NEW MEASURES TO INCREASE THE HEALTH BUDGET IN ROMANIA

By: Silvia Gabriela Scîntee, Cristian Vlădescu and Cristina Hernández-Quevedo

Summary: Romania's health system is characterised by low funding and the inefficient use of public resources. There is a weak link between planning decisions and population health needs, due to a lack of appropriate information systems. The new government has increased the budget for health to: retain the health workforce by stopping the immigration of health workers, dedicate more funds to national health programmes, and ensure better access to medicines. It is hoped that the new measures considered by the recently-elected Romanian government will lead to better outcomes and that increased funding will lead to improved performance of the health system.

Keywords: *Health Budget, Workforce, Access, National Health Programmes, Romania*

Introduction

The new Romanian government, which came to power in December 2016, has increased the budget for health in order to achieve three main objectives on the health policy agenda:[1] retaining the health workforce by stopping immigration; dedicating more funding to national health programmes; and ensuring better access to medicines. These efforts are particularly relevant for a country characterised by an underfunded health system and it is the first time an increase in health care funding is linked to the stated objectives of the government.

In particular, the budget allocated for health in 2017 increased by 23.5%, compared to the budget in 2016 (from 30.28 to 37.4 billion lei / €6.7 to €8.3 billion), representing a total health expenditure of 4.7% of GDP (compared to 4% in 2016). The increased budget is dedicated mainly to improving access to medicines, initiating the building of three regional hospitals and procuring medical technology for hospitals and vaccines.[2] According to the 2017 budget, the Statutory Health Insurance budget administered by the National Health Insurance House (NHIH) takes up 77% of public funds dedicated to health. This is 10.4% higher than the previous year, with the main increase envisaged for home care (14.49%) and ambulatory care (9.89%).[3] These focus areas are in keeping with the National Health Strategy 2014–2020 of increasing the volume of services provided within ambulatory and community care settings and of rationalising the use of hospital services.[4]

Romania ranks last among EU Member States in terms of total health expenditure (THE) per capita (€PPP 816

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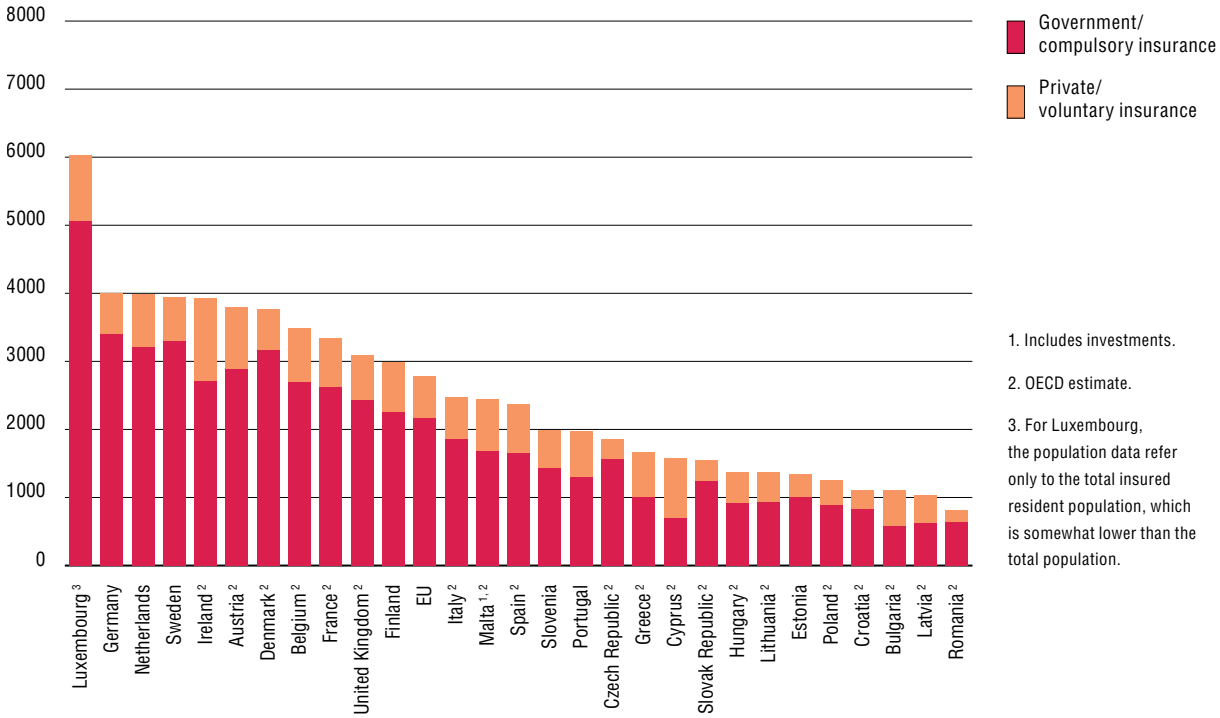
Figure 1: Health expenditure per capita in the EU (2014)



1. Includes investments.

2. OECD estimate.

3. For Luxembourg, the population data refer only to the total insured resident population, which is somewhat lower than the total population.

Source: OECD Health Statistics 2016; Eurostat Database; WHO, Global Health Expenditure Database.

per capita in 2015) and as a share of GDP (**see Figure 1**). THE as a share of GDP has been decreasing steadily since 2010, influenced by the spending cuts implemented to meet the country's fiscal deficit target and the unstable political situation. Public expenditure on health as a share of total public expenditure (11.9%) is well below the EU average (16.3%), although it has been increasing since 2011. The public sector accounts for the largest part of THE (78.9%), in line with the EU average (78.8%). Public sources account for 79% of total health financing, converging with the EU average.[5]

The Romanian health system in context

The Romanian health system is a social health insurance (SHI) system that has remained highly centralised despite recent efforts to decentralise some regulatory functions. The national level is responsible for setting general objectives, while the district level is responsible for ensuring service provision. The Ministry of Health (MoH) is the central administrative authority in the health sector responsible for the stewardship of the system and for its regulatory framework. District public health authorities (DPHAs) represent the MoH at the local level. Also at central level, the NHIH administrates and regulates the SHI system and it is represented at district level by district health insurance houses (DHIHs).[6]

> Increasing income alone will not stop immigration of health workers

Although SHI is compulsory, it covers only 86% of the population. Insured individuals are entitled to a comprehensive benefits package while the uninsured are entitled to a minimum benefits package, which covers life-threatening emergencies, infectious diseases, and care during pregnancy. Out of pocket (OOP) payments take the form of direct payments and informal payments. The share of OOP payments is the second largest source of revenue for health care spending (20%), while the contribution of voluntary health insurance (VHI) is marginal (0.2%).[5] The share of informal payments is thought to be substantial but unknown, although recent legislative changes, which heavily incriminates both making and taking informal payments, could have an impact.

New measures to increase the collection of funds

The 2017 budget increase for health relies on some recent measures. Since February 2017, the national minimum monthly wage has increased from 1,250 to 1,450 lei (from €278 to €322), and the average gross monthly wage from 2,815 to 3,131 lei (€625 to €696).[7] This follows the trend since the second half of 2015, where successive increases of salaries in some public sectors, such as health, education, social assistance, public administration, culture (ranging from 10% to 50% depending on the area) have been taking place. This latest measure is

expected to increase SHI contributions, as they are paid as a percentage from gross income (5.5% from gross salary and 5.2% from the employer, or 5.5% for the self-employed).

Previously, the way SHI contributions were calculated had a limit on the total salary base used, set at five times the average gross monthly wage. This favoured high earners who earned more than this. This measure was recently modified to eliminate the upper limit for the health contribution calculation base. According to the prime-minister, around 36,000 people with a monthly income higher than five average gross wages would now pay a surplus of 500 million lei per year (€111 million) to SHI.[8]

> Access to medicines is limited for patients on low incomes

On the other hand, some measures have been taken which are expected to have a negative impact on the SHI budget. These have an alternative aim of raising population living standards, such as exempting pensioners with a pension below €444.40 per month from making contributions and (from 2017) no longer counting some supplementary incomes, such as investments or bank deposits, as part of total income. Overall, the 2017 health insurance budget from contributions is estimated to increase by 10.6% (€5,233.7 million vs. €4,731.5 million in 2016). Besides this increase in the SHI budget, more funds are expected to flow into the system from introducing tax deductible health subscriptions for employees towards VHI, with a value of up to €400 per year.[7] While it is not clear whether the share of VHI will increase, the value representing the VHI expenditures is expected to rise with this measure. According to national health accounts, the share of VHI as a proportion of THE already increased from 0.2% in 2012 to 0.6% in 2014.[9]

Implications for new legislation

Retention of health workforce

Over the last decade, Romania has faced big waves of workforce emmigration. Although there is a lack of precise data, the MoH issued over 43,500 certificates of conformity for health professionals in 2016 that offer the right to work in another EU country.[10]

To counteract this trend, since 2015, there have been successive increases in health workforce salaries. In addition, the new government has set new allowances for different working conditions:[11] i.e. up to 85% of basic salary for those that apply outbreak control measures, those exposed to microorganisms and those that work in burns units; up to 70% for staff in emergency departments, intensive care units and psychiatric wards; up to 25% for staff in infectious diseases, new-born and maternity wards, laboratories, stroke units, neurology and neurosurgery wards; and other allowances between 5–15% for different personnel categories exposed to different ergonomic risk factors. These measures are currently under debate between specialists, particularly those who stand to lose out from the new allowances, for example, forensic medicine already receive allowances for working conditions of 100% of basic salary and under the new regulation their income will decrease. Moreover, a new law on salaries will come to force by January 2018 that aims to increase the average income for doctors to the equivalent of 70% of the EU averages.

Increasing income alone will not stop emmigration. Besides low salaries, the most common reasons for leaving the country include low levels of satisfaction with social status and lack of recognition, limited career development opportunities, and discrepancies between the level of competencies required and working conditions (equipment, access to consumables, drugs and modern diagnostic tests).[6] During 2016, a multiannual plan for human resources strategic development was developed, but was not officially adopted.

More funds for the national health programmes

Current national health programmes are not contributing enough to increasing the health status and satisfaction of patients. The preventive component is often weak and some important health problems, such as cardio-vascular diseases, are not included. Moreover, patients have difficulties accessing treatment offered under curative health programmes due to the fact that drugs can only be disbursed after a complicated authorisation process.[6]

The Government Programme for 2017–2020 includes the introduction of a national programme for early detection of cardio-vascular diseases and establishing a dedicated budget for the treatment of rare diseases. A first step in improving existing health programmes is to include patients with advanced fibrosis under the new treatment (interferon free) for Hepatitis C.

Another measure already taken is the simplification of drugs disbursement under the national health programmes. Previously, the process to obtain reimbursement was cumbersome; however, through a recent government decision, medical specialists are able to prescribe specific medicines under certain criteria. Patients now have rapid access to 106 drugs covered by SHI that previously needed authorisation. These latter measures have raised cost concerns as the authorisation process was the main mechanism for cost control of medicines. Since the health programmes have a dedicated budget but physicians have no prescribing limits, the system may face the challenge of accumulated debts. In response, the NHIH has prepared an online system for validating prescriptions based on a set of therapeutic criteria. Through the new system, the specialist fills out an electronic form sent instantly to the DHIH and after the confirmation is received, he/she may issue the e-prescription.

Ensuring better access to medicines

Access to medicines is limited for patients on low incomes by co-payments. Moreover, when a generic medicine (covered by health insurance) is not available, the patient must pay the full

price of the available product. Also new treatments may not yet be added to the reimbursement list.

> Romania spends less on health care than most EU countries

The new government has attempted to improve access to medicines on one hand by increasing the income of vulnerable groups, and on the other hand by decreasing the cost of medicines and increasing their availability. Thus, besides increasing the national minimum monthly wage and minimum monthly pension, it was decided that pensions under 2,000 lei (€444) are exempted from income tax (16%) and the health insurance premium (5.5%), leaving pensioners with more resources available for basic needs, including drugs.

Further, thirteen new innovative medicines are now covered, with or without co-payment, mainly for cancer, for conditions and diseases relating to blood and blood-forming, lung diseases, rare diseases, rheumatic diseases, and diabetes. New innovative drugs are included after a Health Technology Assessment evaluation of new molecules. Measures to reduce the price of medicines have also been proposed through changes in the pricing methodology, but this has raised opposition from the pharmaceutical industry. There may also be the risk of parallel exports if prices were to be reduced, which may further decrease access to those medicines.

Conclusions

Romania historically has committed a relatively low share of its GDP to health care. Part of the difference arises from Romania's relatively low public expenditures on health and part from low private expenditures. Most comparisons suggest that Romania spends less on health care than most EU countries and in parallel, health outcomes are lagging behind EU standards. Thus, Romania is facing several challenges, including user dissatisfaction, lack of access to quality care by the poor and other vulnerable groups, and decreasing numbers of medical staff. There is broad agreement within the Romanian community that investments in human development, and particularly in health and education, represent important factors contributing to the acceleration of Romania's convergence and integration with the EU.

The program of the new government includes measures to tackle some of the problems in the health sector, which aim to increase the quality and efficiency of health services delivery and to generate better health outcomes, including an important growth in the incomes of medical staff as a method of retention, together with the overall increase of the health care budget. These changes are expected to be developed in a financially sustainable manner, without neglecting the required fiscal consolidation. Whether these measures are sufficient to enhance the competitiveness of the Romanian economy and to reduce inequalities in health and access to health care services for the Romanian population, remains to be seen.

Romania: health system review

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Copenhagen: World Health Organization 2016 (on behalf of the Observatory)

Number of pages: 170 pages; **ISSN:** 1817-6127

Freely available to download at: http://www.euro.who.int/__data/assets/pdf_file/0017/317240/Hit-Romania.pdf?ua=1

The Romanian population has seen increasing life expectancy and declining mortality rates, however both remain among the worst in the European Union. Some other troubling trends are also apparent; for example, although social health insurance is compulsory, only 86% of the population is actually covered. Those that do have such insurance should have access to a comprehensive benefits package, however, the population seems dissatisfied with both service delivery and quality.

Reform to tackle these and other issues affecting the Romanian health system has frequently proved ineffective, due in part to instability in health governance. Whilst efforts have been made to strengthen the role of primary care, health care provision remains characterised by under-provision of primary and community care and inappropriate use of inpatient and specialised outpatient care. Reforms have been hampered by the relatively low number of physicians and nurses, compared to EU averages, something attributed to the high rates of workers emigrating abroad over the past decade. However, measures introduced to counter these shortages do not seem to have made a difference.

Contents: Preface, Acknowledgements, Abstract, Executive summary, Introduction, Organisation and governance, Financing, Physical and human resources, Provision of services, Principal health reforms, Assessment of the health system, Conclusions, Appendices.

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