The Short and Medium Term Health Ministry Strategy

Interview with the Romanian Health Minister Ladislau RITLI

Personal information
Date of birth: 08 June 1948, Oradea, Bihor county
Marital status: married, 2 children

Specializations
1997 – University of Medicine and Pharmacy „Carol Davila”, Bucharest
1973 – Institute of Medicine and Pharmacy, Timișoara; Pediatrics Senior Pediatric Physician; Specialist in Public Health and Management; Specialist in Oncology

Professional experience
2009 - 2011 Medical Director - Dr.Gavril Curteanu Hospital, Oradea
2003 – 2009 General Director – Public Health Authority (PHA), Bihor
2002 – 2003 General Director – Clinic Children’s Hospital, Oradea

Teaching activity
2009 – present Deputy Head, Medical Department of Oradea University; Faculty of Medicine
2006 – 2009 Deputy Head, Department of Pediatrics, Oradea University; Faculty of Medicine
2003 – present Associate Profesor, Department of Pediatrics, Oradea University; Faculty of Medicine
1998 – 2003 Lecturer, Department of Pediatrics, Oradea University; Faculty of Medicine

Others: Teaching materials (courses, practical guides, electronic materials) elaborated: 6; Books, monographs, treaties: 4; Scientific papers published and communicated (total no.): 43

National/international studies, grants/contracts
2007 – 2010 Coordinator: „Rapid alert systems in case of epidemics”; project lead by PHA Bihor in collaboration with ANTS Beker, Hungary
2008 Coordinator „Epidemiological study regarding the awareness on organ transplantation"
2008 National research study „Approach to improvement of haemophilia care in Romania” Novo Nordisk Haemophilia Foundation
2007 Health promotion campaign „Together for children’s health”, coordinated by the Pediatric Department of Romanian Society of Pneumology, financed by GSK - Romania
2006 – 2007 Coordinator - Study „Prevalence of asthma in 9-10 years children cohorts, Oradea”, coordinated by PHA Bihor, financed by MSD
2007 International Project „IL 1 – TRAP in treatment of systemic JIA”, financed by Regeneran Pharmaceutical, coordinated by PRINTO, Switzerland-Italia (step 1- Feasibility study) etc.

Member in professional associations
Present – member of the Romanian Association of Public Health and Management
1996-1998 Vice president of the Romanian Association of Public Health and Management
1995 President of the Romanian Association of Public Health and Management
Member of the Romanian Society of Pediatrics
Vice president of the Romanian Society of Pediatric Oncohematology
Member of the Romanian College of Physicians

Foreign languages: Hungarian, English, French

R: Minister, it could be said that the Ministry of Health is one of the very difficult ministries to be coordinated, and you have the possibility and responsibility to develop a high-performing health system able to insure high quality healthcare to all citizens. In times of economic crisis government is proving difficult in terms of providing solutions and results expected by the professionals and population, but even in these difficult conditions the central management of the health system should identify critical points and predict appropriate solutions for the area coordinated by it.

- Please describe the main issues facing the healthcare system in Romania and also the strategic priorities of the Ministry of Health (MoH) on short and medium term?

Ritli Ladislau: Priorities are part of the MoH strategy and they are correlated with the main problems of the health system; they were the key points on the agenda of the sessions planned in this regard at the beginning of this year.

Regarding the current period, I would like to refer to the priorities for 2012 because they are elaborated in close correlation with my mandate term. In this context, these priorities can be divided into several domains/pillars:

- the first domain is represented by the health care providing.

It is essential to implement an intervention plan to ensure, on one hand, the completeness and continuity of healthcare, and on the other hand, the hospitals relieving of cases that do not necessarily call for continued hospitalization (eg: by targeting funds to primary care and day hospitalization); a first step was already taken, the percentage of primary care funding increased to 15%, and the point per capita increased in value from 3 to 3.5 Ron, while the agreed strategy for the family doctor payment is to increase the fee-for service part of their activity. Although the Romanian hospitals look much better than a decade ago, and the reality also proves this, the hospital system remains one of the sectors on which we must especially turn our attention. The first problem would be related to the overcrowding and extra-charging hospitals with simple cases that could be solved by providing cheaper services with the same effectiveness. Therefore, money for specific hospital care does not reach to all cases, and I am referring to severe and serious and life-threatening cases.

Emergency care sector, most of it, works very well, but in addition of SMURD and Emergency Receiving Units (UPU) we need to establish hospital departments able to take over all emergency cases, equally functional and well equipped: the reform of emergency care sector must continue on this path, and in that sense, for this year we planned further development of infrastructure in this sector with the procurement of two helicopters and several ambulances equipped at high standards.

Another constituent of health care, hardly ignored, is represented by medical offices for students, community care,
and social medical units wherefore some programs should be developed with local authorities in order to push forward expansion of these networks.

Of course, all these levels of healthcare must be integrated and connected, such as that integrated system provides a foundation for efficient and continuous health services provision that patient needs. And for a prospective ensuring the continuity of services we consider the possibility of developing specialized networks (oncology, pediatrics, diabetes, nutrition, etc.) around family doctors or specialists doctors (if applicable); these networks should include multidisciplinary specialists teams, so the patient will be in the centre of the network activity and will be treated and monitored throughout the all pathway during the illness and the case management will be assured from the patient system entry to the case resolution.

In this regard, we appreciate that significant steps have been taken, partially, the core of these multidisciplinary teams was assured and, in this respect, I mention community nurses and roma health mediators, for which we get a 25% increase in number (number provided by the State Budget Law for 2012); of course, their employment problems persist (requiring unlocking the jobs, with some difficulties) but, strategically, we must apply the action plan that we developed, with as few concessions as possible.

Another strategic component might be ensuring access to medical services, and mainly for the rural population. In this regard, it should be noted that the number of permanent medical centres was doubled, and for their funding we will consider a further evaluation of the sums allocated; we also took into account the existence of multifunctional centres closer to rural areas so that through these measures to improve the access of rural population.

- the second domain is represented by prevention. Prevention represents one of the main objectives of public health, next to health promotion and life quality improvement.

National Health Programs is a model applied in many countries and the major benefit of their implementation is the fact that they are consistent with population needs and allow their prioritization and implementation of those most efficient that bring major benefits to the population, despite of the insufficient financial resources.

As regarding communicable diseases, we intend to continue the vaccination program for communicable diseases prevention, program that has been proving to be effective and efficient.

Non-communicable diseases raise large public health problems, especially by their mortality and morbidity rates but also in terms of treatment effectiveness. Therefore, we have to continue some of the national programs and for oncology (where the preventive component was missing), we consider starting a screening program for cervical cancer; medical education and promotion campaigns that aim to awareness and inform people about the negative consequences caused by cervical cancer and about the importance of early stage disease detection should continue; the coordinator of these programs should receive the money allocated for prevention component.

This problem of money allocation where resources are consumed is another problem to be solved immediately: for example, money for the preventive health programs should get/stay in MoH which is the coordinating institution for prevention and health promotion actions. If we take as example the implementation of cervical cancer screening, it will result a reduction in costs for treating this disease, the necessary money to carry out the screening (and by our calculations, we rely on screening 600,000 women per year - of the total of 1,200,000 women eligible for this program over a five years period of implementation) should be managed by MoH (and not by CNAS).

Maternal and child health is one of the priorities that made us to extend the new-born screening program (eg. for phenylkeltonuria, hearing disorders, etc.) and to start a monitoring program for pregnant women and infant.

- the third domain is the financial management

The resources of the health system are insufficient and our activity will focus on detection of supplementary financial resources and solutions for revenues increase, and cut off financial losses mechanisms. A major component of our strategy is the regulation of pharmaceuticals, and here were already addressed some mechanisms like clawback or the list of generic drugs, and at this stage we aim to continue the drug policy in order to ensure access to cheap and rare drugs (manufactured in small quantity on drug market); we consider the development and exploitation to a maximum capacity of the local drugs industry (Unifarm, Antibiotics Iasi, Institute “Cantacuzino” etc.) in a common effort to protect ourselves against unexpected fluctuations of the pharmaceuticals market.

Also, by introducing co-payment system, we rely on a medical services providing system adjustment. This mechanism of co-payment has the role to adjust the patient circuit in the system and will be a control mechanism of costs and of inefficient use of system services.

Of course, the selection of a basic package of services to be covered by public contributions to National Found of Health Insurance is on our list of priorities and, perhaps by the end of April, we will be able to present this basic package.

- strengthening and broading of public health activity coordination, responsibility of MoH, by rethinking the entire control system. Decentralization of Public Health Directorates will go on; these authorities will have and will perform coordinated tasks, in order to lead to a prolific level of discipline (financial, technical, etc.) and to facilitate activities coordination of the entire health system.

R: Minister, there are almost two decades of health reforms and results are most often debatable. Romanian health reform has reached that stage where should be reformed itself and current efforts proved a forces back off where health and allied health specialists, health professionals and patients associations, and the civil society in general try to identify best solutions for the time being and consensus.

- What elements do you consider the new Health Law should include?
RL: Although the law proposal from the beginning of this year contained important elements accepted by professionals, mostly the public was not informed enough, and I think this was a weakness of the process.

Regarding the new law, of course, the major element will be the funding mixed formula (public-private) expected to be introduced in the new law. We can not predict the weight of the two components, because the option of choice belongs to the population who may opt both for the basic package and for the additional package of medical services, either a public insurance or a private one; perhaps, at the beginning, the share will be in favor of public insurance (population will decide this issue). This solution will increase population access to health services; even today a large portion of the population prefer and sometime is even forced to use good quality private services, being willing to pay out of pocket (usually co-payment) for private services received. In this situation, hospitals need an overhaul, and we considered several solutions and theories of which I would like to stress empowerment, corporatization, and privatization. All are viable solutions, and the idea of public hospital with private management seems to take shape at this stage; these conditions seem to be met in the foundations which allow staffing based on carefully evaluated needs and without legal constraints. It is not mandatory that all hospitals become foundations; this is an option of the owner: either State or local authority. Conversion of a hospital in foundation allows the establishment and implementation of performance based payment mechanisms.

Population benefits reside in the ability to choose between a District Health Insurance House or a Private Health Insurance Agency, being able to choose (by paying an premium) and type of additional services not included in the basic package (eg elective surgery, dental, and even on-demand services etc.); this right to choose will be reflected in an increased access to services. The basic package is not reduced and the list of drugs covered by insurance did not undergone major changes. So, population will have a basic package and for additional services will be able to choose good quality services (in public or private sector).

Another major element is the development of an efficient quality control system in order to guarantee the quality of care (technology, procedures, guidelines, etc.).

Population acceptance on law proposals represents a priority for the law development. In this respect, it was formed a team of specialists and experts working on the law, and I personally will take care to acquire involvement and active participation of all stakeholders (professionals and patients associations, civil society etc.).

R: In a financial crisis period that cut off major investment initiatives, human resource represents the health system engine. One of the leading causes for the insufficient number of medical staff is the migration of health professionals, and the current crisis will contribute to the increase of migration phenomenon of health professionals in other countries were the level of remuneration is higher.

- What incentives did you imagine in order to stop health professional’s migration and to motivate physicians to work in these areas so that the continuity of basic healthcare to be assured (especially in rural areas)?

RL: This is a very common question because it is a real problem; it is due to the working conditions and remuneration. State invests in training medical professionals (doctors, nurses), but is unable to provide a satisfying salary. MoH can interfere by implementing measures related to resources planning such as creating more jobs, new specialties, increasing the opportunities for postgraduate specialization (eg to establish two residency sessions per year, etc.), and also by assuring conditions for multiple fields postgraduate training.

Moreover, the community can interfere indirectly by providing incentives (housing, transport etc.), and under future circumstances when hospitals become foundations, these foundations will be more flexible and able to provide incentives from funds saved for this purpose.

R: The hospital system has undergone great changes over the past two years, both in terms of management and in the reorganization. Hospital restructuring has led inevitably, and as expected, to complains from professionals and population. Since the target audience of our journal cover also hospital managers:

- How do you imagine the hospital system development in the future?

RL: Reorganization of the hospital system is on the right track. Despite the dissolution of some hospitals, the money is hold in the system. They went up to improve conditions in those hospitals providing effectively hospital-based services. Transforming disband hospitals in nursing homes, medical and social centers, multifunctional centers, I feel is a good measure facilitating the progress in the hospital system reform, so that population will benefit of quality health care.

Restructuring hospital beds is also a key point for hospitals improvement. The National Beds Plan was not set to dismantle in fact a number of beds, but required standards accounting, in fact, for contracting restrain. The financial benefits are obvious and we can relocated the most of the hospital beds that remain in place to other activities in order to provide services like one day healthcare, private services etc.

Management is a profession today, and it should be treated as such. Professionalism of healthcare managers should be grounded by an authorized specialist training. I recommend that management training should be followed in our country and not abroad, because the manager will have to deal with special conditions present in the place where, in fact, they will practice.