MANAGEMENT OF THE PUBLIC HEALTH CARE SYSTEM REFORM
- Theoretical and Pragmatic Grounds

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CONCEPTS. DEFINITIONS

In an etymological perspective, the term „management” defines the science of organizing and leading an organisation, by elaborating systems, programs, methods, and techniques designed with the purpose of increasing competitiveness [1].

Experts who studied over time the grounds of this science, defined „the management” under multiple forms. Therefore, prestigious works which defied the passing of time kept for us definitions of the art of leadership, such as:

- „knowing exactly what people want to do and supervising them in order to do this through the best and the cheapest possible way” [2];
- „to predict, organise, order, manage and control” [3];
- „the process in which the manager operates with three fundamental elements - ideas, things and people” [4].

In a concise, but encompassing definition, J.J. Serven Screiber appreciated that „Management is the youngest of sciences and oldest of arts”.

The credit for grouping managers’ activities after criteria aiming the character and directions of action, called management functions or functions attributed to the management, is given to the Frenchman Henri Fayol, the founder of the school of management thought and the author of the „General and Industrial Management” work, published in 1916.

In the author’s opinion, management was seen as a rational system, managed based on a set of elementary principles.

Henri Fayol identified five functions of „leadership” aiming: forecasting, organization, coordination, command and control.

The study of management as a science constituted a constant concern for Frederick Taylor (USA) as well, recognised in the specialty literature as „parent of scientific management”. His proceedings focused on distinct elements identification composing physical work, in order to redesign or modify these elements, with the defined purpose of obtaining the most effective and rapid way of working within an organisation.

Based on theoretical notions of the management concept, any activity field or organisation can design in an own conception a certain management style in order to obtain the best results.

The management of the public health care system reform implies a translation of theoretical grounds towards the pragmatism or application of management functions on medical care services. This article had as support direct assessments of the sanitary system, prestigious publications in which the research results of this field were presented, as well as processing some data and public information. In Romania, the current public health system summarizes inadequate organizational policies, applied gradually over at least two decades, in which the increased administrative bureaucracy operated against a flexible system that would allow the attention to be focused on achieving a high-quality medical act.

Lines of action to be implemented shall offer the national health system minimal features aimed at providing high quality health services, in which patients have the dual role of donors (through contributions paid to social health insurance) and of partners in making the best decisions to ensure a high level of medical services.

Keywords: healthcare system, management, current status analysis, Romania.

In this perimeter the management of the public health care system reform is also classified, by which a translation of theoretical grounds towards the pragmatism or application of management functions on medical care services is proposed.

The defining elements of the decision-making system which guarantees performance in any reference field aims: grounding, with the three dimensions: forecasting, organization and coordination of system’s procedural actions, adoption or implementation of the objectives harmonized with management decisions, assessment or issuing some value judgements and control or analytical examination of obtained results.

These benchmarks constitute support points guiding the decision to identify procedural components of the activity of sanitary units, as well as interconditioning between them and regulations governing them.

The report with the topic „Management of the public health care system reform -theoretical and pragmatic grounds” has its genesis in a study performed on the current state of the Romanian medical system.

As a methodological approach, this report had as support direct assessments of the sanitary system, prestigious publications in which the results of field researches were presented, as well as processing some data and public information.

Public health - undeniable and immeasurable „treasure” of the quality of life

Politics in the field of health care constitutes a component of the general management science, a field of national interest found in a comprehensive process of reform.

[Page 4]
Just like in the case of the educational system, health represents a priority centred on national realities and traditions. Experts’ concerns with a common vision with regards to the decisive role of health on the quality of life converge towards performing some high quality medical services, capable of transposing the most recent results of this field’s researches in clinical applications, oriented towards prevention and public health improvement.

The health care system comprises a spectrum of activities imposing a strategic approach at national level, without ignoring the globalization effects. From this perspective, we notice a specific feature, defined by the expression „unity in diversity”, in the sense that we are part of a heterogeneous system generated by cultural socialization processes and, equally, we are part of a unitary system under the aspect of the approach manner of health care policies.

The assessment of health care services aims the identification of vulnerabilities, of slippages or strong points and creating premises of a systemic, integrating, generating performance approach.

In Romania, the unitary system is subject to a comprehensive process of decentralisation aiming the entire public administration. In these conditions, the health care field is governed by a legislative arsenal of legal rules with a regulatory role.

This generous system of legislative acts has its source in the constitutional provisions of our country.

In addition to the national legislation, the Romanian medical system harmonises its internal regulations with the ones provided in the Regulations of the European Parliament and the Council of Europe, pertaining to the field.

The concerns at national level converge towards the actions of Member States, with the specification that the European Union completes and supports the national efforts of the EU countries, without ignoring the cooperation with third countries. On the same level of concerted actions in the medical field collaboration with the World Health Organisation (WHO) is recorded as well and the increase of the complementarity degree of health care services from cross border areas [5].

From this perspective, the three pillars of the public health assistance, aiming: promotion of health, preventing diseases and improving the quality of life – have as support political and legislative measures, programs and strategies addressed to determinants of health.

In fact, EU countries reunite in their strategies directions of action similar to the ones at national level with the purpose of contributing to the public health improvement.

Health is an undeniable and an immeasurable resource of human personality, of the individual and of the society as a whole, placed among the most important national values.

In the opinion of the World Health Organisation, public health is identified with „the science that studies health problems of a population, the community health state, environmental hygiene services, sanitary general services and management of care services. It is closely related to concepts of preventive and social medicine, equally approaching EU health, veterinary public health”.

Approaching health as a first class competence, that joins efforts at national level, particularises it from other sciences by its procedural, progressive and multiaxial character. The role and importance of public health are coordinated with a direct impact on the way of approaching this field, in the sense that the health concept can be analysed only based on a set of criteria or under multi-criteria aspect.

On the other hand, the fact that health is a fundamental constitutional law and both a “national treasure” that sustains society’s evolution must not be omitted. From this perspective, it can be stated that there is equivalence between the concept of health and the quality of life.

As a corollary of the presented aspects, we underline that health investment, although it is not measured in terms of „immediate profitability”, constitutes that support of „society welfare” that creates externalities in the other fields of the economic and social activity.

In the given context, the public health care system is a long term investment imposing an effective connection between policies of this field and the other state social policies that ensures a flexible human capital, capable of managing any situation and guaranteeing probable evolutions of the environment in which it operates.

By summarising, we appreciate that on a national plan or as an integrated approach at national level, public assistance has a fundamental role in the regulatory, control and evaluation activity of the impact of other activity sectors with associated effects on the health of citizens.

The diagnose of the public health care system at national level, based on identifying slippages and dysfunctions is an action similar to diagnosing a patient by his/her attending physician.

Experts who evaluated the Romanian medical system, as well as governors invested with such powers focused their attention on the public health care analysis and evaluation, and the constant concern for improving the quality of indicators specific to this activity had as a finality the elaboration of some strategies for reforming the hospital system.

 „The National Strategy for the Rationalisation of Hospitals” [6], recently elaborated by the Ministry of Health in collaboration with experts of the World Bank, as well as with personalities with medical expertise brought to the foreground the difficulties of Romania’s health care system, by formulating requests that, to the extent in which they are implemented, they can contribute to the improvement and even reformation of the Romanian medical system.

The data and information of studies which were the basis for the strategy elaboration offer the possibility of a realistic assessment of the current state of the Romanian medical system.

We notice the fact that the evaluation of the public health care system as a whole cannot be dissociated by the
demographic situation of the country, by infrastructure and the dispersion of inhabitants on geographical areas, as these indicators directly influence the planning of medical networks and, implicitly, funds allocation with this destination.

Thus, even since 2006, a configuration of our country’s surface was planned (238.391 Km²) in eight development regions, without them having the territorial regime of some independent territorial-administrative entities, resulting from a consensus of local public authorities.

The administrative-territorial regionalisation was also motivated by the creation of some balanced areas from an economic point of view and in terms of inhabitants’ number so that procedures for accessing European funds to become as easy as possible.

Schematisation of the 8 euro-regions [7] with the attachment of some demographic indicators is presented as follows (table 1):

### Table 1. Demographic indicators, regions of Romania, 2008

<table>
<thead>
<tr>
<th>Region</th>
<th>Number of inhabitants</th>
<th>Surface</th>
<th>Ascribed counties</th>
</tr>
</thead>
<tbody>
<tr>
<td>NORTH-EAST</td>
<td>3.674.367</td>
<td>30.949 Km²</td>
<td>Iaşi, Neamţ, Suceava, Bacău and Vaslui</td>
</tr>
<tr>
<td>WEST</td>
<td>1.958.648</td>
<td>32.034 Km²</td>
<td>Arad, Caraş - Severin, Hunedoara and Timiş</td>
</tr>
<tr>
<td>NORTHERN - WEST</td>
<td>2.740.064</td>
<td>34.159 Km²</td>
<td>Bihor, Bistriţa-Năsăud, Cluj, Maramureş, Satu-Mare and Sălaj</td>
</tr>
<tr>
<td>CENTER</td>
<td>2.523.021</td>
<td>34.100 Km²</td>
<td>Alba, Sibiu, Mureş, Harghita, Covasna and Braşov</td>
</tr>
<tr>
<td>SOUTH-EAST</td>
<td>2.848.219</td>
<td>35.770 Km²</td>
<td>Vrancea, Galaţi, Brăila, Tulcea, Buzău and Constanţa</td>
</tr>
<tr>
<td>MUNtenia - SOUTH</td>
<td>3.379.406</td>
<td>34.450 Km²</td>
<td>Prahova, Dâmboviţa, Argeş, Ialomiaşul Călăraşi, Giurgiu and Teleorman</td>
</tr>
<tr>
<td>BUCHAREST - ILFOV</td>
<td>2.226.457</td>
<td>1.821 Km²</td>
<td>Bucharest and Ilfov</td>
</tr>
<tr>
<td>SOUTH-WEST</td>
<td>2.330.792</td>
<td>31.211 Km²</td>
<td>Mehedinţi, Gorj, Vâlcea, Olt and Dolj</td>
</tr>
</tbody>
</table>

The public health assessment involves the use of some indicators, representing specific sizes of probable evolutions commensuration, as well as of its determinants. As standardised units of information structuring [8], health care indicators measure interrelations between phenomena, by associating data available in a formula that should allow identification of components and changes occurred in the health care system.

Modifications operated in the medical system can be reproductive (radical or silent) and evolutionary [9] in the sense that they involve either fundamental structural modifications (such as those that determined the construction of some European models), or the improvement of already existent systems (for example the systems of Germany, Great Britain, the Netherlands etc.), by renouncing at the operation of some radical changes. In Europe the models applicable to health care systems take the following forms:

- Model of the national health service – NHS - Beveridge type;
- Model of the social health insurance system – SHI - Bismarck type;

- Model of a state centralised system - SCS - Semashko type.

### Diagnose of the Romanian Sanitary System

In Romania, the operational model of the public health care system was of Semashko [10], type, the management being exerted by the Ministry of Health, with funding provided from the state budget. The centralised decision-making act in terms of organisation and functioning of the medical system worked against an effective functioning. The model of Şemashko type is of Soviet inspiration and is based on the principle of equity and of free access to health care services.

According to this centralised type management, the public health care system is divided in different sectors with independent functioning. From this point of view there are no functional connections between primary assistance and the hospital one, between the care for promoting health and curative care.

Another disadvantage of the organisation form of Semashko type is reflected in the management plan of information specific to the system. Also, the study and assessment of intersectoral policies’ incidence on population’s health, intersectoral communication, as well as measuring impact economic and social factors is almost nonexistent. Or, performant management in terms of health care can be performed only by scientific models, rationally grounded, computer-assisted, and able to ensure the integrity and interrelation with the other sectors of economic and social life, given that health constitutes a determinant factor in ensuring the quality of life.

An illustrative role in the evaluation of the Romanian medical system is represented by the analysis in dynamics of some significant indicators, as well as natality and mortality.

According to official data available at national level, natality and mortality recorded during the time interval between 2000 and 2009, the following values (table 2):

### Table 2. Evolution of natality and mortality indicators, Romania, 2000-2009

<table>
<thead>
<tr>
<th>No.</th>
<th>Period</th>
<th>Natality</th>
<th>Mortality</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>2000</td>
<td>10.5</td>
<td>11.4</td>
</tr>
<tr>
<td>2.</td>
<td>2001</td>
<td>9.8</td>
<td>11.6</td>
</tr>
<tr>
<td>3.</td>
<td>2002</td>
<td>9.7</td>
<td>12.4</td>
</tr>
<tr>
<td>4.</td>
<td>2003</td>
<td>9.8</td>
<td>12.3</td>
</tr>
<tr>
<td>5.</td>
<td>2004</td>
<td>10.0</td>
<td>11.9</td>
</tr>
<tr>
<td>6.</td>
<td>2005</td>
<td>10.2</td>
<td>12.1</td>
</tr>
<tr>
<td>7.</td>
<td>2006</td>
<td>10.2</td>
<td>12.0</td>
</tr>
<tr>
<td>8.</td>
<td>2007</td>
<td>10.0</td>
<td>11.7</td>
</tr>
<tr>
<td>9.</td>
<td>2008</td>
<td>10.3</td>
<td>11.8</td>
</tr>
<tr>
<td>10.</td>
<td>2009</td>
<td>10.4</td>
<td>12.0</td>
</tr>
</tbody>
</table>

Source: MoH – NCOEHIS: Ministry of Health – National Centre for Organizing and Ensuring the Health Information System” (NCOEHIS) – Romania
The schematisation above reveals that the rate of natality for 1000 inhabitants recorded slight fluctuations, the general tendency marking a slight increase (graph 1).

The mortality rate in the comparable time interval placed above the natality rate level, with slight oscillations, but with an increase tendency.

The main causes of decease with incidence on the evolution recorded by the mortality rate were: diseases of the circulatory, respiratory and digestive system, tumours and accidents. It is significant the fact that the demographical indicator reflecting mortality is in a relation of dependency towards economic and social development, on a certain time horizon taken as reference in the analysis. Dissociation of the two concepts: mortality – economical and social development cannot ensure premises of a realistic evaluation of the public health system. Precarious economical and social situation, especially in rural areas, constitutes a major risk and a potential cause for the increase of the number of annual deceases.

Gross mortality rates to 100.000 inhabitants recorded on types of diseases in Romania, on a time horizon corresponding to the period of 2000 - 2008, is presented as follows (table 3):

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Diseases of the circulatory system</td>
<td>701.8</td>
<td>710.6</td>
<td>771.3</td>
<td>762.1</td>
<td>734.8</td>
<td>753.8</td>
<td>742.8</td>
<td>717.4</td>
<td>712.1</td>
</tr>
<tr>
<td>Tumours</td>
<td>184.0</td>
<td>190.8</td>
<td>199.1</td>
<td>201.0</td>
<td>203.0</td>
<td>207.7</td>
<td>210.6</td>
<td>210.7</td>
<td>216.2</td>
</tr>
<tr>
<td>Diseases of the respiratory system</td>
<td>66.1</td>
<td>62.9</td>
<td>70.6</td>
<td>64.7</td>
<td>63.1</td>
<td>61.7</td>
<td>58.7</td>
<td>58.8</td>
<td>57.2</td>
</tr>
<tr>
<td>Diseases of the digestive system</td>
<td>64.0</td>
<td>70.6</td>
<td>74.3</td>
<td>71.5</td>
<td>69.8</td>
<td>68.0</td>
<td>65.8</td>
<td>67.6</td>
<td>71.9</td>
</tr>
<tr>
<td>Accidents</td>
<td>64.2</td>
<td>63.7</td>
<td>66.9</td>
<td>65.0</td>
<td>62.1</td>
<td>60.3</td>
<td>59.2</td>
<td>56.9</td>
<td>59.5</td>
</tr>
</tbody>
</table>

In the chart below available official data are presented, of the standardised general mortality rate (in 100.000 inhabitants) indicator, recorded by some European countries, information with relevance in performing a comparison between the situation from Romania and these European states taken as reference (graph 2):

The examination of data presented in the chart reveals that Romania recorded high values of mortality, placing our country between the European states with unfavourable indicators, a fact confirmed also by the studies performed for the strategy elaboration in the health field.

We emphasize that a report made public in 2008 on the policies' analysis in the public health field, was recording the fact that the national health care system presents major dysfunctions, although some indicators specific to the domain recorded improvements [11]. In the document the fact that due to the inadequate sanitary system, some diseases that in European countries were eradicated long ago also currently affect a significant number of inhabitants, is noticed.

For supporting this assertion, it was estimated that the incidence of hepatitis B is double compared to the average of EU countries, and affections such as tuberculosis or cervical cancer majors the risk.
of cervical cancer, placing Romania among countries with a high mortality rate.

Considering the above, statistics at national level confirmed that the annual number of deceases exceeds 60,000 persons.

Also, it is not without significance the fact that mortality profile places Romania amongst less developed countries, given that most deaths are caused by infectious diseases, and infant mortality reaches critical values.

Theoretical Grounds and Pragmatism in the Management of Public Health Care System Reform

In order to objectively analyse the relation between knowing management theoretical grounds, presented in the material preamble and the pragmatism as an expression of the implementation of management functions in the process of public health care system reform, it is necessary to specify that according to the model of Denver epidemiological approach – derived from Lalonde’s concept, factors determining the health care are:

- biological factors (heredity, the demographic characteristics of the population);
- environmental factors (physical and social environmental factors);
- behavioural factors, attitudes, habits;
- health care services (preventive, curative, recuperative).

The present study focused on public health care services, as a subsystem of the health care system, its structure comprising a global distribution of functions between system organisations providing medical assistance.

As already mentioned, Romania inherited the Semashko system introduced from 1949 by Law of sanitary organisation, that had as a ground a centralised planning in which the state owned monopole on sanitary services, so that private providers of services were almost inexistent [12].

The Ministry of Health represented at the same time the authority at central level as well as the decisional centre for local authorities. After approximately five decades from the operationalisation of the Semashko model, the Romanian medical services were characterised by severe underfunding, unsuitable medical devices, unbalances and inequalities in ensuring medical services in different areas of the country, poor quality of medical services or of medical act, aspects with negative impact on the health status of the population.

In the given context, starting with 1990, the change of medical system organisation and functioning was imposed from itself, which led to the foundation of National Health Insurance House (CNAS).

The legislative project promoted in the initial phase aimed for a fundamental reformation of the system, in the sense that the administrative structures were elected at local level, disposing of autonomy and responsibility in collecting the wages as funding resources. Such a method of organisation offered to the local authority legality and responsibility, the local medical system being connected to the citizens’ needs. However, what seemed to be a substantial reformation of the medical system was not feasible, giving the conditions in which the legal regulation project was not accepted by the political spectrum, the law being fundamentally modified.

Nevertheless, we observe that authorising the functioning of private entities generated the liberalisation of medical services provision, decision that represented the timid trial of reforming the Romanian medical system.

Subsequently, the introduction of obligatory social health insurance system by renouncing to financial resources that came from taxes and fees, built another stage of change, ensuring the transition from the Semashko model to the Bismark model.

Legal regulations and legislative acts were constantly and progressively introduced through which structures of public health services were founded, offering them a complex pluralist character as opposed to the hyper-centralised system, inherited from the period prior to 1990.

In this context, the bodies with decisive role in planning, coordinating and funding the Romanian medical system are: the Ministry of Health and the county public health departments, National Health Insurance House, the county public health houses and the insurance houses of some ministers with own network of medical units; Bucharest College of Physicians from Romania and county colleges as well as other similar professional organisations; individual health services providers: medical offices, hospitals, diagnosis and treatment centers, pharmacies and laboratories.

Low no 95/2006 on healthcare reform makes CNAS legit as autonomous institution that manages the social health insurance system, with a three-party management having representatives from unions, employers’ associations and state authorities.

According to the law, CNAS is invested with competence in implementing and performing health national programs, being responsible at the same time for ensuring, following, highlighting and controlling the funds attributed to the healthcare field. Apart from these responsibilities, CNAS ensures monitoring, control and analysis of physical and efficiency indicators, through the health insurance house.

According to the results of some studies on this topic, in the public healthcare system there were some areas insufficiently well managed by the decision making factors aiming mainly aspects related to patient’s safety, ensuring the quality of the medical act and risk management.

Another area predisposed to major vulnerabilities, due to maintaining some obsolete mechanisms is constituted by allocating financial resources in a discretionary manner, without well defined criteria and without ensuring transparency in distributing them based on priorities.

Deficient management of information in healthcare system as well as the absence of some technical,
statistic data at a national level created the premises of ineffective use of much diminished financial resources in relation with needs, aspect that favours the wastefulness phenomenon of public funds attributed with this destination.

Medical assistance of centralised type generated the increase in number of medical units so that in 2008, Romanian medical system included the following structures (table 4).

Table 4. Absolute number of medical facilities, Romania, 2008

<table>
<thead>
<tr>
<th>Medical units</th>
<th>Number in 2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitals with possibilities of admission</td>
<td>457</td>
</tr>
<tr>
<td>Ambulatory units</td>
<td>897</td>
</tr>
<tr>
<td>Specialised medical offices</td>
<td>9,038</td>
</tr>
<tr>
<td>Imaging laboratories and medical units</td>
<td>2,555</td>
</tr>
<tr>
<td>Family medicine offices</td>
<td>11,279</td>
</tr>
<tr>
<td>General medicine offices</td>
<td>1,033</td>
</tr>
<tr>
<td>Dental offices</td>
<td>11,025</td>
</tr>
<tr>
<td>Pharmacies</td>
<td>6,127</td>
</tr>
</tbody>
</table>

Source: MoH - NCOEHIS

The hospital represents the entity with legal personality through which medical, preventive, curative and recovery services are provided. The Romanian framework of hospitals’ regularisation authorises the performance of medical scientific research activities, in their perimeter, based on some contracts concluded with the sponsor of the research.

The sanitary system focuses on hospital assistance, against some integrated networks of preventive, curative and recovery services. The absence of a realistic evaluation of the institutional and managerial capacity at local level constituted a barrier in accomplishment an authentic decentralisation.

In real plan, this step was materialised by transferring the responsibility in charge of local public authorities, which faced an acute lack of financial resources.

A compared analysis of the data provided by Eurostat, show that in Romania, hospital assistance prevails other intervention methods, registering at 2007 level a number of 215.13 admissions per 1,000 inhabitants.

The schematic representation at 2007 level of the admission rate per 100,000 inhabitants registered in some countries from the European Union is suggestive and reveals that Romania outruns some countries taken as reference in terms of hospital assistance as follows (graph 3):

In order to highlight the relation between the theoretical fundamentals of management and their pragmatism in performing the reform of public healthcare system, we propose a sequential analysis of managerial functions applied to the system, as follows:

The hospital management is initiated through planning, forecasting or „planning”, as first stage that sum up decisions related to defining objectives and its structural components, establishing the succession of circumscribed actions that are to be performed, attributing resources in compliance with the stages of the operational process, establishing the responsibilities and the calendar or the chart of activities’ execution.

Enunciating some assertions based on forecasting represents the first step of the management act of public health system, based on which the available resources and methods of their accession are positioned.

Forecasting or planning, represents the managerial instrument by which an effective alignment of the management vision with the attributed resources is performed, obtained based on the analysis of risks associated with medical activities.

Prior to the stage of actions planning the critical analysis of negative aspects identified in the system and presented succinctly in the preamble of this material, of the deficiencies or slippages that define the current status was imposed, in order to avoid the registered failures and to be able to guarantee the normality of future actions within the medical system.

Moreover, it is important to mention that the planning stage preceded by the analysis of present negative effects, creates the premises for decisional reconfiguration or remodelling, by identifying some new mechanisms and by applying effective methods and procedures for the activity execution.
Anticipating the acting method or prospecting the probable evolution of the processes or of actions that aim the medical system in its whole for a period of time, imposes the elaboration of some alternative, flexible, applicable plans in many more standard variants, intended to insure the expected results.

In this direction, the previsions as estimations of action directions are based on the probable evolution of influence factors, in order to diminish the associated risks and to avoid uncertainties in adopting some optimal decisions.

Based on the time spectrum to which it is reported to, the planning takes a strategic and operational form.

Strategic planning or the strategy represents a pragmatic directionality of actions and of objectives established on “long term”, phrase that aims to time spectrums corresponding to a period of time of three to five years, in which objective, actions and responsibilities are forecast depending on the financial resources attributed annually.

Performing the scheduled objectives is conditioned by their realism and by direct relationship with the quantitative and qualitative parameters that aim global results, necessary means and temporal dimension for which they were established.

Another level in the planning process hierarchy is represented by the operational planning, materialised by performing specific actions, implementing or operationalising the annual plan of activity structured on objectives, attributions and execution responsibilities.

Specific objectives regarding the decentralisation of medical services, which are assimilated to the defining elements of “planning” – function of hospital management, aim:

- the transfer of competences regarding the management of sanitary units with beds and the medical assistance management by the authorities of local or county public administration;
- redefining the role of the Ministry of Health in elaborating, implementing and monitoring public health politics and of regulations necessary for health system functioning [13].

For this purpose, after a preliminary evaluation, persons with expertise in this field appreciated that the local public authorities dispose of the necessary administrative capacity of ensuring the medical assistance management, in such manner that it could make possible the option of transferring a number of 370 hospitals from the total number of 435 subordinated to the Ministry of Health in the competence of local authorities.

In the public health system reforming action the sanitary management can not be achieved based on routine or amateurism, but by analysis and careful study of the determining factors and in direct relation with the available financial resources.

The income and expenses budget, as a managerial instrument is the authentic expression of a financial forecast necessary for accomplishing the operational programs, established in direct relation with the designed objectives.

Analysed from the perspective of the structure in which it is presented, the income and expenses budget reflects the composing sources of funds and their destination, becoming the synthetic instrument that directly influences the decisional and operational behaviour of the hospital’s management.

Generally, funding the Romanian medical system has been placed traditionally under the European average, registering in the last years a slight tendency of increase. According to official data, the amounts allocated to the sanitary system, expressed in absolute figures, marked an increase from 90 euro/inhabitant to 200 euro/inhabitant, and as GDP percentage from 3% to 4%.

The funding scheme of the hospital sector reveals that half of available financial resources are attributed from the budget of the Unique National Fund of Social Health Insurance (UNFSHI), these resources being supplemented with funds coming from the Ministry of Health budget, intended to perform investments, infrastructure and medical programs.

A supplementary generous source for financing health expenses, was introduced in 2006, coming from the vice tax instituted on alcohol and tobacco products. Complementary to the previously listed resources, expenses with the public healthcare field are also financed from own incomes, external credits or not repayable external credits, donations or sponsorships.

However, at national level, the predominant financing source is represented by the funds attributed by the National Health Insurance House, the contribution of local authorities in financing healthcare expenses being almost inexistent, giving that, according to official data, it only represents 1.2% out of the total.

Romanian hospitals are financed after the Diagnosis-related Groups system (DRG), even if in a declarative manner the phrase “money follows the patient” is invoked as a criterion or as financing principle.

According to the funds attribution system of DRG type, patients are classified in homogenous diagnosis groups under the aspect of clinical disease and treatment cost, and a fee for moderate case (TCP) is reimbursed to the hospital, which represents a medium cost, previously calculated and weighted for the respective diagnosis group.

The paternity of this system is attributed to Yale University from United States and appeared from the necessity to create a unitary framework of monitoring the services use from the hospital. The diagnosis groups are constituted in order to cover the pathology associated to acute type patients that need admission.
Specialty studies of experts in the field showed that, in terms of attributed expenses for public healthcare system, there are some rules which are far from being flexible, in which the personnel number cannot be directly related with the performed medical activity, but rather a direct connection between the medical personnel and the hospital’s organisational structure is identified.

Or, given that personnel costs represent on average 70% of the budget attributed at hospital level, it results that the resources allocated to cover other costs arising from the purchase of medicines, medical supplies or utilities, occupy a secondary position.

Therefore, from the analyzed management function, which aimed directly planning as a management function, we consider that in order to ensure a normal functioning of the public healthcare system, it must be acted to eradicate the accumulated imbalances, to identify new sources of funding the health system, while increasing the current funding allocation, expressed as a percentage of GDP.

In the systemic acceptance, the organization as management function, involves the concentration of leadership efforts, in order to design or configure a structural architecture comprising organic linked components, which ensures the functioning and regulation of the entire system.

The management organisation function represents a continuous process of making the internal components appropriate with the exigencies of pre-established or pre-defined objectives.

In the sense of the presented aspects, the organisational framework of the hospital aims for two reference levels, two components or two approach perspectives: procedural or structural.

The procedural component of the management organisation function results from the division or detailing internal activities performed by sanitary units in order to achieve planned objectives (fundamental, derived, specific and individual).

Under this aspect, the procedural organisation imposes the identification of actions, competences, attributions and individual responsibilities in relation with the specific requirements of the field, in order to operationalise and implement scheduled objectives.

Structural organisation takes a synthetic form, in the sense of grouping the elements specific to the performed activities or of activity’s components, in order to define the positions and the compartments of a legal entity, which in the present case is represent by the hospitals.

Within the structural approach, a determinant role is played by elaborating documents specific to the performed activity, documents that have to be approved in the conditions in which they comply with the elaboration requirements in a clear, concise and coherent manner, in order to avoid confusions and errors of interpretation and application.

The organisational structure of a hospital contains as a defining element the position, specialised and individualised segment on the person that occupies it, defined as the most simple organisation component which accumulates attributions, responsibilities and individual competences, necessary for performing forecasted objectives.

Individual, general or derived objectives are transposed, on the one hand, in attributions or duties corresponding to the positions, and on the other hand, in aggregate structural components, such as behaviours, so that the management control can operate effectively within an appropriate organizational structure.

In another plan, a component subsequent to the structural organisation that requires increased attention of hospitals is represented by the design of the informational system. This derives from the necessity of having access in real time to international flows and circuits, to processing, storage and information transmission means in order to optimise decision making.

In the conditions in which the Romanian medical system is designed and it functions based on a considerable territorial dispersion in the sense that it disposes of a broad area of action (county, urban sanitary units, etc.), the management must use the informational flows (I.T.) with priority against the direct observation, which, generally alters or delays the relevant information which is so necessary in subtending and adopting optimal decisions.

From this point of view we appreciate that at national level there is no integrated system of collecting and managing information from the medical field. We dispose of independent informational flows, which offer information that does not consolidate the decisional or operational function, as they are not submitted to an integrated processing process.

Therefore, the informational component designed to bring additional knowledge, generally takes the form of two systems which are parallelly managed by the Ministry of Health and the National Health Insurance House. In the given context, the databases system with medical character does not facilitate the provision of informational support which is very necessary in adopting some optimal decisions.

In an executive summary, it can be appreciated that from a theoretical point of view, the organisation as a management function defines the hierarchy of a hospital, so that, through an adequate communication between the compartments and the positions procedurally delimited, the financial resources are rationally distributed towards the forecasted objectives.

In real plan, the vulnerabilities identified in the Romanian medical system emerge, as mentioned, from concentrating the medical activity around the Ministry of Health and of medical personnel; the patient as a direct subject of law of the medical act, of the acute need of health services, has no decisional right on the system that he/she is funding.
Apart from this aspect, we notice that at a national level we dispose of a deficient management of information, in the sense in which the sanitary system manages an information portfolio insufficiently well organized and processed that generates malfunctioning measured by redundancy, informational circuits overload or distortion of the informational message.

Related to hospitals’ management, this is ensured by a manager (natural or legal person) based on the management contract, signed on a period of 3 years, in which performance indicators are provided being subject to an annual evaluation.

Generally, hospital’ management is governed by centralism, the lack of a flexibility which is so necessary and bureaucracy.

In terms of performing the reformation process in the healthcare field, World Bank presented models of organizational change, which are materialized by decreasing the governmental control directly exercised on public hospitals and their more pronounced exposure to the market or quasi-market, or aspects aiming: empowerment, corporatization and privatization [14].

Under this aspect “The National Strategy for the Rationalisation of Hospitals” notices the insufficiency of specialty personnel in the preventive assistance, medico-social, of public health and healthcare management areas, stating that a concentration of medical personnel in urban and in hospitals is registered against the medical system from rural areas.

Based on the data provided by the National Institute of Statistics, in the diagram presented below a comparison done at international level related to the number of medical personnel with superior studies from the European Union that is active from the professionally perspective is showed at the level of 2007 as follows (graph 4):

_Graph 4. Number of medical personnel with superior studies active from the professional point of view, European Union, 2007_

The analysis of human resources performed from another perspective, reveals that at 2009 level, the sanitary system benefited of a number of 204.3 thousands of medical sanitary professionals, as compared with 194.1 thousands of medical sanitary professionals registered in 2006.

Also, according to official data provided by the National Institute of Statistics, in 2009, there were on average 426 inhabitants per physician as opposed to 460 inhabitants in 2006 (excluding dentists).

Available statistic data also confirmed that in 2009, for 10 000 inhabitants there were: 23.5 physicians, 5.8 dentists; 5.6 pharmacists and 60.3 medium sanitary personnel [15].

To summarize, we consider that medical and non-medical personnel that represent the most important resource of the system faces two major problems regarding two reference levels: total number of employees employed in the system and their distribution on medical specialties or fields. Also, we cannot ignore the fact that the medical system faces an acute shortage of medical staff at national level, since the free movement of workers within the Community.

In another plan, human resource management is deeply affected by the existence of a system deficient in motivating its personnel, inadequate work conditions, limited opportunities in terms of career development.

**CONCLUSIONS**

To conclude, we can appreciate that current public health system, summarizes inadequate organizational policies, applied gradually over at least two decades, in which the increased administrative bureaucracy operated against a flexible system that would allow the attention to be focused on achieving a high-quality medical act.

Taking into consideration the precarious state of public health system registered at a national level since 2009, summarily presented, healthcare decision makers, government experts, representatives of the World Bank, prestigious personalities of medical life, based on a realistic assessment, have combined efforts in order to establish within the national strategy for the rationalisation of hospitals, general and specific objectives regarding the reorganization and improvement of hospitals, as well as concerning the decentralization of hospital management.

We emphasize that the concern for health reform was strongly manifested in the last two years, aspect confirmed by performing general objectives and specific to the field, provided in the national strategy for the rationalisation of hospitals. According to this document, the operational activities required for the public health system reforming process are contained in an action plan to be implemented by institutions authorised in this regard,
such as: Ministry of Health, National Health Insurance House, National School of Public Health and Sanitary Management.

The operational plan should be done after a schedule that includes the 2011-2012 period and that mainly covers the following activities:

- hospital network reorganization following the geography of the established demographic areas (the eight Euro-regions which were previously named), achieved by a judicious distribution of hospitals, designed by the local and regional map;
- implementing the information system integrated at national level that can allow the management of a complete database, necessary in optimising decisions and their adoption in real time;
- reconsider the hospital financing system (DRG system), attributing resources after a chart that aims a proper sizing of personnel costs, correlated with decreasing the excess capacity of admission;
- adopting a system aimed at introducing modest co-payment directly to the healthcare provider, showing a reasonable care to disadvantaged people, in order to use compensatory financing mechanisms;
- identification and use of appropriate financing mechanisms to facilitate the attraction of private insurers in the health insurance system.

Lines of action to be implemented shall offer the national health system minimal features aimed at providing high quality health services, in which patients have the dual role of donors (through contributions paid to social health insurance) and of partners in making the best decisions to ensure a high level of medical services.

Translated by: Alina Cumpănășoă, a sworn translator authorized by the Ministry of Justice of Romania

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