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REFORMING ROMANIAN HEALTH CARE. MARKETS IN HEALTH AND LESSONS FROM CENTRAL EASTERN EUROPE.

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Contents

Abstract

After a long procrastination, the Romanian health reform entered a dynamic phase with the adoption of the 1997 Law on Social Health Insurance. Romanian reforms follow the convergence track with the other Central East European countries. The soviet style health system is replaced with payroll based social insurance, capitation for GPs and prospective budgets for hospitals become the main payment schemes for providers, and the reimbursement of drugs is based on reference pricing. There is no competition between insurers. The process is under way, but the indications are that within this specified frame the less controversial alternatives are being chosen. This confirms the cautious approach to reform Romania had so far and avoids the worst mistakes of other CEE countries.

The new system is an improvement over the previous set-up. Social insurance will ameliorate the macro-efficiency dimension and equity will not be damaged. But the very limited scope for competition will restrict the improvements in micro-efficiency and choice. The mechanism designed for public involvement is corporatist and cumbersome, and is likely to fail. This will maintain the Romanian health system provider-focused and paternalist.

Introduction

Romanian reform of the health sector progressed cautiously, as it otherwise happened in most sectors of the economy. The current system still preserves the main features of the soviet style healthcare. The Law on Health Social Insurance that came into effect this year introduces major changes in the administration of the health system, the method of financing and the payment of providers. The law allows a degree of flexibility and some important decisions will be taken while implementing the legislation. The next couple of years will therefore be crucial for designing the shape of the Romanian health system for many years to come.

Romanian reforms coming later than in other former communist countries creates the possibility of a transfer of experience from countries that faced similar problems and adopted comparable solutions. It is the aim of this essay to analyse, in the limited space available, the health reform in Romania from the perspective of the international experience to date, and especially of the other Central East European countries. The paper is structured accordingly in three parts. The first chapter analyses the market failures that lead to government intervention in the health sector, and the objectives that guide this intervention. The next chapter discusses what are the lessons from the health reform in the CEE countries, with an emphasis on the Czech Republic - the champion of market-led changes. The last three chapters present the Romanian case: chapter three - the situation prior to the current reforms, chapter four - the changes now being introduced, and chapter five - the evaluation of these changes.

Finally, a few remarks about sources. The international literature on healthcare is very rich and the only real challenge is for the ability to summarise it. The literature on health reform in CEE is comparatively thinner, and diversity is not helped by the fact that many authors rely on the same main secondary sources - e.g. reports from international organisations like the World Bank and the World Health Organization. The real problem is Romania. There is not much written about the country or its health sector in the first place. More important, there are not many sources to discuss a process initiated by a 1997 legislation that came into effect in 1998. Accordingly, in presenting the current reforms I relied on the text of the law itself, and on the recommendations for implementing it prepared with Phare assistance by the Institute of Hygiene, Public Health and Health Services Management (IHPHHSM) and the German consultancy BASYS. Apart from the Institute, I have to thank Mr. Richard Florescu from the World Bank Mission in Romania who made available WB reports, and Mr. Adrian Caretu, Country Manager of MSD Romania, who kept me briefed on the latest developments.

It is important for the reader to keep in mind that health reform in Romania is an on-going process, that crucial decisions are still to be made and that therefore much of the analyse in the following pages is based on educated guesses about probable developments rather than on hard facts. I have tried to make this distinction clear in the paper whenever was the case. While this uncertainty reduces the ability of the author to draw definitive conclusions, it makes the paper prospective rather than retrospective, and hopefully more interesting to read.

Chapter 1: Health Markets and the Objectives of Health Policy

1.1. Imperfections of the health market

The normal economic expectation is that equilibrium between demand and supply in a free market will lead to the socially optimal level of output being produced, therefore maximising the social welfare. There are strong arguments why this does not hold in the health market, and why such a market failure require the intervention of government.

1.1.1. Insurance

The deep root of the failures of the adequate provision of health goods and services by the market is to be traced to the fact that there are significant intermediaries between the producer and the consumer. The two practically exclusive funding mechanisms are by public bodies (either by tax or by tax like social insurance) or by private risk-related insurance, with fee for service paid by the consumer being rather marginal. The consequence is that the cost perceived by the consumer (i.e. patient) is (close to) zero and therefore is to be expected to lead to an over-demand of health care provision. In such an institutional set-up, because the consumer demand will not be restrained by the cost of the medical procedure, it will grow till the (medical) benefit to the

patient of an extra intervention will be zero[1]. This is what Paul Krugman (1994) calls "flat curve" of medical expenses. What is obvious is that the equilibrium level will be substantially above what the maximisation of social welfare would require.

1.1.2. Supplier induced demand

In addition to the insurance failure, the prescription of health care is mainly in the hands of providers (i.e. health professionals) who have an in-built incentive to stimulate the demand for their services – therefore leading to a provider-induced over-demand (Helms, 1981).

1.1.3. Asymmetry of information

Connected to the previous point, a very important contribution to the mal-function of the health care market is brought about by the specificity of the information in health care. The high level of technicality of the medical knowledge results in an asymmetry of information between the patient and the health professional. In addition, the nature of the health market impedes the normal mechanism for accumulation of knowledge by the consumer: trial and error. During a lifetime the patient will encounter many different conditions, that many times will not repeat, so there is little

[1] To be more exact, the patient still pays a cost apart from that of the medical act – e.g. time spent, travel cost etc. The demand will be expected to stabilise where the marginal benefit from the health service will equal this marginal cost, that actually is different from zero.

opportunity for accumulating information. More important, the risk involved in a wrong decision is prohibitively high, as one might not live to err again (Mossiaslos, 1993).

1.1.4. Barriers to entry

In addition to the failures of the health care market, there are specific traits of the health industry that depart from the perfect competition model. These affect especially the pharmaceuticals, but are valid to the rest of the industry too.

The pharmaceutical industry is highly concentrated, with a small number of multinational companies dominating the market, especially in the research-intensive development of innovative drugs. These traits of the industry are explained through the high expenditure required for developing and marketing a new drug, resulting in high barriers to entry. In addition to its oligopolistic nature, the pharmaceutical market is very segmented in different drug classes, therefore reducing further the competition, and granting to certain companies a quasi-monopoly position in some of these sub-markets. This is reinforced by the patent system that allows up to 20 years of monopoly for the patent owner in producing the respective drug (Taggart, 1993).

In the rest of the health sector, barriers to entry are represented by the complexity of medical knowledge and by stringent government regulation of the license to practice and by the professional associations, which usually enjoy a legal monopoly position.

Given this institutional arrangement, it becomes clear that there has to be a *rationing* of health care, through government intervention, in order to bring the level supplied towards the social optimum.

1.2. The increasing trend of health expenditure

However, there are a series of developments that put the need for rationing in the forefront of the debate about health care. The last two decades have seen a steep rise in the health expenditure (measured as percentage of GDP) in all developed countries (Abel-Smith 1992). This trend has been somewhat restrained in the mid 1990s, but it is still worrying for the public finances.

There are a few factors blamed for these developments. On one hand, it is admitted that, for whatever reason, in aggregate countries start to spend a higher percentage of GDP on health as they get richer (Abel-Smith 1994). However, the expenditure increases rose questions about the sustainability of the trend. Ageing of the population is widely held responsible for the rising demand for health care (Abel-Smith 1994). With longer life expectancy and low natality, this phenomenon is expected to continue in the developed world, and is the basis for the doom scenarios about the cost of social programmes spiralling out of control. In addition, the mentality nurtured by the consumer society increased the expectations of patients about the quality and quantity of health services. Things are made worse by the resistance developed by taxpayers to increasing their contributions, what especially fuels questions about the basis of the (West)

European model of welfare state. However, Abel-Smith (1994) finds that the single largest cause of increased health expenditure is the huge cost of new technology (i.e. equipment and drugs).

Even if starting a much lower level of wealth and health expenditure than the western systems, these trends constitute real challenges for the transition former socialist countries and their hard pressed public budgets, as we shall discuss in the next chapter.

1.3. Dangers of over-regulation

As stated above, the case for intervention is serious. However, many authors seem to over react to these facts. After all, many of the imperfections of the health market are common to the other insurance markets (i.e. third-party payer) while its asymmetry of information can be found in different industries, all functioning relatively efficient under free market conditions.

The over reaction to the perceived failures of the health market, could result in the over-regulation. Beyond the general case that can be made for the efficient allocation of resources, this could have the result of damaging the health of patients. For exemplification, too stringent cost-containment measures could lead to the under-funding of the pharmaceutical market, therefore reducing the research and development effort, what in turn would postpone the discovery of new, potentially life-saving drugs.

1.4. Objectives of intervention

The intervention measures are aimed to promote the objectives of health policy. Classically, these are described as achieving an efficient use of resources in health care, both at the micro-level (e.g. individual operation or health organisation) and at the macro-level (usually described as percentage of GDP dedicated to health expenditure in the public and private sector), while providing for equity as well as for choice for patients and responsiveness to their needs (Mossialos, 1993). It is of course difficult to operationalise these concepts. The easiest quantifiable is the expenditure, but in order to talk about efficiency we should be able in addition to the cost to measure the end-result – the health status, a more difficult operation. The other variables (choice, responsiveness) are more difficult to grasp, while equity is rather elusive, as it involves a moral judgement instead of a mere statement of fact. That is why in many respects I prefer the simpler formulation of aiming for the best health care at the lowest possible cost - even if it is hardly any more precise it clearly states that there is a trade-off between cost and quality of health care, and the aim is to achieve the right mix.

1.5. Tools of intervention

When the government considers politically desirable that certain services should be provided, services that are not being available in the desired format in the market, it can make recourse to three main mechanisms. The government can decide to supply those services directly to the target group, it can use public funds to pay for a private provider to supply the services or alternatively

could regulate the market so that the services will be privately supplied in the politically desired parameters.

The consequence for the health services are three main models of organising health provision. The first mechanism corresponds to the state-owned integrated system. The British National Health Service (NHS) is the best known exemplification of this type, that is also present in Scandinavian countries. The second mechanism corresponds to the social insurance system, dominant in (Western) continental Europe. Finally, the third model is notoriously exemplified by the United States. The structure of the health provision system is closely connected to the choice made by the respective country in the design of its overall welfare structure.

Chapter 2: Health Reform in Central Eastern Europe

2.1. Reforming health systems

Trying to differentiate what level of change represents a reform of the health system, I shall follow Elias Mossialos. First, it has to be an important change in the health services provided. Second, there must be an institutional dimension to these changes. And finally, the changes must be sustainable - e.g. from both a financial and political acceptability perspective.

2.2. Evaluating health reform

In order to assess the health reform process there must be taken into account the repercussion of the changes on all four objectives of the health policy. As discussed in the previous chapter, these are cost (macro level efficiency), (micro-)efficiency, choice and responsiveness to the needs of the patient, and equity.

2.3. Health reform in CEE

Central Eastern Europe practically represents the former satellites of the (former) Soviet Union. After 1989 all the countries of the region have embarked in a troubled transition from the state socialist towards a system based on political liberal democracy and free market. The speed of political and economic changes differed from country to country, as did the priority attached to reforming the health system. This depended on the economic situation of the country and the ideology of the government. More stable economies, and more free market governments decided to tackle sooner the socialist inheritance in health. The most obvious example, in both criteria, is the Czech government of Vaclav Klaus. At the opposite pole, Romania had both a more cautious approach to change in general and (possibly as a consequence) had to face prioritarily an unbalanced macro economic climate. The result is that health reform proceeded slowly, and it is only this year that it is actually being implemented.

However, notwithstanding the rhythm of reform, all CEE countries present similarities in the starting point of reforms (both in health status and structure of the health system) and in the overall direction of change. These similarities make it interesting to analyse the performance in the countries more advanced in the process, and attempt to use their experience in the benefit of those who only now engage in the implementation of changes - point supported by Ensor, 1993. Further on, I shall look at the main common features over the region of the problems faced by the health systems, of the structure of these systems and finally of the reforms they engaged in.

2.3.1. Health status

Health economics studies found that the best predictor of health status in a country is the GDP (per capita, at purchasing parity value - ppp) (Chellaraj, 1996). From this perspective, the socialist countries performed better than their wealth would have predicted. Compared to these predictions, they had higher health expenditure, longer life expectancy, and lower IMR (infant mortality rate). Their great success was in the 1960s when they successfully controlled communicable diseases morbidity through public health measures, resulting in a dramatic decrease of the rate of mortality caused by these. In addition, they provided universal coverage, and are perceived to have performed well on equity grounds (Ensor, 1993).

However, since 1960s CEE life expectancy rates started to fall behind those from Western Europe. The opinion of the experts is that they failed to cope with the rise of the non-communicable diseases, mainly self-inflicted through diet, pollution and other life-style factors, as the main source of mortality (Ensor, 1993).

2.3.2. The structure of the health system

All CEE countries had soviet style state-owned integrated health systems (Ensor, 1993). Health facilities were owned by the state, mainly by the central government, the finances came from national taxes, practitioners were paid fixed salaries, and the management of the system was centralised with the Ministry of Health.

The main complaints raised against such an institutional set-up were that it was bureaucratic and did not promote flexibility, responsiveness to the needs of the patients and choice of services[2]. The salaried system did not reward performance by the doctors (but the wide spread gratuities system partly mitigated this shortcome, however with obvious effects on equity). And there was no competition between providers. (see IHPHHSM, 1997)

2.3.3. Problems

As consequence of these structural failures, the socialist healthcare systems were provider-focused, and their performance was characterised by poor emphasis on primary and preventive care, and high inpatient to outpatient ratio (see IHPHHSM, 1997).

2.3.4. Recommendations for reform

The recommendations from foreign institutional consultants focused on tackling these problems by improving efficiency and increased emphasis on the development of primary care and on public health (preventive) actions. The increase in efficiency was envisioned through decentralisation of ownership: either outright privatisation or transfer from the central government to the local authorities, and increased competition between providers through the

payment system: capitation for general practitioners, outcome-based for specialists and case-mix for hospitals. On the financing issue, the recommendations converged towards the replacement of tax finance with mandatory (social) insurance, supplemented by copayments, and complemented by excluding non-essential services from coverage. However, it was also emphasised the need for a careful approach towards reforms. (Preker, 1994)

2.3.5. Main features of reform

In the main, reforms in all CEE countries followed along these lines. Tax financed systems are replaced by social insurance - in effect ear-marked taxes - with the objectives to solve the perceived under-funding of the healthcare system (Ensor, 1993). All systems introduced purchaser-provider separation in order to foster competition between providers. But the countries differed over the decision to have competition between purchasers too. They maintained the right of patients to chose their provider at all levels: primary, specialist and hospital care. But patients are required to register with one primary care doctor, that has the role of gate-keeper towards other services, through the referral system. (McKee, 1994). Further on, I shall look beyond these common features, by analysing the effect of the choices made in the Czech Republic.

[2] In contrast, it must be mentioned that there was practically free choice of specialist or hospital, but limited by geographical availability and reduced resources of the system.

2.4. Czech lessons

The Czech health reform are the most commented in literature, because they are seen as an example of how not to conduct the process. The miscalculation of the incentive structure built in the institutional reform lead to dramatic over-spending. Moreover, the reversal of some of the initial policies and the subsequent regaining of control over the health expenditure provide a rare lab-test-like case on the validity of theoretical insights.

The Czech scheme for health financing is founded on payroll based social insurance with competition between both providers and insurers (McKee, 1994). The root of the troubles was that in the initial phase of reforms, started in 1992, the payment to providers (both general practitioners and hospitals) was based on a fee for service system, while the insurer funds worked within an implied budget (NERA, 1996), because social contributions levels and insurance premiums were decided by the parliament.

The expected consequence of such a payment system was supplier induced demand. The safety mechanism introduced into the scheme was a point system, by which each operation had allocated a certain number of points. The physician (or the hospital) were paid the materials and other costs incurred, and what money was left was divided between providers according to how many points were worth the operations they performed (Massaro, 1994). Therefore an increased volume of services would result in a lower value per point (i.e. per service), and total expenditure would stay unchanged.

This institutional arrangement created a ‘prisoner dilemma’ for practitioners: not knowing how many operations the other doctors will perform, each individual had the interest to produce as high a volume of services as possible, even if in aggregate this resulted in lowering the value of a point (Schwartz and Busse, in Schwartz 1996). In addition, the modest role played by co-payments (restricted practically only to pharmaceuticals) meant there was no constrain on patient demand, further fuelling the provider induced demand.

The failure of the system came from the fact that the insurance funds came under strong political pressure not to lower the value of the point too much (Mullen, 1998). This blocked the safety mechanism of the system and resulted in insurance funds running into debts and even closures. The health expenditure as a percentage of GDP almost doubled in the first year of reforms (Chellaraj, 1996).

Things were made worse by the fact that there was a state guarantee behind the insurers: the debts of the failed funds were covered by the budget (in proportion of 80%) while their clients were taken over by the state insurer fund VZP. On one hand this increased the burden on the state budget. This was also increased because, there is some evidence that, in spite of the law, the funds were able to use cream-skimming, leaving the worst risk patients to the state fund. On the other hand, the guarantee was a disincentive for the funds to realistically asses their risks, in the context where being required by law to be non-profit organisations they had no risk-bearing shareholders to begin with. It was also a disincentive for the patients to be careful which fund they will join.

After this initial abysmal performance, a reappraisal of the financing system took place. The most important alteration was the replacement of fee for service with capitation for general practitioners and prospective budgets for hospitals. In addition, the use of co-payments was increased and a reference price system for drugs was introduced. Following these changes the rate of growth of the health expenditure was stabilised, and actually it stayed below the rate of GDP growth. (Mullen, 1998)

Other factors than the funding system played a role in the dynamic of the Czech health expenditure. The over-supply of doctors was probably an element. It can reasonably be argued that the bubble of the first year was also the result of repressed demand accumulated in the communist years and of set-up costs in the first year of the new system (ibid). However, such a wide fluctuation of costs is a strong argument in the favour of the theoretical expectation that fee for service results in supplier induced demand, while capitation and budgets are much better tools for controlling health expenditure growth.

Finally, it is only fair to notice that apart from this role as case -study for the illustration of theory, the Czech health reforms had important achievements. They created a wide choice for consumers, a reasonably competitive health market with a multitude of players on both the supply and the financing side. However the latter is hugely dominated by the state fund VZP, with 70-80% of the insured, while the state budget accounts for 65% of total health expenditure. The rate of health expenditure has stabilised around a reasonable 5.8% of GDP. Most important, the reforms have been correlated with an improved health status: both life expectancy and the closer connected to the quality of health services perinatal mortality have ameliorated. (ibid)

2.5. Conclusions

The conclusions that I draw from the evidence presented supports the positions taken by a few authors, mainly foreign consultants from international organisations. The first apparent trend is the conversion of the reform process in the different countries of the region. Starting from similar state integrated systems, they seem to move towards payroll based social insurance, with competition between providers and purchaser-provider separation. Moreover, the payment system is also converging towards capitation for general practitioners and budgets for hospitals, and reference pricing for drugs is gaining ground. In addition, many countries play with the idea of introducing DRG (diagnostic related groups) payment for hospitals (and perhaps specialists), but the decision to jump to such complicatedly to administer a system is procrastinated. The one thing that differs is whether there is competition between the insurers too, but even in the Czech case that provides for an insurer market, there are more similarities than differences. The insurers are heavily regulated and the market is hugely dominated by one player - the state fund VZP. This convergence is a relatively new phenomenon as it contradicts the trend noticed by McKee (1994) towards diverging solutions for common problems.

It is interesting to notice that the model to which the health systems of transition countries are converging is the one recommended by international bodies (especially World Bank) and bares strong resemblance to the actual German health service. The choice made by country after country could have something to do with each of these factors: the importance of consultants

from international organisations in the whole of the transition process, the high prestige enjoyed by Germany in all the countries of the region, as well as to what ‘objectively’ international experience seems to prove so far.

The derails of the reform process, best exemplified in the Czech case but also present in Hungary (Chellaraj, 1996), add evidence for the powerful role of economic incentives in shaping the mix of health services supplied to the population. The convergence track of health reforms and the problems experienced by a pioneer of change like the Czech Republic support a cautious approach to reforms, in order to avoid costly mistakes and to learn from the experience of the neighbouring countries. Finally, the Czech experience of correcting initial failures is also prove that any system can be made to work. In conclusion, the best lesson from the health adventures in CEE is that the process of change has to be well thought over and gradual, preserving the positive aspects of the socialist health care system and changing only those aspects that really need change.

Chapter 3: Reforming the Romanian Health Sector

3.1. Health Status

In the preceding chapter was mentioned that CEE countries had better health statistics than their GDP would have predicted. Romania is the exception from this point of view. Romanian health expenditure at about 3% of GDP was lower than in its neighbours. Life expectancy was also lower and infant mortality higher. Due to the natalist policies of the Ceausescu regime, abortions were all but illegal, what resulted in horrific mother mortality rates. Based on anecdotal evidence, in the late 1980s malnutrition cases were reappearing. Morbidity of communicable diseases was also higher - especially hepatitis (A and B) and tuberculosis. The main AIDS population were children, as result of infections through the medical act. However, cardiovascular diseases and cancer represent the main mortality cause.

3.2. Health Structure

The structure of the health care system was typical for the soviet model. The organisation of the healthcare was regulated mainly by Law 3/1978 on the assurance of health of the population, further amended by other laws and decrees. The health system had a centralised, hierarchical structure, in accordance with the whole political system. It was and still is almost entirely public, delivering ‘free’ medical care, except for the pharmaceutical sector. The finance was provided by

national taxes, through the budget. The public health care system was paid and managed by the Ministry of Health and its local structures, with three exceptions. The first exception is the existence of parallel systems operated by the Ministries of Transport, Interior, Defence and Labour, and by the secret service (after 1990 - Romanian Intelligence Service, SRI) and the State Secretariat for the Disabled. My main source of information, IHPHHMS 1997, did not find it possible to obtain reliable data on the (current) size of these parallel systems. The second exception is a small number of facilities - especially dispensaries - operated and paid by enterprises. The third exception is that the patients were faced with official and unofficial co-payments, that represent an important part of the income of facilities and staff. (IHPHHSM, 1997)

The Ministry of Health is responsible for the management of the main healthcare network, as well as for devising health policy (including public health) and for medical education. The ministry carries out its functions through its specialised directorates. The basic administrative unit in the organisation of the health services is the county (judet). It is led by the Director of the County Health Authorities, appointed by the Minister of Health (after 1990 with the agreement of the prefect - the local representative of the central government). The district is divided into territorial units having at least a territorial hospital, a polyclinic and a general practice network (territorial and school dispensaries). In every district there are also infants shelters. Some districts have sanatoria and preventoria. A certain number of over-specialised or single speciality hospitals, medical institutes and centres, institutions for the continuos training of doctors and nurses are directly subordinated to the Ministry of Health. (IHPHHSM, 1997)

3.3. Problems in the present health care system

Table 3.1. presents a summary of the shortcomings of the Romanian health system. The lack of adequate funding will be analysed in the next chapter (section 4.3) and the health status has been discussed above (section 3.1.). While some of the prevention programmes are performing well, e.g. children immunisation, others are not effective enough, especially health education and contraceptives provision. This failure is important because some poor health statistics are mainly explained by life-style factors (smoking, lack of physical exercise, unbalanced nutrition, risky sexual behaviour). Parallel health networks undermine the consistency of the health policy. Remote villages experience worse access to health services, and the situation was made worse by waiving the requirement for fresh graduates to spend a three year period in rural areas. (IHPHHSM, 1997)

Table 3.1. Bottlenecks and problems in Romanian health care

∗insufficient funding ⇒ especially low incentives for professionals ∗poor health indicators ∗inefficiencies:
⇒ emphasis on specialist care ⇒ high hospitalisation rates (but average length of stay) ⇒ surplus of hospital beds and low occupancy rates (but no staff surplus)
∗ insufficient quality assurance ∗ poor performance of some prevention programmes ∗ existence of parallel health care systems ∗ decreased access in rural areas ∗ unclear ownership of facilities

source: IHPHHSM, 1997

3.4. Objectives of reform

The main objective of reforms is to improve the health status through increasing the financial resources of the system, and reward the health personnel, improve efficiency, bring more flexibility and responsiveness to patient needs, develop primary care and public health and prevention measures. (IHPHHSM, 1997)

3.5. Evolution after 1989

Changes in the health sector advanced in Romania at a much slower path than in other CEE countries. The consequence is that there was not much change in the fundamentals of the health status. The good part of this immobilism is that the situation did not deteriorate as in other countries of the region.

Starting from 2.37% in 1989, resources dedicated to health fluctuated between 2.82 - 4.04% of GDP (Chellaraj, 1997). While the relative fluctuation seems high, it was on the background of a mainly negative economic context. The rise in share of the national wealth dedicated to health partly compensated the drop in output during the so-called 'period of transition'. According to the World Bank estimates, between 1990 - 1993, the expenditure on health declined 15% in real terms, compared with an over 20% decrease in GDP (Chellaraj, 1996). This trend of conserving real expenditure on health continued after 1993. The impact on health services of the drop in real expenditure was even lower because, against expectations, the share of wages in total health

expenditure declined (Chellaraj, 1996) - with the result that the average wage in the health sector dropped substantially below the national average wage.

The conservation in health services was also matched by constancy of important health statistics like life expectancy. The major positive change is the substantial drop in mother mortality following the liberalisation of abortions in 1990 - from 170 death / 100,000 live birth in 1989 to 60 in 1993. The reverse of the coin, is the upshot of (registered) abortions from 500 / 1000 live birth in 1989 to over 3000 in 1993 - Chellaraj, 1996; see appendix. In addition to the huge increase in abortions, another negative phenomenon from a public health point of view is the substantial increase in smoking (trend matched over the whole region).

The institutional change did not go very far. The private sector on December 31st, 1995 included 2 private hospitals and 56 private polyclinics. Most dentistry and pharmaceutical services have also been privatised (IHPHHSM, 1997). The most important reform was a pilot project started in 1994 and that eventually covered eight (out of forty-one) counties (*judet*). The experiment consisted in developing primary care, with *family doctors* paid by a weighted points combination of capitation adjusted for patient age (60%) and fee for service (40%). The value of the point is variable, e.g. decreases with the number of patients registered with an individual doctor (IHPHHMS, 1997). The family doctors have the role of gate keepers (NERA, 1998a). The scheme was dropped after the change in government following the 1996 parliamentary and presidential elections. However, the current reforms continue most of the elements of this pilot project.

The author had difficulties finding evaluations of the scheme. According NERA 1998a, citing studies of IHPHHMS and the London based Institute of Health Sector Development, patient and doctor satisfaction increased, and the system went some way to achieve its health targets. The number of polyclinic and hospital referrals decreased by a quarter and respectively a half. However hospital admissions and emergency departments attendance rates remained constant, and prescription increased 30%. In addition, NERA's own interviews found that general practitioners complained of the large amount of paper work, that in absence of computers was difficult to handle.

Chapter 4: Current Reforms

4.1. Legal basis

The basic right to health care is guaranteed by article 33 of the 1991 constitution. After a lengthy passage through the bi-cameral parliament, the Law of Social Health Insurance (LHSI) was promulgated by the president in July 1997 and came into effect on the 1st of January 1998. The system created by the new law will be implemented over a transition period, and is to be fully in place by 1st January 1999. Separate laws for the re-organisation of the hospital sector and for public health services are to be passed by Parliament at a later date (IHPHHSM, 1997).

The law institutes the health social insurance, financed by compulsory payroll based contributions. The system is administered by a decentralised network of regional health insurance funds, who contract the providers in the limits set by a national frame contract. The law gives the right for establishment of supplementary, volunteer private insurance. It guarantees the right of the patient to chose the provider at all levels and the insurer fund, but the general practitioner has the role of gate keeper. The national frame contract will also specify the basic package of services that has to be provided by each health fund. (LHSI, 1997)

4.2. Governance

The health system is decentralised. The payer become the county health insurance houses, who collect the social contributions from members. There will be 42 regional insurance houses (one for each of the 41 administrative counties, plus the insurance house of Bucharest, the capital, that accounts for 10% of the population). In addition to the regional health funds, there is the National Health Insurance House (NHIH), that administers the solidarity (i.e. redistribution) fund to which the county houses have to contribute. The administration council of the county health insurance house and of the National Health Insurance House have separately elected representatives of employees, self-employed, retired, house-wives, unemployed, students (art. 74).

The National Health Insurance House and the national College of Physicians negotiate the frame contract, with the agreement of the Ministry of Health (MoH) (art. 11.2). The frame contract provides the basic package of services provided and the reimbursement of providers. Within the limits set by the frame contract, regional health funds will contract the local providers (general practitioners, hospitals etc.). NHIH and the MoH decide annually the list of reimbursed drugs, with the agreement of the College of Physicians and the College of Pharmacists (art. 24.1). The big equipment purchases are approved by a national commission created by NHIH, MoH and the College of Physicians (art. 46.2). NHIH and the College of Physicians are in charge with controlling the quality of medical services (art. 83), and the accreditation of medical personnel (art. 38), and, together with others, in designing the preventive programmes (art. 16.3). The same two institutions create a paritary Commission of Arbitration, whose decisions are executory (art. 85 - 87). The area of responsibility is summarised in table 4.1.

The law does not specify the ownership of health facilities. According to IHPHHSM 1997, the ownership will be transferred from the ministry of health directly to providers, or as an intermediate stage to health authorities. What will be the legal status of a hospital for example is not clear for the author (non-profit foundation?).

Table 4.1. Responsibilities of institutions

Tasks	Ministry of Health	National Insurance House	College of Physicians
Framework Contract	X	X	X
Drug List	X	X	X
Approval of High Tech Medical Equipment	X	X	X
Health Care Programmes	X	X	X
Commissions of Arbitrage Quality of Services Surveillance Accreditation		X	X
Medical and dentistry services		X	X

X = Responsibility
Source: IHPHHMS, 1997

4.3. Reform of Finance

The sources of financing health services are payroll social insurance, the state budget and co-payments (LHSI, art. 51). The payroll contributions amounts to 7% of the gross wage paid by the insured and a matching of 7% of the total wage bill paid by the employer. The social contribution is deducted from the income, respective profit tax (art. 52, 53). Pensioners and the recipients of unemployment benefit pay from their benefits (art. 54). The contribution for the recipients of social aid is paid by the budget of social insurance (N.B. social insurance is separate from health social insurance) (art. 55). Some particular categories of expenses, the most important being capital investments, are paid by the national budget (art. 56). Co-payments apply mainly to drugs (art. 58).

These funds are collected to the regional health insurance fund, and 7% of their monthly revenues are transferred to the National Health Insurance House to form a solidarity fund, available to support those regional funds in financial difficulty (art. 59).

Even if the system is very new, there are already reports of difficulties for the health funds in collecting the payroll contributions, in conditions when the access to health services is still unrestricted (in spite of the implications of the law).

4.4. Primary Care

Currently, there are 12112 general practitioners in Romania, representing 30% of all physicians (IHPHHSM, 1997). Through the reforms initiated, general practitioners, called family doctors, receive the role of gate-keeper (art. 21.1) controlling through referrals the access to secondary care: hospitals (in-patient care) and specialists (out-patient departments). They will be contracted by the county health fund of the territory where they have the cabinet. In order to be eligible for contracting they have to be legally accredited and to be members of the College of Physicians. General practice receives a higher emphasis in the medical education, being up-graded to a speciality status - before the general practitioners were the non-specialist medical doctors.

The patient has the right to chose the family doctor and to change this choice after three months (art. 14.3). Primary care will be free at the point of delivery, and co-payments apply only to pharmaceutical products.

Concerning the payment, the law is vague: it mentions capitation and / or fee for service (art. 45a). Probably the system employed will be the one used in the pilot scheme: weighted combination of capitation (60%) together with fee for service (40%) for a group of prophylactic measures. Local authorities have the possibility to offer special inducements for medical personnel in under-served areas. Currently, a family doctor (in the pilot scheme) has 1000 - 1200 patients. If the number of patients rises to 1500 - 2000, then the value of point declines. (IHPHHSM). Table 4.2 presents the current age adjusted capitation point system.

Table 4.2. Age-weighted capitation payments

Age group	0-1	1-4	5-18	19-44	45-59	60 and older	Total
Points	14.5	10.5	8.5	4	8.5	12.5	x

Source: IHPHHSM, 1997

The main problem identified by IHPHHSM in the primary care sector is the lack of trained personnel for preventive activities and home aid. In addition, there is not a uniform coverage of the territory with GPs, with villages suffering heavily. One solution proposed by the institute is to waive the disincentive to GPs to have more than 1500 patients in the under-served areas.

4.5. Secondary and tertiary care

4.5.1. The specialist sector

One of the aims of the Romanian reforms is to shift the emphasis from the secondary to the primary care. Table 4.3 illustrates this shift. Concerning specialist care the reforms envisage the transformation of all specialist facilities in out-patient hospital departments, and changing the payment from salary to fee for service. To prevent this payment system resulting in supplier induced demand, access to specialist care will be restricted to referrals only and will incur a co-payment. It is also possible for the specialist to have to pay a fee to the hospital for using its equipment, in order to discourage over-referrals to hospitals (IHPHHSM, 1997). In the opinion of the author, very much depends on the value of the co-payment, because referral system per se is not a deterrent against over-use of specialist care: under capitation the GP is under pressure to

'please' the patient and referrals (and prescriptions) are one way to achieve this, especially that it might save time to the GP.

Table 4.3. Financial allocation to health care services

Kind of health care	now	future
1. Hospitals	50%	35%
2. Secondary care	30%	30%
3. Primary health care	20%	35%

Source: IHPHHSM, 1997

4.5.2. Hospital care

As presented in table 4.4., hospital care consumes most resources in the current system. Romania has a number of hospital beds relative to its population similar to that of western Europe (75 beds / 100,000 inhabitants), but higher admission rates: 22 admissions / 100 inhabitants (compared with 17 in average for EU) (IHPHHSM, 1997). In addition, as much as 20% admissions might be social rather than medical cases. There are also wide differences in occupancy ratios across the sector, territorywise and according to the type of medical department (ibid). The structure of the hospital sector is presented in table 4.4.

The over-use of hospital services is stimulated by the payment system. Currently, hospital are financed by budgets. These are construed on historical basis, are inflexible (the management is not allowed to shift money between departments), all the amount must be spent till the end of the respective financial year, and in order to conserve the level of the budget for next year, a 75% occupancy rate is required (ibid).

The staff is paid by fixed salaries, but could make additional income for overtime and night shifts. However, on anecdotal basis, the largest share of doctors' income comes from patient payments (ibid).

The reform steps envisaged are the introduction of flexible prospective global budgets and performance payment - IHPHHSM proposes for the longer term the use of DRGs (Diagnostic Related Groups), and for the high performance rare cases a lump sum and per diem payment for hospital financing; for physicians it envisages a combination of salary and performance payment (ibid). The law itself leaves all the options open: art. 45b provides for hospital financing 'fee per patient, per, day, per service'.

Privatisation of laboratory and pharmaceutical services and 'hotel' facilities is under consideration, as well as some transfer of ownership of hospitals away from the central government (towards local authorities or private owners). However, key hospitals will stay in state hands - they are defined as university hospitals and high performance central clinics. In order to control the number of admissions strict referrals (from GPs and specialists) will be used for non-emergency services (ibid).

Table 4.4. Hospitals in Romania

Kinds of hospital	*Number*
Districts	40
Municipals	85
City	160
Villages	54
Clinical	27
Others	46
Total	412

Source: IHPHHSM, 1997

4.6. Pharmaceuticals

4.6.1. Pre-reform status

There are a few elements worth noting about the pharmaceutical sector. First, it is the sector where privatisation went furthest. The retail sector is practically entirely private (90% according to IHPHHSM, 1997). Private capital made inroads in whole sales too (Cohen, 1996), but the former state monopoly still has a strong market position. The domestic manufacturers are up for sale this year[3]. This higher proportion of private capital in the sector means that it is more sensible to market forces, and therefore the state has less scope for administrative decisions and more for using economic incentives.

Second, Romania has the record (together with the Czech Republic) as the highest spender on drugs in CEE (calculated as a percentage of total health expenditure). While drug expenditure

stayed relatively stable over the transition years, its level at 40% of health expenditure is about double of the average for the countries of the region (see appendix). A large share of the drugs are provided by international producers. This partly explains the high proportion, by the fact that pharmaceuticals will be priced at international standards, while the other health services are paid for at the much lower levels of the domestic economy. In addition, the (slight) real reduction in total health expenditure over the years since 1989 has been partly compensated by a reduction in the personnel budget, what further enhanced the relative proportion of the drug bill. However, the very high proportion dedicated to the pharmaceutical expenditure, and the fact that much of it pays for imports, make this area of the health budget a priority target for cost-containment.

The previous system was based on a positive list of 420 ‘essential’ drugs. Drugs on the list were reimbursed 80% of the (producer) price, the rest being paid by the patient. The exception were children (below 16 years of age) and the chronically ill (IHPHHSM, 1997) for whom the reimbursement rate was 100%. Since the pharmacists were paid on a regression basis, they had the interest to substitute more expensive for cheaper drugs from the list (ibid). The lack of public funds lead to serious delays in reimbursing the pharmacist from the health budget for the price of ‘compensated’ drugs, what in turn lead to many pharmacies refusing to dispense drugs under the reimbursement scheme, and patients being forced to buy the drugs at the full price.

[3] The American based ICN expressed its interest.

4.6.2. Recent changes

IHPHHMS, 1997 recommended the introduction of fixed negotiated prices (without mentioning any criteria for negotiating the price). However, the government preferred to introduce the reference price system. This system was encouraged by the World Bank and was in accordance with emulating the German experience - the model for the Romanian health reform.

Reference pricing is actually provided for by the Law on Social Health Insurance, but the wording is very vague. In addition to reference pricing, the law also states that pharmacists have the obligation to dispense the cheapest product when only the active substance is indicated, and to inform the patient of the replacement options (art. 48). The main details of the scheme emerged only this spring, through a Government Decree (no. 206 / 30.03.1998). It adopted the model one of reference pricing - grouping according to the active substance. There have been designated 159 international non-proprietary names (INN), which in 1997 accounted for 32.5% of the total retail pharmaceutical market (interview with Adrian Caretu).

The clusters include both generics and patented drugs - even if it means that some INN classes contain just one drug. The reimbursement level was established at 80% of the reference price. The main exceptions are children up to 16 years old and the war veterans. Reimbursement prices are supposed to be revised once a year, but this was not systematically observed in the past. (ibid)

In addition to the reference price list, there is a separate list of fully reimbursed drugs. These are 132 INNs prescribed for very serious diseases (e.g. cancer, tuberculosis, diabetes, AIDS etc.).

Prices for domestic producers are regulated by the Office of Competition (from the Ministry of Finance) on a cost-plus basis, while foreign producers are allowed free pricing at entrance, but may not increase the price afterwards, and have to submit their prices in ten western countries for comparison. The hospital sector continues to fully reimburse the whole drug bill. Hospitals are supplied by tenders for INNs. (ibid)

The system of paying the pharmacists was preserved on a regression basis[4]. In addition to the cost-containment effects of reference prices, regional health authorities have the right to impose maximum prescribing monthly thresholds for physicians (both general practitioners and specialists) if they found it necessary for financial reasons. (ibid)

4.7. Next steps

As it was made clear in the preceding sections, much of the shape of the Romanian health system is yet to be designed. The Law on Social Health Insurance leaves many options open to those who are to implement it, and also new legislation is expected. Educated guesses can be made based on the previous reform attempts, and on the suggestions of an influential player like the Institute of Hygiene, Public Health and Health Services Management. However, they remain guesses, more so as the Institute is not infallible, as the rejection of its recommendations concerning drug reimbursement policies proves. Any evaluation of the Romanian health reforms has to take into account that it is still an open process.

The most important decision still to be taken is the composition of the basic package of health services to be offered by the health insurance funds. From the point of view of the system, the equally important decision is the formulae by which providers will be paid. Both these decisions are part of the national frame contract. For family doctors the scheme will most likely copy the one used in the pilot scheme. In the case of hospitals things are more uncertain, but a quick transition to DRGs seems to me unlikely, given the administrative capacity required, problem that stopped countries more advanced in reforms, like the Czech republic.

[4] 25% for a drug price of up to US$ 5.7, 18% for a price of US$ 5.7 - 11.5, and 12% over US$ 11.5 (interview with Adrian Caretu).

Chapter 5: Evaluating the Reforms

As I repeatedly mentioned across the paper, Romanian health reforms are still an undergoing process. I have tried to plug the holes and incorporate the most probable direction of the decisions that are still to be taken by using the Phare study of the Institute of Hygiene, Public Health and Health Services Management on the implementation of the new Law of Social Health Insurance. But these are still educated guesses and not certainties, and this must kept in mind when reading the analysis that follows.

However, even on the elements that are certain alone, the changes in the Romanian health sector fulfil the criteria I mentioned in chapter 2 as defining a reform process. The replacement of the soviet style state integrated system with social insurance, based on purchaser provider separation, is an important change and has big institutional implications. Moreover, the changes currently underway are introduced by a government with a clear democratic mandate, and follow in many respects the plans of the previous administration (that after 1996 forms the main opposition). Apart from the representatives of the electorate, the process involves the other main stake-holders of the health system, the health professionals, and therefore as far as can be predicted meets the political sustainability criterion too. As discussed in the section on macro-efficiency, there is not to be expected that the changes will prove financially unbearable either.

Once established that we deal with a genuine reform process, I shall further on evaluate its likely consequences from the perspective of the four objectives of health policy, discussed in chapters 1 and 2: cost, micro-efficiency, choice and equity.

5.1. Macro-efficiency

Unlike the established health systems of Western Europe and US, the challenge facing the Romanian healthcare is under-funding rather than spending too high a proportion of the national wealth. The health expenditure between 2.8 - 4% of GDP during the transition years, is less than half of what is spend in the developed world (around 9% in Germany - the model of Romanian reforms, or 13% in US). It is also less than in the neighbouring countries of Central and Eastern Europe, but according to the World Bank is consistent with what is to be expected at the current level of economic development of Romania (Chellaraj, 1996). However, behind the introduction of social insurance, in anything but name a hypothecated health tax, was the idea of solving the perceived under-funding of the sector.

The pressure in this direction has also to do with the changes in the Romanian society in the transition period. State employees from non-industrial (in communist parlance ‘non-productive’) sectors have seen their relative incomes eroded during these years. This trend was accentuated in healthcare due to the strategy to try to conserve the real level of health services during years of declining real expenditure (due to drops in GDP) by reducing the share going to personnel. The result is that the wages in the health sector are now below the national average, actually are the

lowest average wages in the whole economy. This compares with the situation before 1989 when doctors were at least perceived as the best earning category[5]. One of the declared objectives of the reforms in the health sector was to address this situation and increase the incomes of medical professionals (especially doctors). The family doctors pilot scheme actually achieved the doubling of the incomes for GPs (NERA, 1998).

How much social insurance will meet this end is debatable. It will collect 7% of the pre-tax wage of the employees and another 7% of the employer's wage bill, what together account for up to 14% of the pre-tax personal income of earners[6]. In addition, the pensioners pay 7% of their income and the budget (state or social insurance) pays for under-aged and the unemployed. The author did not have access to an estimate, but in a country with a low investment rate like Romania this share of personal incomes must account for considerably more than 4% of GDP.

The problem however is how much of this due amount will actually be collected. One of the vulnerable spots of social insurance is the collection of contributions from the self-employed - the other CEE countries had encountered this problem too, case documented for the Czech Republic (Mullen, 1998). In addition, there are social categories whose income is difficult to estimate in monetary terms - as is the case with farmers. While all this is true, it is also true that these social categories that do not pay enough for social insurance would not have paid their income taxes either, so overall the transition to social insurance does not mean less resources. However, the situation in Romania is critical at the time of writing. According to newspaper

[5] A word of warning: this was due not to the official wages, but to the direct patient payments, which continue today and are not included in the wage statistics.

reports, the Romanian health funds had difficulties receiving contributions including from state companies. The situation was made worse, from a financial perspective, by the fact that hospitals continued to provide 'free' care, without asking for evidence of payment of contributions (Evenimentul Zilei, 8th August, 1998). While the Romanian government have had difficulties in collecting taxes and this had repercussions on health funding - e.g. the lateness of drug reimbursements to pharmacists - matters might have been made worse by the change to social insurance. It is conceivable that economic agents consider less dangerous to delay payments to health funds, what bears as maximum consequence that their employees will no longer have health coverage, than do break the law by not paying taxes to the treasury, and thus risk fines and theoretically even prison.

The second (and opposite) macro-efficiency risk is that the incentives for individual practitioners or patients will result in an over-shooting of health expenditure. As mentioned in chapter 2, this was the case in the Czech Republic. This is less likely in Romania. Unlike in the Czech reforms, there is no competitive insurance to start with. Also, capitation payment for GPs and prospective budgets for hospitals are adequate tools for controlling expenditure. In addition, the disincentive for GPs to have a very large number of patients reduces the competition, and therefore the risk of over-referrals, as a mean for 'pleasing' patients.

[6] A correction is needed for self-employed whose 7% contribution is not matched by a contribution from an employer.

5.2. Micro-efficiency

The same tools that are useful for reducing the macro-efficiency risk, by reducing competition, might reduce micro-efficiency in the same time. Le Grand in Robinson (1994), developed the conditions that would allow quasi-markets to approximate the efficiency of competitive markets - these conditions refer to: market structure, information, transaction costs and uncertainty, motivation and cream-skimming. In an environment with little competition like that provided by the Romanian reforms, cream-skimming and transaction costs are not likely to create problems. The market structure is represented by two local monopolies: the health fund and the association of physicians. Opposing monopolies satisfy Le Grand's criterion for quasi-markets, but, for reasons to be detailed in the next section, the author does not expect the health funds to be motivated to behave like perfect agents of the patient community. The market structure is further vitiated by the high entry costs (legal monopoly of the physician association) while forced exit (i.e. bankruptcy) is not a likely alternative. Finally, if the health funds are captured by the providers, this will also vitiate the price-setting process, and with this the market information.

5.3. Choice and responsiveness

In theory the Romanian system assures the cherished freedom of choice of both provider and insurer. But since the health funds are in practice regional monopolies, the choice of insurer does not exist, except perhaps in a restricted way for people leaving close to the neighbouring county. With the restriction of insurer comes the restriction of provider to those contracted by the

respective insurer. While the choice is relatively wide concerning primary care practitioners, it narrows considerably when dealing with specialised care, especially hospital care. Perhaps more important than this is the fact that providers have limited room to differentiate one from another. They cannot compete on either price or the range of services, because these are stipulated in the national frame contract. The only thing left is, the otherwise important, quality of care.

The mechanism left open to the patients for adapting the system to their (perceived) needs is the democratic vote. This is not the place to discuss the democratic failure literature, but it is easy to be sceptical about the practical value of this mechanism. The most important features of the system are provided through the frame contract, decided nationally - this reduces very much the power of the individual patient. The representative mechanism is designed on corporatist basis, what diminishes its democratic character and makes it more obscure. More important, the elections for the boards of the health funds are separate from other elections and the corporatist basis preclude the direct transfer of party loyalties to this vote. In this conditions is difficult to see how the candidates could have access to the political infrastructure that would allow them to really communicate to the electorate. It is much more likely that the whole negotiation process will be captured by providers (i.e. medical doctors). Actually, the technical difficulty of organising these elections motivated the decision of the Health Minister to cancel them and instead nominate the boards for the first term, ending a democratic pretence.

5.4. Equity

Notwithstanding the reservations I expressed in the first chapter concerning the use of a such a value-loaded concept like equity, in the following discussion I shall use the more generous definition of equity as *equal care for equal need* (i.e. without concern for the ability to pay).

Romania, similar to the other former socialist states, started the post-communist transition with a good record on equity (Ensor, 1993) and some authors are afraid that the introduction of social security might lead to exclusions from coverage. I find little support for these fears. First, the social insurance system, in spite of its name, is a tax-like system, and therefore leads to redistribution. Second, the law provides for state support for the more vulnerable categories: the unemployed, children, the very poor. Finally, the experience so far is that the ethos of the health system is rather equalitarian, and hospitals continued to provide care without asking for proof of payment of the contributions.

The real equity challenge for the system is the geographic distribution of services. As I mentioned earlier, this was a problem in the communist regime too, and the situation in rural areas worsened after 1989 when young doctors were no longer forced to work for the first three years in a village. The social security system currently being implemented was designed with a regional focus. While this will not affect the rural / urban divide, it might have consequences for the quality of care across counties. In Romania there are large geographic income inequalities, with the western counties (i.e. most of Transilvania) and Bucharest substantially richer than the eastern part (i.e. Moldova). For exemplification, Bucharest, with 10% of population, accounts for

30% of GDP. The 7% redistribution level provided by the law will probably not suffice to overcome the inequality in resources that is built in a payroll based system. To continue the exemplification, public expenditure (not counting the wages of central government employees) in Bucharest represents only one third of the taxes paid by the city, what represents a much higher level of current redistribution.

Conclusion

Romanian healthcare reforms follow the convergence track with the other Central East European countries. The soviet style health system is replaced with payroll based social insurance, capitation for GPs and prospective budgets for hospitals become the main payment schemes for providers, and the reimbursement of drugs is based on reference pricing. As far as we can tell at this moment, within this track the less controversial alternatives are being chosen - e.g. type one of reference pricing for drugs. Crucial, the current reforms deal at arms length with market mechanisms: they shy away from competition in the insurance market, and the competition between providers is tightly regulated. These choices confirm the cautiousness that characterised the whole approach to reform and allow Romanians to avoid the worst mistakes made in neighbouring countries, as exemplified by the Czech Republic.

The current reforms represent an improvement over the previous institutional set-up. Social insurance will improve the under-funding of the system, therefore ameliorating the macro-efficiency parameter. The question mark in this respect is the ability of the health funds to enforce the collection of the social contributions. The paper did not find evidence to support the claim that the introduction of social insurance will damage the good record on equity inherited from the communist health system, by limiting the coverage of medical assistance. The danger is however that the regionalisation of healthcare will increase the geographic inequalities in the distribution of health services, that already existed in the previous regime.

The cautious and market-sceptic approach that makes us expect a relatively good performance on the macro-efficiency and equity criteria, leads the system to fare worse on the other two objectives of health policy: micro-efficiency and choice. Without competition between the insurance funds, with no possibility for the providers to compete on either price or the type of services provided, the market structure is vitiated and the choice for patients drastically reduced. The compensatory mechanism envisaged by the designers of the system is to replace the freedom to chose in the market with the democratic vote for the boards of the health funds. Given the inherent limitations of the democratic process, augmented by a cumbersome corporatist mechanism, the author is sceptic over the efficiency of this tool. The likely outcome is that the health funds will be captured by the providers (i.e. health professionals) they are supposed to negotiate with, what will maintain the provider-focused and paternalist nature of the Romanian health system.

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