Romania – Health Sector

Policy Note

ECSHD
HEALTH SECTOR

Summary: Health outcomes in Romania have steadily improved during the last decade. But further improvements are needed and will require that health policy makers meet four core objectives: (i) increasing access; (ii) reducing the burden of health spending on households; (iii) focusing spending on prevention and primary care and (iv) improving hospital performance and quality of care. Current health spending is biased toward costly in-patient hospital care. Correcting this bias is the single most important step Romania can take towards meeting these objectives in order to improve health outcomes and increase the welfare return on its public investment in health. This note builds on the findings and conclusions from the World Bank’s most recent work on health as an input to the Bank’s program of support to Romania’s health sector over the next three years.

I. Health Outcomes in Romania and International Benchmarks

1. After a period during the mid-1990s when health indicators worsened, outcomes have improved; however, Romania still lags behind its peers. Some health indicators such as male life expectancy and standardized death rates (SDRs) worsened in the mid-1990s while others continued to improve. Maternal and infant mortality are now at their lowest levels since 1970. Infant mortality rates are below the average of countries with similar income levels, while maternal mortality is slightly above average. However, these rates are higher than every other country in the European Union, and the other candidates for accession.

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<tbody>
<tr>
<td>Female life expectancy at birth</td>
<td>70</td>
<td>72</td>
<td>73</td>
<td>74</td>
<td>75</td>
<td>76</td>
</tr>
<tr>
<td>Male life expectancy at birth</td>
<td>66</td>
<td>67</td>
<td>67</td>
<td>66</td>
<td>68</td>
<td>68</td>
</tr>
<tr>
<td>SDR ischemic heart disease 0-64 per 100,000 males</td>
<td>26</td>
<td>42</td>
<td>55</td>
<td>72</td>
<td>63</td>
<td>62 (2003)</td>
</tr>
<tr>
<td>SDR all causes and ages, per 1,000 live births</td>
<td>1,236</td>
<td>1,284</td>
<td>1,169</td>
<td>1,224</td>
<td>1,098</td>
<td>1,076</td>
</tr>
<tr>
<td>Infant mortality rate</td>
<td>49</td>
<td>29</td>
<td>27</td>
<td>21</td>
<td>19</td>
<td>17</td>
</tr>
<tr>
<td>Maternal mortality (per 100,000 live births)</td>
<td>116</td>
<td>132</td>
<td>83</td>
<td>48</td>
<td>33</td>
<td>24</td>
</tr>
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Source: WHO HFADB and MoH Statistical Annual Book.

1 This note was prepared by Dan Sava, and Rekha Menon with inputs from Daniel Dulitzky, Richard Florescu, and Truman Packard.

2 The international benchmarking exercise consists of running a linear OLS regression of the outcome in question (for example, the infant mortality rate) on the log of per capita GDP, using the PPP adjusted value. Countries that are significantly far from the regression line could be over or underperformers depending on the outcome being discussed. For example when the outcome is infant mortality, countries below the line are performing better than would be expected given their per capita income levels. The sample in the regressions in this chapter includes all of the countries in the Europe and Central Asia region for which data are available, based on the European WHO database. Regressions are weighted by population.
2. **Moreover, there are large regional disparities in health outcomes, which are masked by national averages.** Infant mortality rates at the Judet level vary between 9 (Bucharest) and 25 (Ialomita) deaths per 1,000 live births. This is partly the result of regional socioeconomic differences but also reflects wide disparities in the distribution of public resources for health.

3.

Figure 1. Infant Mortality and GDP per Capita in Europe and Central Asia

![Figure 1](image1)

Source: World Bank based on WHO HFADB.

Figure 2. Maternal Mortality and GDP per Capita, Europe and Central Asia

![Figure 2](image2)

Source: World Bank based on WHO HFADB.

4. **Furthermore, communicable diseases persist while the prevalence of non-communicable diseases is high.** For instance, although the incidence of TB has been decreasing steadily from 26566 new cases in 2002 to 22860 new cases in 2005, it is still the highest in Europe. Romania also has the highest incidence of other infections disease such as syphilis, viral hepatitis, rubella, and mumps (see Figure 3 and 4) largely due to low education and living standards. Tackling these issues requires a comprehensive approach including an assessment of prevention and vaccination practices and outcomes, public health and education measures as well as better treatment procedures.

5. **Poor health outcome indicators reveal a lack of emphasis on prevention.** There has been little progress on prevention and control of cardiovascular diseases. Romania has the highest cervical cancer mortality rate in Europe, in part due to late diagnosis and ignorance about risk factors and symptoms. In addition, the high infant mortality rate and maternal mortality rate in the region stem from a combination of socio-economic factors as well as the low quality of primary care, obstetric and neonatal services.

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3 National Center for Calculations and Health Statistics.

4 Romania, Reproductive and Health Survey, 2004.
Figure 3: The incidence of syphilis in selected European countries

![Chart showing new cases of syphilis in selected European countries in 2004.](chart)

Source: National Center for Calculations and Health Statistics

Figure 4: Incidence of viral hepatitis in selected European countries

![Chart showing new cases of viral hepatitis in selected European countries in 2003.](chart)

Source: National Center for Calculations and Health Statistics
II. Health Spending in Romania and International Spending Benchmarks

6. **Public spending on health has been increasing at a sustainable pace.** Public spending on health has fluctuated between 3.4 and 4 percent of GDP. The 2006 budget allocation for health is around $4,139 million ($3,241 million for the National Health Insurance House (NHIH) and $898 million for Ministry of Public Health) which amounts to approximately 3.3 percent of GDP. Public spending is expected to increase or at least remain steady at the current rate given the recent decision to earmark part of the excise tax revenues from alcohol and tobacco for the sector, which were increased in 2006. International benchmarking shows that as a share of GDP public spending on health in Romania is in line with that of other countries with the same level of development,

![Figure 5. Public Spending on Health as Percentage of GDP, Selected Countries, 2002](image)

*Source: World Bank estimates using WHO HFADB.*

The Unique National Social Health Insurance Fund is currently financed through contributions from employees (6.5% of their income) and employers (6% of the payroll fund). The sin tax and general tax revenues are also important source of the health budget. With an increasing trend in public spending (as more and more people access the system and prices rise), particular attention should be put when deciding to decrease the contribution of either the citizens or the firms without adequate compensation from other sources of financing. With an aging population, keeping per capita health expenditures at current levels and even considering an increase given the possible increase in demand for health services would be reasonable.

III. Key Challenges in the Health Sector

7. **Romania needs to improve the efficiency of its health care spending and the single most important problem in the health sector is the bias towards hospital-**
based service delivery. Approximately 53 percent of the health budget of the National Health Insurance House is spent on hospital care, compared to the OECD average of 40 percent. The bias towards hospital care is also reflected in the number of inpatient care admissions which is much higher than in the group of countries that joined EU before May 2004, those that joined after and, even higher than in Bulgaria and Croatia. Moreover, this bias appears to persist as admission rates in Romania have been steadily rising during the period from 1995 to 2005.

8. **An important source of inefficiency is the excessive number of cases that are treated in hospitals when they should be handled on an outpatient basis.** This tends to increase the cost of care and health spending. Figure 7 shows that Romania has more than 16,000 inpatient surgical procedures per 100,000 population annually, the highest number in the ECA region, almost three times the EU average, and among the highest in all of Europe.5

![Figure 7. Inpatient Surgical Procedures per Year, per 100,000, 2002](chart.png)

Source: WHO HFADB.

9. **Reports from 2004 show that six out of the 20 most frequent DRGs**, which account for almost 10 percent of the cases treated in hospitals, can be treated at lower levels of care. The planned construction of 8 regional facilities to provide costly specialized care at the regional level is expected to result in a further upward pressure on health spending. This along with the plans to construct 20 new county hospitals will also increase what is already excess hospital capacity. This is part of the current policy to

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5 “Health for All” database

6 These are medical problems of the back, high blood pressure, diseases of the liver with the exception of tumours, cirrhosis, alcoholic hepatitis without complications and co-morbidities, chemotherapy without acute leukaemia as secondary diagnosis, esofagitis, gastroenteritis and other digestive disorders >17 years, without complications and co-morbidities, and menstrual disorders and other female genital apparatus disorders.
10. **Restructuring in the recent past has aggravated the bias toward hospital care.** In 2002, Romania introduced case-based payment. Prior to this, hospitals were paid by historic budget and then by days of care. There was excess bed capacity and regulations that tied the number of doctors and nurses to the number of beds. Reductions in hospital personnel in recent years were directed mainly at ancillary and non-medical personnel. This resulted in an increase in hospital costs, as salaries under Romanian regulation, are fixed costs. Constant pressure to hire new doctors and nurses, especially in university hospitals further pushes costs upwards.

11. **While the average length of stay has decreased significantly over time and bed occupancy rates are relatively high compared to other countries in Eastern Europe** making the Romania hospital system look efficient, in reality this reflects the current practice of boosting utilization rates by increasing the number of cases admitted in a manner that more than offsets the decreased length of stay. For instance, in the last three years, while the total number of beds has remained unchanged, the number of surgical beds increased together with occupancy rate. According to the Center for Calculations and Health Statistics, in 2005, the national average utilization rate of surgical beds was 289.5 days which was to equal to an occupancy rate of 79 percent. It is clear that because of excess supply of beds and the current payment system, in order to cope with the fixed costs, hospitals admit patients very easy.

**Figure 6: Number of admissions in Romanian hospitals**

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of admissions (millions)</th>
</tr>
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<tbody>
<tr>
<td>Y2005</td>
<td>4.66</td>
</tr>
<tr>
<td>Y2006</td>
<td>4.86</td>
</tr>
<tr>
<td>Y2007</td>
<td>4.72</td>
</tr>
<tr>
<td>Y2008</td>
<td>4.66</td>
</tr>
<tr>
<td>Y2009</td>
<td>4.65</td>
</tr>
<tr>
<td>Y2010</td>
<td>5.02</td>
</tr>
<tr>
<td>Y2011</td>
<td>5.36</td>
</tr>
<tr>
<td>Y2012</td>
<td>5.02</td>
</tr>
<tr>
<td>Y2013</td>
<td>5.30</td>
</tr>
<tr>
<td>Y2014</td>
<td>5.34</td>
</tr>
<tr>
<td>Y2015</td>
<td>5.34</td>
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</tbody>
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Source: The Center for Calculations and Health Statistics

12. **With the implementation of the DRG system, hospitals use various mechanisms such as increased admissions, to increase revenues in order to cover fixed operating costs.** Because tools for controlling admissions are not used, this is done mainly by admitting patients that can be treated in ambulatory; these patients incur low costs but bring good revenues helping the hospital survive but leading to an overall
inefficiency of the system. Hospitals also increase their revenues through provision of ambulatory care, day care (especially abortions on request), one day care, etc. These types of services can be provided with low costs in ambulatories. The introduction of the Australian DRG system which comprises more precise coding of the hospital activity (more DRGs and some procedures recorded separately) together with the elimination of historic adjustment in calculating hospital payments are good steps to controlling this issue but also direct measures such introduction of admission criteria should be considered.

13. **Hospital expenditures usually exceed their current revenues, leading to unnecessary shortages and low quality care.** Hospitals frequently run out of basic medical supplies like bandages, disinfectants or even pharmaceuticals, and as a consequence patients are asked to bring these needed materials themselves. This is due to the chronic mismatch between hospital expenses and hospital revenues. In order to survive hospitals ought to improve performance and efficiency. This could be achieved by reducing costs and closing wards, by improving their procurement practices and by implementing more rational spending practices.

14. **Quality assurance mechanisms are needed in the Romanian health system.** The authorization and licensing procedures are complicated and compliance with standards is not enforced. Some hospitals operate without basic sanitary licenses. Hospital care is not based on guidelines, protocols, and the performance and outcomes of activity are not properly assessed and monitored. Clinical activity is not systematically audited and peer reviewed. Nosocomial infections seem to be recurrent problem. Although a rather complex regulation regarding the issue exists it seems that further actions are needed to implement it. There is a common practice to prescribe antibiotics for any kind of surgical operation even for non-septic operations like ventral rupture for prophylactic reasons. But when prophylactic prescription of antibiotics is done on individual basis and not by a common hospital protocol there is a good chance that strains of germs might become resistant to antibiotics. There were outbreaks of nosocomial infections, especially in Obstetric & Gynecology wards with grim consequences especially on new-borns. This issue ought to be addressed in a more comprehensive manner. Another quality assurance tool, accreditation of hospitals is not enacted despite the requirement in the Health Act.

15. **The negative effect on health outcomes of the current bias towards in-patient care is aggravated by a lack of ambulatory, primary and preventative care.** Romania spends only 15 percent on outpatient care compared to an average of 35 percent in OECD countries. The public health insurance spending on outpatient care is approximately 11 percent of its services budget, while the proportion of health insurance services budget devoted to primary care by NHIIH has been constantly decreasing since from 9 percent in 1999 to 4.9 percent in 2006. Despite policy emphasis by several governments on prioritizing and improving primary health care, until recently this has largely remained just rhetoric. The recent rise in payments is a good step towards recognizing the importance of this segment of care but many remain to be done especially in increasing access to care for the people living in remote and underserved areas. It is here where mortality rates are higher, because there are no providers available to
diagnose diseases, recommend and render treatments. In addition, there are no pharmaceutical services too, in these areas.

Figure 8: Primary care expenditures as a percent of total service expenditure of National Health Insurance Fund, 1999 – 2006

Source: National Health Insurance House webpage

16. The age structure of family physicians and increased labor mobility (with EU integration) is expected to cause considerable strain on the health system. A recent USAID study\(^7\) shows that majority of family doctors are between 45 and 55 years of age and will retire in 10-15 years, while few young physicians are entering family practice. If this trend continues, the supply of doctors, especially family doctors, will decrease dramatically, leading to decrease of access and increase in operating costs of the system. This could be addressed through incentives, such as increased wages and fringe benefits, to encourage new medical graduates to enter family practice or to locate in rural areas. Obviously the present benchmark is family doctor’s income in Western Europe. The recent increase in number of resident positions for the primary care specialty is a way to address the issue but an alignment of policies towards increasing the attractiveness of these underserved areas together with an incentive package is needed.

17. With EU integration, Western European markets which offer higher salaries, have become very attractive to Romanian doctors and nurses. While this is a global phenomenon which is difficult to tackle, this is expected to create considerable strain on the health care system in the coming years. Therefore a human resources strategy tailored to the new position of Romania as member of EU and its specifics is needed.

18. **The high level of spending on pharmaceuticals is also creating upward pressures on overall spending.** Drugs and medical supplies for outpatient care account for around 23 percent of outpatient care spending and 9 percent of hospital spending in the health insurance budget. As a result, 32 percent of the insurance budget for services is spent on drugs and medical supplies, making it the second largest item of expenditure after hospital services. The NHIH expenditure on drugs in ambulatory care, national programs and as share of hospital expenditures, increased steadily over the years. Drug pricing regulation could be improved together with controlling the volumes reimbursed. These include rethinking the list of drugs reimbursed by NHIH based on evidence of effectiveness; reshaping the co-payment policy on prescribed pharmaceuticals; and the introduction of pharmaceutical prescribing monitoring and controls. Increasing competition in the pharmaceuticals market could also help reduce drug prices, increase efficiency and effectiveness.

**Figure 9: Structure of Expenditures of the National Health Insurance Fund by category**

![Figure 9: Structure of Expenditures of the National Health Insurance Fund by category](chart)

Source: National Health Insurance Fund webpage

19. **Exclusion is also a problem as people in rural areas still have difficulty accessing health services.** A considerable number of people especially in rural areas do not appear to benefit from the health system. This may be due to a number of factors such as failure to contribute to the insurance system; lack of health providers in their area of residence; or in cases where providers exists limited facilities or hours of attention. Transportation to the nearest open medical facility is usually difficult impeding access. Pharmacies in rural areas are rare.

20. **While there has been some improvement in access recently, particularly for reproductive health care, there are still key problem areas.** Survey data show that the
increase in access has not benefited all populations equally. Only 54 percent of women in the lowest socioeconomic third were assisted by a physician during birth compared to more than 90 percent of women in the highest third. Access to care is also differs by ethnicity. For example, only 47 percent of Roma women and 50 percent of Roma men report being covered by health insurance compared to 84 and 80 percent respectively for the population overall. Since hospitals absorb a disproportionate amount of public resources and are concentrated in major cities, the geographical bias in spending exacerbates the regional inequality in allocation of resources. The number of beds by county varies from 300 per 100,000 in Ialomita to 1,110 in Bucharest and 1,020 in Cluj. This bias manifests itself in sharply contrasting health outcomes that disfavor vulnerable groups. Rural households and the poor are also least likely to use health services when sick and the distribution of reimbursements from health insurance go disproportionately to the wealthy, which have better access to modern technology in their care.

21. **The proportion of people paying directly for health services out of pocket is growing, and these expenses have risen, increasing household financial vulnerability and leading to poverty.** One of the objectives of national health insurance is to prevent households from having to make large payments in case they need care. Without health insurance a health problem can impose a huge burden if care is expensive. While some form of co-payment is reasonable to limit excessive usage of health services, excessive out of pocket payments can impose enormous losses. In the case of individuals living in households where at least one person was treated in a hospital, about 31 percent of them had to pay out of pocket more than 30 percent of their monetary consumption. Some segments of the population are exposed to large negative shocks to their consumption due to out of pocket payments for catastrophic health care — formal and informal — that the health insurance system was in principle designed to cover. Health out of pocket payments, particularly for hospital treatment, has even resulted in some individuals falling into poverty. Romania’s total poverty headcount in 2004 was 2 percent higher due to out of pocket payments while extreme poverty was 8 percent higher.

22. **To tackle these (and other) problems Romania has passed important reforms** such as introducing mandatory universal health insurance, and separating financing from service provision through the creation of the National Health Insurance House (NHIH) - a purchasing agency in charge of buying health services from providers through its district health insurance branches. Furthermore, the Government passed a large package of laws aimed primarily at improving accountability and governance in the hospital sector. Still there is a lot to be done in this respect.

23. **The principle challenge now lies in implementing these initiatives in a coordinated and coherent manner** and particularly in ensuring the reform program becomes more firmly anchored in the budget process. There are two aspects to this. The first is ensuring that the budgetary resources that are envisaged for the sector over the medium term are commensurate with the task. The second is elaborating specific spending plans that are in line with the overall thrust of reform agenda. A key factor of success in this endeavor is a good communication strategy so that all stakeholders in the system can understand and participate at this common effort.
IV. Conclusions and Policy Recommendations for the Health Sector

24. **Even though health outcomes in Romania have been improving during the last decade, there are serious lingering challenges, and further gains will require more government action.** Increasing access to health services among populations in remote and underserved areas by educating the public, facilitating transportation and encouraging health providers to open businesses in underserved areas, reducing the burden of out of pocket health expenditures—both formal and informal—and focusing on prevention and primary care services are among the priorities to be considered. The government has already begun to focus on these priorities but its actions have to be fine-tuned in order to reach those groups where outcomes have not yet improved.

25. **Romania should change the composition of health spending, increasing the proportion spent on primary and ambulatory care.** The hospital rationalization strategy provides an excellent road map to reduce bed capacity for acute care, shift services to less expensive ambulatory or day services, and put in place new models of care, especially with regards to social and aged care and rural and remote populations. Shifting the focus from inpatient to outpatient care would partially address the problem of lack of access by certain vulnerable groups, particularly in poor rural areas, as large hospitals would be replaced by alternative mostly outpatient models of care. The few steps envisioned like separate payments for day care and the inclusion of new services in the primary care package have to be followed by more comprehensive strategies combining the continuum of care for patients with efficiency gains in ambulatory sector.

26. **The implementation of the hospital rationalization strategy is likely to produce net savings, but only after a transition period of additional expenditures.** It could be argued that the investments for restructuring hospitals should take place sequentially, only after beds have been closed down and savings have been generated. However, the experience from other countries that implemented the restructuring of their hospital sector—like Canada and Estonia—suggest that a simultaneous approach may be preferable. Those savings could in turn be used to shift resources to primary care and to redevelop the non-hospital health services, in parallel with the hospital restructuring. To accommodate the transition costs of hospital rationalization and EU accession, it is more realistic to anticipate a gradual increase in health spending to around 4.5 percent of GDP by 2010 financed in part with the taxes provided for in the Health Act. A further extent of taxes or excises for unhealthy products could also encompass refined sugar and salt.

27. **To improve the efficiency of current health spending and even generate savings, the current hospital structure should be streamlined.** The MOH has implemented two rounds of bed reductions: first, 20,000 beds that were no longer in use were eliminated, and then 9,000 beds were reduced by applying stricter standards. Still, the number of beds can be reduced. The number of beds required to service a given population can be controlled by reducing admission rates, reducing the average length of stay, or increasing occupancy rates and of course by closing empty beds through administrative decision. Romania has one of the highest admission rates in the world, and
could improve average length of stay, and occupancy rates further as well (Figure 10). The Latvian authorities determined that it would be possible to reduce the total number of acute care beds from a total of 21,594 to 11,606. Some beds would be eliminated and others would be shifted to long term and social care facilities, and nursing homes. At the same time some facilities would have to be renovated and new facilities of different nature would have to be built. The cost of renovation was estimated in US$34.3 million and the cost of new construction in US$250.6 million. Extrapolating these numbers to Romania would mean that the total cost of hospital restructuring would amount to US$2.1 billion. This is not a small number, as the total public health budget per year is about US$4.1 billion. As for savings, a rough estimate suggests that shifting approximately 15,000 beds to long term and social care would save approximately US$47.8 million per year, and closing approximately 60,000 beds would produce savings of the order of US$480 million per year. Another possibility is the creation of hospital holdings that will restructure their internal bed structure aligning it to local needs.

28. But current MTEF projections for public spending in the health sector need to be updated to include increased revenues accrued to the sector and the budgetary impact of reforms. The MTEF projects a reduction in health spending from 3.3 percent of GDP in 2006 to 2.5 percent of GDP in 2009 mainly due to the increase of GDP. In addition, these projections do not seem to take into consideration revenues generated from the “sin tax” part of which is due to be spent on Ministry of Health expenditures for building new hospitals and taking over some national programs through the creation of National Programs Agency under the Ministry of Public Health. In 2006, the revenue from “sin tax” is estimated to be 925 million RON (US$330 million) and is approximately 58 percent of the current health budget allocation. The budget estimates for 2007 allocates around 3,400 million RON or US$1.24 billion with 1,900 million RON coming from general revenues and the rest from sin tax revenues. Due to a projected GDP increase, per capita expenditure on health is expected to remain the same or show a very little increase. Moreover, the experience of most countries in the European Union and the OECD suggests that the proportion of GDP spent on health tends to increase rather than decrease as GDP grows. The GDP growth assumptions in the MTEF would, by the end of the MTEF period, place Romania at a level comparable to the current GDP per capita in the high-income countries among those joining the EU since 2004—like Slovenia—or among low-income EU members like Greece or Portugal. Countries at that level of GDP per capita are spending at least 5 percent of GDP on health. The strategy of the government to increase health spending up to 5% of GDP or even more by 2008 needs a careful estimation of budget revenues especially from the health insurance

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8 A pilot study in preparation for the implementation of DRGs was conducted in 24 hospitals in 2002 and determined that 57 percent of beds were unnecessary when compared to a sample of hospitals in the United States. The hospital rationalization strategy prepared in 2003 recommended a reduction in acute beds from 160,294 (in 2001) to 96,805, and transferring 14,908 for non-acute activities. Ray Blight: Hospital Rationalization Strategy, 2003.

9 This calculation is based on the following assumptions: (i) there is no change in utilization patterns but only in the number of beds; (ii) annual cost per bed equals hospital costs divided by total number of beds as of 2004, i.e. approximately US$8,016 per year per bed; (iii) long term and social care costs per bed are 60 percent cheaper than acute hospital care; (iv) 14,908 beds are transferred to social and long term care; and (v) number of acute care beds is reduced from 160,294 to 96,805.
contributions and sin tax. In short, the timing, direction and especially the budgetary impact of the sector reforms need to be better factored in Romania’s fiscal plans.

**Figure 10: Average Length of Stay, all Hospitals, selected Countries**

![Diagram showing average length of stay for selected countries over time](chart.png)

*Source: WHO HFADB.*

29. With these issues in mind the Bank makes following recommendations:

- **Redress the bias towards hospital-based service delivery.** This will require further reductions in the number of hospital beds, the closure of some hospitals and greater specialization of services among the remaining hospitals and further expansion non-hospital-based service delivery mechanisms, in line with the Hospital Rationalization Strategy.

- **Reorganize hospital services** into acute and chronic care, aged care, and social care, with only the first one to be treated in hospitals, while reducing the number of beds by applying stricter bed targets in acute care hospitals.

- **Expand community based services** and medical services in small and rural areas in order to reach underserved populations.

- **Improve current hospital practices** through new service modalities like day surgery and better therapeutic and diagnostic capacity; this will generate additional long-term savings, as they represent cheaper alternatives to providing the same services in hospitals.

- **Improve hospital efficiency through better patient management** by setting admission criteria, introducing clinical pathways, elements of managed care and drug formularies.

- **Improve the quality of care rendered in hospitals** by introducing specific measures to curb nosocomial infections and general measures such as clinical audits and peer review. Accreditation of hospitals should be considered as a tool for improving quality of care.
- **Improve payment systems** This will entail extending the application of diagnostic related group systems, refining the methodology to control the abuse of the system and developing new payment modalities to support models/facilities for service delivery outside the hospital system.

- **Improve the economic mechanisms on the pharmaceuticals’ market** and also implement mechanisms for the drug management in hospitals.

- **Develop a communication strategy** to insure adherence of the public and the professionals to the objectives of reform.

- **Cost the fiscal impact of the proposed reforms**. The budget and the medium term expenditure framework need to reflect adequately the transition costs of hospital rationalization, a practical approach to the opening of any new regional or local hospital facilities, and the transition to a level of health spending more consistent with that of recent EU accession countries and with Romania’s increasing per capita GDP. The full assessment of the financial impact of the new package health laws is needed.