ITALIAN JOURNAL OF PUBLIC HEALTH

Romanian health system strategic directions for the next decade

Cristian Vlădescu[1], Adriana Galan[2], Victor Olsavszky[3], Silvia Gabriela Scîntee[4]

[1]University of Medicine and Pharmacy Victor Babeş, Timişoara, Romania; [2]Institute of Public Health, Bucharest, Romania; [3]World Health Organization, Country Office, Bucharest, Romania; [4]EHG, Copenaghen, Denmark

Correspondence to: Adriana Galan, Institute of Public Health Bucharest, dr.Leonte 1-3 street, 050463 Bucharest, Romania. E-mail: agalan@ispb.ro

Abstract

Background: The exceptional changes in the Romanian society after 1989 have strongly influenced the reforms of the health system.
Methods: Several tools were used for this health policy review: finding the evidence to prove that there are important public health problems in Romania, as well as reviewing the existing legislation and policy papers related to health system, stakeholder analysis, meetings and working groups with key players from the health sector.
Results: Health indicators for Romania are some of the poorest in the WHO European region, not only at EU level. A mix of specific indicators for developed countries (e.g. high mortality by cardiovascular diseases, increasing incidence of cancer) and specific indicators for developing countries (e.g. re-emergence of some communicable diseases, like TB) can be noticed. Unfavourable comparisons also exist for the indicators describing the performance of the health system: poor access to basic health services especially in rural area, inadequate human resources management, lack of integration of the health services in order to assure the continuity of care, poor health information management, and reduced intersectoral cooperation. Six major intervention areas have been identified by the Presidential Health Commission set up in 2008, in order to address the dysfunctions of the health system: Health system financing, Health system organization, Drug policy, Primary care, Hospital services and Human resources. In order to address them, 29 specific recommendations were made.
Conclusions: If the declared intentions of the new minister of health are implemented in line with the proposed presidential strategy, then coherency might finally have a chance to drive the process forward.

Key words: health systems, health policy, right for health, health care reform, health care, stewardship

Introduction

The exceptional changes in Romanian society after 1989 have strongly influenced the reforms of the health system. Before 1989, the Romanian health system belonged to a uniformed model known as Semashko system, as were other countries from Central and Eastern Europe. The state provision of services to the whole population, the limited choice left to the healthcare user and seeking to achieve a high level of equity were the main characteristics of this system. The Ministry of Public Health was operating a highly regulated, standardized and centralized health system.The heavy legacy of the Semashko system is reflected in the problems that the health system has faced since 1989.

Two distinct periods can be identified in the development of the health policy after 1989: the first one from 1989-1996 and the second starting in 1997. The main difference between the two periods results from the introduction of the health insurance system after the 1996 elections .Table 1 summarises the health care reforms and policy measures from 1990 to 2008.

At the end of 1994, a Government decision, introduced major changes in the provision and payment of GP services as a pilot in eight of Romania's 40 districts. The system changed from the fixed allocation of patients to GPs according to residence to one of universal free choice of GP. The payment model moved from that of a fixed salary to a combination of age-adjusted capitation, fee for service (related mainly to prevention) and bonuses related to difficult conditions of practice and professional rank [1].

An evaluation of preliminary pilot experience

Table 1. Major health care reforms and policy measures in Romania, 1990 – 2008.

Year	Measure
1992–1994	Simulation testing of primary care reform (financing) in four districts
1993	A Healthy Romania, strategic document produced by team of experts, funded by World Bank
1994	Social Health Insurance Bill approved by the Senate
1994	Government Decision (no. 370/1994) to pilot primary care reform in eight districts (ended in 1997)
1995	Legislation to establish the College of Physicians
1997	Social Health Insurance Bill approved by the Chamber of Deputies (implementation started in 1999)
1998	Public Health Law (no.100/1998)
1999	Ministerial Order (no. 201/1999) placed restrictions on number and distribution of pharmacies (amended in 2005)
2002	Emergency Ordinance (no.70/2002) decentralized ownership of public health care facilities from central to local government
2002	Emergency Ordinance (no. 150/2002) modified initial National Health Insurance Law
2002	Law on Mental Health Promotion and Protection of Persons with Psychiatric Disabilities
2002	National Anti-Poverty and Social Inclusion Plan, Government Decision (no.829/2002)
2004	National Public Health Strategy
2005	Government Ordinance removed National Health Insurance Fund from coordination by Ministry of Public Health
2006	Health Reform Law (no.95/2006)
2007	Ministry of Public Health strategic plan for 2008–2010
2008	Ministry of Public Health strategy for decentralisation 2007-2009
2008	National Strategy for the Prevention and Control of NCDs (ongoing process)

Source: adapted from Vlădescu C et al [1].

was carried out in 1995, providing some preliminary findings. After two years of the pilot, 86% of the population was covered by family doctors, with 8% higher coverage in urban areas. Surveys indicated that family doctors had become more "patient oriented". The output of family doctors increased, providing 21% more consultations and 40% more home visits, and 87% of GPs provided emergency coverage at night or on weekends. However, differences in access between rural and urban areas persisted, as financial incentives included in the scheme to attract more physicians to rural areas were too limited. The pilots continued until 1997, when they were discontinued by the new government [2].

The Social Health Insurance bill was approved by the Senate in 1994 and by the Chamber of Deputies in July 1997. Financing based mainly on general taxation was replaced with a system based on mandatory insurance premiums paid by the employee (6.5%) and the employer (7.0%) as a fixed percentage of income. The insurance law contributed significantly to the development of the private health sector. Prior to the law, access of private health care providers to public funds was rare. Moreover, the previously state-employed GPs became independent practitioners, the majority of them being self-employed.

Another crucial moment for the Romanian society as a whole and for the health system in particular, was the beginning of 2007, when Romania joined the European Union (EU) together with Bulgaria. Due to the accession

process, Romania has been required to harmonize its legislation with European Union requirements. However, there is still a gap between the legal developments and actual implementation. Since 2007, the population health status and the health services from the other EU Member States became the reference comparison for the Romanian health system.

Over the time, the main actors involved in the health sector reforms in Romania were:

- The *Ministry of Public Health*, which plays a major role in the decision-making process in health policy as the *governmental system* to a large extent continues to operate as a centralized command and control bureaucratic system. Almost all of the major health policy documents have been initiated at the MoH level.
- The *National Health Insurance Fund* sets the rules for the functioning of the social health insurance system and coordinates the 42 District Health Insurance Funds; it negotiates the framework contract that sets up the benefit package to which the insured are entitled, together with accompanying norms.
- The *Ministry of Finance* is the public body in charge of monitoring the spending of public funds in accordance with state regulations.
- The *College of Physicians*, established in 1995, has been an important participant in the reform process, physicians supported the health insurance system and the increase in private medicine initiated in the early 1990s.
- The *Romanian Medical Association* and the *Society of General Practitioners* operate as traditional professional associations, acting more or less successfully in shaping the process of health policy-making in their specific areas of interest.
- *Political parties* have direct influence on the health care sector through the health related legislation, especially the Health Budget Law. Generally, important officials within the Ministry of Public Health and the local health authorities were/are also members of the ruling party, constituting another source of political influence on health policy.
- *Civil society*.There has been little or no popular debate or consultation on health sector reform. Despite notable exceptions, there has been limited development of NGOs or collective and community-based groups and associations in the country [1].

Methods

Methodological approach for the development of the strategic directions for the health system reform

The development of the Health Strategy entailed five stages:

1. *identification and ranking the priority fields and problems;*
2. *stakeholder analysis;*
3. *debate and adjustment according to the expressed opinions of the identified stakeholders;*
4. *de facto development stage;*
5. *public presentation and debate.*

A number of structures were set up to prepare the new Health Strategy. The preparation was overseen by the Presidential Commission, nominated by the Romanian President (which also acted as a Steering Group). The members of the Commission represented both key areas of expertise related to health, and also main regions of Romania with extended expertise of health issues both at the regional and national level. The Commission had overall responsibility for the consultation process and for the development of the strategy. During the first stage, a consensus meeting with the nominated members took place. They identified the main sections for the future strategy and prepared a list of priority health problems. The Commission, supported by a technical group, undertook a stakeholder analysis and invited representative of key stakeholders to participate in the preparation and debate of the Strategy in the form of a Consultative Forum. In addition to the plenary sessions, the Forum was divided into 9 working groups to deal with specific issues: *funding, delivery systems, drug policy, hospital care, primary care, human resources, population health, quality; and patient rights*. They developed specific reports, which were approved and then incorporated by the Commission in the strategy document. The whole process, including the literature review and analysis of main documents on public health policies, from Romania and from abroad, lasted 11 months. The draft document took into account the official statistics published in the Romanian Yearbook of Health Statistics, WHO database "Health for All", together with existing legislation and sectorial strategies. The whole document was approved by the Romanian President, and then launched for public debate, as the last stage in the strategy development. The strategy draft was posted on the Presidency web site, asking for the comments of experts and/or health institutions interested in the field. At the same time the draft strategy was

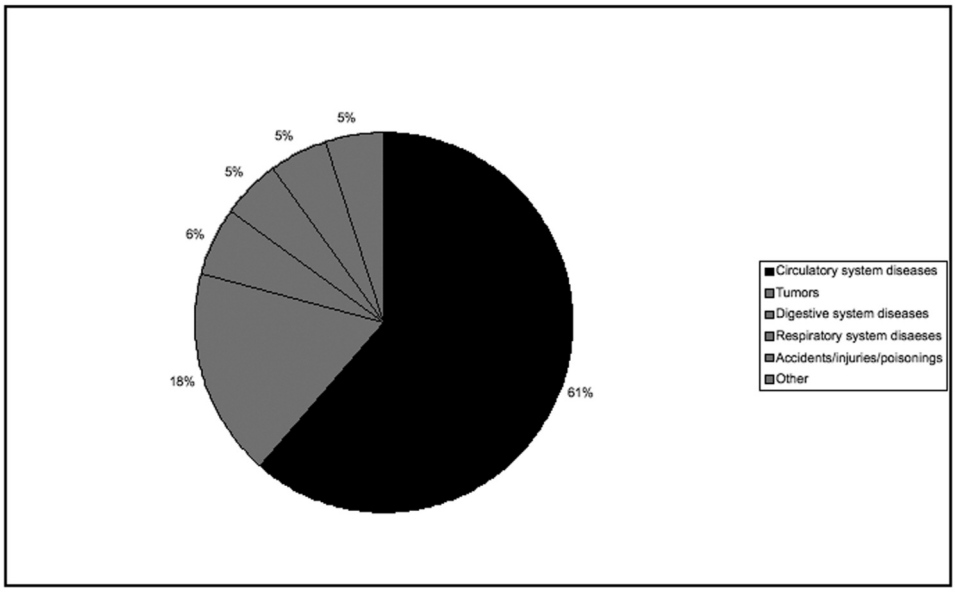
sent to the main public health institutions in the country asking for their opinion in their specific field of competence.

Results

Situation analysis

The analysis of the health status of the population reveals that Romania has one of the poorest indicators for health in the WHO European region, not only at EU level. A mix of specific indicators for developed countries (e.g. high mortality by cardiovascular diseases, increasing incidence of cancer) and specific indicators for developing countries (e.g. re-emergence of some communicable diseases, from TB to sexually transmitted infections) can be noticed from morbidity and mortality data. Regardless of a slight increase, the level of the life expectancy at birth of 72.6 years for 2005-2007 [3] represents one of the lowest in the region. Infant and mortality rates that are strongly correlated with the health system performance place Romania among the worst in the EU. Figure 1 shows the main causes of death in Romania for 2007: circulatory system diseases, followed by cancer, digestive diseases, respiratory diseases and accidents/injuries/poisonings. If in Western countries of the EU there is a decreasing trend of mortality due to cardiovascular diseases, conversely, Romania shows a marked increase. Thus, the relative contribution of different causes of death to the changes in the level of crude mortality rate in 2006 compared with 1990 in Romania was about +80% for cardiovascular diseases, +30% for tumours, +14% for digestive system diseases, - 16% for respiratory system diseases, and -6% for accidents [4]. The standardized death rate (SDR) due to circulatory system diseases for all ages is 2.5 times higher in Romania than the EU average [5]. Mortality from tumours, even if very close to the EU average, is characterized by a high number of avoidable deaths. For example, SDR due to neoplasm of cervix uteri, 0-64 years is 5 times higher in Romania than the EU average, SDR due to neoplasm of trachea/bronchus/lung is about 20% higher, while SDRs due to breast neoplasm is relatively similar [4]. This proves the inability of the Romanian health system to answer the real needs of the population. It should be mentioned that the morbidity and mortality patterns have changed a lot in the last decades, with an important increase of the prevalence and mortality due to chronic diseases. This phenomenon can be explained by the process of population ageing, associated to the multiple actions of biological, environmental and life style risk factors and to the influence of socio-economic and health care provision conditions. Almost 1/5 of the total number of deaths can be considered avoidable deaths if primary and secondary preventive actions had been undertaken in Romania. In 1992, the number of avoidable deaths was 51 798, while in 2002 it decreased to 46 647. The leading causes of avoidable deaths by primary prevention were, in order: for males - neoplasm of trachea/bronchus/lung, followed by ischemic

Figure 1. Structure of deaths by main causes, ROMANIA, 2007.



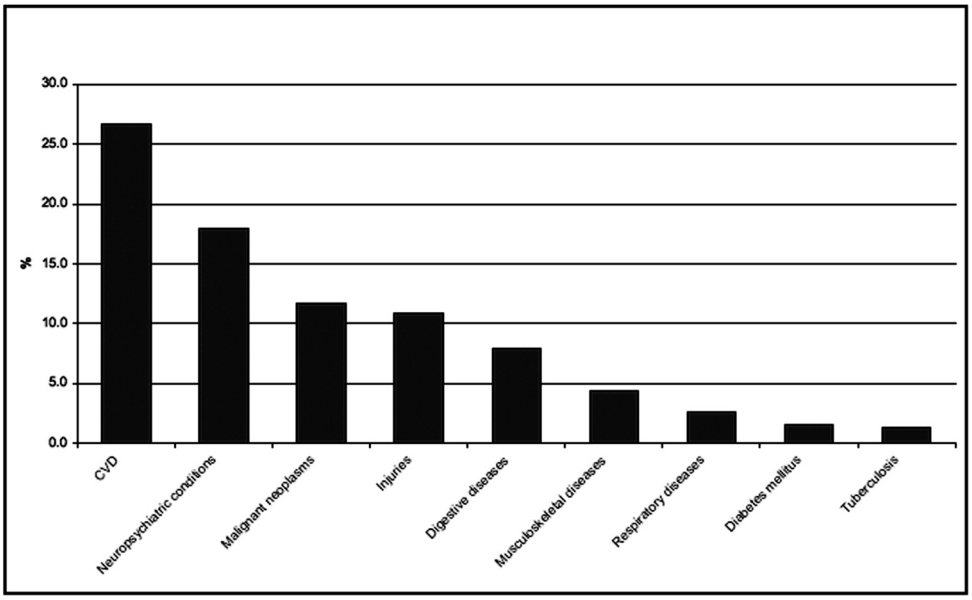
Source: Ministry of Public Health. Health Statistics Yearbook, 2008 [2].

heart diseases, liver cirrhosis and road traffic accidents; for females - ischemic heart diseases, followed by liver cirrhosis, neoplasm of trachea/bronchus/lung and road traffic accidents [4]. Taking into account the burden of disease measured by DALY (Disability Adjusted Life Years) indicator, it should be underlined that chronic diseases are also the main burden, but the ranking is rather different: figure 2 shows that in 2002, the most important causes of DALY in Romania were: cardiovascular diseases (4.886 DALY per 100.000 inhabitants), neuropsychiatric conditions (3.294 DALY per 100.000 inhabitants), malignant neoplasm (2.135 DALY per 100 000 inhabitants), injuries (2.002 DALY per 100.000 inhabitants), digestive diseases (1.446 DALY per 100.000 inhabitants), musculoskeletal diseases (805 DALY per 100.000 inhabitants), respiratory diseases (488 DALY per 100 000 inhabitants), diabetes mellitus (281 DALY per 100 000 inhabitants), and tuberculosis (232 DALY per 100 000 inhabitants) [6].

As for the health status indicators, unfavourable comparisons exist for the indicators describing access to basic health services. Romania has one of the lowest number of physicians, nurses or pharmacists per population unit, or the number of consultations per population unit in the EU. There are not only international disparities related to access to health services, but also internal ones, between regions and areas in Romania. The most prominent discrepancy is encountered in the rural area, where the number of health personnel in general and especially the number of physicians is several times lower than in urban areas. A study done in 2006 by the Health Statistics Institute [7], revealed a dramatic situation regarding primary care coverage for the rural population (Table 2). The same comment can be done for the number of health units, starting with pharmacies, hospitals or health centres.

Human resources management in the Romanian health sector is inadequate, in addition to the fact that the level of coverage with health personnel is the lowest in the EU (in 2006, Romania had 192 physicians per 100 000 population, while the average for the EU was of 315 physicians per 100 000 population) [8]. Important aspects should be added to the existing geographical imbalance: the shortage of specialized personnel should be noted especially for the fields of prevention, medico-social work, public health and health care management; an inadequate percentage of the ancillary staff; concentration of health personnel in urban areas and at the hospital level. Other problems are related to the lack of incentives for young people to choose their medical profession, young specialist doctors who are not financially supported, the continuous education process and postgraduate training which are not properly organized, the low level of salaries, and the missing official link between performance and income level. All the above-mentioned aspects represent critical reasons for Romanian physicians and nurses to leave the country, this emigration of health personnel is a new phenomenon for the Romanian health system, and a very worrying one. A study carried out in 2007 by the National

Figure 2. The structure of DALY due to the main causes, ROMANIA, 2002.



Source: WHO Global Burden of Diseases Estimates 2002 [5].

Table 2. Health personnel at primary health care level, ROMANIA, 2004.

	No. family doctors	Total no. of inhabitants	No. of insured persons	No. of nurses	No. of community nurses	No. of localities with no family doctor
Total	10595	21624689	19226642	13769	478	98
Urban	6094	11880347	11294464	7370	107	0
Rural	4501	9744342	7932178	6400	371	98

Source: Health Statistics Institute [6].

College of Physicians revealed that more than 4% of the practising physicians (meaning over 1000 physicians) have left Romania to work abroad. [9] France, Germany and UK are the favourite destination countries for Romanian physicians, mainly due to the fact that they have active policies for recruiting staff from other countries, including Romania. The specialties most in demand in the destination countries are: family medicine, intensive care and psychiatry. The increasing mobility of the health workforce (as a result of EU integration) is expected to put a lot of pressure on the Romanian health system.

Another major problem of the Romanian health system is the lack of integration of the health services in order to assure continuity of care. The different levels of care are rather independent, i.e. primary care has no functional links with hospital care, while health promotion and prevention are not connected to curative care. The present model of care is based on the high specialization of services and on the shortage of interdisciplinary teams, these factors also contribute to the lack of an integrated approach. Under these circumstances, long-term care, home care and the social services are very weak; which results in hospital services not being relieved by viable efficient alternatives [8].

The health information management is also poor. There are several parallel health information systems coordinated and controlled by different owners (Ministry of Public Health and its subordinated units, National Health Insurance House, National Health Programmes, hospitals, private cabinets, research and education institutes, etc). Standards (definitions, indicators, coding systems, classifications, etc.) are missing in many cases. All of these weaknesses result in data inconsistency, information is not accessible or missing, with a deep negative impact on health system functioning and on the decision-making process.

The Romanian experience in intersectoral cooperation is much reduced. Multiple actions on

Table 3. The performance of the health systems[1].

Rank	Country	Rank	Country
1	France	48	Czech Republic
2	Italy	50	Poland
5	Malta	58	South Korea
9	Austria	55	Albania
14	Greece	62	Slovakia
17	The Netherlands	66	Hungary
18	UK	70	Turkey
25	Germany	77	Estonia
30	Canada	99	Romania
34	Denmark	102	Bulgaria
37	USA	130	Russian Federation
38	Slovenia	144	China
43	Croatia	167	North Korea
		191	Sierra Leone

Source: The World Health Report 2000 [9].

[1]The WHO concept of performance includes 3 main pillars: 1. improving the health status; 2. increase of the capacity to meet the expectations of population; 3. assure the equity concerning the financial contribution

Table 4. Major intervention areas and recommendations for the Romanian health system reform.

Intervention area	Recommendations
1. Health system financing	• Increase the level of funding for the Romanian health sector • The development of a health resource allocation system based on transparent criteria and medical evidence • Introduction and support of the payment mechanisms based on the efficiency and quality of the medical act
2. Health system organization	• System reorganization with organizational and decisional decentralization • Development of the quality assurance system in health • Redesign the health sector information system
3. Drug Policy	• Improving the process of establishing the content of the reimbursed drugs' list • Adjustment of the reimbursement rules and of the price establishment, in order to ensure the cost-efficient use of the public resources • Developing a monitoring system for prescribing and releasing of medicines and its correlation with incentives for rational use of medicines
4. Strengthening of the Primary care	• The development of primary care interdisciplinary teams • Improvement of resource allocation at primary care level, simultaneously with raising efficiency of their use and the integration of health services • Significant increase of the resources dedicated to primary care development, in areas like human resources, physical infrastructure, information and communication systems and medical equipment
5. Improving hospital care	• Restructuring and reorganization of hospital services in four main categories: - Care for acute cases - Care for chronic conditions, on which the hospital services will focus in the future - Care for the elderly, transferred to new settings and services - Care for social cases, also transferred to specially created settings and services • Hospital management decentralization and establishment of county hospital agencies to assure coordination of the hospital services at county level • Diversification and use of new hospital services financing methods based on performance and quality of services provided to the patients • Development of new management methods for assuring continuity of care for the patient under treatment and economic efficiency conditions
6. Human resources	• Drafting a coherent sectorial policy for training, development and allocation of health human resources • Increase of the availability of human resources in the health sector in Romania • Stimulate the professional career development in the health sector

Source: adapted from Vlădescu C et al [7].

the health determinants (other than the health services) are not addressed by well coordinated programmes or effective interventions. Health impact assessments of the policies developed by other sectors is not a common tool in Romania, even if very useful and highly recommended by international organizations [7].

The performance of the Romanian health system is rather poor, Romania ranking the 99th in the world, behind countries like Albania (55), Slovakia (62), Hungary (66), Turkey (70), and Estonia (77) (Table 3) [10].

Given all of the negative aspects mentioned above and due to the inadequate level of the population health status, a Presidential Health Commission was set up in 2008 in order to determine the priority directions of the health system reform.

Major areas for intervention

The Commission decided to select and focus on those intervention areas which could display medium term outcomes, and also on those areas that are mainly under the influence of the health authorities. Thus, six major intervention areas have been identified in order to address the dysfunctions of the health system:

- Health system financing
- Health system organization
- Drug Policy
- Primary care
- Hospital services
- Human resources

Based on a detailed situation analysis, for each of the above mentioned areas a set of recommendations was made with the perspective of solving the respective problems. All of the recommendations are summarised in Table 4.

In December 2008, a new Government was appointed as a result of the general elections from November 2008. The new Minister of Health has just announced that the strategic directions for the short-, medium- and long-term are generally the same as the strategic directions established by the Presidential Commission. Thus, the main priority areas for intervention for the Ministry of Public Health (the name of the ministry has changed to the Ministry of Health since January 2009) are:

- a new drug policy
- a new health policy for the rural area
- reorganising the health system by means of organisational and decisional decentralisation
- increase the economic efficiency of the health system and of the hospital care in particular
- real implementation of the health information system in primary care [11].

Due to the fact that non-communicable diseases represent the main burden for the population health status, the Ministry of Public Health launched, in November 2008, the process of outlining the national strategy for the prevention and control of non-communicable diseases, under the coordination of the Institute of Public Health, Bucharest. The national strategy is based on the principles and main directions established by the WHO European Strategy for the Prevention and Control of Non-communicable Diseases. Consequently, the general objectives of the national strategy are similar to those of the European strategy:

- to take integrated action on risk factors and their underlying determinants across sectors (with special focus on tobacco use, alcohol use, unhealthy diet and physical inactivity, common risk factors for the most important non-communicable diseases)
- to strengthen health systems for improved prevention and control of non-communicable diseases (priority non-communicable disease: cardiovascular diseases, cancer, diabetes type II, obesity and chronic respiratory diseases).

Discussion

To implement the above-mentioned proposed interventions, an interval of 3-7 years will be necessary; however it is feasible to implement some of these within the next 12 months. Other measures require a longer implementation interval, especially those using an integrated approach to the health determinants that are usually under the control of other sectors such as education or the fiscal system.

The expected results of these interventions for the health system in Romania would be:

- *provision of integrated health services, based on continuous care*

Integrated health services appear to be more and more one of the most desired outcomes, especially after years of patchy approaches to reforms. After the political changes in 1989, many changes occurred outside of a clear vision of the future health system. Priorities were influenced by various health professional groups or other groups of interest. The introduction of new types of services, like family planning, was initially poorly integrated with other services and donor driven. In addition to this, the lack of a body of professionals in policy analysis and the lack of interest from the government for such assessments caused important decisions to be

taken without proper evidence. Also, the provision of health services in the "command and control" system, where the Ministry of Public Health and the local bureaucracy played a part in almost every decision of the health units, severely limited the ability of managers and political decision-makers to gain experience in using information, incentives and competition to achieve the desired results [12].

- *patients/citizens will become partners in the decision-making process for their own health*

As a consequence of the democratisation of the entire society and the increasing demand of the civil society to increase the accountability of the entire system, participation to the decision making process becomes a necessity and a tool to achieve better results.

- *the new system organization will facilitate a better access to relevant information for all the actors in the health system*
- *the health system will increase its transparency, in order to make information available to patients and their families so that they can make informed decisions when choosing a health care provider, a hospital or an alternative treatment.*

Information concerning safety, evidence based practice and patient satisfaction should be also included. Transparency is not regarded only as a mean for better planning or informed decision making process, but also as a desired way to combat and prevent corruption.

- *all the decisions made in the system, starting with those related to resource allocation at national level and ending with those related to the diagnosis and treatment methods, will be based on the best available scientific knowledge.*
- *assuring the quality of the medical act will become a key element of the health system.*

Quality of care is not regulated by a specific act, but existing regulations includes some references to quality of care in each precise sector of the healthcare system i.e. hospitals, laboratories, primary care facilities etc. The key health policies established from 2000 onwards formally sought to: "increase access to high quality, effective and safe drugs"; or "increase of life quality by improving the quality and the security of medical act". In this regard, improving the institutional framework is considered as an essential step towards better quality of healthcare. Elements of quality are to be found in different regulations issued by the Ministry of Health but in the absence of a dedicated or individualized quality assurance framework it is difficult for authorities to evaluate and assess properly the quality of care [1].

- *safety* will be a basic characteristic of the health system
- *co-operation* between specialties and professions will be encouraged, both between the different levels of care, as well as between the specialists at the same level of care.

The development of interdisciplinary teams to provide services will also require changes to the educational medical system at all levels.

- Health system organization will facilitate *intersectorial co-operation*, which is crucial for an integrated approach of the determinants with a high impact on health.

If the declared intentions of the minister of health are implemented in line with the proposed presidential strategy, then coherency might finally have a chance to drive the process.

References

1) Vlădescu C, Scîntee G, Olsavszky V, Allin S and Mladovsky P. Romania: Health system review. Health Systems in Transition 2008; 10(3): 138.

2) Jenkins S, James J, Waddington C. Evaluation of the health reform in eight pilot districts in Romania. London: Institute for Health Sector Development, 1995.

3) Ministry of Public Health. Health Statistics Yearbook, 2008.

4) Marcu A, Galan A. Report on review of policies and capacities for integrated prevention and control of NCD, including cancer. Available from www.ispb.ro [Accessed February 20, 2009].

5) WHO HFA database, July 2008.

6) WHO Global Burden of Diseases Estimates 2002. Available from www.who.int/healthinfo/bodgbd2002revised/en/index.html [Accessed February 20, 2009].

7) Ministry of Public Health Report. Perţache I, Ursuleanu D. Population coverage with health personnel at primary care level, 2006.

8) Vlădescu C, Pascu O, Astărăstoaie V et al. Report of the Presidential Commission for Romanian Public Health Policies Analysis and Development, Bucharest 2008. Available from http://www.presidency.ro/?lang=ro [Accessed February 20, 2009].

9) Dragomirişteanu A, Fărcăşanu D. Galan A. Physicians migration in Romania, National College of Physicians Bulletin, Bucharest, 2008.

10) WHO. The World Health Report 2000 - Health systems: Improving performance, WHO, 2000.

11) Ministry of Public Health. Press Release concerning the Strategic Directions of the Ministry of Public Health, Bucharest, January 14, 2008. Available from http://www.ms.ro/ [Accessed February 20, 2009].

12) Shakarishvili G, Decentralisation in Healthcare, Analyses and Experiences in Central and Eastern Europe in the 1990s. Open Society Institute 2005.