



PUBLIC HEALTH SERVICES IN ROMANIA IN TERMS OF EUROPEAN POLICIES

Mariana STANCIU¹

Ana-Diana JAWAD²

Abstract: *The article presents several of the most serious problems concerning public health care in Romania, as seen from the perspective of some similar public policies and practices in the European space. For more than two decades the public health system of Romania has undergone a so-called reform process with the main result of the continuous deterioration of both the labour conditions within the system and the quality of the provided services. This situation was created by the severe under-financing over the long term of the reform process; the continuous decreasing of the territorial units for medical services distribution; the exodus over the borders of Romanian physicians in their search for better work conditions; and, as a consequence, the limitation of the population's access to the public health assistance and medication. The picture of the current situation inside some nations within the European Community that have recently applied reforms in the medical area strongly contrasts with the situation within Romania. Both through adopted policies and the actual medical practices that are carried on inside Romania, Romania seems deeply dissociated from all that takes place in the European Union, in the domain of medical service delivery development. Therefore, it is no wonder that for two decades the Romanian public health system is constantly situated at the end of the rankings concerning the performance of medical services, and at the beginning of those rankings regarding the incidence of morbidity and mortality within the European Community. The article also presents the authors' vision concerning privatisation of some public medical services, the efficiency of the services delivered in Romanian hospitals, the stage of the reform and the adoption of the new health law. Within this context, there are also presented some Romanian facts and managerial practices that have kept the system in a state of dysfunction and inefficiency for a long time.*

Keywords: *health services reform, policies, drug consumption*

¹ PhD, Senior Researcher, Institute for Quality of Life Research (ICCV), Romanian Academy, ROMANIA. Email: mariana1stanciu@yahoo.com

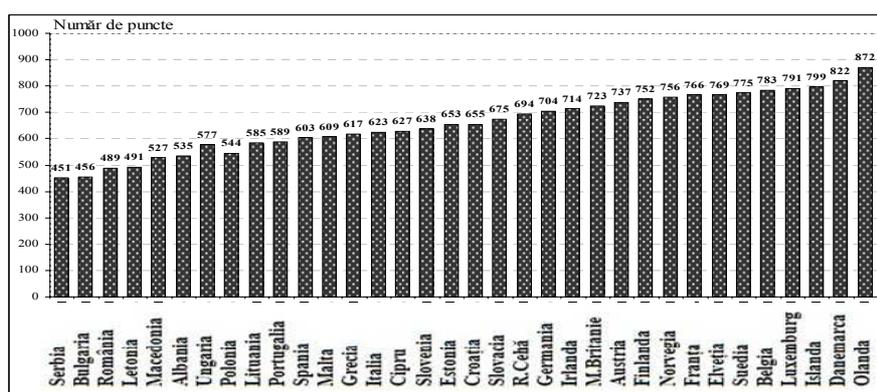
² Associated researcher, Institute for Quality of Life Research (ICCV), Romanian Academy, ROMANIA. Email: anadia_007@yahoo.com

1. Introduction

In most European Union member countries, the continuous improvement of the quality of the public health services is a major concern that is strongly supported by reform policies, employment policies and consistent financial efforts. This support is the result of the concrete initiatives of the European Union and from the wealth of ideas displayed by the related literature focusing on the reform and upgrading of the public health services.

Between 2003 and 2008 the European Union initiated the *Programme of Community action in the field of public health*, which includes a list of 88 indicators for the field of the public health. Beyond analysis of the health and health services of the European populations, this program also states the European vision, values and conception on the public health (**ECHI *European Community Health Indicators*). In the interval 2008-2013, the EC tested the relevance of system indicators for social practices, aiming to establish the bases for a consolidated European system monitoring public health. The used indicators measure the social situation to determine whether the situation supports or does not support the health policies applied by each national health care system. The image created by the indicators displaying the state of health of the population, the determinants of the public health and the performance of the health services (***Determinants of health, Public Health*, 2012, European Commission), are enriched by the Euro Health Consumer Index (EHCI), calculated by Björnberg (2012) for the past few years. It evaluates the performance of the different national health systems on a scale of three for each indicator.

Chart 1. 2012 Euro Health Consumer Index (EHCI)



Source: A. Björnberg, Euro Health Consumer Index, Health Consumer Powerhouse, 2012

For Romania, the EHCI index shows that, despite the financial contribution from the EU during the recent years, no signs of change for the betterment of the Romanian health care system can be noticed.

Many authors contributed dedicated papers to this subject worldwide: Garner, Docherty, Somner, Sharma, Choudhury, Clarke, Littlejohns (2013), Elissen, Nolte, Knai, Brunn, Chevreul, Conklin, Durand-Zaleski, Erler, Flamm, Frølich, Fullerton, Jacobsen, Saz-Parkinson, Sarria-Santamera, Sönnichsen, Vrijhoef (2013) etc.

2. European policies

Article 152 of the EC Treaty stipulates that “the definition and implementation of EU policies and actions provides a high level of protection of the human health” (***) *Public health*, 2013, European Parliament).

The main social policies of the EU that address public health are included in the “WHITE PAPER Together for Health: A Strategic Approach for the EU 2008-2013”, published by the Commission of the European Communities in 2007. This document proposes to improve the state of health of the European populations starting from several basic principles and common strategic objectives for the EU member states (Commission of the European Communities, 2007). The basic principles for the direction of action are: focusing on the interests of the patients and alleviating the unequal offer of public services; acknowledgement of the close relation existing between the state of health and the economic status of the patients; direct or indirect promotion of the public health interests in all political areas; and more active involvement of the EU in the field of public health worldwide by cooperation with international organisms such as WHO, OECD etc.

The EU strategic objectives in the field of public health are: decrease the risk of disease and of the potential threats to the health within the European nations; promote a healthy life style; facilitate the cooperation between national medical authorities within the EU with the purpose of attaining public health parameters as high as possible in each European country. The Lisbon Strategy highlights the relations between public health and economic prosperity. It acknowledges the right of the people to self-determination in the field of their state of health and of the consumption of medical services. The strategy stipulates activities targeting public health in all sectors of European economic and social development (in the chapters dedicated to the domestic market, environment, consumer protection and social business).

The role of the EU in the field of public health has also been reasserted in the Treaty for reform agreed by the EU heads of state and government in Lisbon on 19 October 2007. The Treaty involves the community level in the fields of disease prevention, food safety and, in general, the safety of goods and services, including medical services, curbing smoking, coordinating blood transfusion, tissues and cell transfer, transplant of organs regulations at the community level, monitoring the quality of the air and water and the establishment of agencies active in the field of the public health.

Some recent evolutions in the field of European public health demand the review of European and national regulations and the definition of a new strategic approach. This approach must address demographic changes within each European country, demographic ageing, and the development of new pathological patterns that put pressure on old national health systems whose parameters have been designed for different dimensions of the social needs. The establishment of necessary conditions for a healthy ageing of the European population presumes lifelong promotion of health and narrowing the inequities in the field of public health generated by social, economic and environmental factors. Given the present conditions of social life at the national, continental and worldwide level, pandemics, major physical and biological incidents and bioterrorism create serious threats to the public health. Additionally, climate changes produce new categories of transmissible diseases. These new threats call for coordination and rapid reaction for the sake of the public health of the EU and the third countries that are essential to the European Community.

The most developed European systems of health care have progressed much over recent years by the development of new technologies that revolutionize the monitoring and protection of the public health (information and communication technologies, innovations in genomics, biotechnology and nanotechnology, etc.), and in the manner of preventing and treating the diseases. Large gaps exist, however, between the national health services. While the health services from countries such as Romania and Bulgaria have very low performance and very slow progresses, the western systems use very updated systems to evaluate their health systems so as to identify the areas with less efficient health care practice (*Garner, Docherty et al, 2013*).

The intentions of the European Commission to narrow the inequalities in the field of health state of the European populations, particularly regarding access to the services of public health are shown in the “Solidarity in health: reducing health inequalities in the EU (***)Public Health, European Commission, 2009). Presently, the inequalities in the health state among the European countries are rather large; for instance, the rate of infant mortality is five time higher in some

countries than in other, while the life expectancy is as much as 8 years longer for women and 14 years longer for men in some countries compared with other countries. The rate of morbidity and the age of death are indicators that are strongly influenced by the rate of employment, level of the income, level of education and ethnic affiliation. The EU acts through its own policies and in collaboration with the national health care authorities to alleviate the gaps in health care.

The EU policies to promote health and alleviate differences in health are integrated within the European and national programs for public health; employment of the labour force, including health and safety at the place of work; social policies; fundamental human rights and equal opportunities; policies in support of cultural diversity and non-discrimination on racial grounds; scientific research financed through framework programmes of the EU; Europe 2020 Strategy for sustainable development; promotion of social inclusion and cohesion; management of the EU structural funds to alleviate the gaps in the economic and social development.

Medical and sanitary policies alone cannot strongly influence other determinants of the public health. Hence, it is necessary to coordinate common actions and initiatives so that the protection of public health becomes possible. According the EU Treaty, all European policies must follow the approach “*Health in all policies*” (HIAP). Since a nation’s state of health is determined largely by agents outside the strict field of the health services, an efficient health care policy must involve all the relevant fields, such as: social and regional policies, public taxes and dues, environmental protection, public health and the direction of scientific research.

European sectoral policies in the field of health care share the objective of enlarging access to health care services for poor segments of the population (“pro-poor”). This presumes expanding the social basis of insurance from public systems in terms of basic packaging of public health services in addition to more accurate targeting of social assistance benefits for the categories of the population that run the risk of remaining uninsured by insuring health care and establishing community-type schemes to finance health care (particularly in communities with a high proportion of workers in the informal sector, for example in rural areas), and concluding contracts between the public and private sectors that improve the quality of health care services in basic health care packages.

European governments must assume the universal coverage of a minimal package of services that include services of maximal importance for the poor segments of the population. European governments must also establish national programs of public health as well as health programs targeting particularly poor segments. The

experience gathered so far by EU member states has shown that socially correct targeted programs are among the most efficient in increasing the access to health care services for the poor segments of the population.

Over the past two decades there have been enormous changes in the social-political role of the government and in the role of the public sector in the provision of health services within European countries. Among these changes we may notice: the trends of decentralisation and deconcentration of governmental functions in the field of public health; involvement of the private sector in the formulation and implementation of social policies in the field of public health services; and higher involvement of civil society in the activities of the public sector in the field of health services. These processes are extremely different among different countries in terms of coverage and social effects. The institutional vulnerabilities, the corruption, the extreme social-economic limits of local capacities to assume the initiative, and the legislative, fiscal or institutional inadequacy, are just few of the problems affecting the normal progress of the public sector in each country.

The private sector offers health services to countries that have little resources to finance public health services. The private sector's involvement usually has three major objectives: expand access to services, improve the quality of health care services and the use of non-prohibitive prices (co-payment) for the services. None of these three objectives is easy to attain; any of the three presumes interventions at multiple levels of political decision-makers, providers of services and users. The consumers of health services are seen increasingly as the main starters of the factors leading to the achievement of these objectives, although the role beneficiaries of health services play in offer definition is still little studied and presently unknown.

3. Problems with the public health system in Romania

3.1. Reform of the public health system and the current situation of the draft of the health law.

The failure of passing the draft of the health law in 2011 led to a broad debate on the problems in the public health system. The analyses of different specialists revealed both the serious deficiencies of the draft of law and the actual state of the system, which was infrequently present in the provisions of the draft. The government of Premier Boc showed little interest for the actual situation of the public health system and was interested only in passing the law swiftly through the Parliament with no impact study commissioned by the Ministry of Health, despite the radical changes proposed by the draft. The new law, which was supposed to start a new reform of the public health system (the previous one was done just 5 years before), includes several ideas, highly debatable, in terms of opportunity and

the sustainability of the proposed changes given the current stage of social development in Romania. The new law also had debatable consequences in terms of access to health care services for population with average or low incomes. The draft proposed the privatization of the health insurance of county houses while insurance would remain unchanged within the national house, and hospitals would be open to privatization. The most recent proposal of reform in the field of public health requires a choice between preserving the under-financing of the public health system because of the lack of political will to get involved more actively in the control and financing of the public health system and the privatization of the “market of services for health insurances.” This second option would dramatically decrease demand and, implicitly, the offer of health services. Privatization itself cannot be a solution to the problems. The notion of “failure of the market of services for health insurances”, as well as in the field of public education is well-known. The market for health services cannot operate correctly based on the principles of the free markets.

3.2. Low wages of the medical staff

Although the wages of the medical staff were raised over 50% before 2008, they still are too low compared to those in the Western countries, particularly in relation with the social importance of medical intervention. These low wages influenced adversely the amount and quality of delivered services and caused the medical staff to migrate towards west European countries while maintaining the system of informal payments at rather high levels (informal money paid by the patients in order to be treated more attentively by the medical staff or as a token of gratitude). In 2005, the system of informal payments was estimated to 300 million lei per year, which has certainly deterred the access to health care for many of the people on low incomes (***Crisis and reform with the health care system, RAS, 2012*). Because doctors go abroad to work, the system is confronted with an increasingly acute crisis of the medical staff – a crisis that has already existed in the system for a long time. In order to change this state as fast as possible, the Government must act swiftly to fix this problem where it exists by applying the policy of liberalizing the wages of all the staff employed by the public health system. Professional performance and the quality of work must be the criteria for the pay rise. Ignoring this problem further will shortly cause the system to jam.

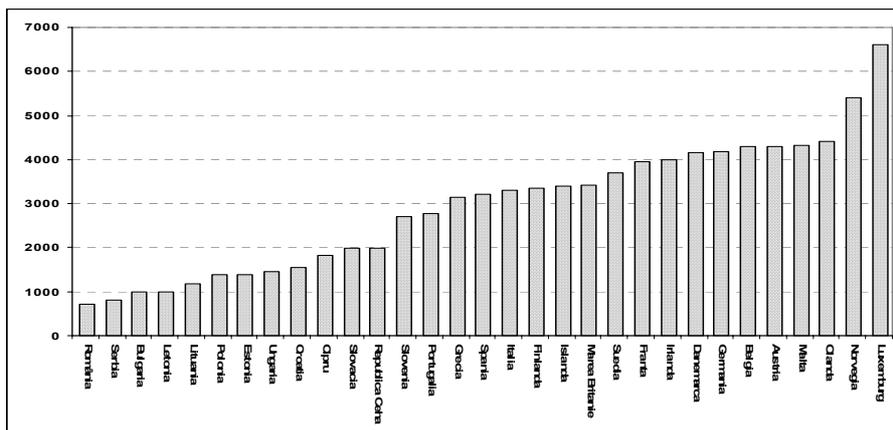
3.3. Financing of the health system

The deficient financing of the national health system has a long history that started immediately after 1989 and remains until the present. The lag between the funds allocated to the public health system and social needs that increased during

the years of stronger economic crisis was becoming increasingly acute since the population was increasingly informed and aware of the possibilities of diagnosis and treatment from other European countries. Little progress has been made: simply the allocation of funds to university hospitals in order to establish several points where health care is properly articulated. Also, little has been invested in emergency health, which was almost non-existent during the early 1990s.

Irrespective of the particularities of a system of public health (except for those financed from the state budget with the universal access of the population to the services), the system's financing should take into account several clear landmarks: 1. Structure and cost of the package of free services available for everybody; 2. Establishment and stability of the source financing the package of free services available for everybody; 3. Categories of population for which access can be done on the basis of medical insurance; 4. Range of services for the insured people – depending on the cost of insurances and their coverage based on the resources collected through funds of insurances and other sources; 4. Size of the possible co-payment born by the beneficiaries in order to cover the full cost of the services. No matter what economic difficulties it might encounter during this stage of its historical development, Romania must define its strategy in the field of public health in line with the community policies that promote the following principles: universal coverage for at least a minimal package of services, solidary financing of the costs, equitable access to the services and to high quality health care.

Chart 2. Expenditure for health, per capita, in PPP, US Dollars, 2009

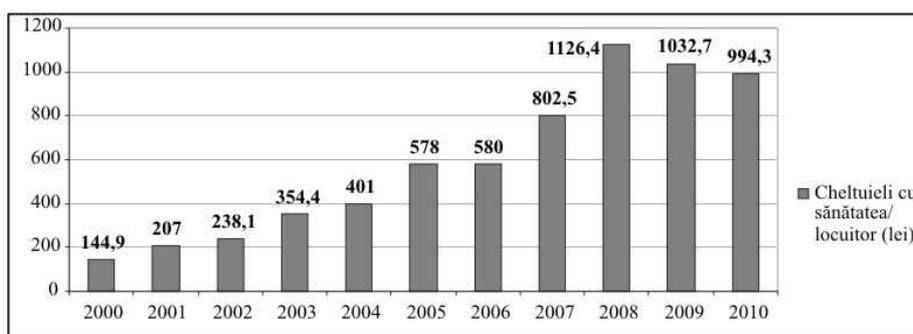


Source: World Health Organization Database, January 2012, in Björnberg Arne, Health Consumer Powerhouse, *Enro Health Consumer Index*, 2012, www.healthpowerhouse.com/ehci2012

Despite reformist rhetoric, authorities keep postponing finding viable solutions to the major problems of the public health system in Romania. In reality there is no real and viable alternative to a stronger involvement of the state in the financing and control of the public health system. The solution to the under-financing of the public health system is merely to reconsider the real priorities of present-time Romanian society and to find solutions for drawing additional resources for the public health system. Much of the Romanian population is very poor. The purchasing power of the Romanian people is about 40% of the euro zone average. Nevertheless, Romanians had to endure extremely harsh measures during the past two decades in the field of health care with an extra burden on the rural poor because infrastructure and services are much worse in the rural areas than in the urban areas, and offers of free public services are extremely scarce. The universal financial coverage of health care services is a major objective, although the road to such an ideal has proved rather difficult for much wealthier countries. The universal financial coverage of health care costs may be achieved, however, even in Romania, at least in some categories of services (not just for emergency situations).

Although it integrated within the EU from 2005, the extremely precarious financing of the national health care system is widely known not just in Romania, but also abroad. The share of funds for the national health system within the GDP remained constantly outside the European trend for the past two decades.

Chart 3. Expenditure for health care per inhabitant (lei) in 2000-2010



Source: Culita Laura, 2012. The year and the minister: 10 alarming statistics about the health care in Romania, 13 May 2012

During the decade 2000-2010, the public expenditure for health care in Romania increased a little and peaked in 2008. However, the health state of the Romanian

population didn't improve at a pace close to the improvement of the funding for the public health system, which constantly lagged behind the European average. Of course, the relevant lags in the health state indicators are not due exclusively to the low level of funding available to the public health system. Nevertheless, the distribution of funds within the health system and the way money is spent are contributing factors. The lack of flexibility of hospital financing determines a high consumption of medical services that often does not improve the health of the population and, sometimes, has no connection to necessary treatments for patients. As the patients go to the hospitals for the primary check, the role of the family doctors becomes strictly bureaucratic (issuing the recommendation to the hospital after the diagnosis has already been set by the hospital doctor, who has also decided the admission of the patient to the hospital).

The high valorisation of public health in EU countries is not a luxury affordable only to rich nations; rather, this valorisation is a consequence of the knowledge and acknowledgement of the social and economic effect that a superficial approach in this area may set off. The consensus of stakeholders in western countries (policy makers, providers of services, third paying parties, beneficiaries) on the level of financing for the public health speaks for itself. Germany, for instance, the country with the oldest system of health insurance, increased the level of the compulsory contributions for health again in 2011 (from 14.9% to 15.5% of the gross income) in order to compensate for the deficit of funds for social insurance and to increase contributions to the public health budget. France enlarged the basis of the contribution to health services (also using incomes, not just the wages). Other countries such as Spain, Greece, Ireland and Italy took measures to reduce the health-related expenditure of the population by a strong decrease up to 25-30% of the price for the generic medicines (*Țigăniuc, 2011*). Romania must and can learn from the experience of the EU countries, not just by reorganising its financing for the public health system but also by acknowledging the strategic importance of the public health sector for the social welfare and economic development of the country.

3.4. Financing of the private health system

Private hospitals displayed a significant evolution over the recent years. According to data released by the Ministry of Health, in 2009, more than 40 private hospitals concluded contracts for health insurance; a number that increased to 52 in 2010. The current system of financing allows payments for medical services at higher rates for the private system than for the public system. Within the context of the current financial crisis the underfinancing of the health system is worsened by the unlawful competition of private hospitals that access

funds from the system of public health insurance. Fair norms of financing must be set out and implemented in order to prevent throwing the system out of balance because while private hospitals can turn down medical assistance to patients with high risk of complications (because the pre-set limit of expenditure can be exceeded), this is not allowed for the public health care units, which have to respond to all demands while brushing aside financing aspects (***) *Report of the Government of Romania, 2011*).

3.5. Accreditation and closing down of some hospitals. Decrease the waste and the fraud within the health system

The process of accreditation of hospitals, started so far, was challenged by large difficulties due to the lack of money for the required investments. Many hospitals have waited for over 10 years to be evaluated. IMF pressure to make the hospitals efficient resulted only in closing down 68 units, which produced much social dissatisfaction because those hospitals were the only ones in very large geographical areas. Their discontinuation not only failed to increase the quality of the health services or to cut the operational costs (the proportion of the resources from the total budget allocated to these hospitals was rather insignificant), but it also strongly decreased the access to the basic services for much of the population living on low incomes.

The fraud and the waste of system resources appear because of scarce surveillance and because the stolen resources are not recovered from the culprits. Some exemplary measures in this direction would deter many aspirations for illegitimate enrichment. Preventing the frauds and the inefficient expenditure can be done by making transparent all inputs into the system and outputs from the system, by making them available to the agents that contribute to the establishment and operation of the system (analysts-specialists, politicians, beneficiaries, suppliers of medicines, providers of services, etc.). The use of IT may ease this process very much. The purchases made by the hospitals must be planned and done by areas or by hospitals with similar specificity in order to avoid the fraud by using preferential prices or products. The manner of financing paraclinical investigations must be reviewed in order to avoid the higher costs of analyses in some health units (both the work and the reagents can be similarly analyzed), while preventing the useless repetition of the same analyses by passing from one level of medical assistance to another (***) *Crisis and reform within the public health system, RAS, 2012*).

3.6. Restricted access to the health services

This situation can occur for several reasons: the *economic criterion* – some medical costs that are on the account of the patients (co-payments, treatment and

hospitalisation, transportation etc.) cannot be covered by them or are covered with a lot of difficulty because the people have incomes close to or below the poverty threshold; the *large distance between the place of residence of the beneficiaries and the location of the health unit* (often with aggravating circumstances because of the extremely precarious health state of the patient and of the decreasing number of the medical staff); *large qualitative disparities in terms of the offer of services* in territorial and residential profile; *problems of occupational status of the beneficiaries* correlated with the eligibility for treatment or quality of insurance for beneficiaries; *the access of the population to relevant information* – namely the population has difficulties accessing useful information regarding the existing opportunities of health care; *access to decent dwelling (including running water source)*. These characteristics may cumulate sometimes and generate reciprocal disadvantages. Most frequently, among the excluded people are persons from the families with no health insurance who live on incomes that are too low to allow them make health insurance, or on occasional incomes; the people with uncertain or transitory socio-economic status (pensioners of different categories who didn't yet receive the notification for retirement, young people working with no sure employment status etc.); poor families from rural areas or from other areas where there are very scarce possibilities to demand health services; old people with no income or with very low incomes – particularly former cooperative members from the rural areas, and children and young people with no family or with no stable residence (Stanciu, 2003).

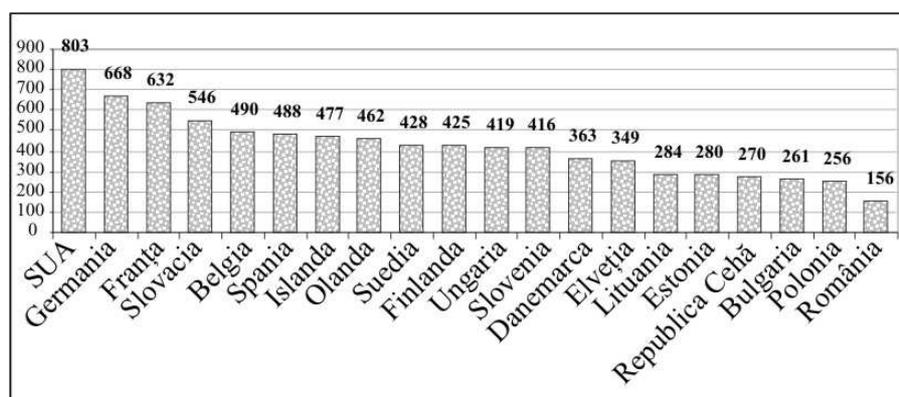
4. Consumption of medicines

The consumption of medicines by a population is not just function of the incidence of the different categories of morbidity; it also depends on the level of the population's incomes, on access to health services, on the general level of education and on the level of information. For instance, a survey conducted in Australia in 2009-2010 regarding the consumption of medicines (applied to 9,774 households), revealed that the households with rather low incomes – between AUD\$92 and \$164/week – (many of which are pensioner households), have very little money left after paying the bills for the basic goods and services, which include the consumption of medicines (costs are partially compensated by the Australian state). The purchased medicines cost \$11-\$42/month for the households entitled to higher compensations and \$34-\$186/month for the household entitles to lower compensations for the cost of medicines (Kemp, Preen, Glover, Semmens, Roughead, 2013).

Romania reported the lowest consumption of medicines per capita at the purchasing power parity, being about 40% lower than some less developed

European countries such as Poland, Lithuania or Estonia. *The consumption of medicines prescribed by the doctor usually is around 100 Euro per capita; this puts Romania on the penultimate position within the EU whose average consumption amounts to 450 euro per year. The proportion of the national consumption of medicines within the total expenditure for health is about 22%, which puts Romania below some countries such as the Czech Republic, Hungary or Slovakia, whose proportion is around 30%. About 80% of the medicines consumed in Romania are imported, which burdens the purchasing power of the population and the capacity of the health care system to meet the existing necessities with the available funds. The value of the cumulated budget expenditures for the health services and the consumption of medicines per capita in Romania decreased from 280 euro in 2008 to 275 euro in 2010 and to just 230 euro in 2011. The compensated medicines take about 7-8% from the budget of the health system, which is much below the necessities; this only worsens the health state of the people who cannot afford to buy the prescribed treatment (Pana, 2011).*

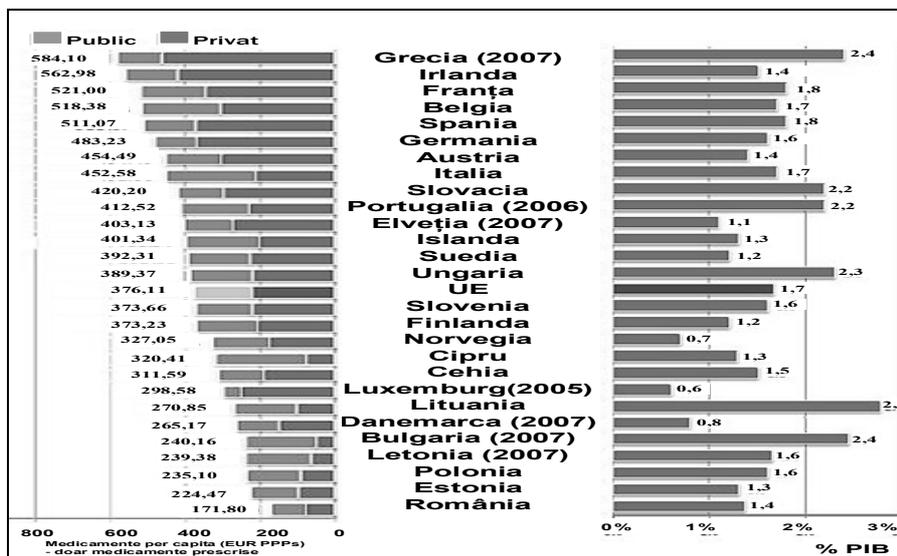
Chart 4. Consumption of medicines per capita, at the PPP (2009)



Source: *** MIND Research & Rating, CNAS, MFP, 2012

Although the incidence of diseases among the Romanian population is high, Romania reported the lowest consumption of medicines per capita and one of the lowest proportions of the consumption of medicines within the GDP.

Chart 5. Expenditure for medicines per capita, as proportion of the GDP, in 2008

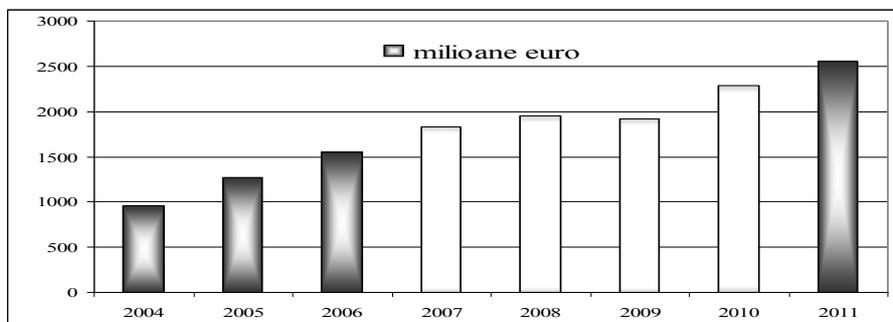


Source: OECD/European Union (2010), *Health at a Glance: Europe 2010*, OECD Publishing, SAR, 2012

The economic relations from the market for medicines change rather fast in EU countries. In Romania, however, important processes on the proper supply of medicines on the domestic market depend (evaluation and revaluation of the available stock of medicines, study of the impact on the budget of compensating specific medicines, etc.), are too slow.

In the background of the picture of decreasing general access to the public system of health services for the general population and a low level of incomes compared to other countries, the consumption of medicines nevertheless increased in Romania from year to year because of the general increase of the morbidity. At the end of 2010, the health care system recorded an excess spending of almost 300 million euro, probably due to the much delayed payment by the Government of the compensated medicines to the suppliers of such medicines. As creditor of Romania, the International Monetary Fund demanded the Government to pay the debts with the consumption of compensated medicines in order to prevent the increase of the budget deficit.

Chart 6. Evolution of the pharmaceuticals market in Romania (euro)



Source: Centre for management, documentation, IT and marketing (Cegedim), Ziarul Financiar, SAR, 2012

However, in order to solve this issue the producers of medicines had to pay for excessive budget expenditures. Such taxes imposed on the medical industry cannot be operational for long because the concept of *compensated medicine* will gradually lose its economic consistency since the state (as the agent of social protection) doesn't exercise its attributions. In no country does the pharmaceutical industry assume long-term tasks of social protection. Generally, the delayed payments of the Government towards the providers of medicines end in an unwanted effect on the medicines market. Such effect is, according to NewsIn, that generic medicines are at risk of disappearing from the market (statement of the Romanian Association of the manufacturers of generic medicines). The previous prolongation of the period of payment from 120 to 210 days already determined the disappearance of about 1600 rather cheap medicines and the payment of about 250 million lei by the patients. Furthermore, many independent pharmacies and two large distributors went bankrupt (***)*Over 2000 medicines at risk...* *Bloombiz*, 2011). Because the medicines distributed into the national pharmaceutical system (the imported ones included) are frequently recorded at the lowest price in Europe (40% of the prescribed medicines, while 50% have the price little over the minimal European level), over 20% of the existing medicines are re-exported and never reach the Romanian people. Thus, although the strategy of decreasing the prices for the Romanian consumers is basically laudable, it proves to be deeply counterproductive.

5. Conclusions

The European Union acts in tandem with integrated national systems in order to ensure the health of the European citizens. Nonetheless, the member states hold

the main responsibilities for their policies in the fields of health and the supply of health services to their citizens. Therefore, Romania cannot solve the present deficiencies of its public health system just by waiting for solutions and resources from abroad. The internal initiative in this field must have a decisive role.

The under-financing of the national health system has extremely serious and adverse consequences both in terms of quality of services and economic development. Investors hesitate to come to Romania because they know that they cannot benefit from good medical resources. The criterion of infrastructure development and that of the quality of the public health services are basic for the decision to invest in a particular country.

The decrease of the highly skilled human resources from the national health system cannot be overlooked. The exodus of specialists to countries that pay better and acknowledge their professional status, as well as offering them better working conditions, cause important losses for Romania. This drain causes deteriorating services gradually. The deficit of medical staff, going on for several decades, should be a serious warning to Romania. In 2008, Romania had 2.2 doctors for 1,000 inhabitants, compared to the 3.2 doctors for 1,000 inhabitants which is the EU27 average; in 2012, Romania had just “about 43,000 doctors”, which means “less than 2 doctors for one thousand inhabitants [...] while the average of the European countries was 3.6 doctors for one thousand inhabitants (***Realitatea.net*, 30 March 2012).

Romania reported the lowest consumption of medicines per capita at the purchasing power parity within the European Union. The proportion of the national consumption of medicines within the total expenditure for health care (about 22%) puts Romania in the last place in Europe for this indicator. There is no consumerist competition here but a situation describing the state of health of the nation. On the other hand, about 80% of the medicines consumed in Romania are imported, which strongly affects the purchasing power of the population and the capacity of the health system to meet needs with existing funds. The compensated medicines are consumed far below the level of needs, which aggravates the state of health of the people who cannot afford paying for the prescription. This also is a consequence of the abusive and/or inefficient practices concerning the trafficking of medicines (import-export) and the delayed payment by the state budget of the expenditures incurred by the health care units, while the price/cost of medicines increases constantly.

Meanwhile in the economic sphere that constantly focuses on profit, the strategic orientation towards privatization may be legitimate and may generate welfare due to the strong orientation towards market interests. In the sphere of the public

health system we cannot allow attaining desiderates such as better payment for medical staff or the elimination of waste materials, at the expense of sacrificing access to health services of the population earning incomes below the average income. This would probably decrease the rate of thefts from the system and will provide quality services but only for a minority of the population that can afford paying for private health insurances. The conditions provided by some of the private hospitals from Romania are incomparable with the conditions provided by public hospitals; however, statistics don't yet provide data on the number of people benefiting from such services. These arguments are also supported by the disagreement of the population for such measures, demonstrated when the government attempted to privatize the emergency health services (the Arafat episode). The different so-called "solutions" for privatization of some elements from the public health system have already been rejected clearly by the population from countries such as Hungary or Poland. Taking care of public health is more than mere profit-generating merchandise for oriented company owners. The state of health of an entire population cannot depend on the disposition of a private manager, after public health became a human right guaranteed by Constitution for many decades. Solutions to stop waste, to improve the efficiency of using funds and to improve the quality of the health services may be found without facilitating overnight enrichment of people having good reflexes in terms of privatization.

References

- Bărbulescu I. G., Iancu A., Ion O. A., Toderaş N. (2010). Tratatul de la Lisabona. Implicații asupra instituțiilor și politicilor românești. *Studii de strategie și politici – SPOS 2010*, (1), Buharest: IER
- Björnberg A. (2012). *Health Consumer Powerhouse, Euro Health Consumer Index*. Health Consumer Powerhouse, [Online] at <http://www.healthpowerhouse.com/files/Report-EHCI-2012.pdf>, accessed March 23, 2013
- Culiță, L. (2012). *Anul si ministrul: 10 statistici alarmante despre sănătatea din România*. 13 Mai, [Online] at <http://www.wall-street.ro/slideshow/Social/131499/10-statistici-alarmante-despre-sanatatea-din-romania/5/de-ce-boli-mor-romanii-locul-2.html#anchor-of-navigator>, accessed March 13, 2013
- Dancu, I. (2011). *Lista celor 67 de spitale închise de Guvern*. Adevărul.ro, Actualitate (01.04.2011), [Online] at http://www.adevarul.ro/actualitate/eveniment/Lista-spitale-inchise-vineri-Guvern_0_454754805.html, accessed March 20, 2013
- Doboş, C. (2006). Dificultăți de acces la serviciile de sănătate. *Calitatea Vieții*, (1-2), 7-24
- Elissen, A., Nolte E., Knai C., Brunn M., Chevreur K., Conklin A., Durand-Zaleski I., Erler A., Flamm M., Frølich A., Fullerton B., Jacobsen R., Saz-Parkinson Z., Sarria-Santamera A., Sönnichsen A., Vrijhoef H. (2013). Is Europe putting theory into practice? A qualitative study of the level of self-management support in chronic care management approaches. *BMC Health Services Research* 2013, **13**:117

- Garner S., Docherty M., Somner J., Sharma T., Choudhury M., Clarke M., Littlejohns P. (2013). Reducing ineffective practice: challenges in identifying low-value health care using Cochrane systematic reviews. *Journal of Health Services Research&Policy*, (18), 6-12
- Gheorghită E. (2013). *Colegiul Medicilor din România către Ponta: 14.000 de doctori, pentru care statul a investit 3,5 miliarde euro, au plecat din țară.* [Online] at <http://www.mediafax.ro/social/colegiul-medicilor-din-romania-catre-ponta-14-000-de-doctori-pentru-care-statul-a-investit-3-5-miliarde-euro-au-plecat-din-tara-10615853> accessed February 16, 2013
- Jaanus P., Sava D. I. (2009). *România - asistența tehnică pentru sprijinirea actualizării strategiei spitalicești.* Raport al experților Băncii Mondiale. Buchaest
- Kemp A., Preen D. B., Glover J., Semmens J., Roughead E. (2013). *Impact of cost of medicines for chronic conditions on low income households in Australia.* *Journal of Health Services Research&Policy*, 18(1), 21-27
- Pană, M. (2011). *Sănătatea României (II). Falsa economie a reducerii prețurilor la medicamente. Cum se compromite vârsta de pensionare.* [Online] at <http://cursdeguvernare.ro/sanatatea-romaniei-ii-falsa-economie-a-reducerii-preturilor-la-medicamente-cum-se-compromite-varsta-de-pensionare.html> accessed March 20, 2013
- Stanciu M. (2003). Premise actuale de excluziune, în domeniul asistenței medicale. *Calitatea Vieții*, (1), 1-10
- Țigăniuc, B. (2011). Perspective privind finanțarea sănătății în România. *Viața Medicală*, [Online] at http://www.viata-medicala.ro/*articleID_2706-dArt.html, accessed January 14, 2013
- Veress R. (2012). *Îndemnul lui Bănescu a dat roade. România rămâne cu cei mai puțini medici din UE!*, 30 mai, Jurnalul. [Online] at <http://www.jurnalul.ro/observator/numar-medici-romania-ue-614148.htm>, accessed January 21, 2013
- *** *Carte Albă, Împreună pentru sănătate: O abordare strategică pentru UE 2008-2013*, Comisia Comunităților Europene (2007). [Online] at http://ec.europa.eu/health/ph_overview/Documents/strategy_wp_ro.pdf, accessed January 21, 2013
- SAR (2010). *Crișă și reformă în sistemul de sănătate. O radiografie la ză,* [Online] at <http://www.sar.org.ro/files/rap%20detaliat.pdf>, accessed January 21, 2013
- *** *European Community health indicators (ECHI)*, [Online] at <http://ec.europa.eu/health/indicators/echi/>, accessed January 21, 2013
- *** *European Health for All Database* (2012). WHO Regional Office for Europe, [Online] at www.data.euro.who.int/hfad/, accessed January 21, 2013
- *** *General government expenditure statistics.* Eurostat (2012). [Online] at http://epp.eurostat.ec.europa.eu/statistics_explained/images/d/da/Total_general_government_expenditure_on_health_by_country%2C_2005-2009_%28%25_of_GDP_and_millions_of_euro_in_2009%29.PNG, accessed January 21, 2013
- *** *Health policies.* Eurostat (2012). [Online] at http://ec.europa.eu/health/health_policies/policy/index_ro.htm accessed January 21, 2013
- *** *Healthcare staff statistics at regional level.* Eurostat (2012). [Online] at http://epp.eurostat.ec.europa.eu/statistics_explained/index.php/Healthcare_staff_statistics_at_regional_level, accessed January 16, 2013
- *** *Hospital, beds, 1999-2009, per 100000 inhabitants.* Eurostat (2012). [Online] at [http://epp.eurostat.ec.europa.eu/statistics_explained/index.php?title=File:Hospital_beds_1999-2009_\(per_100_000_inhabitants\).png&filetimestamp=20120514093740](http://epp.eurostat.ec.europa.eu/statistics_explained/index.php?title=File:Hospital_beds_1999-2009_(per_100_000_inhabitants).png&filetimestamp=20120514093740), accessed January 21, 2013
- *** Raportul din 31.03.2011 al comisiei de selecție a unităților sanitare cu paturi care nu pot încheia contracte cu casele de asigurări de sănătate (2011). Monitorul Oficial, Partea I 22 din 31.03.2011.
- *** Veniturile și cheltuielile sistemului de sănătate, Scurtă analiză comparativă a variantelor de reformă (2012). EFOR, *MIND Research & Rating*, Bucharest: EFOR Policy
- *** *Sănătate publică* (2013). Parlamentul European, [Online] at http://circa.europa.eu/irc/opoce/fact_sheets/info/data/policies/consumer/article_7304_ro.htm, accessed January 29, 2013

*** *Peste 2.000 de medicamente riscă să dispară de pe piață*, Bloombiz, 23 Februarie 2011, [Online] at http://www.bloombiz.ro/business/peste-2.000-de-medicamente-risca-sa-dispara-de-pe-piata-_1487764, accessed January 25, 2013

*** Realitatea.net, 30 martie 2012, [Online] at http://www.realitatea.net/situatie-alarmanta-in-romania-au-ramas-doi-medici-la-1000-de-locuitori_928114.html, accessed January 27, 2013

*** *Solidaritatea în domeniul sănătății: reducerea inegalităților în UE (2009)*. Luxemburg: Oficiul pentru Publicații al Uniunii Europene