

# THE SWOT ANALYSIS OF THE ROMANIAN HEALTH CARE SYSTEM

Claudiu CICEA  
Cristian BUSU

The Bucharest Academy of Economic Studies, Romania

## ABSTRACT

*The complexity of the problem the national health care program confronts with and which must be solved through the measures of the respective reform lead to a **SWOT analysis**, particularly for this reform.*

*The **strong points** consists of the voting and coming into force of the Law concerning the health care reform, the large number of services suppliers, for every type of medical assistance, the existence of medical excellence centres leading to an afflux of patients, regardless of the area where they live. The implementation of the hospital financing system - DRG – financing based on solved case – represented a process approved through a MH project that has benefited from the financial support of the European Union, through PHARE 2003 program.*

*The Romanian health care system consists of the following **weak points**:*

- *The necessity to increase the financing level of the Romanian health care system;*
- *The lack of a unique integrated information system;*
- *The lack of real self-sufficiency;*
- *The high rate of infectious and chronic diseases*
- *The rate of problems related to the lack of knowledge of related services*

**KEYWORDS:** *indicators system, SWOT analysis, strong points, weak points, financing health care, health care expenditure*

## Introduction

One of the objectives of sustainable social development could be the increase of healthcare services financing and a more effective management of the existing resources, taking into account that social development is directly influenced by the investment in human capital. The problem consists of the efficiency of the resource collection and management system and of the acknowledgement of public healthcare field as a sector requiring investments, for a long-term sustainable development.

## 1. Strengths of the romanian healthcare system

We can consider strengths the voting and proceeding to bring into effect the *Law on healthcare reform*<sup>1</sup>, the relatively high number of service suppliers by each type of medical care, the existence of medical centres of excellence which leads to an inflow of patients, regardless of the area they live in.

### *Implementation of hospital financing system – DRG – case-based financing*

The DRG system has been successfully applied in Romania since 1999, by means of several projects run by MS (Ministry of Health), CNAS (National Health Insurance Funds), CMR (Medical Board), INCDS (National Institute for Health Research and Development) and the Centre for Health Statistics and Medical Documentation (CSSDM) with the financial support of USAID Romania. The system was officially initiated in 2002, as a financing mechanism for 23 hospitals. Based on local experience and on experience of other health care systems, the decision was made to introduce gradually this system, through a series of stages to be completed within the next three-five years. To support this process, a MS project was approved and has received the financial support of the European Union, through PHARE 2003 program.

Diagnosis-related groups were developed in the USA, at the Yale University, by a group of doctors, economists, statisticians that were trying to imagine a system for assessing hospital results (the '70s). The Health Care Financing Administration in USA (HCFA) has adopted the system, has generalized it and decided to use it for hospital financing starting with 1983 (the financing currently exists based on the model). Other countries also use this system, either for assessing hospitals activity, or for their financing: Belgium – hospital activity assessment, Italy – private hospital financing, France, Ireland, Austria, Spain, Hungary, Germany, Singapore, Norway, Finland, Sweden, Denmark – public hospital financing and regional settlements, Portugal, Australia – public and private hospital financing and regional settlements.

### *Classification of a discharged patient in a diagnosis-related group*

**First stage:** Obtaining clinical data regarding discharged patients – there are seven mandatory data categories for each patient: age, gender, hospitalization duration, main and secondary diagnoses, surgeries or other therapeutic procedures or diagnosis performed: condition at discharge; weight at birth (for newborns only); data are collected from the general clinical record of the patient.

**Second stage:** Encoding diagnoses and procedures in view of report standardization; the encoding is performed based on the international classification diseases ICD 10, developed by OMS.

**Third stage:** Electronic collection of data required for classification within DRG in a database comprising all discharged patients and their clinical data. Hospitals reports discharged cases to INCDS according to the order of the Minister

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<sup>1</sup> Nicolăescu Eugen, *Reforma sistemului sanitar – scenariul Nicolăescu*. Medica – Revista Colegiului Medicilor din Romania, Anul 1, Nr. 2, 2009, pp.4-5

of Health no. 29/2003. To ensure data confidentiality, all files are sent in an encrypted form.

**Fourth stage:** Grouping of every patient in a diagnosis group, based on an algorithm. This automatic process uses software that is also known as a grouper.

## 2. Weaknesses of the Romanian health care system

- *The necessity of increasing the financing level of the Romanian health care system*

What has taken place in Romania after the introduction of health insurance system in 1997 was in fact (in contradiction to the ruled objectives at the initiation of the reform) the existence of a hybrid system between the financial control of the Health Insurance Funds and, at the same time, of the Ministry of Financing, resulting in many distortions in resources allocation and, first of all, a conversion of a part of these out of the medical system. Analyzing the operation of this hybrid system, some specialists in the field consider that there was no need for Romania to switch to the health care insurance system.

But people dissatisfactions and expectations were diffuse after 1990 and they were not related to a certain means of functioning, but to the obviously poor quality of medical services and doctors discontent related to low wages and difficult work conditions, under the conditions of lack of sanitary materials, facilities and utilities. In my opinion, the transition to the new financial pattern has created a new administrative mammoth, an annual consumer of important financial resources, I am talking about the National Health Care Insurance Funds (including also the county branches), whose administrative efficiency in relation to the costs is controversial.

Why was the insurance-based system chosen? This is one of the questions.

Analyzing the European models<sup>1</sup>, the two options for a change would have been: the actual *Bismark* model, currently used in Germany, Austria, France, based on insurance and the *Beveridge* model in Great Britain, Italy and Sweden, based on general tax revenues.

One of the specialists' explanations<sup>2</sup>, is that the chosen model was more convenient to the Romanian inter-war reality and that it was a middle way between two options supported by two sides: the supporters of the free market for the functioning of the health care system and the supporters of government planning.

According to some interviews taken to policymakers in the healthcare field, the transition to the new system was performed without a very clear analysis of the implications of various European models in the Romanian context and it has rather consisted of preferences of clerks and officials within that government for the German health care insurance model. In fact, during the period following the

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<sup>1</sup> Doboş Cristina, "Serviciile publice de sănătate și dezvoltarea socială". *CALITATEA VIEȚII*, XVI, nr. 3-4, 2009, pp. 1-13, <http://www.iccv.ro/romana/revista/rcalvit/pdf/cv2009.3-4.a11.pdf>.

<sup>2</sup> C. Vlădescu (coord.), *Sănătate publică și management sanitar. Sisteme de sănătate*, 2004

'89 moment, in Romania there were not many trained specialists in the health care management or health care policies field.

The question is whether initial expectations of people and professionals within the system were met. These expectations included: the increase of services quality and the increase of medical personnel wages, through the financial independence of the system, the increase of its financial resources and the transparency of resource allocation.

The current problems within the system are related to the fact that the current functioning and legislation have deviated from the initial objectives and philosophy of the Health Insurance Law, as the analyses performed by the indicated author have shown a significant difference between the alleged policy and the implemented reality in almost all listed sections: decentralisation, new mechanisms for resource allocation, institutional autonomy<sup>1</sup>.

Health Insurance Law was came fully into effect only in 1999. It was subject to a series of consecutive amendments during the years after the implementation (one of the Romanian post-revolutionary traditions, as this has happened to multiple laws), so that the initial philosophy of the law was significantly changed. According to several studies, even from the beginning, the new law has only introduced partial changes by means of its regulations.

The precarious condition of financial resources allocate to the health care system during 1990–2009 has continued the *trend* of scarce investment in the health care system over the past decades in Romania. This has led to the poor endowment of public health care units with modern medical equipment and high-tech utilities and to low wages for the personnel within the system as compared to their self-perceived status. The result has reflected directly on the quality of medical services people benefitted from. The way the medical personnel perceive the work conditions provided by the system and their social status, along with the dissatisfaction towards low remuneration enables them to request extra-payments for the medical services. This restricts the access of poor people to medical services as they also consider that additional payment is a necessary/established practice.

Public health expenses amounted to only 2.8% of GDP in 1997 and to 3.8% in 2009. Thus, the overall health care expenses as a GDP percent and as net income ranks Romania at the end, between Central-European countries and between countries with similar GDP/per capita. Public health care expenses are less than half, as compared to many European countries. Hence, by introducing social insurances, the resources have only increased with 1% of GDP.

Currently, financing sources for public health care expenses are: health care insurance funds, the state budget, local budgets, own income and external resources.

The budget of the Ministry of Health and the budget of the National Unique Social Insurance Fund manage about 95-96% of the total health care expenses and the rest is managed by other ministries with own health care network.

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<sup>1</sup> Doboş Cristina, "Serviciile publice de sănătate și dezvoltarea socială". *CALITATEA VIEȚII*, XVI, nr. 3–4, 2009, pp. 1 – 13

*The lack of an unique built-in information system* interconnecting all medical services suppliers as well as the institutions with responsibilities in health insurance, allowing a better management of available funds and, at the same time, providing an "intelligent" method to store data that would lead to a database allowing long term synchronic and diachronic analyses and forecasts that would increase system adaptability to the real needs of people.

- **Lack of real financial and managerial autonomy**, impairing all major aspects of the activities of qualified institutions within health care system, from functional organization, to collection, financing, contracting, settlement, information etc.

- **High incidence of contagious and chronic diseases.** The low living standard and the lack of information are some of the reasons why statistics rank us among the "foremost" as regards severe contagious diseases such as AIDS, syphilis, TB, Hepatitis C or chronic diseases such as diabetes – the treatment of which amounts in certain cases to 6 – 7 thousand RON/month for an insurant. This also leads to an increase of pressure over the system, i.e. the continuous increase of medical services demand following the constant deterioration of population health condition.

- **The incidence of problems related to the ignorance of services related to family planning**, a problem with multiple consequences, from the large number of abortions due to the lack of information, thus problems that are not only related to health but also to demographic aspects, to STDs.

### 3. Threats – Opportunities

THREATS – OPPORTUNITIES	
1. Major determinants of health condition	
<b>1. Recoil of social-economical determinants</b>	<ul style="list-style-type: none"> <li>a) Although <b>Romania</b> amounts about 6% of the total EU inhabitants (15), <b>only produces 1.5% of GDP (PPS) of UE.</b></li> <li>b) The analysis of the <b>human development index (HDI)</b> in Romania, during 1990-2009, reveals important differences, not only against the countries within EU (15), but as well against the last 10 countries that have accessed (0.778 in 2009 at Romania level, as compared to index between 0.936 and 0.946 in EU-15 and between 0.895 and 0.850 in countries such as Slovenia, Cyprus, Malta, Poland).</li> <li>c) As compared to the EU average (15), Romania distinguishes itself <b>by a high share of people aged between 25-64 and with an average education level: 60.9% against 43% (UE average-15); but in Romania, the segment of population aged between 25-64, with a higher education level, only amounts to 9.6%, as compared to the same share on the EU assembly -15 of 21%.</b></li> <li>d) <b>Employment</b> indicators in Romania highlight the existing difference against those registered by EU-15.</li> </ul>

<b>THREATS – OPPORTUNITIES</b>	
<b>2. Unreasonable health care behaviour related to health risk factors</b>	<p>a) <b>Tobaccoism</b> incidence has mainly increase on male segment, as Romania distinguishes by a cigarette consumption (62% of the adult population in 2009), highly exceeding the EU countries average (where the range of this share varies between 19% - Sweden and 47% - Greece).</p> <p>b) <b>The average yearly consumption of certain foods</b> that can impair health show for Romania <b>an alarming deterioration of people nutrition</b>, having effects over the health condition, mainly for deprived segments of population; it is noticed the <b>tendency to increase consumption per inhabitant during 2000-2007, of all foods</b> (not including sugar) <b>considered risk factors that can harm health</b>: calories from 2953 (year 2000) to 3233 (year 2007), alcohol from 8.9 l to 9.6 l, vegetable and animal fats from 14.3 kg to 17.2 kg.</p>
<b>3. Poor environmental conditions</b>	<p>a) The huge difference Romania registers as compared to EU countries related to the environmental conditions is emphasized <b>by the very low share of population having access to a quality water source</b> (58% in 2000) and quality sanitary installations (53% in 2000).</p> <p>b) Possible morbidity shocks, under the conditions of the powerful damage to the environment (acts of God) and of the urban decline (the absence of investments in utilities), marginalisation of the dropped behind areas</p>
<b>4. Health promotion</b>	<p>As opposed to UE, where a series of effective measures were taken, with visible results and retrieved as synergetic effect in reducing the morbidity and mortality degree of population, <b>in Romania</b> is it possible to <b>assess that a conjugated action is required of all involved factors in ensuring the performance of the national health system</b>, so much the more as morbidity rates have increased for the main contagious diseases (tuberculosis, syphilis, viral hepatitis...)</p>

### Conclusion

At the level of all European health systems, there are discussions about the profitable, effective development direction of health care services in view of a sustainable social development. Fiscal pressures also cause developed countries to pose questions regarding new financial sources, a new management as effective as possible of these or alternate ways to organize services.

We can say that, at European level, health is considered a social right all citizens must have access to, as opposed to USA, for example, where health is an individual good for which people must pay high costs.<sup>1</sup>

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<sup>1</sup> Vlădescu Cristian (coord.), *Sănătate publică și management sanitar. Sisteme de sănătate*, București (Centrul pentru politici și servicii de sănătate), Editura CPSS, 2004

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### **References**

1. Doboş Cristina, “Serviciile publice de sănătate și dezvoltarea socială”. *CALITATEA VIEȚII*, XVI, nr. 3–4, 2009, pp. 1-13, <http://www.iccv.ro/romana/revista/rcalvit/pdf/cv2009.3-4.a11.pdf>
2. Doboş Cristina, “Serviciile publice de sănătate și dezvoltarea socială”. *CALITATEA VIEȚII*, XVI, nr. 3–4, 2009, pp. 1 – 13
3. Nicolăescu Eugen, “Reforma sistemului sanitar” – scenariul Nicolăescu. *Medica – Revista Colegiului Medicilor din Romania*, Anul 1, Nr. 2, 2009, pp.4-5
4. Vlădescu Cristian (coord.), *Sănătate publică și management sanitar. Sisteme de sănătate*, 2004
5. Vlădescu Cristian (coord.), *Sănătate publică și management sanitar. Sisteme de sănătate*, București (Centrul pentru politici și servicii de sănătate), Editura CPSS, 2004