Project number: 2018-1-ES01-KA203-050606

Unit 11 - The Romanian Healthcare System

Reading

The evolution of medical care, medical education and health organization is dependent on the economic, social and cultural factors of society. Medicine from the beginning of the 19th century, as a reflection of the economy of the Romanian Principalities, was rudimentary and, at the most tried to cope with great epidemics, namely: the plague epidemic of 1813 - 1814 in Wallachia, the plague of Caragea, which made 60 000 victims, the one from Moldova from 1816 to 1818, the plague of Calimachi, in Iasi which made 150 - 200 victims per day, the cholera epidemic from 1830 to 1831 which only in Bucharest caused the death of 30 218 out of the total of 33 560 patients, to a population, of both Principalities, with a little over 2 million.

Economic growth had an impetuous influence on the development of Romanian medicine. Over the course of 80 years, between 1859 - 1940, Romanian medicine has succeeded in achieving a level aligned to other countries in Central and Eastern Europe that had been influenced by Western Europe for centuries. However, a number of challenges such as medical, social and healthcare in rural areas made it precarious. In 1922 the rural area had a doctor in service for 15 393 inhabitants; out of 390 rural constituencies, 193 had no doctor. Life expectancy was relatively low and overall mortality high, generally exceeding 20%. The sanitary law of 1930 made, for the rural area, the recommendation of one doctor per 10 000 inhabitants, which was difficult to achieve.

On the whole, however, there is a permanent improvement of the sanitary situation, an evolution to which the great organizations contributed. In 1935 there were 830 private institutions for social assistance and protection and only 50 states, 63 communes and 8 counties. There is continuous contact with the Western medicine, both through the studies or specializations carried out in renowned centres, as well as through the participation in congresses or through individual visits. For example, Dr. Victor Climescu, valedictorian of the Faculty of Medicine in Bucharest, is sent to France to Prof. Etienne Sorrel, then to Switzerland to Prof. Rollier, to specialize in osteo-articular tuberculosis. Upon returning to the country (1925) he was entrusted with the management of the sanatorium at Carmen Sylva (now Eforie Sud), which he developed and modernized.

Communism brought in medicine, as in all other aspects of social life, a complete reversal of values! All medical subjects were interpreted under the communist idearium, especially those that were prone to interpretations, such as biology, for example, introducing pseudo-scientific notions and theories. Genetics, the one that is about to revolutionize medicine today, was considered a "reactionary science". As for the language of communication in medical sciences, a dramatic change occurred, the Russian language being imposed.

In the other subjects, frequently, if not exhaustively, citations of Russian or Soviet authors were required. It was almost obligatory for any Romanian scientist to draw on Russian names, as was the prerequisite for Soviet medical sciences to be studied and used in medical work and publications. The staff selection on the basis of merit and value was replaced by the political criterion, “correct” social origin and nepotism, hence the promotion to medical management positions of persons imposed by the communist forums, without

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the proper training and without moral and professional authority. Social insurance disappeared, the state claiming that it can fully cover the expenses necessary for the medical care of the whole population. Chronically isolated and underfunded, lacking information opportunities and courageous personalities who would openly show its shortcomings (because those who did try were immediately removed, or imprisoned), Romanian medicine knew an unprecedented disruption in its history. The gap between Romanian and Western medicine has progressively increased throughout the communist period, a gap that unfortunately has persisted until today.

Even for those who were lucky enough not to be removed from university education, the situation was not comfortable. Some professionals experienced pressure by the communist establishment; some experts were formally forced to adhere to the official doctrine.

A notorious case is that of Dr. Emil Gherman, lecturer since 1972, and head of the Clinic of Orthopaedics and Traumatology of the Medical School in Cluj since 1975. Modest, cultivated and devoted as a teacher to diminish human suffering, he became a reference for his students and collaborators. Despite multiple professional achievements and unanimous recognition of his value, Dr. Emil Gherman failed to scale up in his carrer beyond the rank of lecturer due to prejudices about his "social origin".

As communism matured, terror became more masked and less obvious. Although it could be slightly mitigated, the promotion on political criteria had persisted until today as a legacy of the years of communism, to which material, personal or group interests were the prevailing principle for promotion. The post-communist Romanian healthcare system has been under constant reform for the past twenty-five years.

The Romanian healthcare system, not unlike those of its European (and maybe international) neighbours has been shaped and consolidated as a form of socio-political response to critical times such as those previously mentioned, be they of an epidemiological nature or of a political one. Once more, the Romanian medical system faces a challenge that seems to have encumbered the entire planet: COVID-19.

On an international level, the global pandemic generated by the new coronavirus in 2020 has triggered more and more surprising international reactions in connection to the national health systems, to the role of the political and professional decision-making bodies in connection to actions recommended in a state of emergency, recommendations which deal with interdictions, renouncement, responsibility and discipline. The management of the pandemic was dependent on the perception about the national health system, its capacity of reaction to cases of emergency, about its human resources and infrastructure as well as about the citizens' attitude to authorities' recommendations, their responsible acceptance or feinting them. These attitudes are deeply ingrained in the citizens' relationship with authority, be it political or medical.

On a national level, the Romanian Covid-19 pandemic brought to light, during these uncertain and vulnerable times, two main concerns: a psychological/sociological one related to the political system's crisis management measures and a medical/epidemiological one related to the faults and possibilities of the indigenous medical healthcare system of facing the current situation.

The first concern relates to the fact that, sociologically and psychologically speaking, thirty-one years later, during the Covid-19 pandemic; Romania is unexpectedly facing, once more, the spectrum of its communist

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past. Press, social networks and the population introduced in the public discourse topics which resemble those of totalitarian regimes which had existed for many decades in the so-called Warsaw treaty countries, among which Romania occupies a very illustrative place. The Romanian citizen who lived in those years of totalitarianism reacted painfully to some of the measures taken by the Romanian government during the Covid-19 pandemic, measures otherwise aligned to steps taken in other European countries: home isolation, social distancing, diminished interaction with friends and family, fixed hours for going outside. The military decrees issued by a committee called to manage the pandemic nationally were communicated in a cold official voice that rekindled, in the collective memory, images from the communist past. These decrees contained words such as restrictions, decision, lies, fake news, fines, penal file, prison, which were part of the reality during communism. Even in the countries where the communist experience represents merely a historical, documentary and journalistic issue, involving no personal implication, there were voices who raised the problem of personal freedom being infringed upon by an exaggerated intervention of the state and the worrisome perspective of the authorities maintaining a control system affecting the citizens even after the quarantine is lifted.

In the Romanian communist regime, the state exerted a powerful control both in the public and the private existence of the individuals. The state decided on the treatment to be received, the beneficiaries of the treatment and the place where the procedure was to be performed, how many children one may beget and who is to be responsible for the children involved.

The second concern relates to the fact that, amidst the pandemonium unleashed by the new virus in all corners of the world, the medical healthcare system is by no means prepared to tackle the massive intake of Covid-19 patients, thus going into overdrive. Serious questions have resurfaced now, more than ever, questions that echo, at national level, those from around the world. Looking at the critical situation in Spain and Italy and fearing the prediction that their country will be subjected to the same pattern, Romanian citizens started to be aware of the incommensurable fallacies of their own medical system and of the faulty political management of their society. The concerns regarding food, survival, health, hygiene, personal safety, the assurance that, in case they come down with some disease, there is a medical system and the professionals who could care for them, all these represent common preoccupations of any individual, irrespective of time or political regime.

The issues that resurfaced during the Covid-19 pandemic are not only related to the management of the patients suffering from the virus but also to other factors such as demographics, mortality, overall well-being of the population, poverty, all of these being of paramount importance to the effect that the Covid-19 pandemic will have on the Romanian population. Let’s take a look at the main aspects of Romanian healthcare today.

So, how good is the health of the Romanian population? Over the past three decades, life expectancy in Romania has increased to 69.9 years for men and 77.5 years for women. There has also been a huge reduction in the likelihood of death before the age of 5 (decreasing to 12 deaths per 1 000 inhabitants) of live births and maternal mortality (currently 21.1 maternal deaths per 100 000 live births). Cardiovascular disease is the main cause of death in Romania, meaning that success in cardiac interventions is important for the success of the health system as a whole. This is an area where Romania has been successful. The standardized mortality rate for heart diseases in Romania for both sexes (194 per 100 000 inhabitants) is

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well below that of countries with similar income levels (330 per 100 000 inhabitants), even if the country has had limited progress in terms of achieving results similar to EU countries.

In preventive medicine, Romania does not compare favourably to other countries. A dramatic example is the mortality due to cervical cancer, which can be avoided by detecting and treating cervical lesions. There is a high rate of cervical cancer in Romania. More worrying is that the mortality rate caused by this condition increases or stays stable, while in most European countries it is decreasing.

Access to health services of the poor is still limited. Many poor people that required healthcare do not get it. There is a huge gap, particularly in the treatment of chronic illness, as 42% of poor people claiming to have chronic illness do not seek assistance compared to 17% of the wealthy. The real gap is even greater because most poor people with chronic illness are unaware of the need for medical care. Recently, years of economic growth have increased the access to treatment of the whole population from 61% in 1996 to 71% in 2008. However, during this period, increased access was concentrated among high-income groups.

We should ask ourselves what the main shortcomings of the Romanian health system are. The financing of the Romanian healthcare sector has always been a problem. The share of health expenditure in gross domestic product varied over the years. The frequent comparison with countries to which Romania looks up with envy has always made us notice that the health budget places us well below that in those European countries. The allocation of resources to the health sector has always been a key indicator in development in the twentieth century. In Romania, the ambiguity of collecting public money and redistributing it to various public systems has been decided by the political context. The administrative system has always been rigid, the accountability mechanisms absent at all levels and intra- and inter-institutional communication has been very poor.

Most comparisons suggest that Romania spends less on health as compared to other countries. Among the decision-makers in Romania co-exist two different perspectives on financing issues in the health sector. The two visions derive from different views on the evolution of health financing in recent years. The first view is that the health sector does not have control over its own expenses. The second view is that the sector has suffered from arbitrary change of rules decided by financial authorities along the years. The supporters of this view point out that the post-communist reform of the health sector has created a health insurance system funded by a specific tax. However, the amount of wage tax allocated to the health sector has been significantly reduced over the years of economic growth and has not been brought back to the previous level during the slowdown in economic growth. It resulted in a sharp reduction in the amount of total government spending on the health sector. Because of this continuous disagreement on these issues, no strategy has been developed in the private health sector either.

Additionally, the decision to close some hospitals due to lack of performance and budget economy has led to cope with dramatic situations. Medical facilities that had just been refurbished or equipped with World Bank-funded surgery rooms were suddenly evacuated and were left waiting for a new destination. The patients were loaded in vans together with various materials, beds and other devices and moved - relocated - to other units. Medical staff, community members and patients protested in different locations of the country. Some doctors refused to leave medical units and continued to work without being paid.

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Ambulances came in front of closed hospitals and were turning back, looking for another nearby emergency unit.

Romania has inherited a large, out-dated and distorted hospital sector, with very few outpatient treatment facilities and a poor quality regulated system dating from the old communist system. Even if some progress has been made in modernizing the network, much remains to be done as professional and financial incentives have continued to direct investment and human resources towards hospital service delivery. Current payment systems are contrary to the government's declared policy. Examples include the following: numerous general practitioners work only a few hours a day and may considerably increase their services. This is partly due to the small share of their revenue that is paid from service charges, but largely it is due to maximum normative threshold by the number of patient visits. Plans aimed to increase the fee for the services to raise the income of physicians from 30 to 50% have been implemented, although if the regulatory threshold is not abolished, they will not be receptive to these incentives. Similarly, the massive sub-use of doctors for outpatient care is reported. Again, this is due to a maximum threshold on the number of points that can be earned on the working day and the absence of incentives for outpatient procedures. Physicians have no incentive to limit referrals because they can charge for each referral, receive no penalty for exceeding them and have no reason to provide themselves with a wider range of services than needed.

Also, the Romanian medical system is a sick-care type rather than a health-care type. There are people who, around the age of 50, are registered with preventable diseases. Well-structured preventive national strategies are needed, as well as regional and local ones. Aspects such as those relating to workplace conditions and the reduction of environmental threats must be taken into account. Encouraging physical activity (such as the issue of bicyclists in big cities in the country), food safety and obesity control, prevention and exposure to smoking, strengthening methods of prevention, prevention and control of infectious diseases, prevention of drug use and alcohol abuse are just a few things that any healthcare system should consider.

As mentioned above, there are indications that preventive healthcare is fairly poor in Romania. It would be very helpful to increase the budget for primary care (PMP) gradually, but substantially. Such an increase could amount to at least 10-12% of the total health spending in no more than five years to form a financial and professional base for general practitioners to develop their profile and prestige. General practitioners should provide preventive medical services, such as tests for early detection of cancer, diabetes and TB, and should be involved in the care of the elderly, especially those in disadvantaged areas, in the small hospitals especially adapted to suit their needs.

Moreover, 17% of the adult population suffers from obesity in European countries and it is considered that an adult of two and almost one in three children is considered to be overweight. In Romania we can easily see that the number of people with obesity has increased in recent years as well. By acting proactively, we anticipate the changes that can occur and we can plan a strategy. The predicted changes will no longer be regarded as insurmountable but as obstacles that can be approached and defeated. Capacity of being pro-active gives us the ability to think and act.

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Furthermore, “brain drain” is another key issue of the Romanian medical environment. The South African Medical Journal defines “medical carousel” as the process by which doctors move continuously to countries with a higher standard of living. The medical profession is described as “portable possession” so it enables mobility. Physicians often prefer to work in urban areas, leave rural areas, and live in capitals, instead of small towns such as Bucharest to the detriment of Iaşi, Craiova or Oradea. Romanian physicians mainly move to the United Kingdom, France and Germany. So, studies have reported the influence of emigration of physicians on medical systems in the United Kingdom, the United States, Canada and Australia. Beyond lack of perspectives and non-motivating salaries, the departure of doctors from Romania requires a wider analysis.

Western and North European public health systems have reached a certain degree of maturity. However, they still have a lot of difficulties (i. e. the reduction of the cost of healthcare). And public systems in southern Europe are strongly criticized by their beneficiaries because of excessive bureaucracy, low state involvement in funding, high costs of direct spending on health services, but the worst case is given, apparently, by the Central and East European countries which, despite the numerous attempts to reform, after the fall of communist regimes, still fail to respond satisfactorily to the domestic demand for medical services and the expectations of the population. In Romania, where the medical system has been underfunded for several decades, and the reform attempts have not brought the much-anticipated improvements to the medical act, the system has suffered in the last few years by the massive reduction of the number of specialists. One of the main threats to the population’s health represents, besides the extremely difficult economic situation, the appalling state of the public healthcare sector. In Romania, however, beyond the chronic problem of the most inconsistent financing of the public sector, compared to the medical systems of the Central and Eastern European countries, a number of shortcomings also arise from: unfair access to services of certain categories of population (low income, rural population, some Roma communities, population in isolated localities; the lack of transparency and the low efficiency of spending in the system, as well as the problem of corruption inherited from the old regime; problems of public reputation often evoked in the speeches of politicians and medical specialists; the non-application of the legal provisions in force (free of charge, but under-funded assistance programs for mothers and the newly born for the treatment of diseases such as cancer, AIDS, tuberculosis, etc.). In primary care, a poor sector in Romania, the most sensitive issues are generated by unbalanced distribution of general practitioners in the territory, which limits access to services for certain categories of population in less-favoured areas. This is due to the deficits and deficiencies of the infrastructure serving primary care, as well as to the lack of qualified staff and specialized institutional structures for initiating and supporting preventive activities along with the absence of qualified staff to assist in the accommodation of patients in serious condition. The introduction of insurance financing in Romania took place in a vulnerable economic environment, in the context of an undergoing reform, containing institutions in transition or in crisis, with poor social legitimacy, which was not favourable to healthcare systems. Over the years, the National Health Insurance Fund has become deficient in the long run, forcing the state budget to support payments, the scarcity of resources seriously affecting the equity and the quality of healthcare. This is also because medical insurance imposes high costs for the support of contractual relations between the various service provision structures, which often leads to the overrun of the resources available in the system. In the mentioned circumstances, the long-term financial contribution of certain categories of policy holders often proved to be inoperable when the policy holders, after having resorted to the system, found that the

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system could not serve them because it was in a major crisis of resources. Such situations have discouraged taxpayers and, in the opinion of many, reduced the social legitimacy of public health insurance systems.

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