

Romania

Systematic Country Diagnostic

BACKGROUND NOTE

Health

June 2018



THE WORLD BANK
IBRD • IDA | WORLD BANK GROUP

Acknowledgments

This note was prepared by Kate Mandeville, Marcelo Bortman, and Cristina Petcu.

Contents

Overview	2
Governance	5
Social Inclusion.....	5
Aging	5
Health Worker Migration.....	6
Conclusion.....	7

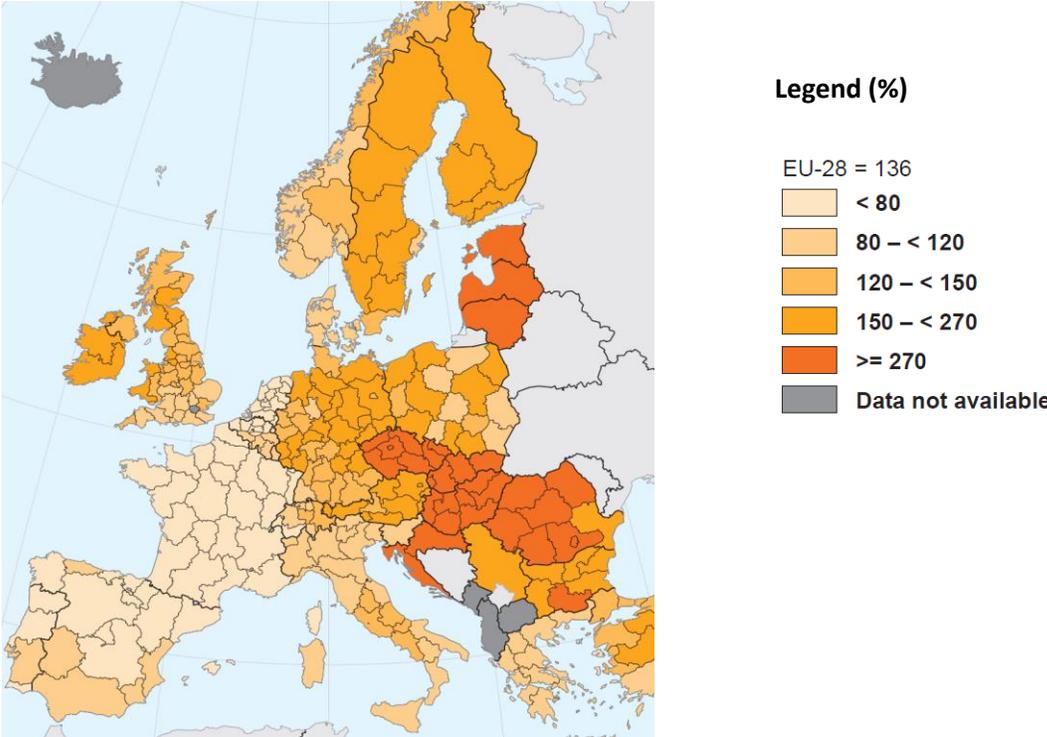
List of figures

Figure 1. Standardized death rates per 100,000 population from ischemic heart disease, NUTS 2 regions, 2011–2013	2
Figure 2. Top 10 causes of years of life lost in 2016 and percent change, 2005–2016, all ages, number ...	3
Figure 3. Romania’s population by age group	6
Figure 4. Change in the number of practicing physicians per 100,000 population by NUTS 2 regions, 2004–2014	7

Overview

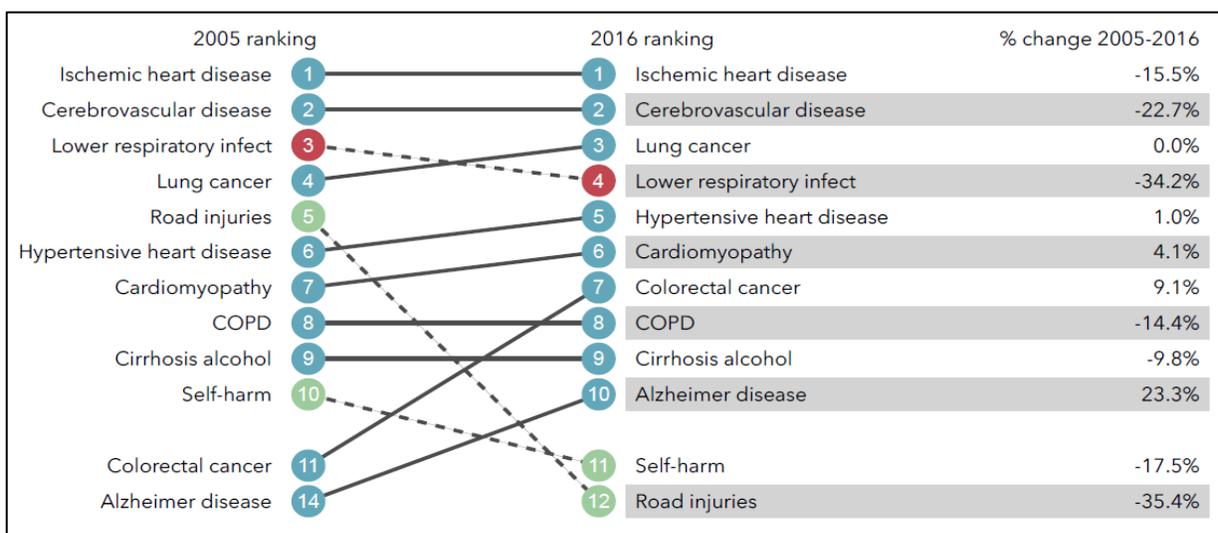
- 1. **Romania lags behind other EU countries in many health outcomes.** Life expectancy at birth has been increasing gradually, but remains several years lower than the EU average, at 78.7 versus 83.3 years for women, and 71.5 versus 77.9 years for men. The main cause of death is heart disease, for which the rate of death adjusted for age is among the worst in Europe (Figure 1). This, along with cerebrovascular disease (mainly stroke), led to the most premature deaths in Romania in 2016 (Figure 2). Mortality from cervical cancer, a good barometer of health system performance because of its responsiveness to robust screening and early treatment, was three times the European average in 2012, and was similar to those of Bangladesh and Kyrgyzstan. Infant mortality remains an enduring challenge, with the highest level in the EU at 7.6 deaths per 1,000 live births according to 2015 data. Vaccination rates for diphtheria-tetanus-pertussis and poliomyelitis, which were 99 percent in 2000, dropped to less than 90 percent in 2013.
- 2. **Chronic underfunding of the health sector has been compounded by multiple reforms and high political instability.** After rising steadily, health expenditure as a proportion of gross domestic product (GDP) has stagnated since 2010 and is currently 5.8 percent, according to 2014 data. Total health spending per person in Romania was \$868 in constant 2011 international dollars in 2014, less than a third of the European Union (EU) average of \$3,379. With more than 25 ministers of health since 1989, there has been near constant reform in the health sector, with little opportunity to embed or evaluate changes.

Figure 1. Standardized death rates per 100,000 population from ischemic heart disease, NUTS 2 regions, 2011 – 2013



Source: Eurostat.

Figure 2. Top 10 causes of years of life lost in 2016 and percent change, 2005–2016, all ages, number



Source: Institute of Health Metrics & Evaluation.

3. Fragmentation of healthcare providers leads to inefficient and suboptimal service provision.

Healthcare providers are poorly integrated, both vertically and horizontally. There is little care coordination and a lack of formal referral and counter-referral networks. About two-thirds of the 557 hospitals in Romania are public, with a quarter managed by the Ministry of Health (mainly tertiary hospitals and some secondary hospitals) and three quarters by local authorities (lower-level hospitals). A number of public hospitals are monoprofile, treating specific conditions such as infectious diseases, dermatology or lung diseases only. The remaining 187 hospitals are private, with both day and inpatient beds, and the number of such facilities increased four-fold between 2008 and 2014. There is little central direction on the functions or services of each hospital, leading to duplication, gaps in provision, and poorly defined care pathways.

4. A historically large hospital network, compounded by poor stewardship, has embedded overutilization of acute services.

In 1990, the number of hospital beds per 100,000 people was 790. While there has been a marked reduction in acute beds since then, this has slowed in recent years in the face of strong public resistance. In 2015, the number of acute hospital beds was 500 per 100,000 people compared with 396 in the EU, with 2896 annual hospital discharges per 100,000 people for circulatory disease compared with 1206 in the United Kingdom. Recent pay rises for hospital staff have exacerbated the proportion of NHIH funding spent on inpatient care (49% in 2017). Spending on ambulatory care has never risen above 18% since 2006, with primary care accounting for just 5.8% of spending in 2017. Just 14% of cataract surgeries were carried out in ambulatory care in 2014, compared to an EU average of 82%.

5. This is exacerbated by a weak primary care system.

Primary care took up only 6.2 percent of National Health Insurance House (NHIH) health expenditure in 2014, compared with 37.5 percent for inpatient care. The current payment system for primary care doctors encourages them to maximize the number of patients registered, but not to provide the range of services or coordination of care seen in other countries with similar disease burdens. These factors, along with a large group of conditions that do not require a referral to see a specialist, mean that patients often bypass primary care to seek care directly at emergency departments or outpatient specialists. In 2013, there were 4.8 primary or ambulatory care

contacts per person, compared with the EU average of 6.9 and 11.7 in neighboring Hungary—and 75 percent of hospital admissions in 2010 did not have a primary care referral. Moreover, conditions that should be managed in primary care (for example high blood pressure) made up an estimated 8.3% of hospital admissions in 2016.

6. **There has been little focus on improving quality of care.** The 2013 Eurobarometer survey found that 25 percent of respondents in Romania rated healthcare quality as good compared with an EU average of 71 percent. Despite public concerns, there is little publicly available information on the quality or safety of providers. Performance measures for providers have to date focused on financial or volume indicators, with no selective purchasing based on quality undertaken by the NHIH. While there is a costly national program to screen for cardiovascular risk factors, there is no information on the impact of this program. A National Authority for Quality Management in Health Care was established in 2015, but currently does not hold data on quality indicators.

7. **A comprehensive review undertaken by the World Bank in 2010 identified areas for improvement across the health system and made specific recommendations to strengthen the sector.** The review noted significant problems in health system performance in terms of (i) discrepancy in health outcomes compared to other EU countries as noted above; (ii) poor responsiveness to end users (including waiting lines, informal payments, discourteous handling of patients, poor cleanliness, lack of maintenance, and breach of safety measures); (iii) the poor and other vulnerable groups (for example, Roma communities) suffer from a significant lack of access to services; and (iv) the fiscal contraction of 2008–2010 exposed the weakness of financial controls in the health sector. The review went on to examine four health functions in depth: service delivery, financing, stewardship, and resources (including pharmaceuticals). Based on these findings, recommendations were made for three key challenges faced by the sector: (i) improving governance and management; (ii) streamlining the health service network and re-launching quality control systems; and (iii) increasing preventive services and equity. A number of prerequisites were identified for any expansion of the sector to be sustainable, including a private sector development strategy, stronger fiscal controls, a system of health technology assessment, and stronger management in key agencies.

8. **Since 2010, there has been considerable progress in some areas, such as information systems, emergency healthcare and health technology assessment.** There have been several notable health reforms in the last few years. These include the introduction of an integrated health insurance information system in 2010, a national e-prescription system in 2012, and a national health insurance identity card in 2015. A particular achievement is a highly successful reform of the emergency healthcare system (which even before reform performed better than other aspects of the health system), funded by the World Bank and EU Funds. Health technology assessment has been used to assess pharmaceuticals for reimbursement since 2013, and there are plans to extend this to other areas such as devices.

9. **However, many critical reforms to the health system have been reversed or not implemented.** Set against these achievements are several failed reforms, particularly in hospital rationalization. The 2011 National Strategy for Hospital Rationalization proposed 67 hospitals to be closed or repurposed as long-term care institutions. Only 21 of the identified hospitals have been successfully reoriented to date, with 17 closed hospitals subsequently reopened following political and public pressure. Moreover, important changes to hospital payment systems and human resources have not been implemented because of political instability.

Governance

10. **Public satisfaction with the quality of healthcare is low, and is undermined by enduring governance issues.** The Worldwide Governance Indicators rate the effectiveness of the Romanian government as the lowest in Europe in 2015, with no change in this position since 1996. Citizens' confidence in institutions was also the second lowest in Europe in 2015, with a high prevalence of informal payments in the health sector. A European quality of governance index, which measures citizens' perception of public sector services, including healthcare, based on their experiences of them, found that the quality of governance in Romania was perceived to be among the worst in Europe, although views varied between regions.

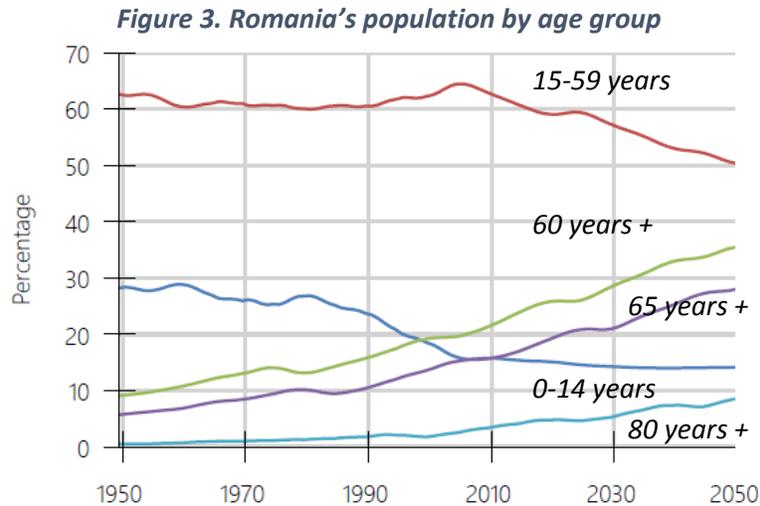
11. **Stewardship of the sector is weak and does not yet make use of increasingly available data.** Performance measures for providers have focused on financial aspects or volume rather than quality of care to date. There is little publicly available information on quality or safety of providers, despite public concerns. Yet with the ethics councils within public hospitals, the patient feedback mechanism, and advances in information systems, there is ample opportunity to harness these data to strengthen the quality of care, as well as patient satisfaction.

Social Inclusion

12. **Access to healthcare for vulnerable and marginalized groups is a particular concern.** While Romania's social health insurance system offers a comprehensive benefit package to 86 percent of the population, uninsured groups are only entitled to emergency, communicable disease, and antenatal care. These groups include agricultural workers, the unemployed, and those working in the informal sector. Other constraints include the poor coverage of Romania's health facility network outside urban areas and high out-of-pocket payments, which have a particular impact on the management of noncommunicable diseases. The 2010 functional review found that 42 percent of the poor persons who declare themselves to have a chronic condition do not seek healthcare, compared with 17 percent of the rich persons.

Aging

13. **Without reorientation of its health and social care sectors, Romania will have difficulties coping with an aging population.** The proportion of citizens aged greater than 65 years is projected to nearly double from 11 percent in 2017 to 20 percent in 2050, with those aged greater than 80 years (the "oldest old") rising from 1.8 percent of the population to 4.3 percent (Figure 3). Recent hospital rationalization efforts have led to an increase in the number of long-term care beds from 0.96 per 1000 population in 1999 to 1.3 per 1000 in 2013. Despite this, Romania has one of the lowest rates of coverage of long-term residential care in Europe, with 90 percent of people aged 65 and over living at home or with their children.



Source: Profiles of Ageing 2017, United Nations Population Division.

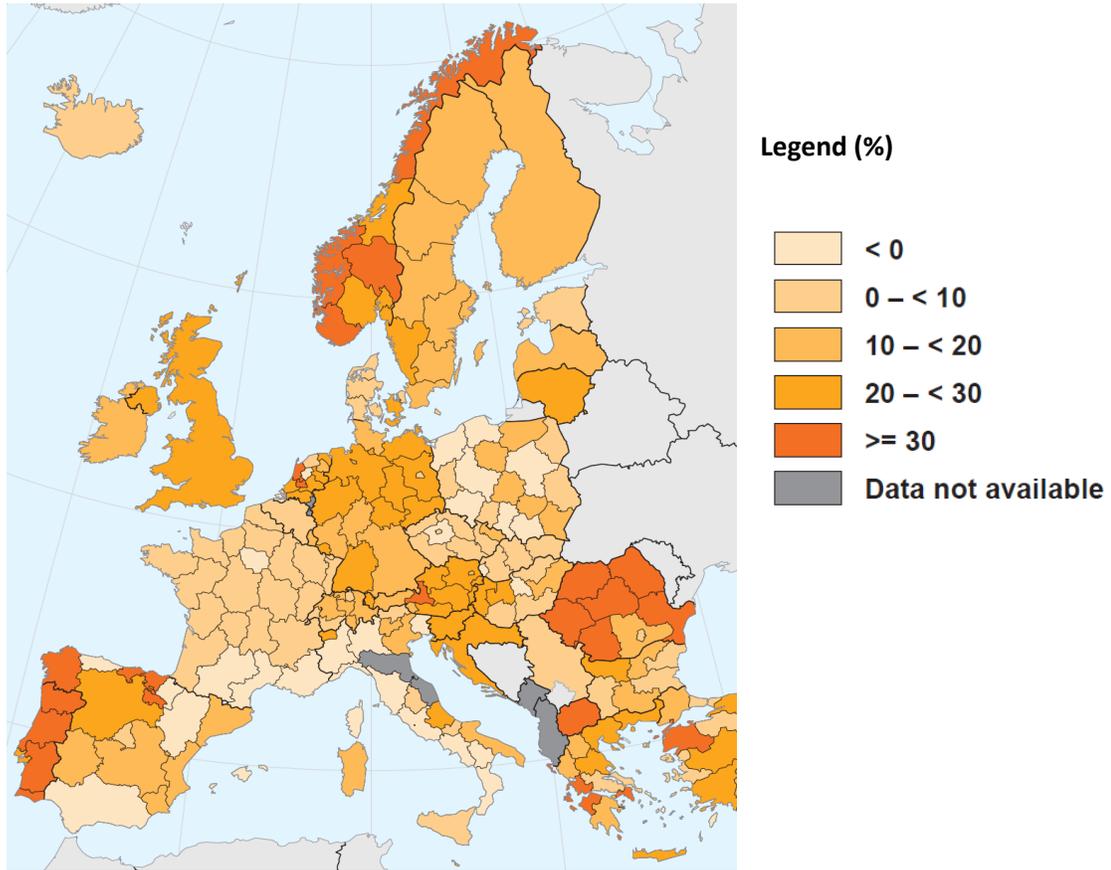
14. **To reorient health service delivery to the needs of an aging population, strengthening the role of primary care is critical.** While primary care reform has been a focus of successive administrations, there is overutilization of emergency and acute services—due in part to the success of reforms to emergency services—and the marked underutilization of primary care. In Romania, there were 4.8 primary or ambulatory care contacts per person in 2013, compared with the EU average of 6.9 or 11.7 in neighboring Hungary. Access to primary care is worse in rural areas compared with urban areas, with fewer general practitioners and higher transport costs.

15. **The scope of practice for primary care doctors has narrowed considerably in the last two decades,** necessitating referral to specialists for many health issues that are treated in general practice in other countries. Current contracts with the NHIH are also highly restrictive, in terms of numbers of patients to be seen, hours worked per day, and uninsured populations. Yet strong primary care orientated around the continuity of care and prevention is essential to improving health outcomes in Romania, and to increasing access for vulnerable and marginalized populations, particularly in the area of noncommunicable diseases.

Health Worker Migration

16. **The health workforce poses a particular problem for health system sustainability, with an expanded wage bill from measures to counter high emigration** (Figure 3). From a low base of health workers compared to neighboring countries, Romania has seen marked emigration pre- and post-EU accession in 2007. For example, the number of Romanian nurses in EU–15 countries increased from 811 in 2003 to 8481 in 2007. This outward flow has been evident particularly in rural areas and certain specialties, with doctor density declining more than 30 percentage points in most northern regions between 2004 to 2014 (Figure 4).

Figure 4. Change in the number of practicing physicians per 100,000 population by NUTS 2 regions, 2004–2014



Source: Eurostat.

Conclusion

17. **The Romania Systemic Country Diagnostic offers an opportunity to highlight catalytic areas in which short- and medium-term action can support the long-term vision for the sector.** With engagement from country counterparts and strong dialogue as part of the development of the Country Partnership Framework, a pragmatic elaboration of priority areas for reform may help to regain momentum in the health sector.