THE PERFORMANCE OF THE ROMANIAN HEALTH SYSTEM IN THE EUROPEAN CONTEXT

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ABSTRACT :

Introduction: Because of what happened in 1989, Romanian society has undergone a massive reform-based modernization process. Rethinking the Public Health System is a highly contested topic. Almost every shift in government personnel has renewed calls for widespread public health education and awareness. To put things in perspective, we analyzed the existing status in Romania, and appropriately emphasize prospective possibilities and viable courses of action in a European context .

Key words: *public health system, healthcare insurance, medical services, oral health, health expenditure, elderly*

INTRODUCTION.

How healthy is the Romanian population as a whole? This question's response is dependent on the point of comparison. Given that Romania is a member of the European Union (EU), it is pertinent to compare Romania to other EU nations. Nonetheless, it is also essential to realize that Romania (with a per capita income of USD 13205 in 2021) is significantly lower than the EU average (with a per capita income of USD 35,089 in the same year) and that the wealth level of a nation is associated with the health of its population [1,2].

LITERATURE REVIEW

- ***Financial sustainability***

How fair is the health care system? Access to health care is a significant issue, particularly for the poor population. Many poor individuals who require medical treatment do not seek care. This accounts for nearly half of the lowest 20% of the population.

This disparity is most pronounced in the treatment of chronic diseases, as 42% of poor persons who report having a chronic ailment do not seek treatment, compared to 17% of wealthy people. The actual disparity is significantly bigger because the majority of poor individuals with chronic illnesses are

unaware of the need for medical treatment [3,4].

In other nations, diseases cause poverty owing to the high expenses of medical treatment incurred by patients out of their own pockets. In Romania, however, the primary issue is the lack of access to medical care, not the high financial expenditures. Based on survey data from 1999 to 2004, a study examined the relationship between health care expenses and poverty. In 1999, health care payments pushed 1.2% of the population below the poverty line, but in 2004 they did so for just 0.4% of the population.

Following the revolution of 1989, Romania began reforming its centralized fiscal structure. The Health Insurance Law of 1997 and the Health Reform Law of 2006 strengthened and expanded the improvements established during the first decade after the revolution.

The goal of the reform was to establish a decentralized and pluralist social health insurance system, in which citizens would contribute based on their income to health insurance funds that would purchase services from health service providers in a market in which quality and safety would be strictly regulated by an independent entity.

Even while great progress has been achieved in bringing the system closer to this goal, many of the old system's characteristics remain, and many of the new system's essential capabilities were not established [5,6].

The health insurance system is controlled by the National Health Insurance House (CNAS), a quasi-independent central entity, in conjunction with 42 county health insurance houses tasked with contracting services from medical service providers. Prior to 2003, it was the responsibility of county health insurance firms to collect health insurance contributions from businesses and workers in their respective counties.

Since January 1, 2004, contributions have been collected centrally, by a special agency inside the Ministry of Finance; county health insurance firms are solely responsible for collecting payments from individuals who engage in independent activities [7,8].

Even though nearly the entire Romanian population of 22 million is entitled to benefits, an estimated 11 million do not pay insurance contributions for social health benefits, either because they are formally exempt from payment (such as pensioners, the unemployed, prisoners, military personnel, people on medical leave or maternity leave, and pupils/students), or because they are active in the informal labor sector and do not contribute [9-11].

- ***Is health care in Romania underfunded?***

Most comparisons suggest that Romania spends less on health compared to other countries. According to official statistics, Romania spends just under 5% of GDP on health, compared to a European average of 6.5% and an average of 8.7% at the level of EU countries. Part of this difference comes from Romania's relatively low public expenditures in the health sector. Official statistics on private spending show that only 18% of health spending in Romania comes from the private sector, a percentage that is very low compared to Bulgaria (41%), Poland (28%) and other neighboring countries [12].

It is probable that these statistics for Romania understate the magnitude of informal payments, but even if greater estimates are used for private spending, they remain relatively modest in comparison. The health sector requires a long-term plan, which should combine a steady rise in public expenditure with a vigorous effort to boost private investment. In addition to steps to boost the efficiency of the health sector, the strategy should also contain compensation measures for the poor population [13,14].

- ***How should the health insurance markets operate?***

The simplest option is to keep it fully private health insurance markets. A

completely private market can destroy everything, leading to the uninsuring of the whole society - just like in the Akerlof model for used cars [15,16].

A second alternative is universal public medical insurance. Medical insurance within the framework of this policy is universal, i.e. all people from a certain population are insured, and it is public and administered by the government the policy of many developed countries, including the United Kingdom and Canada.

Because the government provides health to what extent the demand for health adequately reflects the real needs of the population and to what extent the offer of medical care and the use of health services health are satisfactory. There are three predominant financing systems in the European Union countries:
the "Beveridge" concept is defined by tax-based public financing the "Bismark" approach, wherein finance is accomplished via required insurance; private finance strategy based on voluntary insurance. The majority of European nations have not accepted one or the other of the aforementioned models in its purest form, instead opting for diverse hybrid.

Because of this, the models of extant medical systems may appear as many as the number of European states, despite the fact that their fundamental concepts are very few. Depending on its social strategy and political philosophy, each nation often prioritizes and allocates more resources to a certain system coordinate, at the expense of other system characteristics.

Currently, the financing and structure of the health system in EU member states adhere to their own national institutional, political, and socio-economic traditions. These are expressed in a variety of societal objectives regarding finance and the provision of cost-effective medical care services. Population characteristics and health indicators such as life expectancy, morbidity, and mortality are among the variables used to evaluate the scope and type of healthcare demands. These statistics insurance for everyone and pays for nearly all medical expenses, these systems are known as single-payer systems [17,18].

Another choice is the required insurance. It is required by law for all other users to acquire an insurance policy, which essentially bans it and exposes it to adverse selection. Japan, Germany, and Switzerland are among the nations with some form of mandate policy [19-21].

All health systems strive to meet the needs of the population in terms of health and medical services. It is important to know might also be considered health system indicators.

The proportional importance assigned to each purpose varies greatly among national systems, as well as across the health sector and other areas of government action in each country. To finance a health system, money must be collected from the people in order to contract medical service providers.

The primary goal of the systems is to allocate the expenses of medical services between ill and healthy individuals and to adjust them based on the resources of each individual. This solidarity mechanism represents the consensus among European Union member states that health care cannot be left to market forces.

In no EU member state is the health care system owned solely by the government. In the majority of EU member states, primary care is free under a hybrid system that mixes liberal private medical and public medicine.

All insured Romanians have access to a full range of medical care options, from preventative care through main and specialty outpatient treatment and inpatient hospital care. Dental care is the largest coverage gap; only select populations, such as children or those with chronic diseases, are entitled to treatment from the public insurance system, and even then, only for specific operations.Therefore, Romanians rank fifth among those who are most unhappy with dental treatment in the European Union (5.4% in 2017), a rate that is more than double the EU average (2.7%).

Through individual or collective health-related action, health policies aim to improve overall health outcomes and reduce health inequities for the entire population.

To address contemporary challenges such as increased population aging, a heavy burden of chronic diseases, growing health inequalities, rising pressure from health expenditures, and social expectations for better health conditions [11,12], health policies are shifting from disease-centered to active-health oriented.

The current health policy literature has largely focused on specific health policy changes and their tangible outcomes, such as children, aging, migrants, and mental health policies [7-10], or on specific inequality of health policies in gender, age, race, or socioeconomic status [11,12], rather than responding to and addressing the shift comprehensively. This is worsened by a prevalent misunderstanding that links health policy with health care policy. As a result, many nations have used the term "health policy" to refer to "medical care policy," which is only one element in a country's health equation.

- ***Increasing preventive medical services and equity***

Romania has a serious inequality and poverty problem. It placed second among EU nations in 2008 in terms of the proportion of the population at danger of poverty, with a percentage of 23%, just below Latvia, which had a percentage of 26%. (Eurostat). Given this broad inequity, it would be prudent for the government to create measures that ensure the poor population has access to health care.

Theoretically, Romania provides this protection by exempting participants in the guaranteed minimum income scheme from making contributions and copayments.
In practice, however, this technique is insufficient [22] [23].

According to the Global Health Security Index report (GHS), which analyzes 195 countries, the final score for patient diagnosis is determined by analyzing the laboratory system, real-time analysis and reporting, specialized workforce in the epidemiology area, and data integration between human and veterinary medical systems [24,25].

The United States, the United Kingdom, the Netherlands, Australia, and Canada are ranked first, second, third, and fourth, respectively, in a rating of the Global Health Security Index, which evaluates 195 nations globally in terms of their health systems.

Romania score is 45.8 and Romania ranks 85th in the world in terms of early disease detection, behind nations such as the Republic of Moldova, Niger, and Sri Lanka. In comparison, the war-torn nation of Iraq is on 88. The lowest levels are designated for rapid system reaction and eventual containment of an outbreak. Regarding this metric, the local market falls to 98 out of 195 countries, with a score of 35 [26].

National health insurance programs adhere to three fundamental dimensions. The current and future purpose of health systems is to provide for the health requirements and demand. Understanding the nature, structure, and unique characteristics of the health systems of the European Union states requires knowledge of the finance and organization of health sectors, as well as the infrastructure and utilization of health systems [24].

- ***promoting prevention***

In the general context of the increase in the incidence rate of chronic diseases, but also of the risk of communicable diseases that are increasing on a global and national scale, it is crucial and pertinent to discuss a number of obstacles that can be mitigated through a consistent and improved national prevention strategy. We think that prevention must be the foundation of a sound health strategy; thus, we present a series of proposals that might help to the improvement of prevention within the Romanian health system [25].

Investments in health programs should assist preventative efforts for the Romanian population in order to sustainably reduce

therapeutic crowding. Taking into mind the effect it would have on the country's health system, preventative initiatives will result in substantial cost savings that might be reinvested in other health system pillars [26].

While the EU average for health expenditures was 3.2% in 2017, Romania spent just 1.8% on prevention. When compared to other EU member states, Romania has the second-lowest per-capita spending on prevention. Most national health policy programs, including those addressing cancer and mother and child health, place a greater emphasis on treatment than on prevention.

The most marginalized members of society, such as the homeless, face insurmountable obstacles when trying to gain access to health promotion and health education tools.

There are now some new steps being taken to increase accessibility of preventative treatments (and, indeed, healthcare services generally) for underserved groups. Certain low-income demographics, such as the immigrants, the elderly, and the agricultural workforce, are especially impacted by access inequalities[27].

- ***the romanian concept and the reform of the system***

The Semashko model was used as the basis for the Romanian healthcare system during the system's infancy in 1989. There was no improvement in this scenario until December 1996, seven years after the political system had changed.

As a result of the required insurance quotas paid by contributors, which are regulated according to their salaries, the Bismarck model has become prevalent in the system since 1997, when new reform measures were implemented by Law no. 145/1997.

The Health Insurance Act was signed into law in 1999. After 2004, the Romanian model of public medical services proved less and less adequate to the new demographic and labor market developments, due to difficulties in collecting resources, a social-economic basis of contribution that is increasingly limited, an excessive demand for free medical services, etc. This was also the case with state pension insurance.

There has been a continual process of so-called reform in the Romanian system over the past two decades. It is unclear whether this process has been beneficial to the system, excelling in incoherence and even absurdity in some cases (for example, the abolition of some hospitals in some communities where there is no medical assistance unit within a radius of hundreds of kilometers), or if we were actually dealing with a phenomenon of system degradation rather than a reform process, which should have changed things for the better [28-31].

Most services of specialist medical support are delivered in overly segmented structures that are not conducive to treating multimorbidity or chronic diseases, and this is regarded as a barrier to efficiency.

Disconnections in health care and other areas of service are also a problem. Some of these problems were intended to be addressed by the creation of integrated community health centers as part of the National Health Strategy 2014-2020.Although health care reform efforts have ramped up in recent years, patients and doctors still see the process as disjointed and poorly managed.

As a share of GDP (5.2 percent in 2017), health care spending is much lower than in any other EU member state (the average for the EU is 9.8 percent). As the population ages and the country's resources dwindle, Romania's inability to meet the requirements

of its present population will worsen due to chronic underfunding of the system [31-33].

Healthcare facilities and services are the intended beneficiaries of these restricted funds. This is why primary and community care are still undeveloped, the author argues. The problem is made worse by inefficient health services such as an overabundance of hospital beds, a lack of advances in outpatient surgery, and a failure to properly integrate medical treatment.

The health system interacts dynamically with socioeconomic and behavioral variables of health.

For example, health determinants influence health system performance through a variety of public policies, the most potent of which are welfare redistributive policies (or their absence) [22].

Individuals stuck in poverty are less likely to have access to health care, are more likely to incur catastrophic health costs, and have detrimental exposure and vulnerability as compared to those who remain at the top of the socioeconomic gradient.

Furthermore, the health system can promote impartial access to care and residents' health status. The health-care system also has an impact on social/lifestyle aspects through managing the many implications of disease in people's lives. The importance of health care in contributing to health disparities "is growing as a result of improved disease prevention, diagnostic tools, and treatment strategies" [29]. As a result, health care may reduce or raise health disparities between socioeconomic groups.

Investing in health necessitates investment in the health system as well as social and lifestyle variables adopting a lifespan/life-course perspective: "Social arrangements and institutions (preschool, school, labor market, and pension systems) have a significant impact on the possibilities that allow people to chart their own route in life."

Existing health policy research is mostly focused on specific populations, specific diseases, specific health policy changes and their concrete results, or on the uneven status of health policies across ages, gender, race, socioeconomic position, and so on. Most work focuses on a single health determinant at a time or overemphasizes the function of particular aspects without taking into account the contributions of other factors [34,35].

Furthermore, past research on health determinants have usually focused on the one-way effect provided by social or lifestyle determinants of health, while the counter influences produced by individual actions or the health system have been largely disregarded. This is worsened by a prevalent misperception that links health policy with health care policy, which has limited knowledge or resulted in a misunderstanding of the notion of health policy

CONCLUSIONS

Romania's healthcare system largely complies with worldwide community norms and principles as outlined in the World Health Organization's Constitutive Act [15], while there are areas where more improvement initiatives and alignment with these standards are needed.

Specifically, we are referring to the state's duty to ensure the public's health in a situation where it would be preferable for the government to give health spending a higher priority. In most Central European countries, the percentage of GDP devoted to health care is at least double the level of 5% in Romania (to give just two examples: Slovakia: 9% of GDP; Germany: 11% of GDP[16].

The National Health Programs can pay for the costs incurred by private medical service providers and clinics since current legislation permit their development and operation in specified sectors (as happens in the case of the National Program for the Replacement of Renal Function in Patients

with Renal Failure).

Patients have complete freedom of choice about their medical care provider and hospital while utilizing the private sector. Given that there are now more public hospitals than private ones (with the latter making up less than a quarter of the total), it seems to reason that patients will choose to use them.

Health systems are dynamic entities whose functioning depends on the outcome of numerous interactions. A successful outcome of these interactions depends in turn on policy models, health service delivery mechanisms and control mechanisms. Having a mixed health system, the development of the level of private health care is auspicious, because a democratic society, with a functional economy within competitive parameters within the European economies, also requires social stratification, and citizens with above-average incomes they thus have the opportunity to opt for ultra-performing or better quality medical services from the private system.

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