Administrative Capacity for Acquis Implementation Case Study in Health Social Insurance

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1. EXECUTIVE SUMMARY

Romania officially opened the Accession negotiations in February 2000. New challenges have to be surmounted, as Romania has to assume entirely the membership requirements. This relates above all to the adoption of the whole body of European law, known as the "acquis communautaire", and the administrative and institutional capacity to implement those legal provisions.

Social acquis, i.e. legally-binding norms in the social policy area, is closely intertwined with the free movement of workers and aims at insuring an adequate social protection, improving the living and working condition, promoting high level of employment, and developing human resources and social dialogue[2]. In addition, a series of Council resolutions and recommendations, Commission communications, Green and White Paper are integrated into the acquis.

Romania is committed to adopt the acquis communautaire related to the free movement of workers and on social policy and employment without any transition period or derogation. Romania has unilaterally assumed the date of January 1, 2007 as a working hypothesis for concluding the preparation for accession to the European Union.

The Position Paper of the Romanian Government on "Social Policy and Employment" (Chapter 13) has been officially submitted to the European Commission in June 2001, and the negotiations lasted till April 2002 when the chapter was provisionally closed. Negotiations related to the second chapter of the acquis opened under the Spanish Presidency of the European Union.

This paper includes an integrated overview and analysis of the Romanian Government strategy related to the health social insurance reform according to EU requirements. The paper is organized on three chapters. *Health reform* section presents the main actors of system and their respective roles and responsibilities and identifies as the main challenge facing the health system the introduction of hard budget constrains in hospitals. The governance failings of the Romanian health system, namely the delimitation of competencies between the Ministry of Health and Family and the National Health Insurance House, are also dealt with.

The second section *Implementation of the acquis* presents the main actors that have to deal with the implementation of the health aspects of regulations 1408 / 71 and 574 / 72, the National Health Insurance House (NHIH) and the Ministry of Health and Family (MHF). In order to evaluate the administrative capacity problems that might hinder the implementation of the acquis I present an overview of the two institutions, focused on their respective structures dealing with European integration issues, and the institutional problems

The final section summarizes the arguments, and identifies the major issues, structured around four counts: the compatibility of the Romanian health system with the European model; the implementation of the relevant acquis; administrative capacity; and sustainability of the health system.

Methodology

To prepare the policy report an investigation was conducted in five Romanian public institutions with direct relevance for the research topic the compatibility between the Romanian social insurance system and EU norms. The initial legislative analysis identified the following line ministries and agencies with specific attribution in the field of health social protection: Ministry of Labour and Social Solidarity, Ministry of Health and Family, National Health Insurance House, Ministry of Public Finance and Economic and Social Council.

To assess their activities related to the European Integration and the policy reform in-depth interviews were conducted, both with high-ranking public functionaries within the above institutions and with Romanian experts working closely with international organizations in Romania such as World Bank. The core of the interviews was designed around social security system co-ordination and modernization issues.

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[2] Article 136 (ex article 117) of Treaty of Rome, consolidated version

Two "Interest group" meetings were held during the relevant period[3] in order to provide the necessary feedback. High-level public functionaries and elected official were part of these groups. Their comments, observations were also taken into account in the final report.

Relevant official documents (strategies, programming documents) published by the Romanian Government presented a road map of reform. European Commission documents (green paper, communication, reports) posted on the European Union website gave an insight into recent developments in the filed of health care and of future reforms envisaged.

Several sources were used for statistical data. General statistics were obtained from Statistical Yearbook published annually by the National Institute for Statistics and Economic Studies. Ministries and agencies involved - Ministry of Labour and Social Solidarity and the Ministry of Health and Family, and National House for Heath Insurance - made specific and detailed data available. International sources, such as the United Nations Development Programme, International Labour Organization, World Bank, and International Monetary Fund provided additional date for comparison.

To facilitate the debate on different social insurance reform options, a set of criteria aiming to indicate the core elements of a EU conform reform proposal have been designed. The criteria employed and proposed to policymakers to be taken into consideration when assessing different reform proposals are:

- Financial sustainability and how the reform proposal would affect economy and the health social insurance budget.
- Feasibility of implementation and administration.

2. HEALTH REFORM

Changes in the health sector advanced in Romania at a much slower path than in other CEEC. The first major change has been the privatisation. This progressed further in dentistry that was largely privatised. The pharmaceutical sector has also changed hands, at all levels: retailing is completely private, wholesale has been mostly privatised, and private capital made in-roads in manufacturing too.

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 was variable, e.g. decreased with the number of patients registered with an individual doctor. The family doctors have the role of gatekeepers. The scheme was dropped after the change in government following the 1996 parliamentary and presidential elections. However, the social insurance reforms continue most of the elements of this pilot project.

Following the pilot scheme, patient and doctor satisfaction increased, and the system went some way to achieve its 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, general practitioners complained of the large amount of paper work that in absence of computers was difficult to handle.

Social insurance

After a lengthy passage through the bi-cameral parliament, the Law of Social Health Insurance (LASS) 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 was implemented over a transition period, and came fully in place by 1st January 1999. Separate laws for the re-organisation of the hospital sector, public health services, and the regulation of the medical profession have been passed by Parliament at a later date.

LASS instituted the health social insurance, financed by compulsory payroll based contributions. The system is administered by a decentralised network of regional health insurance funds, which contract the providers in the limits set by a national frame contract. The law gives the right for establishment of supplementary, volunteer private insurance, which was one of the priorities established by the new government in 2001. LASS guarantees the right of the patient to choose the provider at all levels and the insurer fund, but the general practitioner has the role of gatekeeper. The yearly national frame contract specifies the basic package of services that has to be provided by each health fund.

[3] October 2001 – May 2002

Governance

The health system is decentralised. The payer became the county health insurance houses (CHIH), which collect the social contributions from members. There are 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 boards of the county health insurance house and of the National Health Insurance House are nominated by the social partners (trade unions and pensioners, employer associations, and county, respective national government). Recent changes have reduced the power of the administration boards to a consultative role, in favour of the appointed CHIH general manager.

The National Health Insurance House and the National College of Physicians negotiate the frame contract, with the agreement of the Ministry of Health and Family (MHF). The frame contract is then enacted as a Government Ordinance. 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 MHF decide annually the list of reimbursed drugs, with the agreement of the College of Physicians and after consultation with the College of Pharmacists. A national commission created by NHIH, MHF and the College of Physicians approves the big equipment purchases. NHIH and the College of Physicians are in charge with controlling the quality of medical services, and the accreditation of medical personnel, and, together with others, in designing the preventive programmes. The same two institutions create a paritary Commission of Arbitration, whose decisions are executory. The area of responsibility is summarised in table 1.

Table 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: Institute for Health Services Management, 1997

Funding

The sources of financing health services are payroll social insurance, the state budget and co-payments. The payroll contributions amount 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 was deducted from the income, respective profit tax. Pensioners and the recipients of unemployment benefit pay the 7% contribution from their benefits. 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). Some particular categories of expenses, the most important being capital investments, are paid by the Ministry of Health and Family, from the national budget. Local government may pay for maintenance costs. Co-payments apply mainly to drugs, but the government plans to expand their role.

The social contributions are collected to the regional health insurance fund, and 25% of their monthly revenues are transferred to the National Health Insurance House to form the solidarity fund. The regional health funds apply for these funds to the national one.

The health funds have succeeded a relatively good collection performance. Each year the amounts collected have surpassed the initial projections. While this has to do with higher than projected inflation rates (that increase nominal wages, and therefore the nominal value of the collected funds), other factors have played a role, too. The relative low value of the health contribution (14% of wage) made compliance more tempting for economic agents (in comparison with the 35% pension and other social benefits contribution). The presence of the social partners (especially of trade union representatives) in the managing boards of the regional funds has also improved the collection from large state companies (the main debtors to the pension fund).

The main challenge on the revenue side have been the constraints imposed by the Ministry of Public Finance, which regularly forbade the health funds to spend the whole amounts collected. Another risk that is worth mentioning here is the failure so far to connect the access to services with the payment of the contribution. In spite of the implications of the law, the access to health services remains practically unrestricted, what discourages compliance. The government stated in 2002 it is going to tackle this situation, but results are still awaited.

Primary care

Through the reforms initiated, general practitioners (GPs), called family doctors, receive the role of gate-keeper, controlling through referrals the access to more advance care: hospitals (in-patient care) and specialists (out-patient departments). They are 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 choose the family doctor and to change this choice after three months. Primary care is free at the point of delivery, and co-payments apply only to pharmaceutical products.

There are about 11,800 GPs, most of them in private practice. The payment system employed is a combination point system of weighted capitation (children and elderly ‘valuing’ more), together with fee for service for a group of prophylactic measures, and a lump sum medical practice budget. Local authorities have the possibility to offer special inducements for medical personnel in under-served areas. A family doctor has up to 1500 patients, above this threshold the per capita fee is decreasing.

The main problem 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 alternative is to waive the disincentive to GPs to have more than 1500 patients in the under-served areas. As we shall further, the role of GPs as gatekeepers is rather lax, and many patients still by-pass them. This situation is not helped by the GPs lacking equipment and many times training, what sends to the patient the message that the family doctor is only an intermediary of little use.

Secondary and tertiary care

Specialist care is provided in outpatient and diagnostic centres, mostly publicly owned. One of the aims of the Romanian reforms is to shift the emphasis from the secondary to the primary care. In order to achieve this, access to secondary care is, at least theoretically, restricted to referrals by GPs. Patients have however the right to chose the specialist whose advice they are seeking. The payment method is fee for service, and co-payments are envisaged.

Hospital care has been consuming most of the resources of Romanian healthcare. There are estimates that as much as 20% of admissions might be social rather than medical cases. The over-use of hospital services is stimulated by the payment system. Currently, hospitals are financed from CHIH by budgets. These are built according to a set of utilisation criteria (number of admissions, average cost/day hospitalisation, average duration of hospitalisation) 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. In addition, maintenance costs are covered by the local government, and capital investments (e.g. equipment purchase) by the MHF. The new government draft law on hospitals would allow hospitals restricted access to loans or the use of CHIH receipts to cover capital expenses.

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.

Pharmaceuticals

There are a few elements worth noting about the pharmaceutical sector. First, it is the sector where privatisation went furthest. Both the wholesale and retail sectors are practically entirely private. The largest domestic manufacturers have been or are soon expected to be privatised. 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 used to hold the record (together with the Czech Republic) as the highest spender on drugs in CEEC (calculated as a percentage of total health expenditure). This situation has however changed over the last years. However, the 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.

Finally, the availability of reimbursed drugs is also a key political issue. The lack of public funds leads to serious delays in reimbursing the pharmacist from the health budget for the price of 'compensated' drugs, what in turn results in many pharmacies refusing to dispense drugs under the reimbursement scheme, and patients being forced to buy the drugs at the full price. The government has intervened by restricting the number of pharmacists allowed to dispense compensated drugs.

In the hospital sector, the access to drugs is, again at least theoretically, free for the patient. The drugs are acquired by the hospital, through tender processes, and paid for with money from CHIH. There is under consideration the creation of a nation-wide drug-purchasing programme.

In the outpatient sector, different sets of rules apply. There is a positive list of drugs for 26 serious conditions, for which the access is free for the patient, and the funding is provided by the national health programmes (see below). For the other conditions, there is a list of 256 INN (international non-proprietary name) for which the reference price system (variant 1) applies. Here CHIH reimburses 70% of the reference price, the difference to the full price being paid by the patient. For all the other drugs, the payment is out of pocket.

Role of the ministry of health

By the creation of the National Health Insurance Fund, the Ministry of Health and Family has lost most of its management functions. It retains however the important regulatory function. In addition, it manages the 'National Health Programmes', representing about 20% of the public health expenditure. National Health Programmes are somewhat connected to the World Health Organisation (WHO) championed Health Targets concept, but are more priority setting rather than establishing measurable objectives to meet.

Institutional problems

There are two major institutional design problems affecting the Romanian health system. The first concerns the non-competitive nature of the health funds, which are regional monopolies, further restricted by national regulation (i.e. national frame contract). This results in a lack of incentives for regional funds behaving like selective purchasers. This argument and possible mitigating solutions are developed in the next session.

The second unresolved matter is the division of labour between the system of health funds and the government, represented mainly by the Ministry of Health and Family. The current situation practically puts the National Health Insurance House on equal footing with the Ministry – at least in protocol terms the President of NHIH ranks as a full Secretary of State. However, NHIH lacks the right to initiate legislation, and the MoH jealously guards its prerogative of sole responsible for health policy, even if much of this policy has to be implemented by the health providers under contract with the health funds.

Actually, the initial version of LASS was going in effect to create a 'local health government', with the boards of the health funds being directly elected on a corporatist basis, and independent finance through the 7 + 7 % health tax.

The direct elections have been 'temporarily' replaced by nomination of board members by the social partners. The government faces now the decision whether to allow the initial election mechanism to go through, or to make the temporary nomination mechanism permanent. Moreover, repeated changes to the law have consolidated the role of the NHIH versus the county ones, and have eroded the power of the boards in favour of the appointed general managers. The role of redistribution has increased – initially only 7%, instead of the current 25%, of the revenues at the county level were supposed to be transferred to the National House. In addition, the Ministry of Public Finance has encroached on the financial independence of the health funds by restricting the amount of their revenues they can actually spend. We are in the rather strange situation were there is unspent revenue of the health funds, while the debts in the health system are piling up. Finally, the Ministry of Labour and Social Solidarity is considering the unification of the health and pension funds.

The current situation is a stand-off between the NHIH and the government. It is not conducive to good policy outputs, and is unlikely to resist. Anecdotic evidence suggests the relationship between the staff of the NHIH and the MHF is rather uncooperative. This lack of cooperation hinders the development of health policy, as we discovered in the case of EU integration efforts.

The House would like more autonomy, and direct accountability to Parliament instead of to the Government. The Ministry would rather subordinate the House, much on the model of the National House for Pensions and Other Social Insurance Rights which has been re-integrated in the Ministry of Labour and Social Solidarity. It is worth reminding that the Romanian LASS was closely modelled from the Hungarian law. The Hungarian system evolved towards increased centralisation: the elections for the boards have been replaced by nominations, and the supposedly independent National Health Fund was integrated in the Ministry of Public Finance, and then subordinated to the Prime Minister Office.

Current developments: incentive misalignments

The root of the problem springs from the lack of adequate institutional incentives for cost-containment at the hospital level. The hospital sector is very powerful politically, as it comprises the elite of the medical profession. The matter is made worse by the fact that members of these elite form the decision-makers at all levels of the health system: health managers, Ministry of Health and Family, health funds, medical college, and most of the politicians dealing with health.

The lack of competition between health funds (which are regional monopolies, and therefore do not have to compete for clients) creates an institutional set-up where there is no incentive for the health fund to take on these powerful interest groups and enforce hard budget constrains upon hospitals. The dominant strategy is an alliance of the purchaser with the provider to pass the costs to the budget.

In addition, the autonomy of hospital managers is limited, what precludes even the restructuring measures intended by the public-spirited managers. Moreover, the only instrument for motivating managers is the rather gross firing threat, while no incentive plans are available.

Reform plans of the government

The leadership in the MHF has identified the reform of the hospital sector as a priority. It is less clear however whether the decision-makers understand the mechanisms that led to the current predicament, and if yes how are the policies that have been announced going to mitigate the situation.

The main initiatives consist of changing the funding system to DRG (diagnosis groups), and partial privatisation. Theoretically, basing the funding on the case-mix rather than on actual costs would encourage hospitals to be more efficient. The problem is that DRG per se could lead to more efficient interventions, but not necessarily result in overall cost reduction. More important, the full implementation of DRG is a very complicated process, which is going to take years. That is proven by the experience in Hungary, the first country in the area to use this method. Therefore whatever benefits it will bring, DRG is not going to be a solution in the short term. These matters are going to be settled soon, as starting this year the DRG system has been introduced experimentally in a number of hospitals.

Privatisation is a trickier matter. Whether this means outsourcing of some services, or even privatisation of 'hotel' services, it will improve efficiency. Partial privatisation of hotel facilities however bears the risk of part of the costs of these private facilities being passed to the public section of the hospital. A much better alternative would be outright privatisation of whole hospitals (or creating new private hospitals out of scratch).

While both policies have things to be commended for, they fail to address the cost containment of hospital expenditure and the looming crises in the primary care and pharmaceuticals.

A new hospital bill

The current hospital bill is more remarkable through the maters it fails to settle than for any consistent reform. As a sign of the perceived urgency of the hospital sector crisis, the Parliament is faced with two new drafts of the hospital bill. One is coming from the Ministry of Health and Family, and the other is put forward by the College of Physicians (the professional body). The two drafts have many similarities. The main innovation brought by the government is to increase the financial autonomy of the hospital, by allowing it to borrow up to 15% of the contracted income, with the condition that the overall debt level is no larger than 20% of the yearly budget. The College of Physicians goes a step further by allowing depreciation to be counted as a cost.

However, both drafts fail to address some fundamental issues:

- *hospital ownership*

The alternatives are to transfer them to local government, or even better to grant them the status of autonomous not-for- profit organisations

- *financial autonomy*

In spite of the welcome permission to borrow, the hospital management will continue to be construed, and more important to lack incentives for full financial accountability. The drafts would preserve the situation where the management has no incentive to economise on non-operational costs, which are provided on discretionary basis by the national or local government (equipment purchase, and building development are funded from the central budget, while maintenance costs could be provided by the local government). This contrasts which the situation of the operational costs covered by the County Health Insurance House, according to the National Frame Contact, and which bare some relationship with performance (i.e. utilization) indicators.

The effects of the envisaged strengthened control over the management ability to accumulate back-payments are unlikely to have much effect unless the incentive structure is changed.

Conclusions

The hospital expenditure is out of control, and is squeezing out the resources for pharmaceutical products and for primary care. In spite of improved overall funding for health and no increase in utilization rates, hospitals consume an even larger share of health resources. Romania, despite its low wages, is in the paradoxical situation of allocating to hospitals a larger share of public health resources than OECD countries. This situation presents obvious social and political risks. In addition, it undermines the role of primary care as the champion of reform.

The initiatives of the government concerning the hospital sector fail to address the cost-containment problem. While the shift to case mix funding and privatisation are commendable it their own right, their effects will not be seen for years to come. Partial privatisation (as opposed to full privatisation) might even worsen the situation.

The new drafts for the hospital bill increase the financial flexibility of the management. The inclusion of depreciation costs in the balance sheet, proposed by the College of Physicians, is especially welcome. However, they do not go far enough:

- the ability to fund investments is constraint by the limits on borrowing
- no motivation factors for managers are introduced; in contrast, exclusive reliance is placed on administrative controls;
- in addition, the ownership issue is not solved.

The non-competitive nature of the Romanian social health insurance funds is always going to create incentives problems. They can be however partly mitigated by:

- clarifying the ownership of hospitals, by transferring them to the local government, or better by establishing them as independent charities
- creating the incentive for managers to allocate efficient all expenses, by funding capital and operational expenses according to the same mechanism (e.g. from the Health Insurance Fund)
- devising incentive plans for hospitals managers that reward good performance.

3. IMPLEMENTATION OF THE ACQUIS

The acquis relevant for the health sector is represented mainly by Chapter 13 –Social Policy and Employment, and Chapter 23 – Consumer and Health Protection. However, these chapters deal with public health and safety at work measures that have little bearing on social security arrangements, the topic of this study. The health relevant legislative tables of Chapters 13 and 23 are annexed. The only chapter that deals directly with health social security issues is chapter 2 – free movement of people. Again the relevant components of the legislative timetable are annexed.

There are a number of other issues that bear relation to the provision of health services. It is the case of internal market regulations (i.e. competition regulation) concerning non-discrimination between domestic and community companies in public procurement – relevant for preferential treatment for domestic producers in the case of registration of, and tenders for pharmaceutical products (i.e. Romanian manufacturers are not required the GMP standard). Also patent protection is not fully harmonized with EU rules (in what concerns the supplementary protection certificate - SPC).

Further on I shall discuss only the implementation of the regulations 1408 / 71, and 574 / 72 that provide for the compatibility of social security schemes in order to facilitate the free movement of people – the hard core of the acquis on health social insurance.

The main actors that have to deal with the implementation of the health aspects of regulations 1408 / 71 and 574 / 72 are the National Health Insurance House (NHIH) and the Ministry of Health and Family (MHF). In order to evaluate the administrative capacity problems that might hinder the implementation of the acquis I present an overview of the two institutions, focused on their respective structures dealing with European integration issues.

European integration and the National Health Insurance House - Legal base, resources and organizational structure

The activity of NHIH is based on the Health Insurance Law 145/1997, successively amended by the Emergency Ordinances 30/1998, 72/1998, 170/1999, 180/2000, on the Hospitals Law 146/1999 and the National Frame Contract of each year. The document that settles the organization and the functioning of NHIH is the Statute of NHIH, elaborated in 2001. At local level, each NHIH elaborates its own statutes, according to the national legislation and the provisions of NHIH.

At central level, the main decisional structure is the board of NHIH, and the main executives responsibilities belong to the president of NHIH, who is also the president of the.

The funding of NHIH and CHIH is ensured from the Social Health Insurance Fund, part of the State Social and Health Insurance Budget, which is separate from the State Budget, both of them being sent for parliamentary approval by the Government.

There has been no evaluation of the needs of NHIH related to the process of European integration, and no budgeting of these needs. This fact makes it difficult, if not impossible, to schedule actions like training programmes for employees or building a database on EU integration related documents – e.g. an EU legislative library, a collection of studies of impact, and assessments of needs and costs of European integration in the health insurance field.

There are two structures in charge with the foreign relations of National Health Insurance House (NHIH): the Service for European Integration (SEI) and the International Relations and International Cooperation Programs Direction (IRICPD). The structure of NHIH at central level presents two particularities, which question the efficiency of the organization of the institution.

a. A clear separations of the two departments. If SEI reports directly to the president of NHIH, the IRICPD is accountable, together with, for instance, the PR and Marketing Direction, to the Logistics General Deputy Director – a more marginal position.

b. The difference in stature. As it might be noticed from their names, the two structures have different importance – the first is only a *service*, witch result in a scheme of personnel of only five persons, while the second, being *direction,* has 13 persons, including a director. That leads to different budgets for the two structures. The funding for each of the structures is made accordingly to the personnel scheme, with no others supplementary funds. It can be inferred there is a real difference between the two structures in terms of power and responsibilities.

The orientation of the NHIH to the outside, the priority that is given to foreign relations seems to be, judging from the organizational scheme, rather low. Moreover, while Romania is expected to join EU within the next ten years, and accordingly the relations with EU are going to become the main focus of its international activity, the importance given to SEI is not commensurate.

The health social insurance system is relatively decentralized, with the District Health Insurance Houses (CHIH) discharging important functions. CNAS establishes and manages the policy and the general strategy within the social insurance system however.

It is therefore surprising there is no direct connection established between SEI and CHIH. SEI has no counterparts in the counties, no formal direction or service is within the organizational chart of CHIH. We have to bear in mind that SEI is a service – therefore with limited administration power and resources.

The Service for European Integration

The Service for European Integration is directly subordinate to the president of NHIH.
SEI has a double role:

- consulting and analyses, upon request, on integration issues relevant for NHIH;

- drafting and monitoring the implementation of the undertakings of NHIH in the negotiating chapters in which the House is involved (SEI was responsible for the elaboration of point 7 from the *Position paper for Chapter 2 of negotiations of accession of Romania to the European Union – Coordination of social security schemes*).

The reduced prerogatives of SIE mean that the general or sector policies of NHIH which might contravene to EU requirements in this field cannot be identified timely. SEI is making part both of an internal working group (which includes representatives of Judicial Direction, IRICPD, and Evaluation, Incomes and Costs Direction), and of the inter-ministerial working group for chapter 2 of negotiations. The inter-ministerial working group was set up by government decision in 2001, and the coordinating ministries are Ministry of European Integration and the Ministry of Labour and Social Solidarity. Participants in the group are the representatives of the ministries and governmental agencies of Labour (MLSS), European Integration (MEI), Health (MHF), Education (MER), Justice (MJ), Finance (MPF), Foreign Affairs (MFA), Home Affairs (MI), Small and Medium Size Enterprises (MSMEC), Industry (MIR), State Secretariat for the Persons with Disabilities (SSPH), National House of Pension and Other Social Insurance Rights (NHPSIR), Agriculture (MAAP), National Sanitary Veterinary Agency (ANSV), Public Works (MPWTH), Economic and Social Council (ESC), National Agency for Child Protection (ANPC) and National Agency for Employment (NAE). The group had as main task drafting the position papers for second chapter of negotiations. Within the group functioned different sub-groups, one for each section of the position papers. The elaboration of section 7 was made by the representatives of CHIH, MLSS, MHF, MER, NAE, MJ and NHPSIR. This particular group had weekly meetings. The main out-put was the substantiation file for each section of the position paper. The most important problem for this file was the absence of a financial evaluation for the monetary needs, evaluation that was the task of the Ministry of Public Finance[4]. The activity of the entire group has ceased at the end of 2001, and for the moment they are in stand-by (waiting for the reactions from Brussels regarding the position paper).

SEI was created in April 2001 (the structure is still "young" – the oldest employee has only two years in office, not surprisingly if one takes into consideration that the entire NHIH was created in 1999). SEI has 5 employees, 4 of them full-time. Three of them have an economic education, including the head of SEI. The fourth is a medical doctor. SEI does not have any legal expert.

The personnel training on integration issues is not the strongest point of SEI, only the head of SEI participating at two training programs - one in Sofia, Bulgaria, through a personal connection with an NGO, and one organized by the Coordination Unit for Continues Training, within the CONSENSUS III project, „Development of institutional capacity at NHIH and CHIH level". Currently, for the entire NHIH, there are no training programmes regarding the European integration.

As it was already mentioned, SEI has a consulting and analyzing role. SEI is also drawing up reports for both MLSS and MHF. MLSS is permanently informed (as the lead institution for the chapter) over the evolutions of commitments taken in the position paper for chapter 2 (the part concerning NHIH activity).

Co-operation with governmental and non-governmental partners

The communication problems of SEI with MHF and particularly with the equivalent department within MHF causes failures in the daily activity. A solution could be to shorten the communication channel for requests made by other partner government institutions to SEI, by directly addressing the requests to SEI, not through MHF, as done in the present.

Another discontent is linked to the fact the NHIH is reduced to an execution role for punctual requests. What people are missing is the big picture. The solution could be to the full integration of NHIH in the respective process.

On the bright side, there are good relations with MLSS, MEI, and the Delegation of the European Commission. SIE has good relations with the Institute of Health Services Management, the Romanian Foundation for Democracy, USAID, World Bank, World University Service Romania (with the latest they have discussed a partnership for training). The consulting in pre-accession program CONSENSUS III is the only twinning project that is under way with Phare funding. CONSENSUS is a twining program with Germany – pilot-project on institutional development for NHIH and CHIH from seven departments (Bucharest, Arges, Sibiu, Constanta,

[4] From MLSS, SEI received:
The substantiation sheet card
The concordance table
The Budgetary sheet card (financial needs). No guidance was provided for filling in the budgetary requirements, either from Labour or Finance ministries, and no cost-evaluation was performed by any of these organizations. The problem was dealt with similarly in the case of the National House of Pension and Other Social Insurance Rights.

initially Brasov and then Olt, Suceava and Iasi). The emphasis is on communication inside NHIH. The programme is due to end in December 2002.

New developments

Legal base for NHIH activity on EU health insurance market – the new law on expenses clearance (which will include the service package) is its final stages in Parliament. It will regulate the export of benefits and non-contributive-benefits[5]. This new law is expected to clarify who and how will pay the care of the Romanians abroad and the care of foreigners in Romania – but till the law is issued, these matters are dealt with other mechanism[6].

Because there are no legal provisions, NHIH does not have the right to make external payments (the bills for the benefits consumed by the Romanian citizens outside the country are paid by MLSS from the State Budget and not by NHIH from the budget for healthcare).

In this case, there are no impact studies over the different problems that can appear after the law is adopted (nobody knows who will cover the cost differences of health services or what is the solution for the differences between the way drugs are reimbursed in EU and in Romania, especially when we are dealing with different drugs). On the other hands, based on the experience of the current member states the amounts involved are moderate.

European integration and the Ministry of Health and Family - Legal base, resources and organizational structure

Within the structure of the Ministry of Health there is a Secretary of State in charge with the coordination of:

- Department of European Integration and Legislative Harmonization (DEILH),
- Department for privatization and relations with foreign and local investors and
- Department for external relations.

The organisational chart of MHF is annexed.

The projects of the Ministry concerning European integration have been allocated the sum of 0.8 million Euros, representing a meager 0.16% of the 487 Million Euros budget of MHF.

The Department of European Integration

The Department for European Integration was created in 1994. The personnel consist of seven persons plus collaborators from other departments. The personnel are not specialized in the field of integration (training took place practically on the job) - training is needed, and there is a suggestion that training should be provided for short periods, and in Romania. The professional background of the staff is economic and medical; there are no lawyers in the department.

DEILH has as main task granting consultative opinions in the field of drafting medical legislation, certifying whether a draft is formulated in accordance with the European legislation. Nevertheless, the responsibilities of DEILH do not include initiating legislative drafts itself. The drafts arrive to DEILH for consultation from the specialized departments which have proposed them. More specifically, a draft law has to cover the following route inside of the ministry:

- Specialized departments produce the draft law;
- This is sent to the DEILH (and other departments) for consultation;
- After giving its opinion, DEILH sends the draft law to The Department for legislation and judicial review;
- The Department for legislation and judicial review sends the draft law to the Minister of Health and Family

DIEAL has a rather passive role in that it advises on new legislation, but it does not scrutinize existing legislation. DIEAL is able to involve through consultations other departments and services in the process of legislative harmonization. The consultation consists of analyses of draft laws according to community provisions, on a certain policy chapter, depending on the special expertise of the respective department.

[5] The EU forms for benefiting health services within another member state are:
- E 111 – filled in by the employer; it gives the right to benefit of health services in another member state, paid accordingly to rules of the residence state (at the same value paid by the insurer or the insurance system as if the care was provided in the state of origin)
- E 112 – filled in by the doctor; it gives the right to treatment in another member state when there are no equivalent services in the residence state of patient; in this case the insurer of the patient integrally pays the costs.

[6] Currently it is the Labour Ministry that pays for the health services received by the Romanian nationals in other states, which have concluded a convention with Romania. The list of bilateral conventions concluded by Romania is annexed.

The Ministry of Health and Family takes part in the following negotiation chapters with the European Union: 1- The free movement of goods; 2- The free movement of people; 3- The free movement of services; 5 – Commercial Law; 7 – Agriculture; 13 – Social policies and employment; 19 – Telecommunications and information technology; 22 – environmental protection; 23 – Health and consumer protection, 24 – justice and internal affairs; 25 – custom unification

Co-operation with governmental and non-governmental partners

Cooperation between DIEAL and the other departments within the Ministry of Health and Family, as well as with the other public institutions depends greatly on the personal relations. The department cooperates with the other ministries involved in the negotiation chapters. Cooperation with nongovernmental partners is difficult, mainly because MHF is only a co-funder and has little leverage on the recipients compared with EU institutional donors.

DIEAL has the coordinating role within MHF in implementing the Phare projects. The Phare projects the department is involved in are:

- Phare Project 2001 – improving the network of epidemiology (4.8 millions Euro)
- Phare Project 2002 – four projects (20 million Euros) on Public Health, Occupational Health, and Environmental Protection.

The department of European Integration and Legislative Harmonization is involved in the implementation phase of the World Bank II project. The budget of this project rises to approximately 65 million dollars.

Conclusion

The challenges facing SEI and DEILH come both from internal failures of their respective institutions (NHIH, and MHF), and from poor institutional rapports of these with other governmental actors (and especially one with another).

Internally, SEI has a good connection to the top management of NHIH. However the international relations department (IRICPD) is placed far apart in the organizational framework of NHIH, what does not facilitate the co-operation between the two related structures. The situation appears better in MHF, where both the Department of International Relations and DEILH report to the same junior minister.

Both structures lack sufficient resources (both in quantity and in skills). Systematic training is badly needed, and the absence of lawyers specialized in European Law is particularly worrying. The administrative procedures are not very developed either. In both institutions there is no formalized in-house or external evaluation mechanism. For the matter at hand, i.e. the implementation of the two regulations, there has been no institutional analysis for the entire process, no feasibility studies were made. In addition, because the Ministry of Public Finance (MPF) was almost always absent from the discussions for chapter 2 of negotiations, the funding needs were not discussed.

Externally, beyond explanations based on personal chemistry that can carry us so far, the lack of co-operation between NHIH and MHF is to be expected, as I have detailed in the section on the institutional analysis of the healthcare system. On the positive side, the co-operation with the Labour Ministry appears to work better (especially in the case of SEI). However, the relations with the Ministry of Public Finance are rather weak, what prevents the transfer of important budgeting skills, and does not guarantee resources for whatever international undertakings and implementation plans SEI and DEILH might have.

4. MAJOR ISSUES AND RECOMMENDATIONS

We shall resume the argument of the study, structuring them on four counts:
- the compatibility of the Romanian health system with the European regulation and practice in the field
- the approximation of legislation
- administrative capacity
- sustainability of the Romanian health system

Compatibility with the european social model

This is a question that appears often in Romania. Fortunately, as is the case with most social policies, there is little that the acquis positively precludes. As was mentioned in the chapter presenting the acquis, healthcare is still a national prerogative. The European practice is that there are both health systems based on social insurance (as Romania is building now), but also national, tax-based systems, similar to the one Romania has got rid off.

As far as the European social model is concerned, Romania may very well not have reformed its health system. The matter where there is a substantial difference in the Romanian and European practice is the overall resources allocated to healthcare. While most European states spend around 9-10% of GDP for health (with UK the laggard at 7% but with an upwards trend), and even the other CEEC spend over 6% of GDP, global health expenditure in Romania reaches only 4% of GDP. It is conceivable that the concern for social rights at the European level will translate in pressure to increase public expenditure on health. Moreover, as we have discussed in the acquis implementation section, European citizens are entitled to receiving health services abroad if they are not available in the country of residence. This might force a certain increase in health expenditure by back door.

Acquis approximation

The hard acquis on health social insurance is limited to regulations 1408 / 71, and 574 / 72. Romania is in advanced state of translating these regulations into domestic legislation. What is lacking is the preparation for implementation, issue that will be dealt with in the next section (administrative capacity).

Apart from the two regulations on the compatibility of social security systems, there are a number of other problems concerning the internal market regulations, relevant for the healthcare sector. More details presented in the acquis implementation section. Some are specific to the health sector, but most concern general free movement of goods and services provisions, like non-discrimination of foreign versus domestic manufacturers in access to market and rules of public procurement.

Administrative capacity

There are a number of factors contributing to the low capacity of implementing acquis related regulation. On one hand, there are internal institutional design flows: the weak institutional position of the European integration departments – i.e. their marginal position in the decision making process, the separate reporting from the international relations departments (in the case of NHIH). These design flows are compounded by the weakness of the department themselves: poor access to resources, lack of adequate personnel (i.e. lawyers), and lack of training. A role plays here the poor knowledge of decision makers about European integration issues, what both does not allow them to compensate the failures of the European integration departments themselves, and also to recognize the importance of these departments, and therefore allocate them appropriate resources.

The second set of factors is the inter-institutional design problems. Here comes the poor communication between different government agencies, especially with the Ministry of Public Finance (MPF). Specific for the health sector is the rivalry between the Ministry of Health and Family (MHF) and the National Health Insurance House (NHIH), born out from ill-defined competencies. A consequence is the fact that NHIH is still unable to engage in international transactions, and health benefits consumed abroad by Romanian nationals are paid from the budget of the Ministry of Labour and Social Solidarity. This matter is to be resolved soon, however it symbolizes the deficiencies of the system: NHIH had a pressing problem that required legislation, however it was precluded to initiate legislation itself, and was unable to move the Ministry of Health and Family to initiate it in its place.

These two types of administrative failure (inter-institutional co-operation and intra-institutional organization) have resulted in the lack of preparation for the administrative implementation of regulations 1408 / 71, and 574 / 72: the costs are practically unspecified (both administrative implementation costs, and service costs), proper budgeting was therefore impossible, and no training was provided to the staff that is supposed to administer the new legislation, even if on this last count plans are being put in place.

Sustainability

The sustainability of the Romanian healthcare system requires first of all adequate budget control mechanisms at the hospital level. The hospital profligacy sucks in resources destined for primary acre and medicines consumption. The incentive misalignment that results in the current serious funding crisis has been analyzed in the healthcare background section.

A second type of concerns for the sustainability of the healthcare system springs from its ill-conceived institutional structure, as presented above. We have argued in the health background section, that the current status quo is untenable, and it should evolve either towards greater autonomy of NHIH from the Ministry of Health and Family, or, conversely, towards the integration of the House in the Ministry - somehow similar to the situation of the National House of Pension and Other Social Insurance Rights, and along the path the Hungarian health system (a major influence on the Romanian health social insurance legislation) has evolved.

Finally, resource allocation is another reason for concern. Even if Romania has increased the public expenditure on health since the introduction of social insurance, it continues to under-spend when compared both with EU member states, and even with its CEE neighbours. In this context, the Ministry of Finance systematic denial NHIH the permission to use all the funds collected for health is unjustifiable.

On the positive side, the rate of collection of the health contribution has been robust. The recently aired proposal of the Ministry of Labour and Social Solidarity of unifying the health fund with the (poorly collected, heavily in deficit) pension fund raises serious concerns for the sustainability of the Romanian healthcare system, but this is just a tentative development, that should be addressed in another study when more details emerged.

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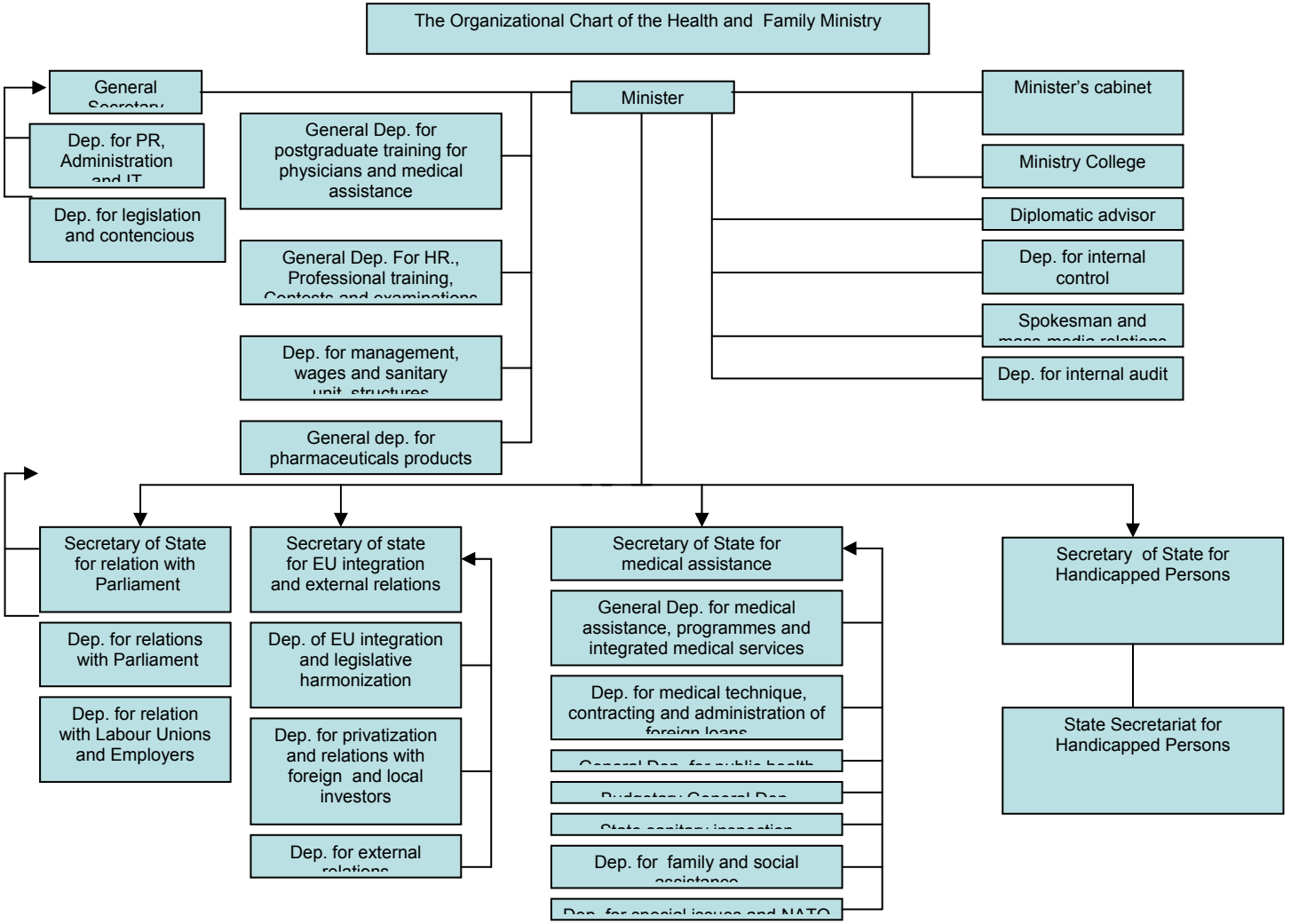
Annex1.

National Health Insurance House – organizational chart

Annex 2.


The Organizational Chart of the Health and Family Ministry
General Secretary
Dep. for PR, Administration and IT
Dep. for legislation and contencious
General Dep. for postgraduate training for physicians and medical assistance
General Dep. For HR., Professional training, Contests and examinations
Dep. for management, wages and sanitary unit structures
General dep. for pharmaceuticals products
Minister
Minister's cabinet
Ministry College
Diplomatic advisor
Dep. for internal control
Spokesman and mass media relations
Dep. for internal audit
Secretary of State for relation with Parliament
Dep. for relations with Parliament
Dep. for relation with Labour Unions and Employers
Secretary of state for EU integration and external relations
Dep. of EU integration and legislative harmonization
Dep. for privatization and relations with foreign and local investors
Dep. for external relations
Secretary of State for medical assistance
General Dep. for medical assistance, programmes and integrated medical services
Dep. for medical technique, contracting and administration of foreign loans
General Dep. for public health
Budgetary General Dep.
State sanitary inspection
Dep. for family and social assistance
Dep. for special issues and NATO
Secretary of State for Handicapped Persons
State Secretariat for Handicapped Persons