THE MANAGEMENT OF HEALTH POLICY IN COUNTRIES OF THE EUROPEAN UNION

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INTRODUCTION

The paper examines the health policy in three countries of the European Union, France, Italy and Romania, by exploring the mechanisms that influence the management of health policy. Scholars have identified a diversity of important factors shaping this policy such as: institutional choices, timing and sequencing of reforms, policy learning, but there is still a lack of sustainable set of causal relations between these factors. Furthermore, various aspects of health policy management in France, Italy and Romania are discussed in the paper. It is argued that decentralization induces changes both in administrative systems and public policy management in the analysed countries. In all three countries, the state is the main authority involved in regulating health policy and it draws strategies followed by the sub-national administrative levels in the implementation of the policy itself. Italy is an exception, due to the legal and managerial role assigned to the regions in the health system.

In the last 20 years the healthcare systems have experienced reforms at various levels, namely regulatory, institutional and managerial. The reform proposals in France and Italy have followed the trends established in early 1990s by most of the then European Union countries, consisting of both decentralization and introduction of management techniques in the health system. By comparison with the other two countries, in Romania, the healthcare reform was delayed. Nevertheless, health policy development followed the decentralization trend and management practices were introduced for improving policy performance. Institutional changes have re-balanced the responsibilities among various levels of government and their involvement in the health policy-making process.

The analysed countries are included in the French administrative model, rooted in the Napoleonic administrative tradition: France is the typical case while Italy belongs to the Southern European variant of the model (Ongaro, 2009; Painter – Peters, 2010). Part of the Romanian literature argues that Romania belongs to the French administrative model (Matei, 2005), despite the Soviet features inherited by its administrative system (Painter – Peters, 2010). The countries included in the French model have common characteristics like the importance of administrative law in regulating the activity of public administration and centralism.

HEALTH SYSTEMS AND POLICY MANAGEMENT

France

The World Health Organization Report 2000 ranks the French healthcare on the first place in the world. Nevertheless, in the last two decades, the French health system passed through managerial changes aiming at reshaping the structures responsible for healthcare management. The year 1996 represents a milestone in French healthcare evolution. The system was changed by the 'Juppé Reform' which aimed at controlling the budget money spending through increased monitoring of hospitals and private physicians financing sources (Minogiannis, 2003). The reform sought to change the system by enabling both the universal health coverage and institutions with a role in system management (i.e. National Agency of Hospitals, regional health directorates). The inquiry that may rise is if the regional directorates led to strengthening the role of the regions in health management. In France, a traditionally centralized state, decentralization reforms included de-concentration of health system at regional level. Although the regional health agencies were representatives of the Ministry of Health in the territory, they had responsibilities on hospitals' budget planning.

In 2004, the Health Insurance Act and the Public Health Act were submitted to the Parliament for sanction. These laws provided for changes in the system management by increasing the role of the Parliament in setting the priorities of healthcare system. An Alert Committee for monitoring the social security deficit was activated (Chevreul, 2010) and

regional health agencies were established. The Regional Public Health Group having the mission to design, implement and monitor the regional public health plan was created by The Public Health Act. The group was led by the prefect—representative of the state—and the group members were local representatives of national public health agencies, taxpayers and regional managers.

In 2009, the regional health agencies started to actually operate and aimed at improving the regional governance system, increased efficiency and public satisfaction. In addition to duties on monitoring the population health, the agency implements the regional healthcare for employees, for people with disabilities, for pupils and students. The state services do not communicate directly with the agency for implementing the health policy at regional level, but must obtain the approval of the National Council for Regional Health Agencies Governance, to which the regional agencies are subordinated. Each regional health agency is represented at department level by a local delegation, which is responsible for both implementing the regional policies and supporting local actors in the implementation of their own projects.

The universal health coverage was established in 1999. It replaced the old system of individual based insurance with a system grounded on the logic of social protection through health insurance. The people with the income below a certain threshold benefited of free healthcare access. The universal health coverage followed the Juppé reform initiated in 1996 and regulated the insurance system based on total revenue.

Currently, planning and regulation of the system involves negotiations between representatives of health care providers, the state (represented by the Ministry of Health and the Ministry of Finance) and the Health Insurance Company. The negotiations results are materialized in the issuing of administrative decrees and laws adopted by the Parliament. Increasing the healthcare fiscal spending and growing health budget deficit have both lead to strengthening the state's role in planning and regulating the healthcare system.

Service providers are paid by health insurance funds or, directly, by patients who, subsequently, receive reimbursement. Service quality is

regulated at national level and every four years hospitals go through an evaluation process. The centre and the periphery share the management responsibilities within the system, while the regional health agencies play a strategic role at regional level and coordinate the outpatient medicine, the hospitals, and the health services for elderly and disabled patients. The legislation guarantees free choice of provider for the patient and an increasing patient participation in decision-making, as well as patient safety and compensation measures.

Italy

In the 1980s the Italian national health system faced many problems, including continued growth in health spending which did not lead to raising the quality of health services. The differences between North and South on health services access equity were noticeable. Furthermore, the system acknowledged both a lack of clear distinction between financial responsibilities at central and regional administrative levels and a high degree of politicization of the management (Lo Scalzo et al., 2009).

Legislative Decrees 502/1992 and 517/1993 brought many changes to the system, some of them contrary to Law 833/1978, which established the National Health Service. The decrees, known also as 'reform of the reform', did not question the principle on which the National Health Service is grounded, namely the principle of universality of benefits to recipient, and brought significant management and organizational changes. Nevertheless, a financing system to curb expenditure growth and promote equity, efficiency and competition among health care providers was provided. Since 1992, there were efforts to transfer management responsibilities to the regions and to adopt management principles in healthcare. Local health units became public entities under the name of 'local health agencies' and were directly subordinated to the regions, while public hospitals became semi-independent public enterprises. The agencies were regional entities with juridical responsibility and patrimonial autonomy, which allowed them both to undertake legal action and employ their own property and to sign legal agreements. Although autonomous, the local health agencies were subordinated to the regions that controlled

them and appointed their managers. As about funding, there was a switch from a bureaucratic type to a management type of financing organization. Furthermore, the delays in financing were avoided by suppressing the chain state–region–local health units and by linking the funding directly to the healthcare providers.

Thus, the reforms of the health system focus on two key dimensions: 1) the decentralization of the health system with strengthening the role of regions and 2) the introduction of management techniques in the health system.

In the early 1990s there was a transfer of powers from local to regional administrative levels, which led to strengthening the role of the regions. This is directly linked to the establishment of public enterprises in the health system. Transforming local health units in agencies marks the transition from a model of political organization type to a managerial model. The regions define policies at regional and local levels, set objectives to be met, evaluate the results and determine rewards. On the other hand, local health agencies and hospitals retain autonomy and are responsible for the way of achieving the objectives and for the outcomes. Furthermore, the agencies were assigned legislative functions for both setting the ruling principles of healthcare services and regulation of local health agencies. However, by the end of 1997 hardly a half of the regions approved the Regional Health Plan, namely the main management tool at regional level.

The Government's role consisted of establishing the broad outlines of the system through the National Health Plan. The plan sets out the general objectives for the prevention and treatment of diseases, on one side, and establishes minimum standards for the provision of healthcare services throughout the country, on the other side. The National Health Plan has become a government programme that does not need the approval of the Parliament, an approval, which may cause large delays in the adoption process.

The reforms were reactivated at the end of the 1990s. The Legislative Decree no. 229/1999 strengthened the role of municipalities, clarifying responsibilities among the various levels of government. It also developed the cooperation between health service providers and the partnership

between the former ones and local authorities in order to promote healthcare in local communities. Regional autonomy increased, the regions became responsible for the supply of services on prevention, treatment and rehabilitation. Also, the regions got involved in realizing the National Health Plan and in determining the resources necessary for the national health system to operate. In addition, the local government acquired attributions in programming and evaluating the health services.

As a result of the reform, the regions define the health policies at regional level, set objectives to be met and evaluate the results. On the other hand, local health agencies and hospitals are autonomous and responsible for the way of achieving the objectives and for the results. The territorial distribution of agencies differs by region, and sometimes the differences are significant. The 223 municipalities in the province of Trento belong to a single health agency, while in the Lombardy region the average is of 110 municipalities per health agency (Maino, 2001).

Since the year 2000, the discourse on fiscal federalism has developed and a programme aiming at abolishing the National Health Fund (which operated at central level and distributed the resources at regional level) and at replacing it with financing from regional taxation resources was established. The regions that failed to cover the necessary funds from additional taxation would obtain additional financing from the National Solidarity Fund, upon the recommendation of both the Government and the State-Regions Conference.

Currently, the system is grounded at regional level and it is organized on three levels: national, regional and local. The responsibility for healthcare policy is divided between the state and the regions. The main directions are set by the state while the regions are responsible for the organization and administration of public healthcare. Decentralizing trend has been doubled by attempts to stimulate competition within the system. Although most hospitals and healthcare service providers are part of the public sector, the cooperation between private companies and public institutions is reflected in projects that seek, on one hand, to renovate the public hospitals with private funding and, on the other hand, to further development of public-private collaboration for health management implementation.

Romania

Before 1989, the Romanian health system was Semaşko-type, namely a system fully financed by the state, with a centralized decision-making, and the health infrastructure was characterized by fragmentation, inefficiency and rigid regulation. After the year 1990, the reform of the health system was enacted with the aim of introducing decentralization and competition in service delivery, as well as mandatory social health insurance and contractual relations between suppliers and purchasers. The changes introduced in the first decade after the Romanian revolution were regulated and sustained by the Health Insurance Act (1997) and, thereafter, by the Health Reform Law (2006). These acts created the legal framework for the development of a decentralized and competitive health system, mainly financed by contributions to public health insurance funds. Also, an increased quality health services in a competitive market of health care providers was envisaged. Although there has been significant progress towards healthcare change in the envisaged direction, many elements of the old system still persist and certain vital capabilities that allow efficient operation of the new system were not created.

The number of actors involved in the decision-making has increased. Since 1999, key stakeholders in the health care system have been: 1) The Ministry of Health, the county health departments and the institutions functioning under its authority or coordination, 2) the National Health Insurance Company and the county health insurance funds, 3) the Medical College of Romania and county-level colleges, 4) the health care providers at different levels of healthcare provision: primary, secondary, tertiary, specialist care. The central authority within the health system, the Ministry of Health, preserved many decision-making responsibilities at the expense of slowing down the healthcare system decentralization process.

The roles of key actors in the system have changed. The Ministry of Health lost the direct control over the system funding and over a large part of healthcare providers, but continued to develop the national health policy and to set organizational and functional standards to improve public health (Vlădescu et al., 2009). The Ministry is represented at local level

by 42 county health authorities, whose role is to ensure the provision of medical services in accordance to the fundamental principles established at ministerial level.

The health system is organized on two levels: a central/national level and a county level. The central level, represented by the Ministry of Health, is responsible for defining policies, strategies, planning, coordination and evaluation. The counties set the provision of public services at the county level and decide both on local and county taxes. Some buildings where the healthcare units operate have been transferred from the private domain of the State to counties, cities, towns and villages. However, the sub-national levels of government lack the financial and human resources necessary for having an important role in health-care policy development.

After the year 1999, when the Health Insurance Act was adopted, public health authorities started to operate at county level as 'decentralized units of the Ministry of Health', namely one authority in each county plus one in Bucharest. The county health authority controlled about a third of the available public funds for healthcare, the rest being controlled by the county health insurance funds.

The situation changed in 2002, when all funds started to be collected centrally on behalf of the National Public Health Fund, a fund that redistributed the resources at local level (Vlădescu et al., 2009). The system functioned in a centralized manner and there was a centre-periphery hierarchical relationship both in administrative and financial control. The health expenditure budget was established by the Ministry of Health and the National Public Health Fund, in accordance with the annual budget law, and the financial resources were redistributed at county level.

The decentralization process continued and the Government Emergency Ordinance 162/2008, which regards the transfer of functions and powers from Ministry of Health to local authorities, was enacted. The Government Decision no. 562/2009 on decentralization strategy in healthcare boosted the reform process.

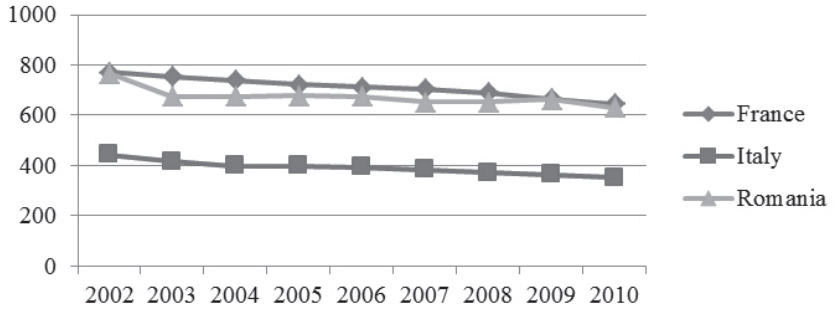
Since 2008, the Ministry of Health has developed two pilot projects by which the management of 18 out of the 42 public hospitals in Bucharest and

of four hospitals in Oradea was transferred to the Bucharest Municipality and, respectively, to the Oradea Municipality.

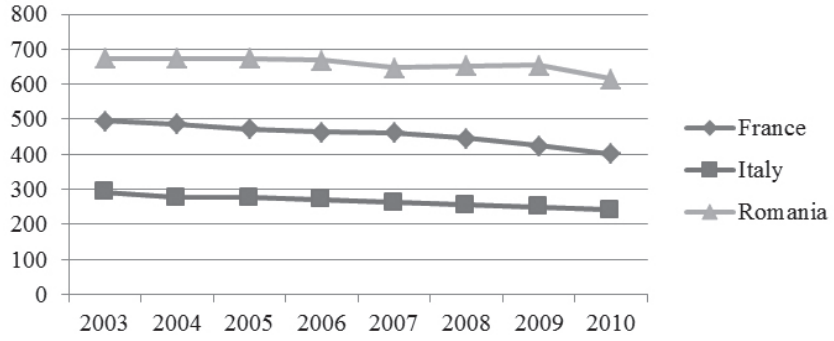
The evaluation of these projects' results showed that the local authorities, which participated in the experiment, possess the administrative capacity to realize healthcare management. Since June 2010, the Ministry of Health has promoted a legislative package that outlines the necessary legal framework for the decentralization of 370 public hospitals management from the Ministry of Health to the local administration authorities. In 2011, the Strategy of rationalizing hospitals was adopted. It sought to improve the management and the operational efficiency of hospitals and to promote a broader reform of the health sector.

The comparison of Romania to France and Italy reveals that in the period 2003–2010, Romania had a high number of hospital beds, in general, and the highest number of public hospital beds to 100,000 inhabitants, in particular (Graph 1 and Graph 2). The figures illustrate a low level of hospital privatization in Romania. Public hospitals have consumed most of the health budget.

Graph 1 Total no. of hospital beds per 100000 inhabitants (Source: Eurostat)

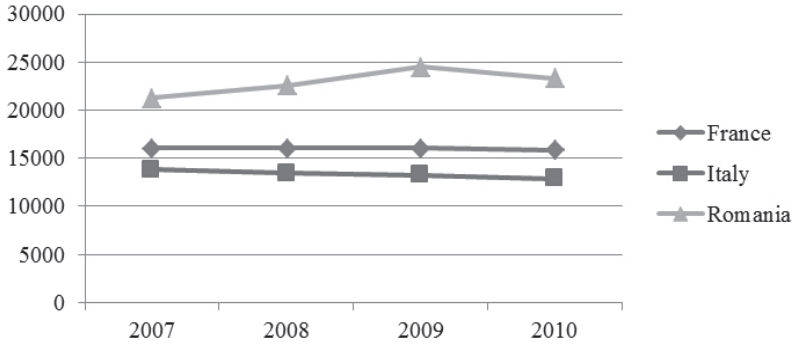


Graph 2 No. of public hospital beds per 100000 inhabitants (Source: Eurostat)



Another relevant indicator is the number of hospital discharges. Romania recorded significantly higher values than the other two countries due to excessive hospitalization. There are situations that require only outpatient treatment but are cured in the hospital and some patients find hospitalization the most convenient way to receive medical services. Furthermore, the hospital managers do not have the authority to effectively manage and to meet the real health needs of the population.

Graph 3 No. of hospital discharges per 100000 inhabitants (Source: Eurostat)



Decentralization attempts of the Romanian health system are evident. However, it is still questionable to what extent the decentralization determined an improvement in the management of the healthcare system and health policy-making.

THE POLICY CYCLE PERSPECTIVE

From the policy cycle perspective, the management of health policy presents specificities in France, Italy and Romania. The policy cycle consists of several phases: agenda-setting, proposal of alternatives and selection of the best solution, implementation and evaluation. In all three countries, the first policy-making phase, namely the agenda setting is characterized by the fact that central authorities have the policy initiative; the ministry sets the agenda and submits it to the Parliament, for approval. In France, the agenda is established by the Ministry of Health, and approved by the Parliament. Health issues are considered of public importance and represent political priorities. An important role is played by the Ministry of Finance that deals with budgetary aspects of healthcare provision. Despite the decentralization reforms, the Ministry of Health has maintained substantial control over the health system. Inside the Ministry there is a General Direction for health that deals with the health policy.

In Italy, the health system is grounded at regional level, but the strategic directions are established at the Centre. Responsibility for public healthcare is shared by the state and the regions. The former one has exclusive competence in agenda setting relating to healthcare general standards and to healthcare access guaranteed to all residents in Italy. The Ministry collaborates with multiple institutions including agencies and consultative bodies that offer support and advice.

In Romania, important steps were taken to introduce the concept of public policy in healthcare. The Government Decision no. 775/2005 regulates the formulation and monitoring of public policies. The institution that manages the policy-making process is the Ministry of Health and its structures including the General Secretariat that sets the agenda.

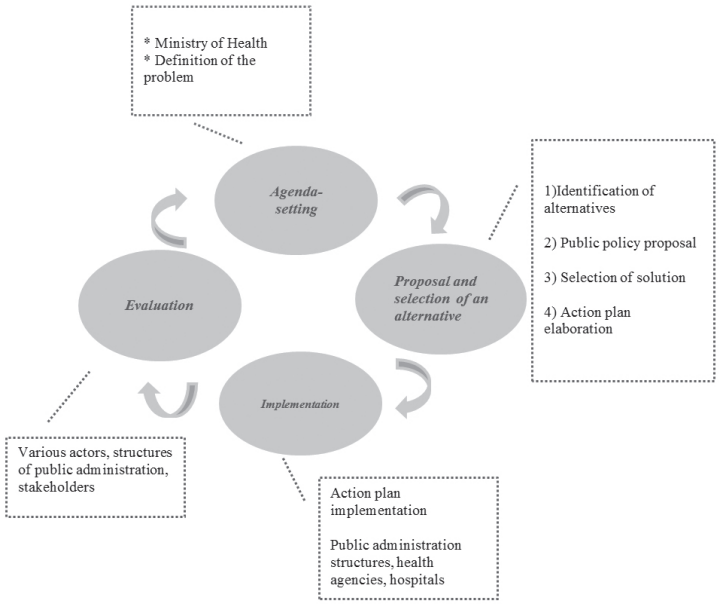
In the second phase of the policy-making cycle, namely the identification, formulation and solution choice, the situation is different. In Romania, despite the efforts for decentralization, the policy proposal is attributed by law to the ministry. In France, the policy formulation reflects the strong legal tradition concretized in the constitutional control of the policy proposals and in the administrative control made by the prefect. In Italy, the health policy proposals are made at the central and the regional

level of government. Both administrative levels share responsibilities in healthcare: the Ministry develops the National Health Plan and the regions decide on matters relating to health service delivery and organization of health care providers.

In all three countries, the public policy implementation usually employs administrative tasks at the central and local levels of government, but other structures such as local health agencies and hospitals network may also be involved.

Health policy assessment shows evidence on the objectives' achievement of the policy document and report problems that occurred during the development of public policy. In all three countries, the objective regarding general health insurance regardless age and health condition was accomplished. However, the equity of access to healthcare still represents a problem. The conclusions drawn from the evaluation are useful to make adjustments and changes necessary to improve the development and implementation of public policy.

Figure 1. Health policy cycle



CONCLUSIONS

During the last decades, in France, Italy and Romania, the healthcare systems have passed through reforms and influential actors within the health system have obtained decisional capacity. Also, new actors were involved in the decision-making process while the dynamics of relations between the centre and the periphery have changed. Important reforms both at institutional and policy level were enacted in the field of health policy. Thus, the health policy development followed the decentralization trend promoted within the systems and management practices were introduced. Furthermore, contractual relationships between purchasers, the health insurance funds and the health care providers were established.

In all three countries, the national level constitutes the main authority involved in drafting laws regulating health policy, in drawing strategies, which are followed by territorial administrative levels in the implementation of health policy. Italy is an exception and the regions have an important role in setting the strategic directions in the management of the health system at local level. In Romania, although there have been efforts for decentralization, the legislation stipulated that the health policy management is attributed to the Ministry of Health. In France, the policy management reflects the strong legal and centralization traditions. On the contrary, in Italy, health policy management and responsibilities arising from it are shared by the central and regional levels of government.

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