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Managerial Perspective on the Dynamics of The Legislative Framework in Romania

KEYWORDS: health system management, institutional actors, healthcare services, health programs

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ABSTRACT *Public health is a field of interest both nationally and at the European Union level, being an important indicator that determines the development of the economy of a state. Directions for supporting public health sector are analyzed in this paper, namely: 1 - primary care provided by family doctors, 2 - secondary care, provided by the specialist doctor, 3 - tertiary healthcare, in hospital, 4 – national health programs and 5 - free medications, specifically with or without personal contribution. In the same time is also tracked the involvement of institutional actors in the different areas of public health such as: interaction between Ministry of Health and the National Social Insurance in implementing national health programs, and the involvement of National Fund for Health Insurance in compensated medicines. Although we want to achieve a modern health system, now Romania has not finalized a National Strategy for Public Health.*

INTRODUCTION

A political objective of the European Union is to ensure people's access to adequate healthcare (Iancu, 2010). This requires a number of medical services providers so that they can meet the needs of the local community (Popescu, 2007).

1.1. PRIMARY HEALTHCARE ASSISTANCE

Primary care has grown significantly in Romania in the past 20 years (Zegreanu, Costin, 2010). This occurred despite the permanently changing context - dominated by socio-economic transitions, changes in demographic and epidemiological, sudden policies changes in healthcare system, its resources and health care provision (European Health Program 2008-2013).

Referring to the list of health indicators in the European Union, we identified 40 indicators grouped in five domains. They refer to: 1 - demographic and socio-economic context, 2 – health state 3 - Health determinants, 4 - health services, and 5 – health promoting.

Starting with 1997, it was established family doctor profession with clearly defined rights for the family and general practitioners. The distinction between the provision of primary care to adults and children has been abolished, and for the family doctors and general practitioners received the role of first contact with patients.

The latest reforms of the 2010-2011 periods have introduced changes in the purchasing of health services by changing the ratio between per capita payment and per service payment (which represents the family doctor incomes). More and more low and middle incomes countries have begun to explore or settle the payment systems based on CSDG - classification system diagnostic groups (Mathauer, Wittenbecher, 2013).

Other reforms included the granting of the right to provide services for the uninsured ones, for a fee per service and limiting the daily number of cases funded by pay per service. These initiatives were perceived in different ways by primary care providers, some of whom were in favor of the positive changes and others arguing that the changes are not substantial incentives for general practitioners/family doctors nor increase global incomes of these (Breton et al, 2013). Finally, the proposed solution has been adopted for emergencies and uninsured people to receive healthcare through pay per service. This limits the number of daily cases for uninsured people.

1.2 SECONDARY HEALTHCARE ASSISTANCE

Secondary healthcare assistance is the one provided in hospital by general practitioners to a patient who has previously received primary healthcare assistance from the family doctor (Manepatil, 2013). The last one diagnosed and treated the patient or considered the case being for a specialist competence.

The main problems of secondary medicine side signaled by specialists are:

- Chronic underfunding and budget allocations volatility impede investment in medical service development and causes patients to seek hospital services for cases that can be treated as an outpatient;
- National geographic coverage in certain specialties is insufficient; patients are forced to go to neighboring counties;
- Secondary healthcare assistance is not integrated with the community, the primary and tertiary; doctors at different levels are not coordinated and do not communicate sufficiently between them about the prescription, the treatment application and patients health tracking (Maestre et al., 2012);
- Practically there are no cooperation between primary, secondary and tertiary doctors, namely feedback to feedback. For example, the patient sometimes forget to go back to the family doctor with the prescribed treatment in hospital, especially if he/she has healed and electronic databases of doctors from primary, secondary and tertiary levels are not interconnected.

1.3 TERTIARY HEALTHCARE ASSISTANCE (HOSPITAL)

Tertiary healthcare assistance is provided in private hospital with beds (Da Costa Leite Borges, 2011). Hospitals can be of several types: regional, county, local, emergency, general, clinical, university clinic for patients with chronic illnesses, sanatorium, health centers etc. Medical assistance is granted under continuous and one day hospitalization (Gibson et al, 2013). Medical services package' provided for insured through hospitals is established yearly by the rules of the framework contract.

As shown on the chart, in Figure 1, the highest National Fund outgoing of total expenditures are those with hospital care, 8.4 billion RON (Romanian currency) while primary care has limited NHS resources, of 2.5 billion of UNFHI total, being located far below European average (World Bank, 2007).

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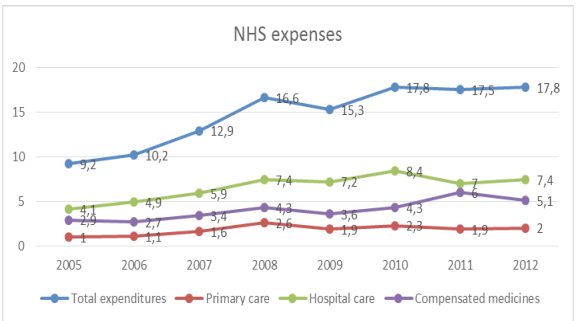

Figure 1. NHS expenses during 2005-2012

Basically, tertiary healthcare is the most expensive component of the health system in Romania (Tavakol et al, 2013). Romania is situated over the values recorded in the ECHR or EU member states. Spending has increased in nominal terms by about 90% and in real terms by over 50%.

Health services in Romania according health indicators established in the European Union has a favorable trend. For example, as the following chart shows, the number of beds for 100,000 people in Romania indicates a position above the European average, during 2000-2008, with a stable trend since 2003 (ECHI, 2013).

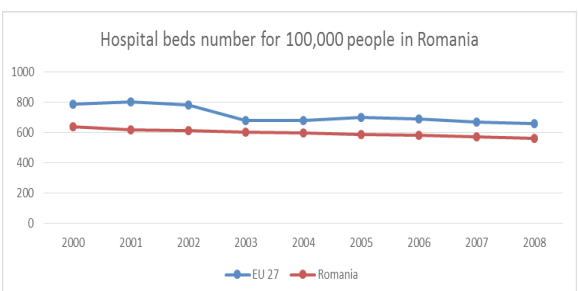

Figure 2. The number of hospital beds in Romania, 2000-2008

2. NATIONAL HEALTH PROGRAMS

National health programs are actions designed to achieve specific health goals. They can be evaluative, prophylactic and curative (Hwang et al, 2013). The list and the rules for implementing national health programs are approved annually by the Government. Their implementation returns either the Ministry of Health or NHH.

However, some objectives of the programs are implemented by NHH, but with funding from the Ministry. This allocation of responsibilities, although unclear to the layman, is the result of financial constraints combined with the aim to broaden the scope of the programs. Service providers in the health programs are family medicine offices, specialty outpatient offices and other medical facilities and pharmacies. They enter into separate contractual relationship with the County Public Health Departments (CPHD) or with the County Health Insurance Offices. Contracting is within the approved budget at the county level and distributed based on the achievements of previous years.

Also in National Health Programs, Ministry of Health completed the Rationalization of Hospitals National Strategy 2010-2012, which aims to achieve a modern health system based on flexible structures which take into account the needs of communities (Anton, Onofrei, 2012).

According to Minister of Health, the document represents a commitment of the Ministry of Health, so that by the end of 2013, the Ministry of Health has to develop a strategy for national public health for the next 20 years based on the county finalized strategies (Ministry of Health official press release, 02.03.2012).

This strategy has not been completed not even today.

3. MEDICINES WITHOUT PERSONAL CONTRIBUTION

Compensated medicines either 100%, either partially, are prescript based on medical prescription in outpatient treatment. Prescription is issued either by the family or the specialist doctor. Drugs are issued by pharmacies in open or, in some cases, closed circuit.

For this purpose, pharmacies sign annual contracts with the County health insurance offices. International common names list - ICN of compensated drugs, and the percentage of compensation is approved by Government decision.

NHS reimburses providers an amount resulting from applying the offset to the reference price. The reference price is the lowest price of a drug in the same list ICN for each concentration. In the original drug case, the reference price is the retail price of them. Doctors are forced to prescribe drugs by ICN list and not by the commercial name.

4. CONCLUSIONS

National health insurance system in Romania, despite numerous policies adopted and existing legislative amendments, despite numerous financing programs, is an area that raises continuous and multiple social discontents, as evidenced by the statistics in the field.

Some hospitals run out of medicines and supplies, and patients are forced to buy them by themselves. Efficiency, effectiveness and economy are three basic criteria, that which together with the cost / benefit can make a difference between one hospital management and another. A hospital classification is needed, on the indicators and performance indices.

Romania has not adopted the patient's assessment, based on a questionnaire of medical service quality, after the patient is discharged.

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