The Importance of Management Contract in Increasing the Efficiency of Health Units in Romania

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Keywords: *private and public medical units; health management*
Abstract: This study aims to emphasize the importance of a management contract signed at the moment of hiring the manager of a medical unit, especially in the case of the public ones.

Many studies in this field spotlighted the fact that the Romanian health care system has confronted with numerous modifications along the 17 years of transition starting with 1989. The first significant modification has occurred in the field of the health policy, with the passage from a community medicine to one whose main concern is the individual. The second major modification is related to the general tendency, also manifested in Europe, to des-centralize some of the competences of the central administration and to assign autonomy to the local one. There also takes place a reconsideration of the role played by the hospital units within the health care system. In this context, there comes out the creation and the development of a health care services market, as a result of the fact that the demand for this kind of services proceed from an individual that has the possibility to choose between the numerous suppliers existent on the market nowadays. This option became possible since the legislation, that has been adapted to UE requests and to the Romanian economic context as well, allowed on the one hand, the passage to a new financing system of the medical services based on the health social insurance, and on the other hand, the occurrence of many types of private medical units. Simultaneously, the supply of new medical materials, apparatus and medicines has increased, which led to competition.

As a result, the hospital, that used to represent the characteristic medical unit in the previous health-care system, and generally any public medical unit, is forced to rapidly adapt to the new circumstances: new types of diseases, the rapid evolution of medical technology, the populations' ageing, the migration of the labor force, new budgetary restrictions. This rapid adaptation supposes the existence of an efficient management of these units and a careful supervision of the activities that take place within them and also of the economic flows they participate into.

This paper analyzes the statistical data related to the types of expenditures and the results obtained within the Romanian hospital units. The result of the research consists in highlighting the main issues that must be solved by the intercession of the management contract.

The study also calls the attention on the fact that the management contract has to become an active instrument in order to get the medical unit efficient, and not a passive instrument, coercive, in order to fulfil some parameters that may become in a short time counterproductive, given the current trend of the health-care service market.

Introduction

Various types of health-care units of the world's countries have always been the „discord apple" as regards the performances and the place they occupy within the hyerarchies of the international institutions of this profile. As a rule, the ones in the countries that are situated on the front positions become models while those in the less developed countries attempt to adapt their own health-care units in accordance to the former ones. The specialty literature gives the criteria according to which the hyerarchy of the health-care systems is made up as general objectives that are to be reached: a high level of population health, equitable distribution of the health-care services, the respect for the individual (that supposses receptivity to his exigences, confidentiality), a high quality of the medical act and the equitable financing[1].

From a more mercantile or purely economic standpoint, one can appreciate the efficiency of a health system according to the manner expenditures are turned into health. Having in view the fact that the necessary data for this efficiency calculation are available (expenditures for treatments, number of cured patients, the expenditures for preventing some diseases, respectively), a hierarchy construction from this viewpoint would be simple. However, if the 5 objectives presented are taken into account, one notice that in order to appreciate the degree they were accomplished, hardly accessible, sometimes subjective information is necessary.

This fact explains in a certain extent why, at present, neither World Health Organization did manage to offer an answer to the question "what type of health system is better performant, more efficient?" More than that, even within some integrating structures, such as the European Union, that promotes policies that have common objectives, there is no uniformity as to the type of health system adopted by the member-states.

A first conclusion that might be drawn from here is that the proposed objectives can be reached even if the health systems by which the effects are produced are different.

The analysis of the health system in Romania

The present Romanian system is considered to be a modified version of the Bismark model[2] based on mandatory insurance taxes whose size depends on the contributor's income, adapted to the economic and social conditions. The bases of this type of health system were set beginning from 1990 and its formation in time was quite slow, the present level of complexity and efficiency being rather low, if the 5 objectives suggested by W.H.O. to be reached are taken into account.

From the standpoint of the health level of population Romania is in the sub-region Eur-B[3] (the average life span 71 years, low mortality in both children and adults), beside most ex-socialist countries that experienced as a health system, the Semashko type (the soviet system). Indicators remain however that place Romania on one of the last places in Europe[4]: maternal mortality - 24.05 (the biggest), standard mortality by all causes - 1.076, 36 (as compared to the maximum 1496,61 of Russia and the minimum 614,93 of Luxemburg), standard mortality by injury and poisoning - (compared to the maximum 211,95 of Russia and minimum 27,61 of Malta), incidence by tuberculosis, 114,30

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[1] *World Health Report 2000*, Health Systems: Improving Performance.

[2] Celea, C. *Organizarea Sistemului Sanitar Național*. University of Bucharest. Sociology and Social Assistance Faculty. p. 2.

[3] *The European Health Report 2005*, pp. 7/12.

[4] The figures represent percentages to 100,000 inhabitants.

(compared to maximum 133,35 of Republic of Moldova and the minimum 3,76 of Iceland), incidence by syphilis - 40,77 (compared to maximum 71,31 of Republic of Moldova and minimum 0,10 of Macedonia), AIDS incidence – 1,10 (compared to maximum 7,64 of Portugal and minimum 0,0 of Bulgaria)[5]. These examples were given since the new health policies of EU[6] are focused on areas such as the catching diseas, the decrease of the disease risk due to smoking, alcohol consumption or incorrect nutrition and obezity, prophilaxy, the decrease of the number of deaths due to accidents, etc.

As to the equitable distribution of the health care services, Romania may be similar to a „paradise" of the access to such services, if we look at the percentage of the contributors to the health insurance fund in the population total: from a total of about 21 million inhabitants, the active population is about 11 million and the occupied one is only 4,6 million that represent in fact the contributors to the Fund. The migratory active population that work abroad is approximated to 4 million. It results that the retireds and the children are about 10 million inhabitants[7].

In the category „respect for the individual/customer" there are positive and negative aspects worth being analyzed. On one hand the physician-patient relationship considerably improved especially in the private sector (we refer here at the new sector shaped after the appearance of the Law of Commercial Societies, that allowed physicians to unfold their activities in their newly founded societies as a consequence of the free initiative and by investing their own funds) as a consequence of the development of the market and competition market. The competition between the private physicians played a stimulating role as to the raise of technological level of their endowments and the improvement of the methods of medical practice as well as to the respect for the patient who bears the expense of the medical act and may choose his physician by himself.

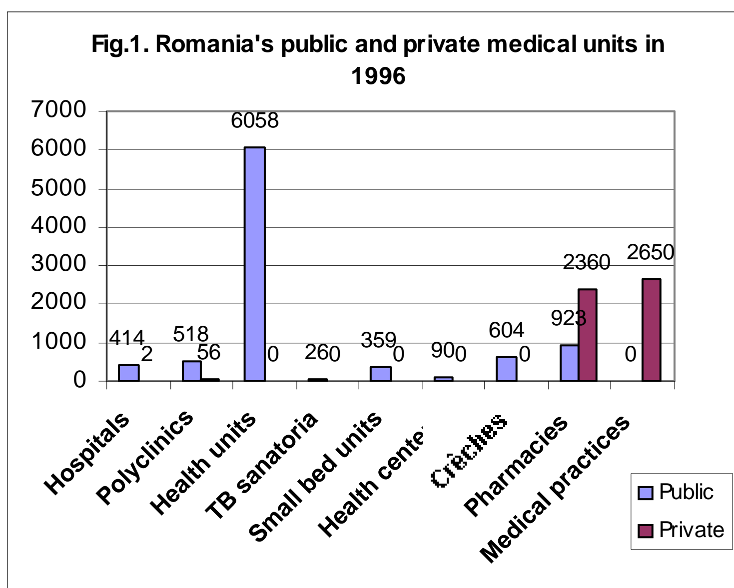
Within the state sector (we refer especially to hospitals, where addressability is high and where first the rural population addresses) the situation improved after 1989 but there still is insatisfaction as to the manner some patients are treated by both physiciand and the auxiliary. Victor Olsavski, the responsible for Romania of W.H.O. remarked that the most difficult problem, but not impossible to solve, is that of corruption that undermines the professionalism of medical personnel and hinders our country's lining to the European medical values[8]. He underlined that besides under-financing, the black market of bribe, irrespective the type of the medical service, from a simple check-up to the surgical operations, made the Romanians' confidence in medical profession decline and menaces the health state of the whole country. At present in Romania there are 2 categories of physicians : GPs or family doctors who, after 1999, had the possibility to manage their own business with governmental funds, according to the patient number they had under treatment and the specialists who are mostly employees of hospitals. Olsavski holds on „ It was observed that the percentage of illegal payments lowered as the physiciand started becoming owners. Since the family doctors have wages according to the patient number, their interest became the way they care after the patients".

Still, the main problem the Romanian health system faces remains the one related to the 5th EU objective: the financing of the health services. Financing any type of economic activity is dependent on the structure and the type of the system thst activity is carried out. Therefore, the financing of the health services, as a strategic sector of whatever national economy, depends on the structure of the health system.

Indisputably, the changes regarding the structure of the Romania's health system, during the last 17 years are obvious, especially as regards the types of medical units that were set and operate in the market. If, until 1996 the changes were extremely slow and the

[5] *Sanitary Statistical Yearbook, 2006*, Public Health Ministry, pp. 311-325.
[6] *European Health Policies*. www.fphm.org.uk.
[7] *The Statistical Yearbook of Romania*. www.insse.ro.
[8] Internet URL: www.thediplomat.ro/feature0205.

evolution of the private sector was not visible (figure 1), after 1998, when the first notable changes of the legislation in this field occurred, the private sector experienced its blooming period.

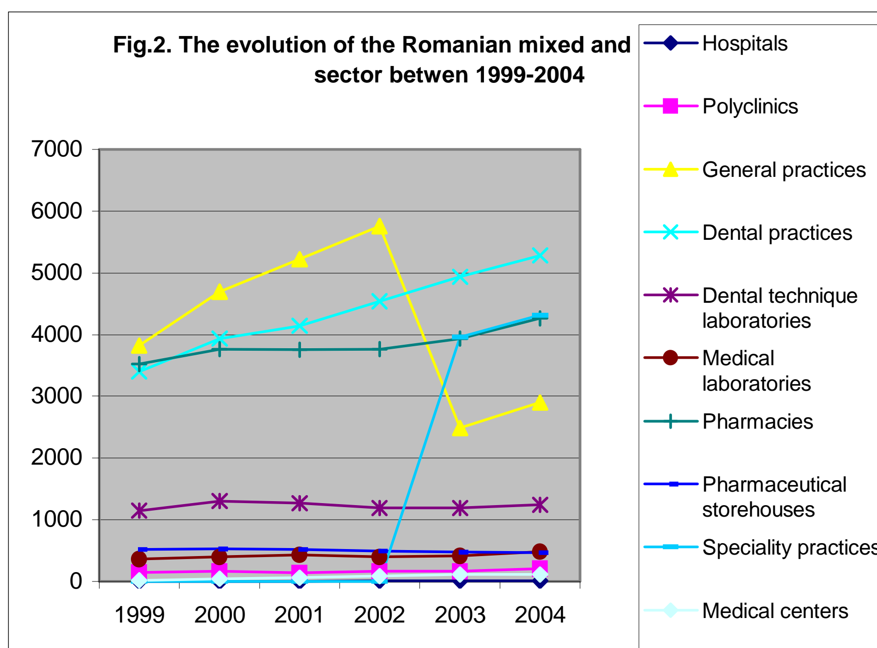


Source: G. Zarcovic and D. Enăchescu. 1998. *Probleme privind politicile de sănătate în țările Europei Centrale şi de Răsărit*. Ed. Infomedica. p. 106.

It is easily remarked the fact that at the end of 1996 there were the 2 distinguished sectors, public, private, respectively, of which the public one held the majority, At the same time it is remarked the private interest in opening pharmacies and speciality medical practices (dentistry, gynecology-obstetrics, internal medicine) a fact that was explained by the large income brought in by this type of investment.

The reorganization and decentralization of financing the health services in Romania started from the moment of the introduction of the health insurance tax, after 1998[9], when the Social Health Insurance National House (SHINH) and its county branches were set, concomitantly with the decentralization of the delivery of health services by the appearance of autonomous providers of the family doctors type, speciality ambulatories and private hospitals. From this moment one can speak of the third type of medical unit, the mixed one, in some reports being assimilated either to the public or to private property (fig.2).

[9] *The Decentralization Strategy of the Public health Ministry 2007-2008.* electronic format.



Source: INSSE, Statistical Yearbook of Romania, 2005

Following the tendency from the European area of decentralization of certain competences of the central public administration and the offering an increased autonomy for the local public authorities, the decentralization of the organization of the health services occurred by passing (starting from 2002) the public health units of county or local interest under the local public administration, concomitantly transferring the sanitary patrimony from central to local level, contributing ever more to the development of the mixed sector.

These changes given, related to the growth of the number of health service providers, the increase of the technologic level and the improvement of endowments that substantially contribute to the increase of the medical act, it would have been quite normal the health state of the population to be improved and to remark a more correct utilization of the funds these services are covered with. Notwithstanding, the analyse carried out at central level show that further on the funds alloted to the health sector are insufficient and that the personnel activating in it, especially in the public branch of it, is unsatisfied. This fact raises the following problem: the moment that the private health sector manages to provide prompt and highly qualitative services, becoming lately competitive on the external market[10], isn't the problem of the public health sector related to a bad administration of the funds and not to their insufficiency ?

In order to enforce these affirmations we take as an example the statistical data reported to the County of Iasi regarding the number and type of medical units and the results they obtained, analyzing at the same time the expenditures that allowed these results.

[10] "Because of its cheap and skilled medical workforce, Romania sees a massive increase in the amount of medical tourism from the USA and Germany". www.thediplomat.ro-features-0205.

Table 1. The type and number of public units in health sector in Iasi county[11]

Public medical units	1998	1999	2001	2002	2003	2004	2005	2006
Hospitals	17	18	17	16	13	13	13	13
Preventories	2	2	2	2	1	1	1	1
Dispensaries	194	26	3	1	1	1	1	1
Pharmacies	15	15	15	17	13	13	13	13
Pharmaceutical shops	2	3	3	1	*	1	1	*
Polyclinics	18	14	2	1	1	1	1	1
Medical laboratories	0	0	0	0	0	0	3	4
Speciality medical centres	0	0	3	3	3	2	2	2
Health centres	3	3	3	2	2	0	*	0
Individual medical practices	0	0	277	289	*	*	*	*
Grouped medical practices	0	0	22	21	*	*	*	*
Associated medical practices	0	0	4	4	0	0	0	7
Civil medical societies	0	0	2	1	2	1	1	1
Hospitals speciality ambulatories	0	0	9	6	10	11	11	11
Dental technique laboratories	0	0	75	57	167	171	176	193
Individual dental practices	0	0	0	0	0	0	66	66
Associated dental practices	0	0	0	1	0	0	0	17
Civil dental societies	0	0	2	2	1	2	3	3
Individual speciality practices	0	0	77	120	37	55	60	83
Grouped speciality practices	0	0	9	8	*	*	*	*
Associated speciality practices	0	0	2	1	*	*	*	*
Speciality civil societies	0	0	9	12	9	8	8	6
School medical practices	0	0	0	17	17	17	17	17
University medical practices	0	0	0	9	9	9	9	9
Speciality ambulatories	0	0	0	2	2	2	2	3
Physicians	0	0	0	0	321	349	345	347

[11] * no data. Information obtained by the kindness of the Director of the Public Health Authority of Iasi County, which allowed my access to some confidential data.

Related to the changes from the public sector of health services in Iasi county between 1998-2006 one can notice a decrease of the number of hospitals, both in the urban and rural area, as a consequence of the fact that some of them became totally inefficient or did not obtain the functioning notification. Also one notice a drastic decrease of the number of medical dispensaries and polyclinics. In exchange, after 2001, as a result of changing the legislation concerning health services, new types of medical units occur, with various juridical form, whose number is increasing. One must specify the fact that the greatest part of the public medical units (90%) functioned, between 1998 and 2001, in urban areas, excepting the dispensaries, whose urban percentage is of 56.18%. After 2001 increases the percentage of the family medicine practices (30%) and of stomatological ones (44%) that are functioning in rural areas, the rest of the medical units being predominant in urban areas (more than 90%). One must take into account the fact that some of the endowments or spaces of the state's unities have been loaned or granted by commodatum in the administration of it's personnel, that was allowed to contribute with it's own funds in order to increase their degree of confort and the technological level, so, normally they should be considered as a part of the mixed sector.

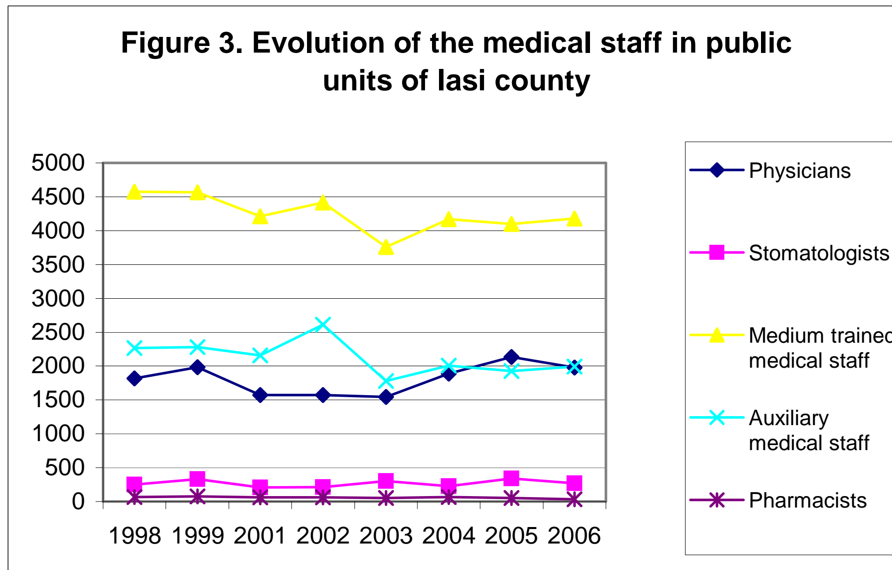
Table 2. The type and number of private units in the health sector in Iasi county

Private medical units	1998	1999	2001	2002	2003	2004	2005	2006
Medical practices	77	80	241	225	175	*	*	*
Dental practices	73	73	203	194	235	264	257	271
Medical laboratories	2	2	3	5	16	9	12	13
Dental technique laboratories	12	12	7	8	20	22	38	34
Pharmacies	93	92	167	188	190	184	*	*
Pharmaceutical shops	3	3	0	5	5	5	0	0
Polyclinics	3	3	7	8	*	*	*	*
Pharmaceutical storehouses	10	10	28	33	24	23	*	*
Specialty medical practices	0	0	0	0	114	139	90	141
Civil medical societies	0	0	0	0	0	0	2	4
Civil dental societies	0	0	0	0	0	0	6	7
Civil specialty medical societies	0	0	0	0	0	0	3	3
Other types of medical units	0	0	0	0	0	0	125	114
Physicians	0	0	0	0	0	174	165	168

The same tendency of the appearance of some units with various juridical forms is remarked also within the private sector of health care service deliverers. Different from the state sector, after 2002, the privates formed as units of medical office type have opted for new types of societies as the family doctors practice type, or specialty medical practice respectively. Parallel with this, in a limited number, units of civil various specialties medical society type appear. Up to 2001, private medical units had activated in the urban area (over 95%) and, beginning with 2002, increases the number of dentistry offices (averaged

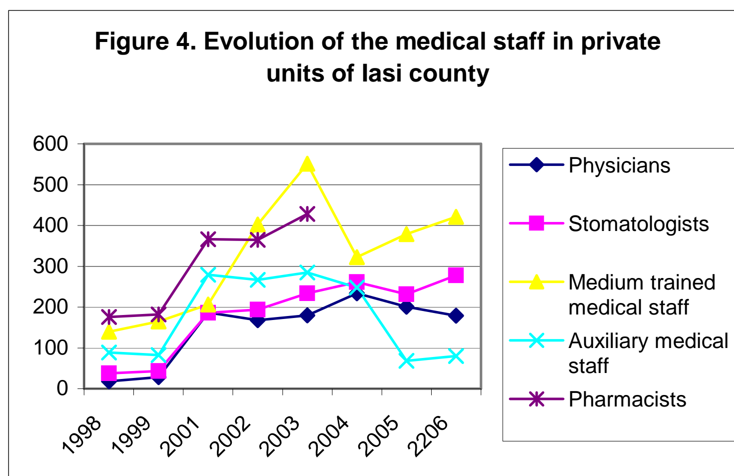
23.7%), of the family doctors practices (from 15.3% in 2001, to 30.35% in 2004) and of pharmacies (average 27%) in the rural area.

The analysis of the personnel that work in the health care units in the county of Iasi shows the physicians' ever increasing orientation and the medical personnel towards the private sector (figure 4), while in the state sector (figure 3) the decrease of the average and auxiliary personnel is shown.



Source: Public Health Authority of Iasi County

The increase of the number of the persons working in the private sector does not necessarily mean that it offers new working places, but rather that the persons employed in the state sector have an alternative of service performing in the private sector, too, in order to complete their incomes .On the other hand, this decrease in the state sector, under the conditions in which the assurance of the county's population[12] with such personnel is 136 inhabitants for one nurse and 1.9 nurses to one general practitioner denotes a weak administration of the human resources, possibly due to the wish to decrease the personnel expenses of the hospitals, in favour of other types of expenditures.



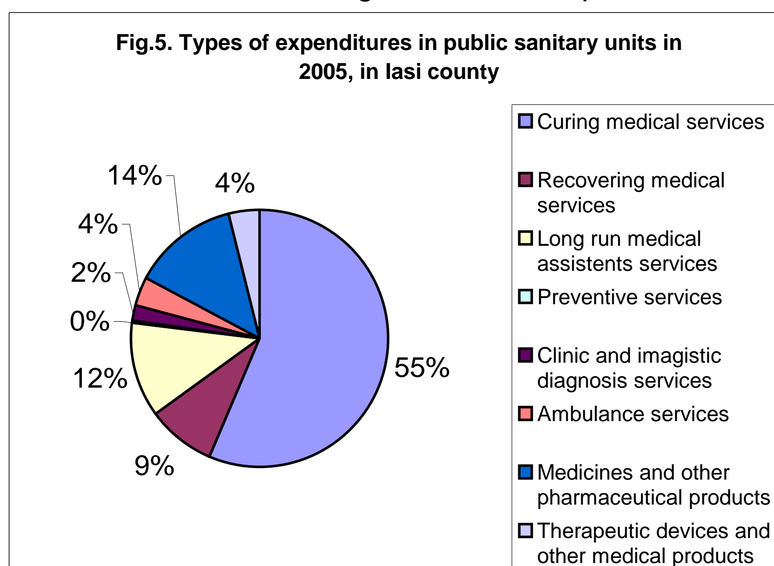
Source: Public Health Authority of Iasi County

One of the specific problems of the personnel working in the state's medical units is that related to its subordination that holds leading positions in 2 ministers. Most times

[12] Concordant to *the Statistical Yearbook of the Health Ministry, 2006*, pp. 329-332; from this point of view, Romania is situated among the countries with the lowest indicators in Europe.

the clinic chiefs belong to the personnel with didactic positions; this means that they are employed by the universities of medicine and pharmacy that are subordinated to the Ministry of Education. At the same time they have the right to half a norm within the medical office subordinated to the Public Health Ministry, as physicians in hospital. As clinic chiefs they have the attributions to fundament the necessary of medicines and medical materials. The issue that appears here is related to the fact that a medium level manager the clinic chief usually is, whose wages is made mainly by the Ministry of Education, within the limits of the salaries in education, will always be tempted by the supply of medicine and medical material providers, who offer them various advantages in exchange of accepting to endow hospitals with their produces. Most times the demand of drug and other material necessary is made without its grounding. Moreover, the relationships system created in time within hospitals between the physicians that also fulfil didactic functions within the universities of medicine and pharmacy became ever more powerful, so that the hospital managers who, most times belonged to it, could not deny the suggestions of the clinic chiefs.

If one analyses the expenditures of the public health units in the county of Iasi in 2005, one concludes that from a total of 307,156,990.85 lei, more than 75% had the hospitals as a destination. On service categories, these expenditures covered: (figure 5).



Source: *The Report of Sanitary Activities in 2005*. Public Health Authority of Iasi County

The fact that the biggest part of expenditures cover the cure services is observed, followed by the expenditures for drugs (out of a total of 41,437,296.50 lei 39,652,137.47 lei was necessary to the hospitals for medicines) and also by the expenditures for medical care in the long run (chronic diseases), while for prevention services were necessary only 917,189.41 lei and only in the small units (family doctors practices, dentistry practices or other specialties).

On source types, these expenditures were covered from the following financing sources (figure 6):

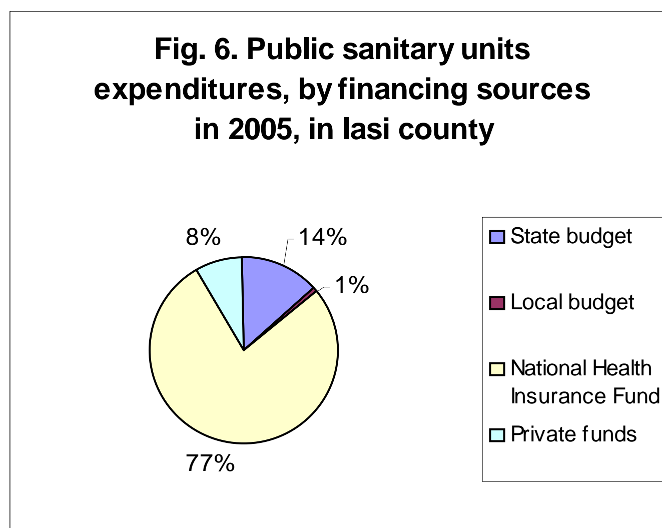


Fig. 6. Public sanitary units expenditures, by financing sources in 2005, in Iasi county

Source: *The Report of Sanitary Activities in 2005*. Public Health Authority of Iasi County

As one notices, the biggest part of the expenditures is covered b from the National Fund of Health Assurance, only 14% being completed from the state budget, the patient adding 8%, the local budget contribution, in spite of the gained authority and responsibility, being non-significant.

Now much work was carried out in the public units to justify the above-mentioned expenditures we can notice from the following graph.

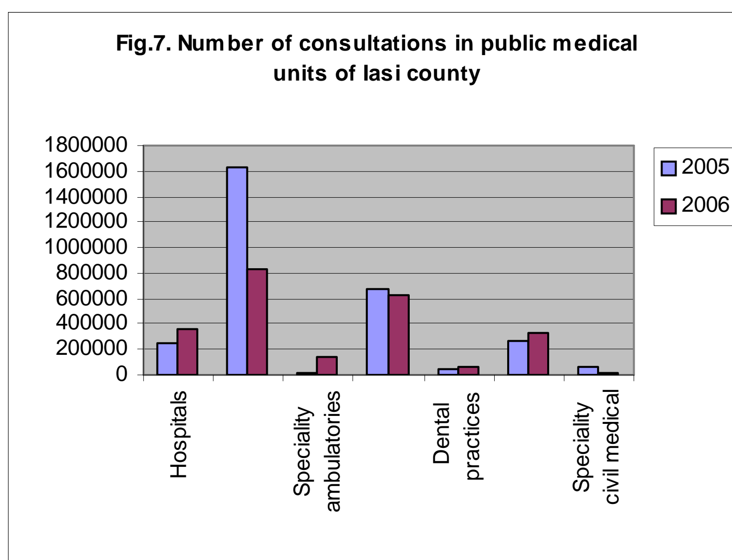


Fig.7. Number of consultations in public medical units of Iasi county

Source: *The Report of Sanitary Activities in 2005*. Public Health Authority of Iasi County

In 2005 out of a total of 3,249,401 consultations[13], 246,791 were done inside hospitals, 1,620,214 in family medical offices, 676,557 in hospital ambulatories, 261,448 in specialty offices and 45,226 in dentistry offices.

In 2006, the total number of check-ups in the public units decreased to 2,834,897, first of all due to the numerous family medical offices that have privatized; in hospitals, the number of check-ups increase up to 353,458, and in the family medical offices it decreased to 829,233, in the specialty ambulatories these were 133,852, in hospital ambulatories 633,394, in the specialty offices 320,971 and in dentistry offices 54,866.

[13] We refer to consultations without hospitalization.

In the private sector, the number of the check-ups without admission in 2005 and 2006 is shown in the following figure.

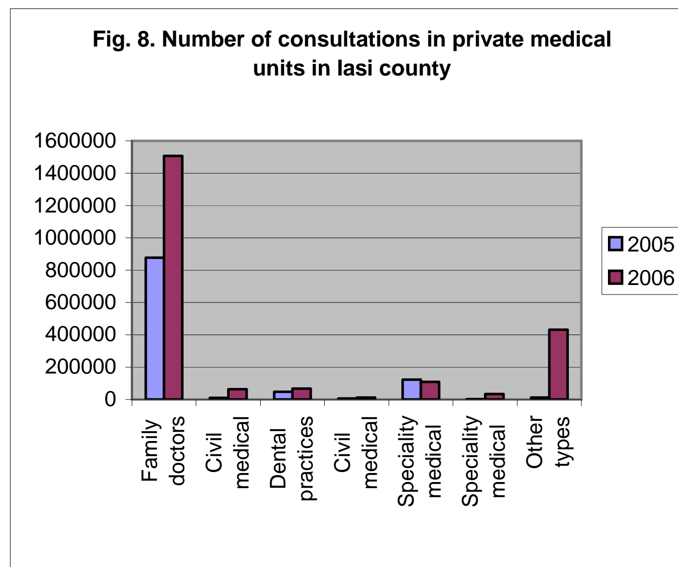


Fig. 8. Number of consultations in private medical units in Iasi county

Source: *The Report of Sanitary Activities in 2005*. Public Health Authority of Iasi County

In 2005, out of a total of 1,075,641 consultations, 877,444 were given in family medical offices, 47,184 in dentistry offices and 122,009 in the specialty offices. Except the dentistry offices that equalled the number of those carried out in the state sector, the other ones are at about half as compared to those in the public sector.

In 2006[14], the total number of consultations increased to 2,223,114, of which 1,506,067 were given in the family medical offices, 62,753 in civil medical services, 67,901 in dentistry offices, 11,839 in civil dentistry societies, 109,319 in the specialty offices, 34,522 in specialty medical societies and 431,523 in other types of medical offices.

An increase of the number of consultations is remarked given in the private sector in 2006, but, unfortunately, the data referring to its expenditures are not available.

One must specify the fact that, save the hospitals, the number of the check-ups given in the urban area is double as compared to those given in the rural area for both public and private sector.

The way the tendencies show, the dimensions of the private sector grow from one year to another inverse-proportional with those in the private sector. This means that, for future, it will be both an ever more searched alternative for the patient and a competitor for the public sector medical units. Similarly, the reform in the Romanian medical sector goes on, that means that neither the private nor the public sector has stabile arranged structures. Yet, what is certain is the fact that both the medical units in the public sector and those in the state sector need a performing management so that they could face the challenges of the domestic or international market. Such a management can be promoted only on the basis of complete and correct information and on the basis of planning.

Conclusions

1. The Romanian health system is crossing a period of profound changes imposed, on one hand, by the transition to market economy and, on the other hand, by the European integration. Not at last, the changes within the Romanian society related to the demographic structure, its actual health state, and, why not, the beginning of changing mentalities, impose in their turn an improvement of this system;

[14] No data available related to expenditures.

2. As in any other system, within the health system there is a series of main general objectives, that must be fulfilled and a series of objectives specific to the units that carry out medical services, related to their size and property type. If for private units that are, as one has observed, more and more numerous and have small and middle sizes, the assuming of responsibility for their administration is made "naturally", as the investor's own money is at risk, their main objective being the profit, in the case of the public units, the administration issue is more complex, because there is a series of specific factors that influence it:
   - the instability of the general economic system in which they activate;
   - the existence of some strong reminiscences of the regime that has administrated the system formerly, reminiscences as the relationship system that implied a preponderance of the politics upon the ethics;
   - operational incoherence and interference in funds using – The National Health Insurance House that administrates the National Health Insurance Fund from which the greatest extent of the expenditures is supported, has no autonomy towards the Health Ministry or The Ministry of Public Finances who gathers the insurance fund;
   - the existence of some communication issues between the central or local authorities, the professional associations of health services suppliers, drugs and medical equipment produces and distributors, international organizations, health research organizations and citizens' representative;
3. In this context, in order to correctly administrate the public units, especially the big ones, as hospitals, whose financing is made especially from the national fund, central or local budgets, it would be suitable to hire a manager from out system, whose hiring is made on the base of a management contract, in which the objectives to fulfil in short, medium or long run to be clearly exposed. According to the fulfilment of the objectives, the manager should be rewarded, paying attention to the fact this fulfilment must be correlated with an adequate using of funds that may differ from one year to another because the economic instability (migration of the labour force, the incomes' decreasing);
4. Such a management can not be exercised unless the information transparency and an infrastructure of communication between those that work/act inside the system are assured, as information feed-back is the base of the control and evaluation function of management. A correct evaluation of the activity inside the system will allow the setting up of its hindrances and the correct diagnosis of the hospital-type enterprise, offering the possibility to observe if the inefficiency of the activity is due to the personnel's incompetence, to the funds insufficiency, to the exaggerated consumption or costs, to the superannuated techniques or is just due to bad management.

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