THE CRISIS MANAGEMENT AND THE QUALITY OF CARE IN THE ROMANIAN SOCIAL HEALTH INSURANCE SYSTEM

Interview with:
Nicolae Lucian DUTĂ, President of National Health Insurance House (NHIH),

Personal information
Birth date: 28 January 1970,
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Professional Experience
•2009–present – National Health Insurance House, president;
•2009 February – 2009 December- National Society of Salt S.A. – SALROM, General Manager;
•2007, Clinical Hospital CF nr. 2, Bucharest, manager;
•October 2004 –July 2006, County Hospital „Sfinții Constantin și Elena”, Ilfov county, General Manager;
•2004, Health Ministry – Nursing Directorate General, Deputy Director General;
•2002-2004, Romanian Academy of Sciences, researcher (by examination);
•2001-2003, University Emergency Hospital, Bucharest, research assistant;

Studies
•2002– present, Endoscopy skills (skills obtained through theoretical and practical sessions)
•2006, PhD Title: „Contributions to the study of esophagus architecture”
•2001-2006, PhD in anatomy
•2001, Specialist general surgery
•1998-2001, General surgery resident physician, Emergency University Hospital Bucharest
•1996 – 1998, Urology resident physician, „Theodor Burghelu” Hospital, Bucharest + Emergency University Hospital Bucharest
•1989 – 1995, BS, School of Medicine – Craiova University
•1985 – 1988, Diploma, Industrial High School nr.2, Department of Mathematics-Physics, Mangalia, Constanta County

Scientific activity
•Numerous papers and conference participation and Congress on surgery and esophagus
•Co-author of the Treaty of Surgery of the Surgery Clinic 2 from the Emergency University Hospital Bucharest
•Co-author in various scientific research grants – gynecology and urology
•Scientific co-author (medical advisor) to achievement of the IT hospital management program „Management@Spital.ro”
•Graduate of hospital management course organized by SNSPMPDS Bucharest.

Personal skills and competences (accumulated lifetime and career, not necessarily endorsed through certificates or diplomas)
•2004 – 2009, General Counsel– General Council of Bucharest
•2004 – 2008, Chairman of the Health and Welfare– General Council;
•2008 – 2009, Project Implementation „, Decentralization of hospitals in Bucharest”, in collaboration with the General Council of Bucharest;
•2008, Negotiator with the Ministry of Health the pilot project with the theme „, Decentralization of hospitals in Bucharest”.

Languages
English (reading, writing, speaking)

Q1. Mister President, for Romania, the year 2010 seems a year when the crisis management will play an important role in the administration. The Social Health Insurance System was and remains one system which raised problems even in the absence of conditions of economic crisis. - Which is your vision for managing the National Health Insurance House, now when the global economic crisis led to economic recession in Romania?

Lucian Duță: If we talk about crisis management and the health crisis, we can say that there is also a good opportunity. Romanian health system is deeply unformed, and the arrival of the economic crisis revealed all its weak points. The concepts of health crisis and the crisis management were used immediately after the revolution, so there is neither the first, nor the last time when we talk about crisis management. If until a few years ago we used to hide the reality “under the carpet”, the year 2010 represents the moment when the society was forced to recognize that the health system is not reformed. Thus, we talk about two major coordinates for crisis management in 2010: first of all, the unreformed health system, which has deep political reasons and secondly, the real economic crisis. Therefore, based on these two coordinates, I believe that crisis management includes a Governmental (macro) part, which is an economic one and another part which depends strictly on the health system managers, i.e. the ministry of health and the president of the National Health Insurance House, who at least can start the process of reforming the health system. In this moment, we can not talk about a crisis management only in the health insurance system, but there is an extended crisis management, because it has a profound economic side.

Q2. Some of the measures envisaged for 2010 appear to be in the detriment of the patients. Since the insured persons are the main contributors to the fund you manage, their high expectations with regard to access to high quality health services are entitled, and in times of crisis one of the indicators required to be
achieved remains to ensure an optimal level of services provided. In this respect:

- What are the main directions of action in regard to health benefit package for NHIH insured persons?

L.D: You said very well that some of the measures we proposed in the Framework Contract seem somewhat unfriendly to patients. The implementation in practice, however, will prove that the benefits of these measures are good. The assumptions related to the patient we used when we started this year of crisis had two components: one is the accessibility, meaning the provision of access for all patients to health services, and the other is the medical effectiveness, meaning that within a year of crisis, like this, with limited resources, we can ensure a minimum quality of medical services which gives the patients the safety of not threatening their life within the health system.

Q3. Mister President, the issue of the Framework Contract has led, every year, to complains from at least one category of health services providers. For year 2010 there are already some issues raised, mainly from the College of Physicians and family physicians. However, transparent discussions with representatives of family physicians subsequently led to consensus on correct understanding of the measures from the 2010 Framework Contract.

- What are the news, concerning the patients, respectively the health services providers, under the 2010 Framework Contract?

L.D: The most important thing, and the one which is much debated in this Framework Contract, is the re-definition of what it means the reference price of drugs. This aspect needs to be discussed with the utmost seriousness and maximum arguments. Have you seen „the attacks” of the drugs manufacturers? They did not waited, even, to see our definition of the reference price based on classes and groups of therapeutical drugs and then to start having comments! They claim that we want to take the level of treatment 20 – 30 years ago. But, in reality, what means the redefinition of the reference price of drugs?

It means that the drugs are divided into classes, the so-called ATC and the NHIH will cover the price of only one generic drug from each therapeutic class. More specifically, we will take in account the daily therapeutic dose and the drug price, so overall we can stay within a normal budget. I say “normal” budget, because I have to recall you that in 2007, NHIH paid for ambulatory reimbursed drugs 700 millions Euro and immediately after the budget cap removal from pharmacies (in 2008), in a single year the NHIH payment increased by 50%, to around 1 billion Euro. At this point, the drugs consumption in the system is not at all controllable, in any way. Therefore, I would say that the introduction of the new reference price for drugs might actually reduce the user charges for some type of patients. In conclusion, I think that the new reference price for drugs is the most important change in the Framework Contract that concerns the patients.

Regarding the medical providers, firstly, I will start with the family physicians. At their level, we have increased the level of payment at the Fee for Service reimbursement from 10 to 30% and consequently we have decreased the per capita payment from 90 to 70% and we limited also the number of enrollees at per capita for a maximum level of 2200 patients. In my opinion, these measures have two immediate consequences. On one hand, they stimulate the provision of medical services and on the other they open the market for young physicians in order to be able to create their own lists of patients. Concerning the ancillary services I believe that for the first time we are able to introduce compulsory certificates for quality, issues by RENAR (N.R. a Romanian Accreditation Agency), which will practically force out of the market the untrustworthy providers. Regarding the hospital services, there are no important changes for year 2010.

Q4. While the existing IT system applicable at the LHHH and NHIH levels is a performing one, yet there are false reports of fictive cases or incorrect assignment of the cases in DRG categories. These reports induce in the system financial deficits and the inability to appreciate the activity and the actual expenses at institutional level. Recently, important voices at the political level have reported this issue of false reporting of medical services, giving it a breaking role in the process of efficiency improvement.

- What are the measures taken to ensure that NHIH pays only services actually delivered to the patients (reported end paid) and not the services which were not delivered to the patients?

L.D: First, we must have a good computer system (IT system) in place. You know very well that, because of poor management during the last 10 years at the level of NHIH and Ministry of Health, unfortunately, they where unable to implement an efficient computer system. In summary, the computer system has four components, namely SIUI (the Unique Integrated Information System), the electronic patient prescription, the electronic patient record and the patient card. For some reasons that I do not want to comment now, during the period of the previous Minister of Health, Mr. Nicolaescu, the system has been broken in two and the electronic patient prescription and the electronic patient record arrived in the “court” of the Ministry of Health. Consequently NHIH was not able to keep a unique and integrated vision regarding the IT system for the health and NHIH. At this moment, we have only one of the four components that really works (with certain deficiencies, but it works! namely the SIUI, but even the SIUI requires an up-grade during the following months. Regarding the remaining three components, we are in negotiation with Ministry of Health at this time and we think we will get them NHIH level, in order to be able to integrate them in a real health IT system.
Q5. The main mechanism for hospital payment in Romania is the DRG system, a performance-based funding system, which pays depending on the complexity of the activity provided toward each patient. Each year the DRG system has undergone some changes, moving from a standardized internationally system (Australian experience) to a system adapted to local conditions and needs. Also the process of decentralization of hospitals continues, local authorities taking over the ownership of hospitals and, with it, the responsibility for the maintenance and effective management of hospitals.

- What are the main measures that can be applied to improve the hospitals payment mechanisms and the transparency of funds allocation, together with the optimizing of hospitals resource allocation?

L.D: First and the most important, we have to say once and for all, that we need to the introduction of quality criteria, namely the accreditation of hospitals. Once established that criteria we’re talking about 20 years, NHIH can say towards the market players, and here I mean the hospitals, “you have accreditation or not and consequently we will contract with you or we will not”. Thus, all those hospitals that are social establishments rather than medical providers (and I mean that in Romania we have maybe hundreds of such hospitals) would somehow be forced to reform and get transformed in other type of institutions or medical providers adapted to the local needs. We are used to call hospitals, and to finance them like hospitals, any social institution that, often, only pretend to offer health care services. This should be the first criterion on which the NHIH should establish a contract with a hospital. Secondly, we should talk about quality of medical services and should find some criteria on which to provide some hospitals with greater resources and some other with less, depending on the quality of the services provided. At the present time, unfortunately, none of this things have been done and all hospitals are founded in the same way. Consequently there are some hospitals, that are providing quality services and hospitals that work almost nothing in reality, but take the same amount of money. In my opinion, this is one of the most difficult aspect of the health reform, that we have to assume that some the hospitals need to be reformed and their role in the system must be redesigned.

- Do you believe that the decentralisation measures of the hospitals towards the local authorities will have an impact in the relationship of the hospitals with the NHIH?

L.D: I was in the past, but also I am one of the great supporters of the health system decentralisation. If you remember, two years ago I was the head of the negotiating committee with the Ministry of Health and I managed to develop the decentralization pilot project in Bucharest. Today, when we talking about the decentralization, only the 18 pilot hospitals in Bucharest are the landmark, the process being considered a success. Overall, decentralisation will have a major impact, because gradually the local community will have to say very clearly, after the decentralisation, whether they will or will not want to have those hospitals. Because for a hospital, you can not only appoint the Director and then saying you have a hospital, but it means that you must assume it, like a kindergarten, or a school. And a hospital is a resources generator without which we can not live. Then, the local community and the society must assume it. And the accreditation process and the health care services quality must be assumed by the local authority (after decentralisation and the passage of hospitals under local authorities subordination). NHIH relationship with the hospitals will be affected positively or negatively depending on the hospitals relationship with the local authorities.

Q6. A significant part of the health providers activity is oriented towards sick leave prescription. The new Government Ordinance on sick leave will be implemented from the 1st of June 2010 and is expected to bring many benefits to the system.

- What are the benefits you predict/estimate that based on the new Ordinance concerning sick leave?

L.D: First it will have an impact on the employers and the institution who pays the sick leave, namely the NHIH. They will be the main beneficiaries. Second, we most say it frankly, some of the sick leaves in Romania are false, in reality. These sick leaves are given when people feel like they need picking the grapes in autumn, they are in the mood for few days of paid leave or have various other problems (e.g. when one hears that it’s job is being restructured). I tell you from my experience that when I was Director of the National Salt Company, the employees being paid in agreement with the production, some of them knew that during the summer months there is no production and they will have low wages. Then, in the summer they took sick leave because that way their incomes where higher and in winter they start working and took salaries of 150-200%. I had no time for changing this behaviour, which was also unfair towards their colleagues. Although many persons find the Ordinance as a hilarious measure and others consider it inappropriate, my opinion is that it will produce the desired effect: no more incentives for prescription of sick leave, if it will be applied with determination and consistent efforts. If the patient is on sick leave, the patient will have to stay at home, not all day long, but will have to announce the residence and will assume its responsibility to be at home; the patient can leave home for several hours, but otherwise the patient will have to stay at home, because the person is sick and the sick leave is given to stay at home. I hope the things will work this way.

Thank you for your kindness to answer to questions.

Interview translated by dr. Mihnea Serban Dosius