by the employer and the insured.

The Ministry of Health no longer has direct control over the financing of a large part of the network of providers. It is responsible for

developing national health policy, regulating the health sector, and dealing with public health issues. However, legal changes of roles and responsibilities have not yet been associated with significant changes in skills and competencies. The representative bodies of the Ministry at the district level are the district public health directorates.

As of 1999, the 42 district health insurance funds (DHIFs) are responsible for collecting contributions, contracting services from public and private providers and reimbursing providers. There are also two countrywide funds, of the Ministry of Transport and of national security bodies, respectively.

Also as of 1999, the National Health Insurance Fund sets the rules and regulations for the DHIFs and has the right to reallocate up to 25% of the collected funds towards under-financed districts. The NHIF negotiates the framework contract with the Romanian College of Physicians (CoPh).

The CoPh has important responsibilities regarding all areas of concern for physicians, who should be registered with the college in order to practice. The CoPh has an influence – through negotiations on the framework contract – over the content of benefits package, the type of reimbursements in place, which drugs are compensated, etc.

Private practice is permitted, although hospitals are publicly-owned (with a few small exceptions). In 1996, there were approximately 12 000 people employed by private health care enterprises, and pharmacies formed the most important private beneficiary of the public sector.

Health care finance and expenditure

Health care financing

Beginning in 1998, earmarked payroll contributions became the main source of health

sector funding (78.4% in 1999). Of these funds, 25% must be set aside for redistribution among districts (by National Health Insurance Fund); 20% of funds in 1998 and 5% thereafter needs to be set aside as reserves; no more than 5% of funding can be spent on administrative costs.

Main system: health insurance scheme

The working population pays a 7% payroll tax and the employer another 7% payroll tax to the fund. The self-employed, farmers, pensioners and the unemployed pay a 7% contribution (in 1998, these percentages were 5% for the employed/5% for the employer and 4% for pensioners, respectively).

The mandatory health insurance scheme covers the whole population. Children, the handicapped, war veterans and dependants have free access to health insurance. Contributions for soldiers and prisoners are covered by the Ministries of Defence and Justice.

Taxes

Taxes continue to be an important source for health care financing (21.6% in 1999) as the state budget retains responsibility for funding public health services and capital investments, as well as priority preventive activities.

Complementary sources of finance

It is believed that out-of-pocket payments are considerable. It is difficult to calculate private expenditure on health, but is estimated that these comprise approximately 29% of total health expenditure (1996 data from individual household surveys). An important part of this sum goes to the public providers or their staff through charges for services or under-the-table payments. The largest identifiable share was for drugs (33%), and while formal co-payments are required for drugs under the new legislation, contracted providers can also charge co-payments for other services, suggesting that out-of-pocket payments have increased since 1996.

Significant funding is also provided by international organizations through bilateral support and private sources. The influence over the health care system by these external sources, such as the World Bank, is apparent (e.g. primary health care).

Health care benefits and rationing

According to the Health Insurance Law, the insured are entitled to preventive services, ambulatory health care, hospital care, dentistry services, medical emergency services, complementary medical rehabilitation services, pre-, intra and post birth medical assistance, home-care nursing, drugs, health care materials, and orthopaedic devices. The exact benefits covered and the conditions for their delivery are laid out in the framework contract, negotiated between the National Health Insurance Fund and the College of Physicians.

Health insurance does not cover health care services for professional risks, professional diseases and work accidents, selected high-technology health care services, selected dental care, curative health care assistance in the workplace and luxury accommodation services in the hospital. Legislation regarding accident insurance is under debate in the Romanian Parliament.

Health care expenditure

Data on health expenditure is problematic because private expenditure is probably underestimated and public expenditure overestimated. The relatively large proportion of private expenditure has unfavourable consequences for equity of access. GDP on health is considerably lower than in all neighbouring countries, although there has been a marked increase in public expenditure as a share of GDP from 1998 to 1999 from 3.2% to 3.9%. Regional differences in spending on health care are large. Unfortunately, to date, the reserved 25% of funds for redistribution to under-funded districts has mainly been used for supporting districts with collection difficulties, not for improving equity.

Health care delivery system

Public health services

The Ministry of Health is the central authority in public health, responsible for setting organizational and functional standards, developing and financing national public health programmes, collecting data and drawing up reports on the population's health status. The Ministry is also responsible for environmental health, through the Institute of Public Health Bucharest. The district level public health directorates are responsible for covering public health in their districts, and their expenses are financed by the Ministry of Health. Communicable diseases are the responsibility of the Ministry, but treatment is covered by the Health Insurance Funds. Among others, there are screening programmes for cervical and breast cancer, radiological screening for tuberculosis and compulsory immunization. Until 1990, there was no family planning network in Romania; now there are eleven reference centres for reproductive health. In addition, health education, previously termed "sanitary education", has been developed into a network for health promotion and education, and currently there are programmes of health promotion and education at national and district levels.

Primary health care

Until 1999, primary health care was mainly carried out through 6000 countrywide publicly owned dispensaries, managed by the local hospital, and patients were assigned to a given dispensary according to place of employment or residence. Since 1998, patients are allowed to choose their dispensary/family doctor or general practitioner, and can change after a minimum of 3 months after initial registration. At the same time, general practitioners changed from being state employees to independent practitioners, contracted by the health insurance funds, but privately operating their medical offices. Since 1990, there are also private medical offices staffed by general practitioners or specialists. In addition

to preventive and curative care, dispensaries provide antenatal and postnatal care, some public health care, health promotion and health education activities.

Primary health care reform began on a pilot basis in eight districts in 1994 with new financing, a shift in responsibility from the hospital to the district health directorate and the introduction of contracts between the directorate and the general practitioners. Access to outpatient care currently requires a referral by the general practitioner, but since 1989, the referral system has been increasingly bypassed and the frequency of primary health care consultations has decreased. A 1998 survey indicated that primary health care services in the current system are generally of poor quality. Primary care will require continued reform attention.

Ambulatory secondary care

Ambulatory secondary care is delivered through a network of hospital outpatient departments, centres for diagnosis and treatment and office-based specialists. Individual medical offices of specialists are starting to be set up in rural areas as well as in towns and since 1990, private medical offices have also been established. Physicians working in private medical offices need a practice license and an authorization for the medical office, and private outpatient services may be accredited for all specialties including outpatient surgery. Recent studies indicate that an estimated 15% of physicians practice privately as well as publicly.

Inpatient care

There are four main categories of hospital in Romania: rural hospitals; town and municipal hospitals, district hospitals and specialized units for tertiary care, such as the Institute of Oncology, etc. In terms of ownership, with the exception of a few small hospitals, all hospitals are publicly owned and under state administration. Hospitals have operational managerial staff and are led by a council board along with a general director who

holds executive power. They are accredited by the Ministry of Health and for training activities, by mixed commissions including representatives of the Ministry of Education. Accreditation specifies hospital tasks and responsibilities.

Hospital maintenance, treatment and staff salaries are financed from the health insurance funds; the initial capital investment is currently financed by the state.

Romania has over 164 000 hospital beds, or 7.3 beds per 1000 people. This ratio for all bed types is below other developed countries, and regional variations exist. Excluding beds for tuberculosis and psychiatry, the ratio of acute care speciality beds is about 5.2 beds per 1000 population, still regarded by the Ministry as a high ratio.

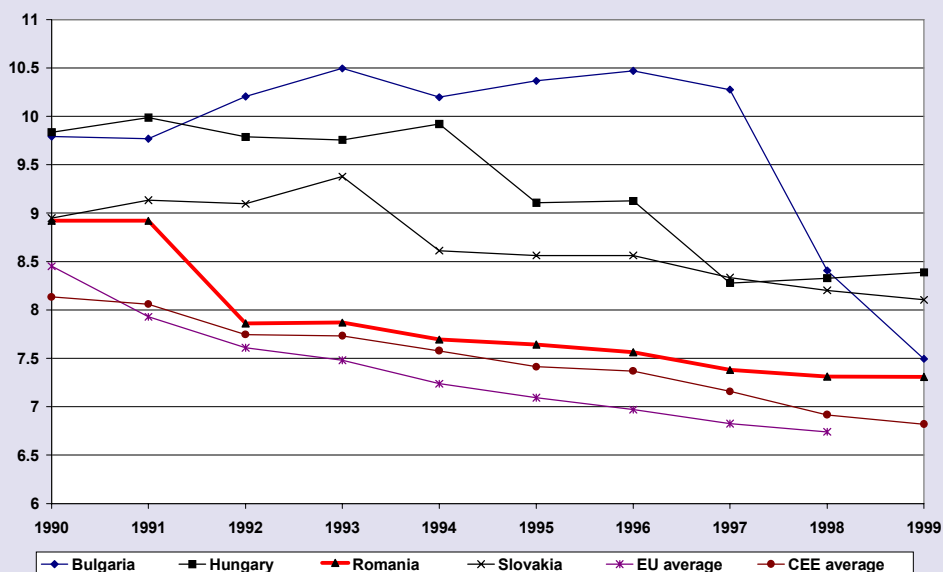
A 1998 survey indicates that the number of admissions is higher than in most European countries, supporting the hypothesis that patients are directly admitted to the hospital without

proper care at the ambulatory level and, at the same time, the high rate of emergency admissions confirms this direct relationship. In addition, average length of stay (excluding chronic care hospitals) is at about 9.5 days, similar to the CCEE average, but above western European countries; the average occupancy rate is within western European figures.

From 1991–1992, the Ministry planned a large reduction of hospital capacity, prompted by such circumstances, for example, as greatly decreased demand for hospital beds by children, due to changes in legislation and improved living conditions.

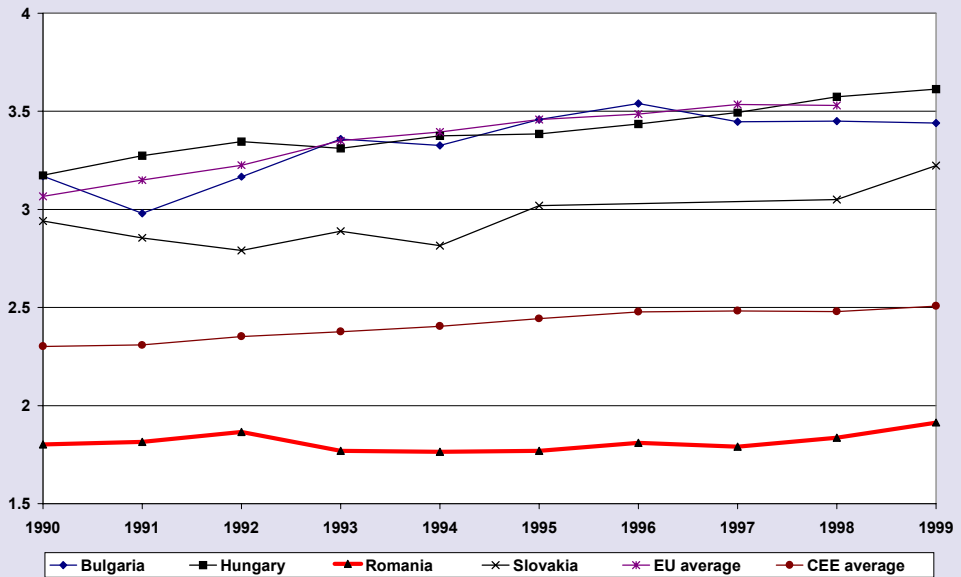
The 1999 Law on Hospital Organization regulates hospital organization, functioning and financing. It introduced global budgets and outlined procedures for contracting between hospitals and the health insurance funds. Gradually, the majority of hospitals will be transferred from the Ministry of Health ownership to local council ownership.

Fig. 2 Hospital beds in all hospitals per 1000 population, Romania, selected countries, CEE and EU average



Source: WHO Regional Office for Europe health for all database

Fig. 3. Physicians per 100 population, Romania, selected countries, CEE and EU averages



Source: WHO Regional Office for Europe health for all database

Social care

There is not yet a proper community-based social care network in Romania, and external support is still important due to the underdevelopment of this sector. As many as 40% of patient days in acute care hospitals are dedicated to social cases, which are patients with minor problems who cannot be discharged due to a lack of suitable alternatives. As health care reform is implemented, hospitals will become under increasing pressure to discharge these patients. The Ministry of Health has historically paid for these non-acute patients, but now, with little support coming from the health insurance funds, the ministry will need to decide how to provide these services. The Ministry is, on the other hand, responsible for units caring for people with certain chronic diseases.

In 1999, the budget and responsibilities for caring for poor, orphaned or abandoned children

were delegated to local authorities. However, as local authorities were unprepared for this, the situation of these children worsened and caught media attention. This led to the discussion of this issue as a barrier to the EU accession process. Thus, the government established a new Agency for Child Protection that will take care of all aspects previously covered by several ministries and state organizations.

The State Secretariat for Handicapped People is responsible for elderly homes and nursing homes. Elderly people with no family have priority access. Residents pay a fee, which is deducted from their pension and passed to the state budget; the local council then pays the nursing/elderly home. Care for those with no income is funded from the local council budget.

A number of NGOs, many with assistance from other countries or international donor organizations, also provide medical and social care in Romania.

Human resources and training

Romania has one practising physician for every 580 people (or 17.7 per 10 000 people). In contrast to most other countries, this number did not change during the 1990s. While low in comparison with European and neighbouring countries, this is an acceptable ratio for providing access to primary and speciality care. The number of nurses, by European comparison, is low. However, what the number of physicians hides are the country's main problems in this area: geographic and medical speciality maldistributions and quality concerns. To address the problem of quality, for example, emphasis has been placed on family medicine and on the professionalism of nursing, and there has been massive retraining of all service providers. The plan is to maintain the same number of medical graduates, further emphasize the role of the family doctor, and adopt a new accreditation system for doctors and pharmacists. Regarding social and community care, the plan is to increase the number of social workers, train personnel in community care and increase the number of trained public health and management specialists.

The social status of doctors and other health personnel is low due to low wages, although this situation has improved since 1999.

Pharmaceuticals

There is no formal drug policy in Romania, although the essential building blocks for developing one are currently being set in place by the Ministry of Health with the support of the PHARE programme (EU) and WHO. Pharmaceutical manufacturing, distribution systems and quality are controlled by legislation, and the Ministry of Health is responsible for legislative decisions. In 1999, the National Drug Agency was created, an independent agency responsible for the registration and quality inspection of pharmaceuticals and related products.

According to an emergency ordinance on drugs which came into force in January 2000, the Ministry of Health sets the prices of locally produced and imported drugs.

Pharmacies and pharmacists were among the first to be privatized and most producers are privatized now.

The share of local production has been decreasing to about 40% of the whole market value, although in volume it still covers the majority of consumed drugs.

The Health Insurance Law provides access to reimbursed drugs to patients. Every year, the Ministry of Health and the NHIF compile two positive lists, which determine the prescription drugs that are covered by insurance. One list contains generic substances covered 100% for people with one or more of 26 diseases; the other contains substances on which the reference price system is applied and of which 70% is covered. Treatment guidelines are expected to be developed and the selection of reimbursed drugs will follow from these guidelines.

Health technology assessment

Technology has to be registered with the Ministry of Health, but the registration requires only proven safety and effectiveness, without a review of cost-effectiveness.

High technology equipment is paid for by the state budget. If it is not yet included in the framework contract, the National Health Insurance Fund and the providers negotiate its inclusion and reimbursement level.

Financial resource allocation

Since 1998, the national budget for health care has two major sources: the state budget (1/3) and the health insurance funds (2/3). The Ministry of Health is responsible for managing the state budget for its national public health programmes, and it allocates funds to the district public health directorates mainly on a historical basis.

The health insurance contributions are raised at district level and are redistributed to providers on a contractual basis. All health services are

covered by these funds with the exception of capital investments, which are the responsibility of the Ministry of Health. 25% of these resources are sent to the National Health Insurance Fund for redistribution to under-financed districts. The two parallel health insurance funds of the Ministry of Transport and national security bodies function in the same way as the district health insurance funds regarding money flow.

Resource allocation among different specialties is determined by the framework contract.

Payment of hospitals

The method of paying hospitals changed to global budgets through the 1997 Health Insurance Law, the 1999 Law on Hospital Organization and the framework contract. Unlike before, when it was related to the number of hospital beds or staff, financing is now connected to hospital activities.

Starting from the last trimester of 1999, hospitals receive global budgets for their inpatient activities. These are set at 70% on a historical basis and 30% on performance criteria. Maintenance and overhead costs, previously covered by local budgets, are now the responsibility of district health insurance funds. Major capital investments remain a responsibility of the Ministry of Health, along with teaching hospitals and national health institutes, which are co-

financed by the Ministry of Education.

Payment of physicians

Currently, medical staff is paid in different ways, depending on sector, although the income for all physicians is provided by the district health insurance funds on a contractual basis. In primary health care, physicians are paid a mix of weighted capitation (70%) and fee-for-service (30%: for preventive and health promotion services) according to the 1999 framework contract. Primary health care physicians also receive a fixed allowance to cover administrative expenses related to their practice. There is no distinction between public and private family doctors.

In late 1999/early 2000, ambulatory specialists and physicians in ambulatory secondary care became paid on a fee-for-service basis. The fee-for-service system used is based on a list of services, with a number of points allocated to each service. The available budget for the type of care and the total number of points for the services delivered determine the monetary value per point. More services delivered mean lower point values and, thus, lower reimbursements per service.

Hospital staff are still salaried. Expected under-the-table payments are a common source of additional income.

Table 1. Inpatient utilization and performance in all hospitals in the WHO European Region, 1999 or latest available year, where acute hospital bed data are not available

Country	Hospital beds per 1000 population	Admissions per 100 population	Average length of stay in days
Albania	3.0	7.7	7.5
Belarus	12.6	29.5	14.2
Greece	5.5 ^c	15.0 ^d	8.2 ^c
Latvia	8.9	22.1	11.8
Poland	6.0 ^a	13.8 ^a	10.1 ^a
Romania	7.3	20.7	9.9
Uzbekistan	5.4	12.9	12.0

Source: WHO Regional Office for Europe health for all database.

Note: ^a 1998, ^b 1997, ^c 1996, ^d 1995.

Acute hospital data provide a more accurate picture of utilization and performance, as well as a more reliable basis for comparison across countries, than the data corresponding to all hospitals shown in this table. The all-hospital data shown here is only for countries which do not provide acute hospital data and should be taken as indicative of general trends.

HiT summary

Romania

Health care reforms

The changes that have taken place to date largely reflect the country's history and influences by different actors. The intention was to take into account positions of all concerned agents, and the resulting changes show clear traces of influence from these different actors, such as the World Bank (primary health care), Germany (health insurance system) and United Kingdom (capitation).

The process of decentralization and moves to diversify the sources of funding started in the early 1990s, but the big change took place in 1997, when the Health Insurance Law transformed the system from a Semashko state financed model to an insurance based system.

Like any major reform, there have been problems and obstacles. Coordination of the process has been complicated, in part due to multiple actors, in part to turnover and change. Health legislation is complex and changes frequently, the country spent little on health in

the 1990s and the social health insurance system has been limited as a solution for increased funding due to collection problems. Equity is of concern, social care is limited and there is still overuse of hospital care. Efforts are underway to address these concerns.

Conclusions

Romania's complete transformation from a centralized, state controlled and financed system to a decentralized, social health insurance model is still underway. While still too early to judge its success, important lessons have been learned thus far, leading to corresponding changes in reforms (e.g., amendments in the Health Insurance Law). These changes are good indicators of the country's flexibility, a characteristic which will continue to be needed as the new system unfolds and assessments of its quality, efficiency, equity, responsiveness and sustainability are made.

The Health Care Systems in Transition profile on Romania was written by Cristian Vladescu (Centre for Health Policies and Services), Silviu Radulescu (World Bank) and Victor Olsavsky (WHO Liaison Office in Romania). It was edited by Reinhard Busse (European Observatory on Health Care Systems).

A draft of this HiT was presented in both English and Romanian to the participants of the Conference on Health Issues of Joint Interest to Romania and the European Union in Bucharest in October 2000; the Observatory acknowledges the responses it received by the participants. The full text of the HiT can be found in www.observatory.dk.

The Health Care Systems in Transition (HiT) profiles are country-based reports that provide an analytical description of each health care system and of reform initiatives in progress or under development. The HiTs are a key element that underpins the work of the European Observatory on Health Care Systems.

The Observatory is a unique undertaking that brings together WHO Regional Office for Europe, the Governments of Greece, Norway and Spain, the European Investment Bank, the Open Society Institute, the World Bank, the London School of Economics and Political Science, and the London School of Hygiene & Tropical Medicine. This partnership supports and promotes evidence-based health policy-making through comprehensive and rigorous analysis of the dynamics of health care systems in Europe.