REMUNERATION PRACTICES OF MEDICAL STAFF - COMPARATIVE STUDY BETWEEN ROMANIA AND FRANCE

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Abstract:
Balance between individual expectations, priorities at society level and resources available in health sector are difficult to maintain, precisely because of the unlimited needs and limited resources available to respond to them. The health system is an important part of a whole nation. When it appears the alert of deficiencies, it is required careful analysis of cause-effect relationships to identify viable solutions out of the situation of "crisis". The Romanian government has tried the establishment of reforms aimed aligning the Romanian health system at medical models of EU Member States. Throughout the paper, we followed drawing the radiography of the present Romanian health system, intended to be, why not the starting point in identifying the "treatment" adequate system disease. The parallels between French and Romanian health system, especially in terms of funding especially, the remuneration of medical staff, is intended to provide a picture of what could become the national health system following the adoption coherent decisions. The main objective of this paper is to emphasize the current status of the Romanian health system.

Key words: *costs, salary practices, medical facilities, medical staff.*

JEL classification: H51, I11, M12, M54, N34.

1. Introduction

In the present context, both Romania and other EU member states at the same level of development (e.g. Bulgaria, Hungary) feel the need to reform the public health system. For this reason derives our research motivation, so throughout the paper we try to present the need for a careful study the allocation of resources in the Romanian health system, focusing our attention on important component of the cost of medical practices: labor related costs concerned medical staff. Naturally simply allocating funds based on imprecisely defined criteria, is not the solution to contemporary issues. Is the impetuous to require a cost control system and system of measuring performance in terms of efficiency (forecast and achieved), effectiveness and economy. As such, we try to offer an image of what healthcare partial variable costs, namely labor costs, have or not a significant importance in all healthcare costs.

2. Research methodology

In this paper we used qualitative research; we addressed such issues in terms of theoretical, descriptive-conceptual manner. So we followed a description of the Romanian health system in terms of its present situation as well as in terms of funding and allocation of funds, particularly for staff remuneration. Salaries of medical personnel are a significant importance in all healthcare system costs.

Research methods that we used are based on research: analysis of documents provided by a number of national and international organizations and institutions as well as those in international databases, compared analysis method when we tried to present: system of medical staff remuneration in France in compared with Romania, non-participating observation for studying the current situation of the Romanian health system.

Healthcare market can not be efficient in exchanges which focuses short term between a small numbers of people that trade, where information on both the good nature and the outcome is unknown, where the property is less substitutability between consumers and where high potential problems related to uncertainty and complexity of decision making (McGuire G.J., 1994).

3. Romanian healthcare system analysis

By law, in Romania the healthcare system includes all the medical structures, public and private institutions and resources aimed at prevention, maintenance and improvement of public health (Public Health Ministerial Order no. 1764 of December 22, 2006).

Public healthcare represent individual healthcare services as well as those addressed to the entire population, including activities that have for objective the influencing of healthcare policies and actions from related sectors with target groups: economic and social factors that influence the environment and act directly on public healthcare.

Although some of health indicators of the Romanian population such as: average length of hospitalization, the relatively small number of disease compared with other countries but also time periods, have improved over the past decade, there are a number of problems that still raises. Romanian government considers that it is necessary to simplify the structure of hospitals, to be able

to increase in efficiency of health costs, but also economies. It is intended that elders care and the acute and chronic conditions to be achieved in hospitals. (Romanian - Health Sector Policy Note).
In 2010, the Romanian healthcare system has acted in new directions (Romanian Health Report, 2011) such as: decentralization, identifying additional sources of financing the system, computerization, structural reform of the healthcare system from primary healthcare direction.
Another measure taken by the Ministry of Health is that all the producers of medicinal products acting on the Romanian market should contribute from 5% to 11% of their incomes (revenue) for financement of public healthcare system; this system is called "claw back". Another direction action of the healthcare system is the health programs; objectives of these programs are to decrease unjustified mortality, assurance of adequate medical services, etc. To mention shall be the action in the equipping of prehospital.
In our opinion the right-now major problem is: healthcare establishments in Romania are the “near to the ground level” of financing health services, which have risen adapted evolutionary innovations in medical technology, the demand for medical services is growing. Romanian health system also faces difficulties in the remuneration of medical staff, as accession to the EU trigger a certain level of wages and the situation requires such alignment community.

3.1 The private Romanian healthcare system versus the public Romanian healthcare system

Private medicine has emerged firstly with the private dental laboratories and cabinets, in the period 1993-1994. Shortly they were followed by the opening of additional laboratory dental radiology, gynecology, and with these the industry of pharmaceutical and medical devices. They have become real industries, especially in terms of: aesthetics, laser therapy and psychotherapy. The private medical services with the higher demand in Romania are: dental services, laboratory investigation services, pediatrics and gynecology. Consequently, private medical practice birth has started in para-clinical healthcare sectors, non-chronic, and it excluded emergency medicine.
On the background of current situation some controversy appeared regarding the activity of the private healthcare sector versus the public health sector activity. Therefore, private sector strengths are: much higher quality services; medical staff behaves more carefully with patients which is not always the case in the public sector, but also lower prices of services in the private sector to the public, because of competition in the area. However, the shortcomings of the private sector, includes on the one hand that it does not cover all segments of health problems, and, on the other hand, the issue of human resources, which sometimes is not specialized sufficiently in the public sector. We must not overlook the fact that the price of private health services is not accessible to the majority of Romanian patients.

3.2 Financing the Romanian healthcare system

Romanian healthcare sector are "poor" compared to European average one, in terms of financial resources per capita. Costs of insurance medical services stand at a low level because the health sectors are considered as one counterproductive, therefore with lower priority in budget allocations. Medical staff deficits around has produced changes in the structure of sector expenses.

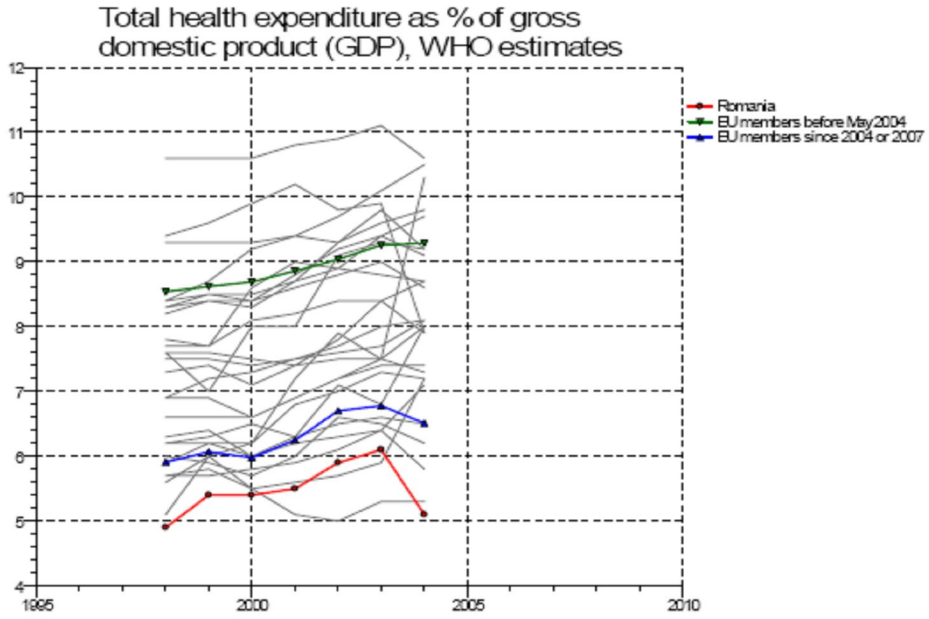
Regarding the wedges system, it is well-known that in Romania, medical staff is lower than the European average.

Health Insurance Agency medical budgets of recent years have increased from about 90 Euro/capita to 200 Euro/capita, but also as a share of approx. 3% to 4% of GDP over the same period of time in which we relate. However, Romania is among the last ranked, relative to health resources allocated. Specialists consider that the future would be desirable to increase health spending per capita because the population ages and rates of morbidity and mortality are increasingly high.

Over the time, public health expenditure budget varied between 3,4% and 4% of GDP. Therefore, in the state budget in 2006, we identify a value of 3,3% of GDP allocated to health sector, respectively 4.139 USD: 3.241 million for Social Fund and 898 million USD for MPH (Ministry of Public Health). Following the allocation of health sector a part of state budget revenue from duty on alcohol and tobacco, is expected an evolution increasing of public spending. International indicators show that in Romania, Public expenditure on healthcare public sector as percentage of GDP is similar to those of other countries from UE with same level of development (D. Sava, R. Menon, 2007).

Among the challenges of Romanian healthcare public system: stands that Romania is seen somehow forced to monitor closely increasing the efficiency of expenses for health care. It is envisaged higher attention to the hospital? In Romania, 53% of budget of the healthcare is allocated by CNAS for care hospitalization, compared to only 40% - average in countries that belong to OECD (Organization for Economic Cooperation and Development).

Figure no1.



Source: Report of the Presidential Commission for review and public health policy in Romania - Expenditure on health system , http://cercetare-sociala.ro/noua-lege-a-sanataii-dezbatere-publica/puncte-de-vedere-organizaionaleinstituionale/item/21-raportul-comisiei-preziden%C5%A3iale-pentru-analiza-%C5%9Fi-elaborarea-politicilor-din-domeniul-s%C4%83n%C4%83t%C4%83%C5%A3ii-publice-din-rom%C3%A2nia

Financing of public health budget is ensured by sources such as: state budget, National Fund of Health Insurance Unic (NFHIU), local budgets, own revenues of hospitals, external loans, external grants, donations and sponsorships.

The NFHIU is financing health system in proportion of 75% of total financing sources. This fund is financed by contributions from employees and employers that is 5,5% of the income of employees, respectively 5,2% of salary fund. Contributions to FNUASS have experienced declining from 14% in 2001 to 10,7% in 2011. The number of direct taxpayers is declining, in 2007 the number decreased by about 4 million people, compared with 2000. Therefore, approximately 5 million people contribute to a system that should benefit a theoretical population of 22 million people. Since 2006, tax on vice of tobacco and alcohol vice is a source of health budget.

The following table evidenced expenditure provided in the Convergence Program 2009-2012:

Table no.1

Expenditure provided in public finances

% din PIB	2000	2007	2020	2030	2040	2060
Cheltuieli totale	33,6	35	39	43.5	42.5	42
Cheltuieli legate de imbatranirea populatiei						
Cheltuieli cu pensiile	6,7	6,6	8,5	9.8	11.7	14.1
Îngrijirea sănătății	3,5	3,3	3,8	4.1	4,4	4,9
Cheltuieli cu educația	3,4	2.8	2.3	2.2	2.1	2.3
Venituri totale	32,1	33,2	34.5	40,5	39,5	39
			- ritmuri medii -			
Creşterea productivităţii muncii	2.5	5.9	3.4	2.7	2.7	1.7
Creşterea reală a PIB	2.4	6.3	3.2	2.1	1.6	1.2
			- % -			
Rata de participare în rândul bărbaţilor	75,4	70.1	70.9	68	66.1	66.3
Rata de participare în rândul femeilor	61,8	56	58.8	56.6	55.5	56.1
Rata totală de participare	68,7	63	64.8	62.4	60.8	61.3
Rata şomajului – BIM	6,9	6.4	6.0	6.0	6.0	6.0
Populaţia în vârstă de 65 ani şi peste / populaţia totală	13,6	14,9	17.4	20.3	25.5	35

Rata de participare se referă la populaţia în vârstă de muncă (15-64 ani).

Source: Convergence Programme 2009-2012, The long term sustainability of public finances, http://discutii.mfinante.ro/static/10/Mfp/pdc/Programconvergenta_ro.pdf

Allocation of funds in the healthcare system is based on a number of differentiation criteria, such as: types of health services offered (primary care or hospital care, curative care and health prevention) different areas of the country (counties, cities), and various institutions of health.

However, there are no published criteria for the allocation of resources also well established and obvious, but also based on written records. Allocation of funds is a subjective situation which leads to inefficient use of resources that are available, but limited. This is reflected directly on the health of the population of Romania. Resource allocation to sections and compartments becomes an unpredictable and inefficient. There were many cases where expensive equipment was purchased and then not used, because of lack of staff or lack of funds for maintenance and functioning.

Absence of clear procedures and criteria for allocation lead to inefficiency of spending decisions on short and long term. An example is the investment announced by the Ministry of Public Health for construction of 28 new hospitals (Report of the Presidential Commission for analysis and public health policy development in Romania, 2008), without explicit criteria provided the basis for decisions about the location, structure, size, etc. of those establishments, while 3 years later the Government decided to close arbitrary without a clear system on stake almost 300 hospitals. Consequences of this decision are materialized in the need of additional funds on the one hand, and the closing down of hospitals.

Compared to Romanian system, the French health system is financed 70% by the state, most of it by the social security organizations; a similar system is in place in Romania but not with the same percentage. However, in the case of France is financing via health insurance system, and the formation of sources of funding is health contributions of taxpayers, similar with Romania, in this case the contributions of taxpayers is not enough, the state has to re-allocate resources from other funds.

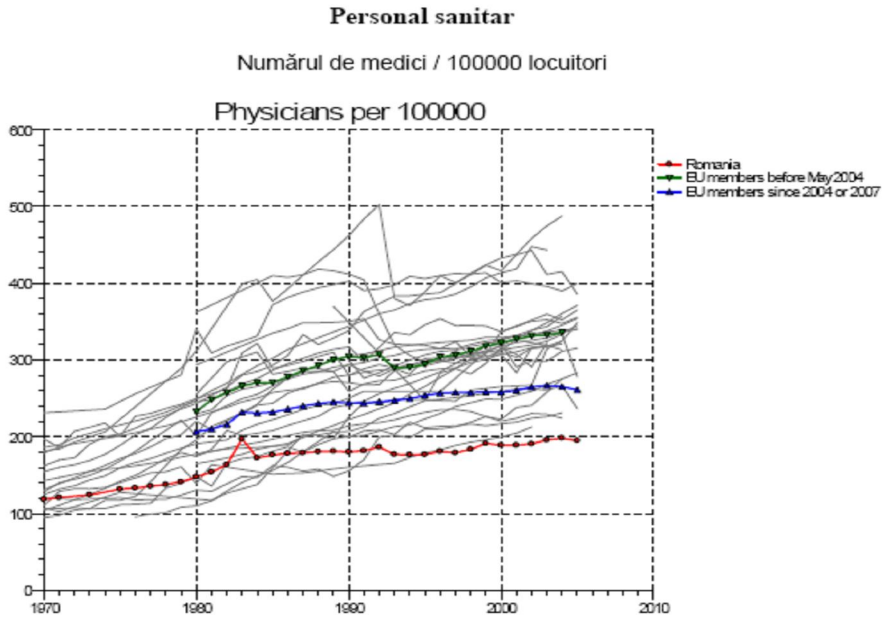
4. The medical staff of the public hospital units

4.1 Romanian Medical staff

The reform in Romanian system started with reform of the hospital sector because it was very crowded speaking of patients compared with the number of beds. In the evaluation of the hospital sector have been used a number of indicators such as number of beds, occupancy rate, number of hospitalizations, duration of hospitalization.

According to the report on "Health Sector Policy Note", were registered staff reductions - auxiliary and non-medical - and the number of beds in hospitals.

Figure no.2



Source: Report of the Presidential Commission for analysis and public health policy development in Romania, 2008, http://cercetare-sociala.ro/noua-lege-a-sanataii-dezbatere-publica/puncte-de-vedere-organizaionaleinstituionale/item/21-raportul-comisiei-preziden%C5%A3iale-pentru-analiza-%C5%9Fi-elaborarea-politicilor-din-domeniul-s%C4%83n%C4%83t%C4%83%C5%A3ii-publice-din-rom%C3%A2nia

Medical staff of Romania complies with the provisions of the Code of Medical Ethics. The doctors' obligation are to protect human physical and mental health, in the ease suffering, in the respect life and human dignity, without discrimination based on age, sex, race, ethnicity, religion, nationality, social, political ideology or any another reason, in the peacetime and in wartime (Code of Medical Ethics, MO nr.418/2005, Annex no. 2 of the Decision. 3 of 25 March 2005 adopting the Statute and the Code of Medical Ethics of College of Doctors in Romania).

Therefore, the Code provides a number of principles because rule is pretty much said that each member of the medical profession assumed at the start of its activities in this field: such as confidentiality, patient rights, co fraternity. Any violation of this code brings some consequences affecting the whole body of health care not just individual itself.

Personnel costs of hospital facilities have a significant importance in all healthcare costs. In our country, public health care staff salaries are established by the Ministry of Health having criteria such as: function, degree and professional level.

Therefore, the basic salary is established by Law Framework unit staff salaries paid by public funds.

Salary of medical is as follows: Individual salary + bonuses related activity

Individual salary is determined by the criteria mentioned above but also depending on the size hospital where they practice medicine. Therefore, the Framework Law for uniform wages paid staff of the public funds requires a number of indexes for each payroll staff in the health system. The salaries calculated according to this law are closely interrelated categories of staff as follows: benefits for management positions in the hospitals> 400 beds, <400 beds, research centers, institutes,

salaries for professional staff and healthcare professionals and auxiliary health care, but also salaries for professional staff and healthcare professionals and auxiliary health of hospitals with legal personality, social assistance and social and medical assistance, separate salaries for professional staff and healthcare professionals and auxiliary health of pathological anatomy and legal medicine.
For each category of health professionals law provides a number of factors depending on trance graduation of service and education level.
For example:

Table no.1

Basic wages for specialized healthcare personnel

No	Function	Level of studies	Coefficients of hierarchy					
			Base	Graduation-appropriate trances of experience				
				1	2	3	4	5
1.	Principal doctor	S	4,20	4,40	4,60	4,85	5,10	5,25
2.	Specialist doctor	S	3,30	3,50	3,70	3,85	4,00	4,15

Source: Law Framework for unit staff salaries paid by public funds

Staff salary supplements are granted in certain sections, for special situations. These vary as according to the type and percentage of work and level of risk to the patient also of doctor. Such situations are as follows: • for staff operating the radiation source or generator of radiation, an increase to dangerous conditions up to 30% of base salary, divided into categories such radiological risk: 10% category, 15% in category II, 20% in Class III and 30% in Class IV; • for very dangerous conditions: leprosy, pathology, TB, AIDS, dialysis, neurological recovery, neuro, neuromuscular and neurological, psychiatric, Legal Medicine, emergency care and medical transportation, ambulance services provided by establishments of the emergencies growth rate is 50-100% of base salary; • for staff working in sanitary units located in isolated areas at altitude, with difficult access routes or where weight is attracting staff, an increase of up to 20% of basic salary; • for specific hospitals particularly an increase of up to 15% of basic salary. (Framework Law)
Currently in our country, minimum wage for a resident doctor is EUR 250, much lower compared to other European countries. For example, in Germany the minimum wage for a resident physician is 2.500 euros / month, in France – 1.300 euros/month, in Italy - the gross minimum wage, 1.750 euros/month in Great Britain - more than 3.000 pounds.
Because of current situation already presented, migration occurs mainly for general practitioners and specialists outside of the country. Since 2010, healthcare staff and other employees (in the public sector) have suffered a number of reductions in salaries, in the percentage of 25% compared to the achieved level.- motivated by economic crisis. Therefore resident doctors, who received a salary of 200 euro, ended up receiving 150 euro.

4.2 French medical staff

In France, the medical system is based on conventions, witch are a type of contracts between the health insurance funds and providers of health services (from complex clinical facilities to country hospitals to individual practitioners). These are agreements between health insurance funds and

health professionals 'practitioners' as appointed, which set tariffs for medical services provided. These conventions are intended principally to ensure good coordination between health care professionals from all over France. The consequence of these conventions is very important to the entire health system, but also plays an important role in the national economy.

It is important to mention that the French public health system is deeply entangled with the private sector one. Therefore we discuss below the work of all professionals from the French health system.

First Convention of this kind mentioned in 1971 and aims to conventional medical setting rates, establishing a nomenclature specific business documents, also prepare a statistical tool called picture Statistical Activity Practitioners.

Over the time there were adopted a number of other conventions that have gradually instituted a series of regulations of new French health care: tracking the incidence of certain diseases cost the health system, establishment of two conventional sectors on the charges of doctors, setting targets annual forecasting, the emergence of the concept of "medical record" electronic transmission of documents needed to repay, and improving access to health book, targeting patients to specialists in the best position should resolve the case, etc.

Last convention signed in July 26, 2011 provides for a performance rewards doctors provided by Insurance, also introducing an optional sector besides the three already existing, secure healthcare fees.

The first sector of activity brings together the doctors who apply conventional rates and the reimbursement of insurance fund is 70%. The sector brings together 91% of general practitioners and 62% of medical specialists.

Doctors belonging to sector 2, sets free rates, but within the professional code of ethics. However some of their medical acts must fall within the conventional tariff. House will reimburse only 70% of the conventional rate, the difference being borne by the patient. The sector brings together 38% of medical specialists.

Third sector brings together the doctors whom may choose or not to sign a healthcare convention. If we signed any agreements, physician practitioner is free to set their own rates, with tact and measure. However, house insurance charges apply "authority" which varies depending on the nature of the disease. It is 1 euro for a consultation.

A special section is the optional created by the Convention of 2011, especially for doctors in sub domain surgery, anesthesia, obstetrics and gynecology. Doctors who adhere to this sector is committed to quality criteria.

Table no.2

Corresponding rates of consultation by treating doctors (applicable March 26, 2012)

Treating doctor	Tariff	Base of refund	Tax refund	Amount refunded
General practitioner (GP) Sector 1	23 €	23 €	70%	15,10 €
General practitioner (GP) Sector 2	Free fees	23 €	70%	15,10 €

Specialist doctor Sector 1	25 €	25 €	70%	16,50 €
Specialist doctor Sector 2	Free fees	23 €	70%	15,10 €
Psychiatrist, Neuropsychiatries Neurologist Sector 1	39,70 €	39,70 €	70%	26,79 €
Psychiatrist, Neuropsychiatries Neurologist sector 2	Free fees	37 €	70%	24,90 €

Source: www.conseil-national.medecin.fr

Table no. 3

Corresponding rates of visits to doctors - specialists (applicable from 26 March 2012)

Treating doctor	Tariff	Base of refund	Tax refund	Amount refunded
General practitioner (GP) Sector 1	26 €	26 €	70%	17,20 €
General practitioner (GP) Sector 2	Free fees	23 €	70%	15,10 €
Specialist doctor Sector 1	28 €	28 €	70%	18,60 €
Specialist doctor Sector 2	Free fees	23 €	70%	15,10 €
Psychiatrist, Neuropsychiatries Neurologist Sector 1	43,70 €	43,70 €	70%	29,59 €
Psychiatrist, Neuropsychiatries Neurologist sector 2	Free fees	37 €	70%	24,90 €
Cardiologist Sector 1	49 €	49 €	70%	33,30 €
Cardiologist Sector 2	Free fees	45,73 €	70%	31,01 €

Source: www.conseil-national.medecin.fr

As mentioned above the minimum salary of a resident doctor is 1.300 euro / month. However, the situation where private clinics and hospitals, and salary could be negotiated up to 3.000 euros a month for a similar position.

As shown below in table no.4, Romanian average wedges are at a different level, as in terms of national average salary, and also average wage of medical specialists. In France, a specialist salary is two times the average salary while in Romania, specialists' salaries are almost identical to medium salary in economy. This shows the importance that the government grants in other European countries to health segment.

Table no.4

Medium wegde in Romania and France for specialist doctor in 2012

Country	Medium wegde for specialist doctor (in eur)	Medium wegde in economy (in eur)	Ratio: Average wegde in economy / Average wegde specialist doctor
Romania	495 €	492 €	100,61 %
France	3.200 €	1.653 €	193,59%

Source: Processing of the authors (INSEE, www.ziare.com, www.sudouest.fr)

5. Conclusion

Romanian health system reform has a slower progress rate than expected. The state has established a series of measures to redress the precarious situation of the health system. However, the main shortcomings of this system is very low funding compared to other EU countries, so there is a need to attract new sources of funding, unequal dispersion of the medical staff by geographic areas, the information level of population is very low.

The Romanian government is trying to align the health system to other European models. As aforesaid, the Romanian health system is well below the European average, as in terms of quality services and also in funds collection and allocation.

The present situation reflects also on the remuneration of medical staff. Following analysis of data presented, we could see the situation of Romanian medical doctor’s salaries. We have seen that a Romanian doctor is paid six times less than a French doctor. Not in few cases, Romanian doctors found as an alternative migration and professional practice outside of the country, so Romania registered a deficiency of qualified personnel. Related to this indicator doctor per capita, we occupy the latest place from EU countries. However, salary fund share in the expenses of hospitals are 68%, quite high considering that the proper functioning of a unit of a series requiring the expenditure for equipment, maintenance, administration, also that wages was reduced by 25%, the system channels are blocked, and some support staff was dismissed.

French health system is more developed. This system benefits from funding sources more consistent than the Romanian one. If Romania receives only 4% of GDP, France gets 11% of GDP, due to the importance that French Government is showing to the health status of its population.

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