

The Health Services System in Romania: A Case Study

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Abstract

Despite over 26 years of continuous efforts to reform the health system, Romania is facing severe problems in meeting the health needs of the population, mainly due to the underfunding of public health units, lack of medical staff, lack of doctors in the rural areas. The economic crisis deepened these problems, which made it more difficult to access the health care of disadvantaged or vulnerable groups of the population. Poor health status of the community, demographic aging, high population share, and high incidence of chronic diseases all lead to increased health care needs. To understand conceptually and the content of health services, it is necessary, besides explaining the concept of service as a whole and clarifying the concepts of health and health system. In this article, we have reviewed the current situation of health services in Romania, statistically evaluating the number of medical units per development regions throughout the country.

Key words: Healthcare services, health services system

J.E.L. classification: I11

1. Introduction

The paper aims to highlight the cursive evolution of the development of the medical system in Romania, describing at the same time the health status of the population from the perspective of the quality of life, using both objective and subjective indicators. At the individual level, good health is an essential component of human capital, allowing people to carry out their activities, to fulfill their goals, to have a full life, and to be active members of society (Dragoi M., C., 2010).

At the societal level, a high state of health is a critical element of the human capital of each country, contributing to its competitiveness over other countries. In the quality of life research, we can consider health as a neglected present value at the level of the Romanian state, being approached from two distinct perspectives (Rădulescu, V., 2011). A first approach is to consider health as a dimension, as an area of quality of life. The proportion of health, like the other spheres of human life, is described by subjective and objective indicators, the emphasis being placed on how people evaluate their health, access to health services, and their evaluation (Baciu, V., 2007).

Assessing one's health status, perceived constraints, satisfaction with them, life expectancy at birth, infant mortality, mortality rates, or spending on health care services as a percentage of GDP are some of the indicators used in medical system research. Characteristics of this approach are the fact that it highlights how people evaluate and feel their living conditions, resources, and opportunities in the sphere of health.

The second approach is that of quality of life from a health perspective, representing a productive direction of study in a variety of life research. In this approach, health is treated from the perspective of people describing different health conditions or during the survival time of the beneficiaries of medical treatments.

2. Theoretical approaches regarding the health services system in Romania

The field of health refers to both the state of health and health care services (access, use, features, etc.). Also, this area includes attitudes and values related to health, which contribute to health status, as well as elements related to the lifestyle adopted (Baciu, V., 2007).

The use of certain concepts, methods, and techniques, specific to one or the other of the two domains, depends both on the level at which it is decided and implemented, as well as on the type of consumer it aims at.

By its nature, the improvement of the individual's health status is a service that implies a rigorous succession of activities, whose design is carried out at macroeconomic level, by the Ministry of Health, specific regulations, and is practically created and delivered by the organizations from field, but health policy does target not only the individual considered separately but also the community as a whole, for which there are a number of organizations active in the public health sector, aiming to promote social ideas and behaviors among a good community — defined geographically and demographically (Rădulescu, V., 2011).

As the hospitality industry developed and an increasing number of services were introduced, it continued to reflect production orientation. The demand for primary and secondary medicine was considered inelastic, and no attention was paid to the patient and even less to the potential consumer (Doboş, C., 2008).

The health sector is today in a continuous change in its structure, the changes that have taken place in the last twenty years being numerous and profound at the level of the countries of Europe and the USA, as well as at the level of our country.

Secondly, after 1980, hospitals were forced to adapt rapidly to market changes; to find a new approach, medical care no longer synonymous with hospitalization. Thus, the treatment of the individual has changed - there has been a transition from the model of therapy in the hospital and that of the treatment at home.

However, the development of health networks is not carried out in the same ways and conditions. The specialized literature abounds with concepts that can be assimilated to health networks: integrated care, integrated services, case management, continuity of care, etc. We speak, first and foremost, of a demographic component of this evolution, including the general problem of population growth and of changing the population structure, which also implies an increase in the complexity and the volume of services. For example, the aging of the population, doubled by the advances of medicine, changes the weight in the typology of the care services, loading the primary care system and relieving the secondary system (Baciu, V., 2007).

Secondly, there is a geo-economic component aiming at territorial upgrading and access of all communities to services, as well as equitable financing and coverage of the system under the new economic conditions. Also, new technologies and scientific progress add new dimensions to the health field and create new services.

Selecting the most appropriate structure depends on the participants' objectives and the financial, legal, and political factors. The basic organizational models can be classified according to the degree of integration and the financing system. Equity and access to health services are a constant concern for European health policies, and they are frequently referred to as fundamental principles: accessibility for all, high quality of health care services, and long-term financial sustainability. Health equity implies that each person ideally has a fair opportunity to reach their full health potential, ie, no person would be prevented from realizing this potential, if this can be avoided. In other words, the goal of health policies aimed at promoting equity would not be to eliminate all differences in health, but rather to reduce or eliminate the factors that are considered to be simultaneously "avoidable and unfair" (Pentescu, A., 2014).

During the last two decades, Romania has introduced a series of reforms in the health sector, in the context of political, social, and economic changes. The improvements focused on the financing of the health system, the management of the health system, as well as on the development of resources.

Therefore, the performance of the Romanian system, as well as access to health services, is still low compared to that reported for other countries in Central and Eastern Europe, as well as for industrialized countries. Lower levels of productivity can characterize the health sector in Romania,

results more economical than those obtained by the other EU Member States, as well as by a chronic under-financing of the system (Doboş, C., 2008).

Romania has the lowest level of total health expenditure per capita at purchasing power parity in all EU countries. Health in Romania is financed mainly from public resources (approximately 78.1% of total health expenditure). Currently, the primary public resources for the health financing system are The National Health Insurance Fund, local budgets, own incomes, donations, and sponsorships. The share of the private sector in total health expenditure in Romania is among the lowest in the EU but has increased slightly since 2007, the year in which public resources proved insufficient to finance the health system (Pentescu, A., 2014).

The Romanian health system is mainly financed from public funds, through contributions to compulsory health insurance, and the provision of medical services is made through the general policy of health units. The health financing system is a combination of public and private resources. As federal spending cannot grow significantly in the future, due to high public deficits, the main challenge for policymakers is to bring more money into the system from private sources. The development of the individual health insurance market and the introduction of eco-payment mechanisms have the potential to mobilize more health funds and increase competition between health care providers. The purpose of these actions is twofold: better services for patients and greater access to essential health services (Rădulescu, V., 2011).

After a rapid decline in the early 1990s, the health status of the population in Romania improved, starting with 1999-2000. Regarding the assessment of the health status, Romania's position underlines precarious health and perception, being located next to the Baltic states and Bulgaria, among the countries where the people assess their health less. The data indicate health as a critical area requiring intervention through social policies, to improve national health and reduce inequalities in the population (Doboş, C., 2008).

3. Research methodology

As in all other branches of the economy, the health services system has been designed to meet needs that appear on the market in the form of demand. The activities that constitute the process of the provision of health services appear as a reaction to these needs, generally perceived as a disturbance of the state of health or the state of well-being.

In health services, there are numerous situations when certain phenomena are more significant than the disease state, which the individual does not realize and which impose measures of prevention or actions to promote health, which is why the term of need is considered more valuable. Chosen when considering public health services (Baciu, V., 2007).

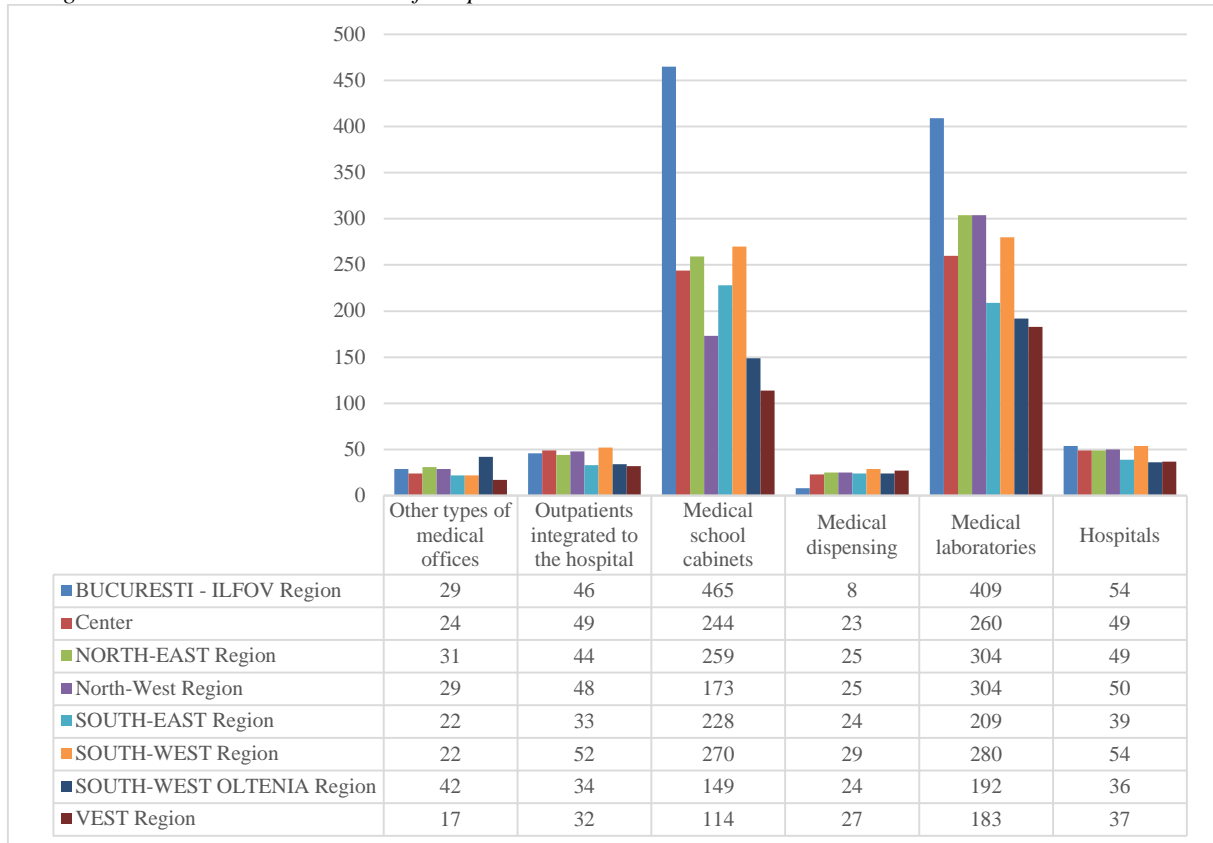
To determine the situation of the health system in Romania, we performed an analysis of the statistical data of the public-owned medical units available in 2018.

4. Findings

We can observe that, depending on the type of medical groups, the medical laboratories are the most common in the territory of the country, in each the development area, in time the medical dispensaries and other types of medical offices are the rarest medical units.

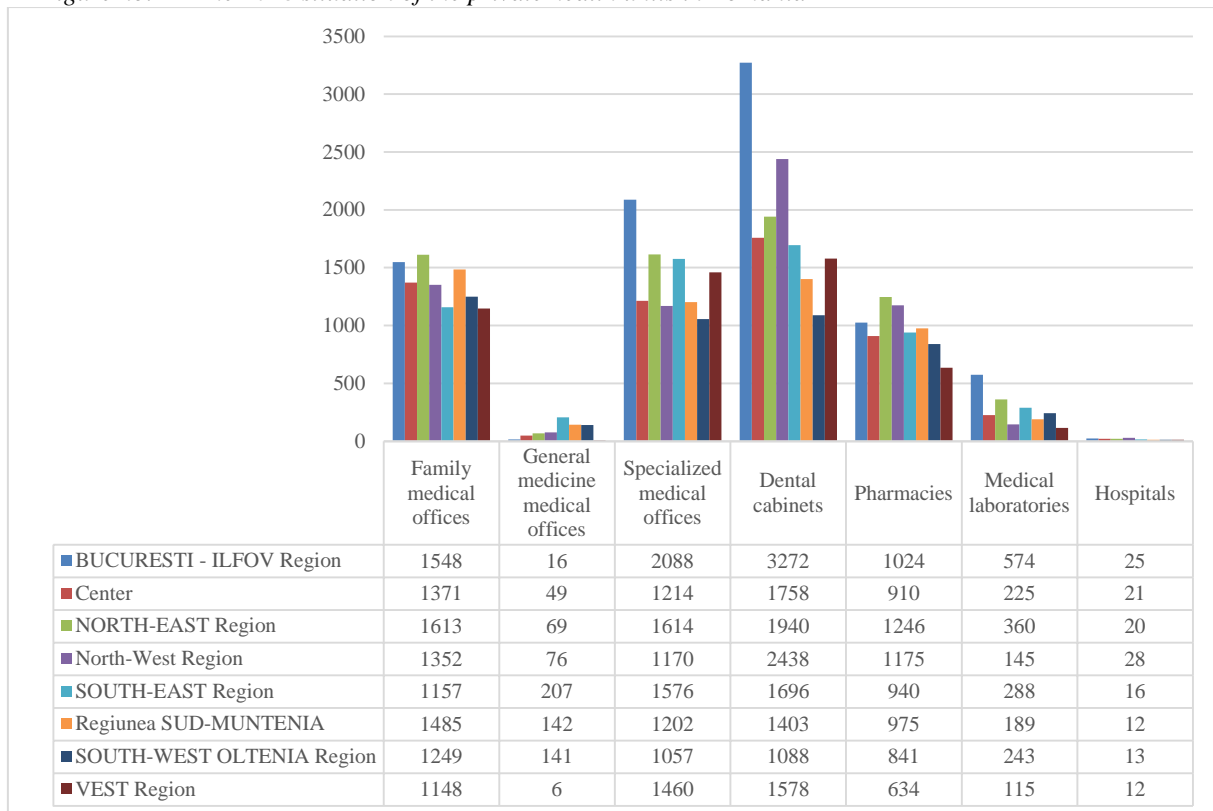
Depending on the development region, we can see that in the Bucharest-Ilfov region, there are the most numerous medical units, areas following the North-East and North-West region with 304 health units.

Figure no. 1 - The 2018 situation of the public health units in Romania



Source: <http://www.insse.ro/> (processed by the author during the research)

Figure no. 2 - The 2018 situation of the private health units in Romania



Source: <http://www.insse.ro/> (processed by the author during the research)

Regarding the private environment of health units in Romania, we can see that their number is substantially higher than in the public setting. In this case, the number of units reaches the number of thousands, having only 2088 specialized medical offices in the Bucharest-Ilfov region. Depending on the distribution by regions, the most significant amount of medical units can be found in the Bucharest-Ilfov Region, followed by the North-West and North-East Region.

Currently, access to public health services is realized on contributory principles by paying the monthly contribution. Conditioning access to services by introducing health insurance has led to the emergence of segments of the population that, through uninsurance, can only benefit from the emergency service. Uninsured persons are selected from the following sections: persons not included in the formal labor market, freelancers, low-income families from the urban area not covered by social assistance, (weak) families from the rural area (a large part of the peasants who obtain income from agriculture). Subsistence), a part of the Roma population. The uninsured population rises, according to CNAS estimates, only to 5-6% of the total population. A large number of people, although they are insured, have limited access to healthcare on the background of the minimal household budget. Low-income families cannot afford the co-payments involved in requesting medical services and purchasing the necessary medicines, paying transport costs, and paying extra for the physician and auxiliary staff.

Urban-rural differences are significant in terms of infrastructure. There are isolated areas in the countryside, where the population does not have access to dispensation, for primary medical services, or these dispensations exist, but they do not have permanent doctors, and they have a very original endowment. What is worse is that it is precisely the areas with the most reduced population, so with the increased demands of medical care, they have these problems. There are no effective health policies for attracting doctors in these disadvantaged areas, the issue of coverage with family doctors being very pressing, in rural areas, and the poverty-stricken regions. The differences between the poor and the affluent counties are significant in terms of the medical staff and the endowment, and they are perpetuated, considering the funds less collected by the county insurance houses, in the weak areas (Olaru, 2013, p. 14)

5. Conclusions

We can conclude by saying that the health system in Romania is continually developing, and despite the forecasts on the development and updating of the public environment, in the private environment, more and more specialized institutions and fields of health services have developed. The market for health services has a series of criteria, these being represented by regulations related to the services provided, differentiating them from the other markets by a set of elements.

- It is not possible to establish with certainty what is the demand for health services at a given time.

- In the market, the price is not confirmed by confronting the application with the offer.

- The services are incredibly heterogeneous, which determines that the relationship between the doctor and the patient plays an important role.

- The state is a demand stimulator for preventive health services. Thus a healthy individual minimizes the need for future health services.

- The free access to this market is conditioned by the control of the various professional associations, there being a maximum number of health centers and doctors in an area, having the role of ensuring the quality of the population's health but also of maintaining a certain price level.

However, the market of the healthcare system in Romania is one that is currently in a recovery phase after a period in which it suffered many losses in terms of the number of hospitals, their quality, and the number of medical staff.

But in recent years, the private medical system seems to be the one to bring this market to life through new services and facilities along with a well-trained staff. And in the case of the public system, it suffers from a lack of trust from the population, which is the main reason why a large part of the community avoids public health services.

The period of economic development in which Romania is currently has contributed a great deal to the growth of the market and its competitiveness within it, at the same time this development has also contributed to the improvement of the state of health and the life span.

6. References

- Baciu, V., 2007. *Marketing in the field of health services in Romania in the context of integration in the European Union*. PhD thesis, pp. 17-37, pp. 50-67, pp.76-84.
- Doboş, C., 2008. Financing of health systems in the countries of the European Union. Romania in the European context. *Quality of life*, No. 1-2, pp. 107-123.
- Doboş, C., 2003. Access of the population to public health services. *Quality of life*, No. 3-4, pp. 3-14.
- Dragoi M., C., 2010. *The health system in Romania in the European context*, pp. 18-43.
- Olaru, B., 2013. Inequalities in access to medical services in Romania and the European Union. A comparative analysis. *Romanian Journal of Bioethics*, Vol. 11, No. 1, p. 14, [online] Available through Google Scholar <http://www.revistacalitateavietii.ro/2010/CV-3-4-2010/04.pdf>
- Pentescu, A., 2014. *Marketing of Health Services. Patient satisfaction*, pp. 25-41, pp.89-93.
- Rădulescu, V., 2011. *Marketing of Health Services*, pp. 52-58, pp.74-79, pp.112-119.