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We still have lot of work to do and we need stability if we are to see improvements

22.09.2015

Tags: Romania, MoH, Minister

Raed Arafat, Secretary of State at the Romanian Ministry of Internal Affairs highlights the key trends in Romanian healthcare over recent years, his own role in reforming the country's healthcare system, and the outlook for the future.

You have been personally involved in some of the more momentous events of Romanian healthcare: specifically your setting up of a mobile emergency service (the SMURD) and how this concept was eventually embraced, scaled up and replicated nationally. Tell us about that.

In the 1980s and early 1990s when I was a student in Cluj and later resident in Targu Mures, it was clear to me that the emergency services were not working effectively. People were not adequately trained, vehicles were badly equipped and there was no overarching system essential for the system to work properly. There wasn’t even single phone number connecting the police, ambulances and fire service. Instead you had to call each one individually. Nor was there advanced life support in the pre-hospital field, where we were experiencing significant delays in response times to patients. Even once inside the hospitals, there was all too often insufficient numbers of trained staff available and no emergency departments or emergency physicians existed.

In 1990, we engineered a successful attempt at reform in the regional city of Târgu Mureș. We created one team for emergency pre-hospital care, a mobile intensive care unit with a trained doctor and nurse capable of responding to critical emergencies. The system was fully run by volunteers and initially I was contributing some of my own money towards the effort.

The idea did not immediately progress to the rest of the country because we encountered a lot of resistance to it. That is until 1991 when I contacted the fire service and suggested we work together in a co-operative effort so that the scheme would benefit them. They agreed to a run a six-month trial period, something which delivered tangible results and was the beginning of a new relationship between the fire service and the hospitals. This was a first for Romania, previously there had been no joined-up thinking between the two services.

Subsequently you were actually invited to become part of the health ministry…

In 2006, the then minister of health asked me and some of my colleague to write the chapter on emergency health care in Romania for the new health care law. We wrote a full paper on this subject, focusing on access to the system, the involvement of the fire service, the first response and emergency care delivery in the hospitals.

In 2007 the same minister, as well as prime minister, invited me to work at the ministry of health to implement the system top-down. We decided to increase the level and quality of our ambulances, classifying them into different levels, establishing the role of the public sector and that of the private sector. The system has seen significant improvements since its inauguration in 2007 until now.

Parallel to this approach, from 1997 onwards, we started developing the air rescue system. In 2007, we started a project with World Bank funding, where we started building up emergency departments. We were assigned a budget of EUR 35 million to equip 63 emergency departments. We built up training centres for physicians and nurses within both the ambulance service and emergency departments. One cannot develop a system of health without the human resources, you can have all the necessary equipment necessary, but without the required training it will not work.

Regarding purchasing, it is all done centrally, allowing us to get a much better price for our equipment. Indeed Romania has become an ambulance manufacturer and exporter since we started with this system. Our ambulances are of the same quality as the rest of Europe, but are

bought for as much as 20 percent less.

Where do you identify outstanding needs in the emergency services arena?

Currently one of our major problems is the lack of human resources. This is not a problem unique to Romania, but there have been some steps taken in the country which have worsened the situation. In particular, the sudden decrease in salaries from 2010, initially by 25 percent, with doctors and nurses eventually losing around 40 percent of their base income, as well as blocking the hiring on a scene of 1 hired for each 7 who leave. This has been extremely damaging for Romania's health sector, with a lot of the young physicians leaving to pursue their career in other European countries. There is already a general mis-equilibrium in human resources within Europe and, according to the European Commission, by 2020 the EU will be one million people short of health workers. The loss of young Romanian talent to other countries lacking such workers meanwhile places our country at a real disadvantage and we need to look at EU wide policies to solve this problem.

How are you dealing with these issues? Can the Romanian authorities act to counter such trends?

There are certainly measures that the Romanian authorities can take. One of the issues is whether we import physicians ourselves, from outside the EU, given that within the EU our salaries are comparatively low. Another step we have taken is to recognize specialties from countries outside the Union as of 2012, including the US, Australia, Canada, Israel and New Zealand where we have a significant Romanian diaspora. A significant number of our citizens have returned with good qualifications that were immediately recognized. Looking at the medium to long term, approaching this from a strictly Romanian national perspective, without treating it as a European wide issue, will only ever be a short-term solution. Human resources can no longer be treated on an individual country basis but have to be looked at on a EU-wide level.

Is the driving force behind this migration of talent purely a matter of low salaries?

There are three issues at play. The low salaries, the workplace, with a lot of our infrastructure needing improvement, and the career path of our young doctors, with a system that is too

hierarchical, based mainly on age. The last point will not be straightforward to change: it comes down to the university system and the mentality of our people. One issue that has created problems in Europe and is rarely discussed, is the working time directive, preventing personnel from working more than 48 hours a week. When you tell a doctor who was previously working 68 hours a week that he is legally obliged to work less, you create a vacancy that needs filling. Although the working time directive has had a positive health impact for individuals, in the Romanian health sector, as well as in other EU member states, it has created a void that has yet to be properly filled.

A common criticism we have heard with the Romanian health system is the revolving door in terms of the ministers of health. How significant a problem is this?

The average lifetime of a minister of health is around eight months. This has had a very bad impact on the Romanian health system, with each new minister wanting to implement their own reforms and hence the process starts again from the beginning. Emergency medicine has taken a different path, with me being at the ministry, through cross-party agreement, I have worked with parties across the political spectrum. What we need is a vision for each part of the system, agreed upon by all major parties, that will therefore been pursued coherently and in a continuous fashion irrespective of who is in power.

The fact I am sitting in the ministry of interior today represents a radical departure. We straddle both ministries and integrate different actors. In emergency care the ministry of health could never have done alone what we are achieving today. Not using the highly professional fire service would require mobilizing expensive alternative public or private sector resources. The helicopters would have needed to be outsourced. There would have instability in the flying component had there been new bidding rounds for helicopter providers every few years rather than calling upon the general inspectorate of aviation from within the Ministry of Internal Affairs.

The government essentially put under one umbrella all the resources necessary for mobile response including emergency medical response. Now operationally we lie under the ministry of internal affairs but the ministry of health remains responsible for ambulance services and emergency departments from an administrative point of view. It ends up being a very well-integrated structure that can endure over the long term. The other day we were even able to call on support from the Ministry of Defense for air support by borrowing a plane to bring burned children to the burns centre in Bucharest after an unfortunate accident in one of the regions. The

cooperation with the Ministry of Defense is part of the system and is not limited only to the medical issues.

What is the decision-making structure of your inter-ministerial department?

Our actions are coordinated by an inter-ministerial technical committee that meets on a bi-monthly basis and is composed of observers from local authorities, the union of the ambulance service and the two ministries. This ends up acting as a clearinghouse for what needs to be done with everything handled in an integrated manner. It’s a shining example of deploying the full resources that a government has at its disposition for combined and enhanced effect.

I believe it is important to not look at a government as several small separate entities, with each ministry being treated in a vacuum. A government has ministries as a tool to implement its strategy and vision, helping serve the population.

What you and your team have managed to create is a beacon example of what can be achieved by making the most out of finite resources. Is this an isolated instance or are there analogous case studies? Can this sort of integrated model be emulated and replicated?

It certainly can. There are many such examples. In 2010, we observed a lot of acute myocardial infarction (AMI) patients were not getting thrombolysis or having stents put in which is the orthodox treatment. The cardiologists came telling us that Romania had a 13% mortality rate in their therapeutic area which represented the highest in Europe. Alarmingly, less than 15 percent of patients were getting stents put in during the acute phase. This meant they were likely to develop complications that would cost the health sector more money over the long run. The main reason was that the sum of money paid by the CNAS (Social Health Insurance) to hospitals couldn’t cover the entire cost. When the costs are not covered completely, hospitals will be reluctant to spend money because they will start making arrears and end up getting blamed for that.

We came with a new joined-up scheme whereby the CNAS would cover the cost of hospital drugs and service provided, but not the stent and additional materials which would instead by co-funded out of the state budget. Patients with acute myocardial infarction would be entitled to the service, regardless of there statute of being insured or not, and the emergency services would also chip in by providing the transport function of transferring the patients to the stenting centres. Due to this

unprecedented teamwork involving the ministries of health and interior, the cardiologists and the emergency services, we today see some 60 percent of patients receiving stents and mortality has plummeted down to 8.2 percent.

A similar project was then established 2 years ago for intensive care departments in emergency hospitals because the intensive care departments were again spending much more on their drugs and consumables than they were receiving from the CNAS. Again co-funding was identified, joined-up action applied and the mortality rates have fallen. Even more recently Minister Nicolae Banicioiu has initiated a third such project for stroke patients. All of these are examples in other areas of joined-up thinking.

It seems one of the main challenges underpinning Romanian healthcare is the chronic underfinancing. What can feasibly be done to overcome this?

The Romanian health sector is only receiving around 4 per cent of GDP while average expenditure across the EU is 8.4 of GDP so it us clear to everyone that we have to slowly increase that allocation. As we forge ahead with securing better tax collection mechanisms maybe an opportunity will emerge to start increasing that proportion. Let’s remember that the CNAS is a social insurance house that allocates public money therefore it is not run like a private insurance company. One possibility that may exist is to establish a second level of insurance that can be given over to the private insurance sector. At present Romania has the model of paying subscriptions to private clinics to be able to be seen by those private clinics, but I do think that we also need to inject some extra funding and this modality can be through complementary insurance to the basic social insurance that could be provided through the private sector.

I believe that the health sector in general does require both the public and private sector, but it needs them in a very well equilibrated way and there are certain parts of the system where the state must have a very strong role otherwise the population may not have access to basic necessities.

In 2012 there was an attempt at privatizing certain parts of the Romanian health system? You publicly opposed these proposed reforms. What was the rationale behind this activism?

It was clear that these reforms were heading towards the full liberalization of the Romanian health sector, putting all the power in the hands of private health insurance and private providers to run the system. This model was based on another European country, the Netherlands, which today is debating going back on such reforms. To date, we still do not know what the perfect system is, and my argument was, why change what is already working when it comes to the emergency sector and the fact that full liberalization of health sectors did not prove to be the best solution in other countries.

What really made me react was the insistence by those writing the bill, on liberalizing the emergency response sector. I considered this proposition not only as a doctor but also as someone with deep convictions formed over a substantial period of time that this sector must not be liberalized. We live in a country where the average income is low, where access to care still needs to be improved, but we have managed to create a public emergency health care system that is working well and importantly can easily be mobilized in case of disasters.

In 2009, there were several attempts by the private commercial industry in emergency response to compete for public money with the public sector. These issues went to court and they lost each case. Our legislation allows for the private sector to exist. We do not deny it a role in Romania. The only condition is that we pay for them from the public purse when there is a particular need, mainly for simple transport and house visits. In emergency response the pool of money is meagre, and if we allow them to compete in this area they will gradually replace the public sector and pose an existential threat.

If we consider it acceptable to liberalize emergency care, why not do the same for national defence or the police force? The concept is the same. Emergency care is part of the national security of our country. It is not merely a matter of public health, but rather a cross-sectorial issue. In a country that has developed an effective public system, tampering with it should only be considered if there is a guarantee it will lead to something better.

Could the politicians guarantee that they would bring something better through privatization? No. Could they guarantee that the system would maintain its level of performance? No. Instead the idea was that the market would supposedly regulate itself. The problem with this is emergency healthcare should not and cannot be treated like a vegetables and fruit market. The danger was that they were willing to tamper with the fine mechanism that had taken years to construct and, once tampered with, would likely never be able to be rebuilt.

Imagine the scenario of some sort of disaster occurring in Bucharest and the state needing to gather 100 ambulances. It’s one matter to have to call up the head of ambulance services and summon his resources and another issue to have to beg private companies to give us what we need when their primary concern will be to know how they will be paid and to demand premiums for operating outside of their contracted geographical locations. Some countries have decided to outsource their services because they didn’t have functioning state services in force so really didn’t have another alternative. We did and it would have been reckless to start tinkering with it like that. One more issue is the increase in the cost that could have accompanied the liberalization of emergency services on the short and long term. At the moment the costs of the emergency response system are well under control.

What is the future outlook for Romanian healthcare?

We still have lot of work to do and we need stability if we are to see improvements. As I said to the political factions once endeavouring to privatize the emergency services: now we feel as if we are on the highway in 5^{th} gear travelling at a fine pace, but with the changes they are suggesting they are forcing us to depart that highway and transition to a small, bumpy rural road of very uncertain direction. This sort of foolhardiness must be avoided at all cost. We need to implement a long-term vision and only make adjustments when they are strictly necessary and have a high probability of producing better end outcomes. The Health sector in Romania generally needs radical reform but this has to be implemented in a very wise and careful manner focusing on the interest of the patients.

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