Project Name: Health Sector Reform (P145174)
Region: EUROPE AND CENTRAL ASIA
Country: Romania
Sector(s): Health (70%), Public administration- Health (30%)
Theme(s): Health system performance (100%)
Lending Instrument: Investment Project Financing
Project ID: P145174
Borrower(s): Ministry of Finance, GDIFR
Implementing Agency: Ministry of Health
Environmental Category: B-Partial Assessment
Date PID Prepared/Updated: 31-May-2013
Date PID Approved/Dismissed: 17-Jul-2013
Estimated Date of Appraisal Completion: 15-Dec-2013
Estimated Date of Board Approval: 27-Mar-2014
Concept Review Decision: Track II - The review did authorize the preparation to continue

I. Introduction and Context

Country Context

Romania’s economy has grown since accession to the European Union, but the country is still facing important development challenges. Romania is an upper-middle-income economy and has been part of the European Union (EU) since 2007. Over the last decade, Romania has implemented a broad reform agenda aimed at improving incomes and living standards and anchored in EU accession. Structural reforms and increased investor interest in the country supported acceleration of economic growth and improvements in living standards. There is broad agreement within the international community that investments in key government institutions are an important precondition for Romania to continue convergence to EU income levels.

During 2009–12 economic convergence slowed and the crisis forced changes in Romania’s growth and reform strategy. Although gross domestic product (GDP) growth was 2.5 percent in 2011, it is estimated to have been flat in 2012, and the outlook for 2013 is only slightly better. In 2012, the fiscal deficit continued to fall from 4.1 percent of GDP in 2011 and is estimated to be close to 2.4
percent of GDP in 2013. It is noteworthy that tax revenues were maintained at about 27 percent of GDP during the crisis (28 percent of GDP in 2012).

**Sectoral and Institutional Context**

The Romanian health system shows outcomes that are below EU standards. Romania is facing several challenges, including lagged health outcomes, user dissatisfaction, lack of access to quality care by the poor and other vulnerable groups, and weak financial performance (indicated by the high arrears in the health sector). Romania had in 2010 the highest infant mortality rate in the EU (9.8 per 1,000 live births, more than twice the EU rate of 4.1 per 1,000); a life expectancy of 73.8 years, which is about 6 years lower than the EU average; one of the highest standardized death rates (SDRs) for cardiovascular disease for people age 0 to 64 in the EU (108.9 per 100,000, more than twice the EU rate of 43.8 per 100,000); and an SDR for cancer of the cervix among women age 0 to 64 of 10.4 per 100,000 (4 times higher than the 2.6 per 100,000 EU average).

The needs that Romania’s health system must address have changed as a consequence of the demographic and epidemiologic transition in the country. The disease burden in Romania has shifted from being dominated by maternal and child health and communicable diseases to a majority of chronic and noncommunicable conditions. Cardiovascular diseases, for example, are the leading cause of death and account for 57 percent of deaths from all causes; cancer, the second-most-frequent cause, accounts for 20 percent. The two combined are responsible for a little over 3 out of every 4 deaths. External causes (injuries and poison) account for the third-highest number of deaths, or 5.6 percent of deaths, and infectious diseases account for only 1 percent of all deaths.

In recent years, Romania has tried to take some important steps toward reforming its health system. Nevertheless, several initiatives to implement sustainable reform failed due to lack of a clear vision of what health care should look like once the reform measures are implemented, and the lack of continuity in policy implementation.

Romania’s health infrastructure and its service delivery system have not adjusted to modern trends and do not meet the current needs of the population. While many hospitals have been modernized and the provision of emergency services has been enhanced, distortions in the service delivery structure have not been eliminated. There are too many hospitals with too many hospital beds, very few facilities for specialized outpatient services and secondary ambulatory care (diagnosis and treatment), and primary care physicians are greatly underutilized. In spite of a 16 percent reduction in the number of acute care beds between 2002 and 2007, the system remains focused on inpatient services, with 6.4 beds per 1,000 population (higher than the EU average of 5.7 in 2007), and a high number of hospital admissions (24.3 per 100 in 2006). In addition, the distortions in health service delivery lead to under-use of prevention and inefficient use of health technology (diagnoses, treatments, and pharmaceuticals).

There is poor coordination of care and a lack of formal referral networks. As noted, primary care doctors do less than they could and refer patients to hospitals who could be treated at the primary level. In addition, there are no formal definitions of what role and function each hospital should have, which leads to service duplication, and in some cases to gaps and significant inefficient health expenditures.

Meeting the needs of the Romanian population effectively and efficiently requires a modern, integrated, patient-centered health system. Technological advances now enable less invasive,
earlier, and better diagnosis and treatment, significantly reducing the need for lengthy hospital admissions if the system is properly governed. Experience shows that coping with the new epidemiological profile requires the following:

i. Effective primary care services, which play an important part in early detection, prevention, and health promotion, managing the bulk of routine conditions, and acting as an effective gatekeeper in patients’ access to referral care.

ii. Expanded secondary specialized services, to introduce high-resolution ambulatory diagnostic and treatment schemes for higher-volume, lower-cost specialized services including ambulatory surgeries, day care, and specialized care for complications from chronic conditions.

iii. Rationalized inpatient services, which emphasize the delivery of quality services in an inpatient regime in a cost-effective manner, with the best mix of technology and human resources inputs, differentiating general hospital “secondary” services from “true tertiary care,” high-complexity hospitals, as necessary.

iv. Specific services for palliative care for terminally ill patients and long-term health care for rehabilitation.

v. In addition, nonhospital facilities are needed to provide social long-term care (LTC) for the elderly and other groups in need of social LTC.

Relationship to CAS

The proposed Project is consistent with the priorities outlined in the FY2009–13 Country Partnership Strategy (CPS). Under the CPS, Pillar III, which aims to protect new and existing poor populations from the adverse effects of the crisis, “social and spatial inclusion” was identified as a high priority. Underneath this pillar, the CPS highlighted the need to support the design and implementation of the government’s health sector reform program to (a) increase the efficiency and improve the quality of health services, (b) mobilize additional resources for health, and (c) improve health outcomes. It aimed to achieve these goals by adopting the Hospital Rationalization Strategy, strengthening primary and community care, and improving the governance and the MoH stewardship of the health sector. The proposed Project is included in the CPS Progress Report No. 60255-RO, November 28, 2011.

II. Proposed Development Objective(s)

Proposed Development Objective(s) (From PCN)

The Project Development Objectives will aim at strengthening prevention and health promotion, rationalizing the health service delivery, increasing secondary specialized ambulatory services, and promoting the implementation of clinical pathways for the most prevalent non-communicable diseases (NCDs).

Key Results (From PCN)

Preliminary results indicators include the following:

i. The first phase of the hospital rationalization plan implemented, achieving all of the following milestones: (a) all 8 regional tertiary hospitals fully operational as head of the regional hospital networks, (b) at least 35 percent of surgeries paid by the National Health Insurance House (NHIIH) and included in a list of electives surgeries are performed as outpatient and ambulatory surgeries, and (c) the number of acute beds per 1,000 inhabitants reduced to 4.5.

ii. 10,000 number of beds converted to Long-Term Care (LTC) and financed separately from the acute health services,
iii. At least 25 percent of eligible women age 25 to 60 tested yearly in the screening program for cervical cancer.

III. Preliminary Description

Concept Description

To achieve these objectives over a five-year period, the proposed operation will focus on three main areas: (a) rationalization of the health facility network; (b) strengthening of prevention, health promotion, and the primary care level; and (c) improvement of health sector governance and stewardship. The proposed Project, therefore, would focus on rationalizing the health facility network to address changing needs created by epidemiologic and demographic shifts in Romania and advances in technology, improving access, quality, and greater efficiency of health care services.

Component 1. Hospital network rationalization. This component aims to support the rationalization of the health care service delivery network through strengthening hospitals’ support systems and services, such as diagnostic services, and laboratory functioning. It will consist of the following subcomponents: Subcomponent 1. Strengthening selected secondary hospitals and Regional Tertiary Hospitals. This subcomponent aims at (a) redefining the hospital’s role in the health care system, (b) merging services and reducing the number of single specialty hospitals; (c) improving the quality of care in hospitals functioning in a multi-building setting by moving them into single buildings with integrated diagnostic and interventional platforms, and (d) concentrating the resources available on the regional and county level. This subcomponent would include civil works (in the facilities current sites), medical and other equipment, technical assistance, and training. Civil works would include the (a) rehabilitation of intensive care units, (b) rehabilitation of operating (surgery) rooms, (c) rehabilitation of emergency departments, (d) improvement of Diagnostic Imaging Services, (e) creation of 4 new burn units (with about 6 beds each within a regional hospital), (f) development of regional pathology and cytology laboratories, and (g) development of regional radiotherapy units. Subcomponent 2. Implementing Specialized Secondary Ambulatory Care. Hospitals are no longer the exclusive institution for delivering numerous forms of routine surgical and medical care. Specialized ambulatory care represents a better option from the patient’s operability and safety point of view, substituting costly medical treatments with cost-effective ones.

Component 2. Primary care strengthening. This component aims to support primary care addressing especially those who are “priority populations,” including low-income groups; minority groups (i.e, Roma population); the elderly; and individuals with special health care needs, such as individuals with disabilities, in need of chronic or end-of-life care, or living in inner-city or rural areas. The component would support the scaling up of multi-functional rural centers currently under implementation with the support of the Swiss Agency for Development and Cooperation (SDC), and in implementing different types of long-term care currently being provided as regular hospital services. Subcomponent 1: Implementing multi-functional rural centers. These centers will support the implementation of community care services for the provision of the primary prevention services for noncommunicable diseases, for increasing the access of vulnerable groups to basic health care services. Community care services will be part of the basic services to be provided to vulnerable groups (including mothers and children, elderly, persons with disabilities, persons with rare diseases, and persons with mental health problems). Subcomponent 2: Implementing Differentiated Long-Term Care (LTC): Palliative care (including care for chronic neurological cases requiring mechanical ventilation, other chronic long-term health care, and terminal care) and social LTC.
Component 3. Health sector governance and stewardship improvement. This component aims to support sector governance and stewardship improvement to bridge the gap between policy and practice and to increase the capacity for conducting and improving the quality of medical care services. Subcomponent 1: Improvement of Health Care Quality: Update of Clinical guidelines, implementing quality control. Quality in services and facilities is a core precondition for Romania to obtain maximum results from available resources. Greater health care quality means better health outcomes, reduction of the unfavorable evolution of diseases, reduction of the readmission rates, and reduction in the number of avoidable medical procedures. In that regard, the existing capacity gap in terms of using norms and protocols aligned with best international practice needs to be overcome. Subcomponent 2: Strengthening Health Technology Assessment (HTA). This subcomponent would support additional technical assistance, equipment and training to further develop standards and protocols and implementation of performing HTA. Subcomponent 3: Strengthening the communications strategy. The main objective of the health sector reforms is not to reduce cost or services, but rather to reorganize service delivery to more effectively and efficiently meet the new needs of the population in a sustainable manner. To mitigate this risk, this component would finance a communications campaign to inform the Romanian public about the reforms program and the expected outcomes of such reforms.

Component 4. Project Management and Monitoring and Evaluation. This component aims to support the Project Implementation Unit to provide day-to-day project management, including the fiduciary tasks of the Project and Monitoring and Evaluation.

IV. Safeguard Policies that might apply

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V. Financing (in USD Million)

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VI. Contact point

World Bank
Contact: Carlos Marcelo Bortman
Title: Sr Public Health Spec.
Tel: 458-9730
Email: mbortman@worldbank.org

Borrower/Client/Recipient
Name: Ministry of Finance, GDIFR
Contact: Carmen Ghita
Title: Head of Office
Tel: 40213112376
Email: carmen.ghita@mfinante.ro

Implementing Agencies
Name: Ministry of Health
Contact: 
Title: Under-Secretary of State
Tel:
Email: arafatr@smurd.ro

VII. For more information contact:
The InfoShop
The World Bank
1818 H Street, NW
Washington, D.C. 20433
Telephone: (202) 458-4500
Fax: (202) 522-1500
Web: http://www.worldbank.org/infoshop