I. Project Context

Country Context

1. Romania’s economy has grown significantly since accession to the European Union (EU), but the country is still facing important development challenges. Romania implemented a broad reform agenda over the last decade aimed at improving incomes and living standards and anchored on 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 human development, and particularly in health and education, as well as in key government institutions and policy reforms represent important factors contributing to the acceleration of Romania's convergence and integration with the EU.

2. The country was affected by the global financial crisis. Convergence slowed and the crisis forced changes in Romania’s growth and reform strategy. Although GDP growth was 2.5 percent in 2011 (table 1 in the PAD), it is estimated to have been flat in 2012, and the outlook for 2013 is close to 1.6 percent. The fiscal deficit widened to 7.3 percent of GDP in 2009, especially due to the effect of the global economic and financial crisis, but the authorities implemented a strong fiscal consolidation program that brought the fiscal deficit back under control, so that by 2011 it had been reduced to 4.1 percent of GDP. In 2012, the fiscal deficit continued to fall and is estimated to have been close to 2.5 percent of GDP. It is noteworthy that tax revenues were maintained at about 27%...
percent of GDP during the crisis (28 percent of GDP in 2012).

3. Economic growth picked up in early 2013, with real GDP growth of 0.6 percent (quarter-over-quarter) in Q1 of 2013 driven by a sharp turnaround in net exports, while domestic demand remained weak. Exports were supported by a pickup in sales of machinery and transportation equipment and greater external demand, including from non-EU countries.

4. The Social Liberal Union (USL coalition) took over the Cabinet in April 2012, and subsequently won the parliamentary elections in December 2012. The coalition remained committed to the country’s precautionary arrangements with the international financing institutions (IFIs). Currently, there is great commitment across the political spectrum to see through International-Monetary-Fund-led reforms. Reduced unemployment, record low consumer price inflation, and an end to anti-austerity protests make for social stability. The new Government, being at the relative beginning of its mandate, is expected to continue with structural reforms of the administration and, ideally, to identify and implement measures to re-launch a path of sustainable economic growth.

5. Despite recent adjustment efforts, the external environment in Europe and the weak growth in Romania will continue to pose a risk to macroeconomic stability. Fiscal policy is therefore expected to continue to play an important role in anchoring overall investor expectations and providing a foundation for future growth. Given the limited headroom for new spending (other than that which can be financed via EU structural funds), there is strong interest in improving public financial management, increasing efficiency and effectiveness of revenue collection, and increasing the efficiency and sustainability of social expenditures. The Deferred Drawdown Option Development Policy Loan (DPL-DDO) in the amount of EUR 1 billion, approved in 2012, is supporting a comprehensive three-year reform program to: (a) improve compliance, revenue, and fiscal discipline; (b) improve governance of energy state-owned enterprises and strengthen their fiscal sustainability; and (c) improve fiscal sustainability of the health sector.

**Sectoral and institutional Context**

**Health Outcomes**

6. Health outcomes in Romania are lagging behind 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. 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 [see table A2.1 in annex 2]). Moreover, the life expectancy gap between Romania and EU15 Since 1970 has almost doubled. This gap is associated to the rising incidence of non-communicable diseases (NCDs). In fact, Romania has 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); the highest SDR for smoking-related causes (428 per 100,000), and an SDR for cancer of the cervix among women age 0 to 64 of 10.4 per 100,000 (four times higher than the EU average).

7. The needs that Romania’s health system must address have changed as a consequence of the demographic and epidemiological 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 non-communicable conditions. Cardiovascular diseases, for example, are the leading cause of death, with 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 three out of every four deaths. External causes (injuries and poisoning) 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.

Service Delivery
8. Romania’s health infrastructure and its service delivery system have not adjusted to modern technologies and do not meet the current needs of the population. While some hospitals have been modernized and the provision of emergency services enhanced, distortions in the service delivery structure have not been eliminated. There are too many hospitals with too many beds, very few facilities for specialized outpatient services and secondary ambulatory care (diagnosis and treatment), and primary care physicians are underutilized. Despite a 16 percent reduction in the number of acute care beds between 2002 and 2007, and further reductions in 2011 and 2012, the system remains focused on inpatient services, with 6.1 beds per 1,000 population (30 percent higher than the EU15 average), and a high number of hospital admissions (23.6 per 100 in 2010, about 29 percent higher than the EU15 average). In addition, the distortions in health service delivery lead to underuse of prevention and inefficient use of health technology (diagnoses, treatments, and pharmaceuticals).

9. Primary care providers see a lower proportion of cases than expected, and the current provider payment mechanism exacerbates this problem. Annual outpatient contacts per person in Romania are 34 percent lower than in the EU15. The current payment system for primary care doctors (mainly capitation payment with a cap) encourages them to maximize the number of registered patients, but does not encourage them to provide a full package of primary and preventive care services. The payment system also does not penalize the referral to hospital specialists or the prescription of high-cost pharmaceuticals, so primary care providers are contributing to excessive use of hospitals and over-prescription of pharmaceuticals.

10. The hospital network in Romania is large and fragmented. Romania currently has 354 public hospitals. Since 2010, most public hospitals have been decentralized, having been placed under the jurisdiction of local public administration, except for some secondary and tertiary hospitals that are still under the jurisdiction of the Ministry of Health (MoH). Hospitals vary in size from large university hospitals that provide the most complex tertiary care services to small hospitals with two to three basic specialties or even only a single specialty. There are also a wide variety of differences in their equipment, their capacity to address complex cases, the number of specialties, and their geographic distribution. In small hospitals, often the types of services provided are limited to the treatment of patients with uncomplicated diagnoses, such as mild upper-respiratory infection, for which only a limited range of medical procedures is performed. Some university center hospitals (such as in the cities of Cluj and Iasi) operate in several buildings (up to 25 to 30 buildings/hospitals) with distances of several kilometers between departments of the same hospital, which requires ambulance transportation of patients from one department to another. This leads to a significant negative impact on the quality of health care and costs and an inefficient use of resources.

11. 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 that 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 gaps in care, and also inefficient health expenditures. Other countries are improving this type of coordination with the use of “defined care
pathways” for the diagnosis and treatment of patients.

12. In addition to being costly, the distortions in health service delivery lead to under-utilization of preventive services. One dramatic example is cervical cancer mortality, which can be avoided to a large extent by screening and treating screening-detected cervical lesions. Figure 1 in the PAD shows cervical cancer mortality in Romania at a very high and rising rate compared with other countries where it is lower and declining.

13. Romania has historically committed a relatively low share of its GDP to health care. Most comparisons suggest that Romania spends less than similar countries on health. According to official figures, Romania spends a little less than 6 percent of GDP on health (public and private) compared with the European average of 8.5 percent and the EU average (all EU countries) of 9.8 percent. Part of the difference arises from Romania’s relatively low public expenditures on health and part from low private expenditures. Official statistics for private expenditures show that only 18 percent of health expenditures are private in Romania, which is low compared with Bulgaria (41 percent), Poland (28 percent), and other neighboring countries. It is likely that these figures for Romania underestimate the magnitude of informal payments, but even if higher estimates for private expenditures are used, they remain comparatively low.

14. Public financing for the sector expanded significantly during the years of rapid economic growth in the early 2000s. In the years of economic crisis, however, the sector suffered from severe financial problems related to a cut in revenues (the payroll tax rate was reduced to levels that are low compared with those prevailing in the EU countries) and to a rapid increase in expenditures—particularly for high-end pharmaceuticals. The combination of a deficit and a weak system of financial controls led to the development of large arrears to providers (especially for pharmaceuticals). These arrears led to the imposition of a number of short-term measures to contain expenditures, which are succeeding at bringing the sectoral deficit under control.

Health Sector Reform and the Government Program

15. In the last eight years, Romania, with the support of the World Bank, updated maternity services and successfully implemented a critical reform of the health emergency services, including hospital emergency departments, telemedicine in emergency services, and development of the Mobile Emergency Service for Resuscitation and Extrication, (Serviciul Mobil de Urgență, Reanimare și Descarcerare, SMURD). SMURD is currently considered one of the best examples in the region. But besides these two areas, no other significant investments have been made in the last 20 or more years, and the rest of the public health infrastructure and its service delivery system have not been adjusted to the new needs of the population and to the new health technologies.

16. Since 2009, with the support of the European Commission (EC), the World Bank, and the International Monetary Fund (IMF), the Government of Romania has been working on a structural reform of its health care system. The reform program seeks to change the business model to increase the emphasis on primary and secondary prevention, reduce unnecessary inpatient admission services, and develop sustainable access to higher-quality secondary ambulatory services. These reforms would lead to an increase in the quality of care and efficiency of system administration, with the aim of improving health outcomes. A hospital rationalization plan was developed and some small hospitals were closed. An interim Health Technology Assessment (HTA) tool to implement evidence-based access to essential technologies is being implemented, and some drugs without proof of health benefits were excluded from the list of compensated drugs.
resulting in significant savings. A new benefits package, currently under design, would provide incentives to shift resources and care to lower levels and increase prevention. A major shift in services provision is expected requiring additional/innovative skills of health services providers at all levels, and for health administrators at the central and local levels. The basic package would be fully functional in three to five years, and during this period it will be necessary to perform continuous monitoring, timely evaluation, and economic/budget impact analysis in order to adjust the package to the population health needs, in accordance to health system performance targets.

17. The introduction of a new benefits package would require a revision in health provider payment mechanisms. The hospital payment system is based on production of services (a Diagnosis Related Group [DRG] system, which was piloted in 2003 and implemented in 2005), but the system needs to be transformed to better estimate the costs and eliminate perverse incentives. For example some mild cases that could be treated in ambulatory services are being admitted because the DRG system overestimates the cost of treating those cases. On the other hand, some more complex cases are being referred because the DRG value is below the real cost. In parallel, in primary care, NHIH allocates (6%) of the total insurance found introducing a cap in the annual contract that eliminate the incentives to increase the PHC services.

18. The pace of health sector reform implementation has been slow due to the lack of resources to finance some critical steps necessary to support the new policies. Most of the hospitals cannot be consolidated if an alternative modern ambulatory service is not fully functional before closing down and eliminating unnecessary beds. Merging fragmented services from multi-building hospitals cannot be completed without the rehabilitation of an appropriate building to host the new comprehensive and articulated hospital.

19. To implement the short- and medium-term interventions required by the above-mentioned health sector reform program (2014–2020), the Government of Romania (GoR) will combine resources from the EU funds for the same programming period and the resources from this proposed Bank-financed project (parallel cofinancing). The total estimated investment amount for the common Reform Program would be about US$1,105 million, and the main interventions will focus on:
   a. Streamlining hospital services, implementation of regional hospitals networks, and reducing redundant capacity for inpatient services. Shifting resources from hospital-based care to primary and secondary ambulatory care, implementing true tertiary hospitals as head of each network, building physical and functional integrated referral networks, and implementing performance-based management in the public hospitals. The number of single specialty hospitals will also be reduced.
   b. Enhancing primary health care services at the community level, by introducing a new basic package of health services with additional roles and payment incentives for the primary care professionals, scaling up of multifunctional rural centers, implementing different types of long-term care, strengthening the role of public health actions at the community level, and increasing the accountability of the local public authority to their population.
   c. Implementing specialized secondary ambulatory care to increase ambulatory day care, ambulatory surgeries, and ambulatory diagnostic and treatment centers for cancer and other NCDs as a better alternative for services currently being provided in inpatient settings. These new specialized secondary ambulatory care centers (currently performing as hospitals) will be located in already existing facilities and will perform as stand-alone facilities or satellites of a larger hospital.
   d. Increasing sector governance and stewardship to: (a) strengthen the implementation of
HTAs (evidence-based protocols, periodically updating the list of compensated drugs and care pathways are to be mainstreamed, continuous scrutiny of new evidence and economic/budget-impact analysis are to be incorporated within periodic reviews of the basic benefits package); (b) improve the management control mechanisms, which includes inter alia centralized procurement and framework contracts, a clawback tax on pharmaceuticals, monthly hospital budget reporting, and the use of e-health solutions to control quality and expenditures; (c) implement health system continuous quality improvement and health system performance assessment; (d) adjust the DRG payment mechanism to incentivize ambulatory and other cost-effective interventions and avoid distortions and perverse incentives; (e) streamline the National Health Programs, moving the focus toward preventive care and promotion of population health services and transferring the financing of specific treatments to health insurance; (f) create the conditions for increasing the participation of private funds and private services to support the sector results; (g) develop a Human Resource Strategy to adjust the production and retraining of health workers oriented to the new needs of the health sector; and (h) strengthen the communications strategy to inform the Romanian public about the reforms program and advantages of the new health service delivery model, and encourage the increased use of generic drugs.

II. Proposed Development Objectives
The Project Development Objectives is to improve access to, and quality and efficiency of, public health services in Romania.

III. Project Description
Component Name
Hospital Network Rationalization
Comments (optional)

Component Name
Ambulatory Care Strengthening
Comments (optional)

Component Name
Health Sector Governance and Stewardship Improvement
Comments (optional)

Component Name
Project Management, and Monitoring and Evaluation
Comments (optional)

IV. Financing (in USD Million)

<table>
<thead>
<tr>
<th></th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Project Cost:</td>
<td>1105.00</td>
</tr>
<tr>
<td>Total Bank Financing:</td>
<td>325.00</td>
</tr>
<tr>
<td>Financing Gap:</td>
<td>0.00</td>
</tr>
<tr>
<td>For Loans/Credits/Others</td>
<td></td>
</tr>
</tbody>
</table>
V. Implementation

The proposed Project would be implemented primarily by the MoH. The existing Project Management Unit (PMU) of the MoH, currently responsible for the APL2 Project (planned closing date December 31, 2013), would also be responsible for Project management. The PMU would include a Project Manager and Project technical coordinators for Components 1, 2 and 3. The Secretary of State for the Department of Emergency Medical Assistance would be responsible for Component 1, while the Secretary of State for the Department of Public Health Policies and Strategies for Health Area would be responsible for Components 2 and 3.

VI. Safeguard Policies (including public consultation)

<table>
<thead>
<tr>
<th>Safeguard Policies Triggered by the Project</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Environmental Assessment OP/BP 4.01</td>
<td>✗</td>
<td></td>
</tr>
<tr>
<td>Natural Habitats OP/BP 4.04</td>
<td></td>
<td>✗</td>
</tr>
<tr>
<td>Forests OP/BP 4.36</td>
<td></td>
<td>✗</td>
</tr>
<tr>
<td>Pest Management OP 4.09</td>
<td></td>
<td>✗</td>
</tr>
<tr>
<td>Physical Cultural Resources OP/BP 4.11</td>
<td></td>
<td>✗</td>
</tr>
<tr>
<td>Indigenous Peoples OP/BP 4.10</td>
<td></td>
<td>✗</td>
</tr>
<tr>
<td>Involuntary Resettlement OP/BP 4.12</td>
<td></td>
<td>✗</td>
</tr>
<tr>
<td>Safety of Dams OP/BP 4.37</td>
<td></td>
<td>✗</td>
</tr>
<tr>
<td>Projects on International Waterways OP/BP 7.50</td>
<td></td>
<td>✗</td>
</tr>
<tr>
<td>Projects in Disputed Areas OP/BP 7.60</td>
<td></td>
<td>✗</td>
</tr>
</tbody>
</table>

Comments (optional)

VII. 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
Contact: ex-ISPA Managing Authority
Title:
Tel: (4) 0213025300
Email: irina.radu@mfinante.ro

Implementing Agencies
Name: Ministry of Health
Contact:
Title:
Tel: (40-1) 314-1526
Email: czobor.francisc@ms.ro

VIII. 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