MEMORANDUM
ROMANIAN HEALTH AND HEALTH CARE

The Open Network for Community Development, a Romanian Belgium initiative, was founded in 2012 and works on different domains of community development. An important one is health promotion and health care. This is done together with the foundation FDAAM and through systems of ‘Local Health Committees’ (CLS) and ‘Community Health Centers’ (ADAM). The Association of Municipalities from the Flemish part of Belgium, ADR – Vlaanderen fully supports the initiative which gives a follow-up on its bottom-up projects the last 22 years all over Romania.

Since 1990 the Romanian health care system was in permanent evolution. The first years showing very slow changes resulting in an arrears situation of the health care system also due to a shrinking economy. From 1995-1998 the health care system was privatized and changed from a state directed and financed Shemashko model to a Bismarck model with participation from the population. The country was divided in 42 CJAS’ses buying care from public and private institutions and responsible for making contracts with hospitals. Despite these changes, health care didn’t move forward very much the past years, resulting in huge challenges for policy makers now and big expectations from the Romanian inhabitants.

This memorandum is designed as a food for thought for political parties and politicians responsible to form the new government after the elections of December 2012 and discussing the new government program for the coming years. We hope this memorandum can be of help since we have a long experience in the health situation in Romania and have through our network contact with the populations and their expectations towards health promotion and health care in Romania. With our network, as well in Romania as in Flanders and Belgium, we are willing to cooperate to set up a qualitative, accessible and affordable health care for everyone in Romania.

1. The need for more financial means

   a) The investment in health care from the Romanian government must urgently rise. This was already promised several times but still not implemented. About 3.5% of the GNP was spent on health care in the past. For 2011 a raise to 5% was foreseen on paper, but in reality it was only 3.6%. Still one of the lowest in the EU where the average is 7.3%. International is calculated that in order to reach the “Health Millennium Development Goals” for 2015 about 60 USD per capita has to be spent. So for 2013 the minimum investment should be 6% of the GNP.

   b) The model of health Insurance in Romania is the Bismarck model. This means that health care is delivered through a system of insurance financed by employers and employees (contribution via salaries and taxes). The reality is that there are not enough incomes. This is due to the fact that the system is implemented without thoroughly been discussed. The new law propositions on health care should be urgently discussed, including at grassroots level.

   c) At the moment around 7 million Romanians contribute (10 million are exempted) for 20 million inhabitants in Romania. This is not tenable. The goal is to come to a contribution of everyone in solidarity. Making a realistic plan to increase the rate of insured people
that contribute. We advocate for an amnesty rule in order to give those who didn’t entered at the start (end of the nineties), the chance still to enter now within a limited period. The reality is that people have to pay such big penalty that they will not do it. Meaning that the state loses money every day for the health insurance. So with a minimum of goodwill and the necessary publicity and incentive one must strive for an as high as possible rate of joining and contribution. Here must be stressed on the ‘solidarity principle’.

d) The question must be asked whether the National Health Insurance Body (CNAS) should not be completely autonomous but controlled by the state. The collected money for the health insurance is not public money i.e. to be used for each part of the state debts. They should be used for, and invested in, health care.

e) If people contribute to the health system, they must be entitled to get correct care and with respect of their dignity.

f) Budgets for the reimbursement of providers per capita and per act, were reduced the last years, meaning providers can hardly survive and continue or start to accept and even ask ‘black money’. Propositions for the contract 2011 were to raise the income per act and decrease the money per capita. Meaning that one try to switch over to a performance-based medicine (the more acts, the more income). Problem is that on the other hand providers (family doctors) are limited in the number of patients they can see a day (max 20/day) and being reimbursed for. So on the one hand doctors should see more patients to have a decent income related to the reimbursement system, but on the other hand they can’t. Insufficient income result also in less investment and as result in less quality of the health care. From our experience (ADAMS Slatina-Timis) we consider that 28 consultations per day and 41 consultations per month, at patients’ home, would fit more for both patients and health providers. Means need to be ensured in order to support health education and prevention. Again from our own experience, the payment limit for stomatological care services for the patients between 1 to 18 years old should be increased to 5000 Ron/month in order to have a healthy population.

g) Private (commercial oriented) insurers skim the market and take advance of the 5% very rich Romanian people while the public system (state) stays for the rest of the population. Contradictorily one can state that on the other hand 80% of the Romanian population wants a private health care system. That requires some explanation. Private can be seen as not public or state directed. This doesn’t mean that the state is not responsible for it and need a good legislation. But within a private system you have also the commercial oriented system with people only looking for profit. They will only go for easy acts, well compensated, no need of expensive and complicated equipment, … All the expensive, complicated and time consuming acts will be left for the public and social-private system, meaning that they have to cover it all and thus don’t have enough money for it.

h) Wealthy people prefer to seek treatment abroad. Meaning also a loss of revenues for the Romanian health care.

i) The “coplata” system discussed for years is not still fully implemented. Goal is that the patient pays himself a personal contribution per act. Doing that way, the responsibility is transferred from the state to the individual. There are however so many exemptions that this system could become a loose cannon.

j) Underpayment of providers and low involvement and participation by what providers moves abroad. This is a serious brain drain that will have bad consequences for the future. Research by the Romanian College of Physicians is considering 50% of all doctors within the next five years to settle abroad. The Romanian Ministry of Health confirmed that an increasing number of doctors go abroad. The last 3 years about 8.200 doctors.

k) The payment of black money (spaga – plic or what’s in a name) has to be stopped immediately. Seems that the inventiveness is high and most of the providers live from that extra money (it’s also not only the specialist or family doctor, but whole the
surrounding people as nurses, secretaries, cleaning personnel, etc.). This also takes evil forms since patients start to believe that providers not asking that black money aren’t good and they go to the most asking ones. See already the situation with gynecologists where women seek for the most asking ones. A recent article in the ADEVARUL mentioning that groups of doctors and pharmacist cash 200 million Euro/year from the health insurance budget speaks for itself. This represents an important amount of money, not available for normal qualitative and accessible medicine for everyone in Romania.

2. The overregulation in healthcare in Romania

a) Providers (family doctors and others) have to hand over their monthly activity overview personally at the CJAS. In most cases this takes a whole day and a waste of time. Time that could be better invested in patients. The more if there is something wrong with the activity report, one has to come back another time. This could be done and communicated electronically. Furthermore a screening should be done on the efficiency of the CJAS’ses. What people see is that they are all housed in splendid new buildings with nice furniture, modern supplies, a large staff and well paid. Furthermore they have (cultivated) an image of bad guys instead of ally for the providers.

b) Following the Romanian rules, a family doctor may work max 35h a week. On the other hand he will get only reimbursement for max 20 patients a day and must spend min 20’per patient. How can a family doctor ever have a sufficient quote and income to survive? What about patients that cannot be helped or treated that day? Of course, quality control is important and needed, but done another way.

c) Family doctors (first line health care) have to be seen as the key figures in health care. A good working local dispensary with multidisciplinary functions is the instrument par excellence for health care. Therefore of course quality, accessibility and affordability have to be guaranteed. The multidisciplinarity and social functions and approach are important. It has to be a real medical-social center (see our example in Slatina-Timis). The family doctor is the gate keeper of the patient, having the whole medical file and picture. He is also promoter of prevention, sanitary educator, counselor and mediator regarding referrals to specialists and hospitals.

d) On the one hand lot of doctor’s move abroad what does foresee that there is/will be a shortage, on the other hand a ‘numerus clausus’ is set on a yearly base by the Ministry of Health and Education. On a long term, this can have devastating effects and create a real shortage that will be difficult to switch again, resulting also in a lack of accessibility of health care and huge investments.

3. Prevention (health promotion)

Prevention is an important task and as well cost refraining for the individual as for the state. This is too little used and stressed. Nevertheless in each Romanian county there is an ASP that is directed and controlled via the national ministry in order to work on prevention with national health objectives. The finding is that they have too little means and stay behind their desks or make leaflets that never reach the target groups. For this, being on the street is important, as well as cooperation with patient organizations and providers, social organizations, NGO’s, schools, etc.

Health promotion and prevention should be done not ‘for the patients’, but ‘with the patients’. ASP, local authorities and providers should develop adequate channels, tools and contexts for
dialogue. One should try to reach each target group, meaning that the approach must be different. See further regarding the local health policy plan.

4. Revalidation

a) The Romanian health law foresees for people recovering from a serious illness or hospital stay, the possibility to get revalidation materials in order to facilitate recovering and also earlier discharge from hospital. The reality is that each CJAS has an enormous waiting list, meaning only few happy people will get those revalidation materials. The financial means to get revalidation materials for recovering should be raised for each CJAS to eliminate the waiting lists. Our network is willing to cooperate on that since we already for several years foresee in renting services of revalidation materials on different places. The same is true for hearing aids.

b) Home care, as well medical as social, is very important to get people earlier discharged from hospitals and to keep chronically ill people at home as well as elderly people. Also here, the Romanian law foresees home care. The reality is that it takes too long to get all the paperwork done and also here there is not enough money to make the system workable. Although this is a cheaper and more human system to keep people at home, together with their family. Also here our network is setting up home care services as well medical as social and has on that a cooperation with Belgian institutes for training and support.

5. Problems with hospitals

a) Everybody knew that there were too many hospitals in Romania, something that drags out past times. Thus, reorganization was needed. Questions to be answered are:
   - What kind of hospital do we want or are needed by patients?
   - What is the role of a hospital?
   - What exactly do we expect from a hospital?

Also here, quality, accessibility and affordability are the key words. Hospitals are no longer organized around services, but around care programs.

b) The so called ‘decentralization’ of hospitals performed in July 2010 is more or less the hidden intention been written of some costs on national level. The hospitals are assigned to city councils or county councils. Financial means didn’t follow the same way. Seems even that depending on the political color of the local administration, more or less money is assigned. The governance is now done by politicians and representatives of other public institutions. Question is however who of them read or learned something on modern “Hospital Governance”? Patient organizations as well as representatives of the local population should be represented in the governance bodies. Good hospital governance starts from the most important stakeholders and as well the local community as the users are amongst them. They need to have a say in the matter. On the other hand, hospitals have urgently to be renovated, modernized and well equipped.

c) In 2011 about 67 hospitals were closed. As stressed above, reorganizations are needed, but this should be strongly planned and organized. It is impossible to cut here and there some hospitals. Both a good strategy and time are needed. And again, good and correct information is needed.

d) Hospitals have to cooperate in future. Merging, alliances, networking, associations? Everything is possible and should be examined starting from an overall strategic plan for the region, but surely starting from the question “what’s the benefit for the patient?”. 
6. First line health care is very important and the base of the health care system

a) Family medicine should be the base of the whole health system. The family doctors are the closest contact with all inhabitants and patients. They are part of the society and know as well the health as social problems of patients and population in a society. They have lot of important information in order to build out a good health care but also a social policy plan. So a strong and good working first line health care system is needed for a qualitative health care.

b) First line health care is on the other hand broader then family doctors. First line is also formed by dentists (prevention through schools), medical assistants, pharmacists, home care and home nursing activities, renting of revalidation materials, foresee hearing aids, follow up diabetes (prognosis that within 10 years around 30% of the Romanian population could get diabetes), elderly care, etc. All items poor developed now and wherefore no means are available.

7. Health and health care is everyone’s business and should be a core business for each local government

In that perspective we are promoting the installation of “Local Health committees” at municipal level. Local health committees (CLS) can be a good way to think and act about the local health situation and health care possibilities. Different players (providers, local government, patient organizations, local NGO’s, volunteers, etc.) are brought together and jointly make an inventory of what exists and what lacks about the local health situation in a ‘social card’. This can be a start of actions and a strong task force to improve local health and health care. Together trying to influence the policy and fight for adaptations where necessary. This teaches citizens to take their responsibility and debate about the health situation in their community. Health is indeed also determined by housing and living conditions, work conditions, environment, etc. Meaning health is influenced by many policy factors.

8. Local governments should be forced to make a “local health policy plan”

Therein health promotion should be an important issue. Although, unfortunately, not all diseases can be prevented or excluded. Good, qualitative and accessible curative services must be present as well. A “local prevention officer” can be a good instrument to achieve the goals of the local health policy plan.

9. In health care, the patient is the key person

Providers should learn how to deal with patients. They should adopt a more customer-friendly approach. The expectations of the Romanian patients are big. Empowerment and knowledge are growing through Internet etc. meaning they don’t want to be treated as a layman. The patient must be central in the whole health happen. Without his trust and cooperation, no cure is possible.
10. It must be clear also that each party has its rights and obligations

A system can only work if one follows the rules. A health care system needs a clear financial plan. A contribution of everyone aligned on each financial capacity is needed. Meaning patients should contribute to the health care insurance system and will have to pay for certain acts and treatments. Of course, social corrections are needed. Good and qualitative health care can only be achieved if sufficient resources are available and that requires also that everybody contribute in solidarity.

11. Models of a new ‘dispensary’ are developed in Belgian-Romanian cooperation, resulting in the setup of ADAM’ses

These local social-medical centers “community health center” work as an NGO on a total new way and based on quality, solidarity, accessibility and affordability. Working with membership, patients are represented in the general assembly and elect the board that is managing the ADAM. They are themselves partially responsible and have a voice. All benefits are redirected within the organization and for the benefit of each patient.

12. New law proposal on health insurance

Here the big discussion is what will be included in the basic basket of the compulsory health insurance and who will have to pay for what? People every day get partial information on those proposed changes. Finally nobody knows exactly what’s going on and what will be the final result. This scares people and is not in favor of implementing changes and a new law. Some urgent questions are:

- Compulsory health insurance: what will be in the basic basket?
- The possibility to conclude an optional health insurance: for whom? For what? What will that cost to the people? People are afraid the basic basket will be very minimal and that for simple follow up one needs to conclude an optional health insurance. In principle the compulsory and optional (complementary), both covered by the health insurance body, should cover most of the matters. An optional (voluntary) health insurance can cover some extras that patient desire as there are a single room, special treatments, etc.
- Persons exempt from contribution: did one made the calculation about how many people are in this case? Who will pay for them? The state?
- The co-payment system: this can be a good choice and it’s important to know that medical care for free is not an available option. Question is what will be the amount of this co-payment? For what services? How many exemptions? So the analysis has to be made if the co-payment is than worthwhile.

13. Health workforce needs

It’s important to forecast and plan health workforce needs. Health workforce planning differs fundamentally and procedurally from any other form of manpower planning. Health workforce planning is fundamental to ensure the availability of good quality health care. Workforce planning or the lack of it can directly influence the health status of the population. Health workforce planning is one of the most important challenges facing politicians and policy makers in Europe over the next decades.
14. Evidence Based Medicine

Evidence-based medicine (EBM) or evidence-based practice (EBP) aims to apply the best available evidence gained from the scientific method to clinical decision making. It seeks to assess the strength of evidence of the risks and benefits of treatments (including lack of treatment) and diagnostic tests. This helps clinicians to learn whether or not any treatment will do more good than harm.

Evidence quality can be assessed based on the source type (from meta-analyses and systematic reviews or double-blind, placebo-controlled clinical trials at the top end, down to conventional wisdom at the bottom), as well as other factors including statistical validity, clinical relevance, currency, and peer-review acceptance. EBM/EBP recognizes that many aspects of health care depend on individual factors such as quality- and value-of-life judgments, which are only partially subject to scientific methods. EBP, however, seeks to clarify those parts of medical practice that are in principle subject to scientific methods and to apply these methods to ensure the best prediction of outcomes in medical treatment, even as debate continues about which outcomes are desirable.

Because this approach is used in allied related fields, including dentistry, nursing, and psychology, evidence-based practice is a more encompassing term. From now on, with one mouse click, family doctors can have access to a treasure of treatment advises.

15. E-Health

E-health is a stimulus for cooperation within health care, improves the communication between provider and patient and can lead to administrative simplification. E-health must also insure better informed patients and caregivers. An investment in ICT in healthcare and the development of e-health can, certainly, in the long run improve the global health mirror of society. Concrete it’s about the building of:

a) Cadaster: an overview of welfare and care professionals and facilities available for everyone that need it.

b) E-Health Box: an electronic mailbox that providers can use to exchange data electronically on a save way.

c) First-line-safe: an electronic patient/client file with core data as well for medical as other care. In a first wave for providers, later on also for patients/clients (whereby the latter determine who can have access to what data).

d) Need of capacity building: the development and implementation of ICT-systems to support first line health care should be accompanied by information, sensitization, training, formation and coaching of involved actors. The development and deployment of a number of ICT-experts coordinating the implementation of ICT-systems and support the providers is needed.

e) Place of the patient in the ICT-development: seen the digital gap, necessary initiatives should be taken as there are the capacity building in order to support the conduct of the care management by the patient/client itself or his representative through this ICT development.

f) The potentiality of telemedicine: within a broader concept of e-health, the term telemedicine / tele-care or remote healthcare using diverse ICT-applications increasingly shows up the last years. Initiatives should be considered f.e. to further explore and experiment on the possibilities of telemedicine in particular in the fields of prevention, home care and chronically care.
16. Finally, ‘measuring is knowing’

The system in place since the end of the nineties should be evaluated and be adjusted. A permanent registration of all kind of interesting dates and facts is necessary. Based on that, an evolution can be made and followed. Since it seems that the Romanian health care system is a hybrid of different other health insurance systems all over the world, it is key priority to boil down to a success level the experiences of the past. Also the different levels (first, second and third line health care) are not interconnected and hardly work together, what’s most important in health care. Even the e-health system and all kind of software provided and permanently changed doesn’t work properly, giving the providers a hard time and seeking for mistakes.

With this reflection paper, The Open Network aims to broaden the scope on the Romanian health care system with the experience of over 20 years’ activities on different social projects in Romania. The insights and knowledge on the systems and how the population is reacting gave The Open Network a strength of analysis which is ready to share today as well as in the future.

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