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INTERVIEW

PRIORITIES FOR ACTION AT NATIONAL HEALTH INSURANCE HOUSE LEVEL

Interview with Adrian GHEORGHE, President of the NHIH (National Health Insurance House)

Date of birth: 03/09/1985
Citizenship: Romanian, British

PROFESSIONAL EXPERIENCE

• 01/2021 - CURRENTLY - President of the National Health Insurance House

• 12/11/2018 - PRESENT - London, United Kingdom SENIOR HEALTH ECONOMIST - IMPERIAL COLLEGE LONDON
Within the R4HC-MENA (Research for Health in Conflict https://r4hc-mena.org) project in Jordan, Lebanon, Turkey and Palestine: I design and implement capacity building activities in the field of health economics. I provide technical and leadership input to health research with R4HC consortium partners, particularly in the areas of cancer and mental health.
At J-IDEA (Abdul Latif Jameel Institute for Disease and Emergency Analysis https://www.imperial.ac.uk/jameel-institute), I conduct research on international financing of epidemiological emergencies. I lead the specialization "Financing of health services" for the health economics module within the Global Master of Public Health.

• 05/10/2015 - 09/09/2018 - Oxford, United Kingdom HEALTH ECONOMIST (CONSULTANT, THEN SENIOR CONSULTANT STARTING JULY 2017) - OXFORD POLICY MANAGEMENT LTD
I led, developed and contributed to the acquisition and implementation of projects in the areas of health financing, strengthening health systems and social policy. We led stakeholder involvement at project and team level (eg technical seminars), as well as client presentations during project implementation. Selected projects: Assessing the feasibility of introducing a national health insurance system (Project Manager - Malawi, GiZ 2016); Assessment of the scale space for health in order to elaborate the strategy of financing health in the country (Project Manager - Cameroon, World Bank 2017); Estimating the cost of perinatal care services in two regions of Uzbekistan (Project Manager - Uzbekistan, UNICEF; 2017); Development, management and delivery of an results-based institutional capacity building program for health financing (Program Leader; Nigeria, World Bank 2017-2018). Estimating the costs associated with implementing strategic plans in the health sector using the OneHealth Tool (UCSF, Ghana 2015; and Swaziland, World Bank 2016). Development of an institutional framework for health technology assessment (Technical Expert; Romania, World Bank 2016-2018); Evaluation of the financial and clinical performances of selected public hospitals (Technical Expert; Romania, World Bank 2016-2017); Evaluation of the cost-benefit ratio for a maternal and reproductive health program, using social marketing and social franchising approaches (Technical Expert; Pakistan, DFID 2015-2016); Estimating the cost of inaction to combat air pollution in Ulaanbaatar (Technical Expert; Mongolia, UNICEF 2017); Development and piloting of a methodology to determine the long-term economic and social returns on investments in children (European Union, Eurochild 2016-2017).

• 01/07/2016 - 01/12/2016 - Bucharest, Romania COUNSELOR - GENERAL SECRETARIAT OF THE GOVERNMENT (DETACHED TO THE CABINET OF THE MINISTER OF HEALTH)
We elaborated, in consultation with the Public Policy Unit, the regional health service plans as part of the fulfillment of Romania's conditionality to the European Commission, approved by Order no. 1376/2016, published in the Official Gazette, Part I no. 988 of December 8, 2016. We had technical contributions to the development of the patient feedback mechanism and to the national bed plan.

• 17/05/2013 - 30/09/2015 - London, United Kingdom RESEARCH FELLOW - LONDON SCHOOL OF HYGIENE & TROPICAL MEDICINE
We designed and conducted cost and economic evaluation studies in the fields of iron deficiency anemia, eye care, cryptococcal meningitis, tuberculosis, malaria in pregnant women. We designed and coordinated four researches in achieving a global synthesis of the economic burden of noncommunicable diseases in low- and middle-income countries. We developed the health financing section for the Lancet Commission for the Future of Health in Sub-Saharan Africa; we developed the technical content and organized and managed consultations with stakeholders (April-September 2015). I held the seminar of the economic evaluation module within the Master of Health Policy, planning and financing organized by LSHTM in collaboration with the London School of Economics.

EDUCATION AND PROFESSIONAL TRAINING

• 01/10/2010 - 01/10/2013 - Edgbaston, Birmingham, United Kingdom DOCTORATE IN HEALTH ECONOMICS - University of Birmingham

• 28/09/2009 - 01/09/2010 - Edgbaston, Birmingham, United Kingdom MASTER IN HEALTH ECONOMICS AND HEALTH POLICY - University of Birmingham

• 01/10/2004 - 15/09/2009 - DEGREE IN PHARMACY - "Carol Davila" University of Medicine and Pharmacy, Bucharest, Romania

• 01/10/2005 - 01/08/2008 - DEGREE IN MANAGEMENT - "Hyperion" University, Bucharest, Romania

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DISTINCTIONS AND AWARDS

• *01/04 / 2020- Non-Resident Fellow - Center for Global Development*

• *01/03 / 2018- Marshall Memorial Fellow - German Marshall Fund of the United States 01/02/2014-Aspen Fellow - Aspen Institute Romania*

"Katharina_Hauck"

Reporter: *Mr. President, you have been coordinating for a very short time an institution of strategic importance in the Romanian health sector.*

- What thoughts do you set out on in this new challenge?

Adrian GHEORGHE: In a broad sense, with hope and caution. Hope because it is a beginning, from several important points of view: a government at the beginning of its mandate; a two-year cycle 2021-2022 without elections; and an awareness of the need for investment and reform in public health, in particular, and in the health system in general, as a result of the Covid-19 pandemic. It is a real opportunity for a decisive beginning of the resettlement of the main health financing instruments in Romania. Caution because we are far from overcoming the pandemic, the macroeconomic context remains difficult and there have been opportunities for "reset" and reconstruction in the past (the financial crisis at the end of the last decade) that have been only partially exploited; In addition, I believe that a lot of inter-institutional coordination will be needed at a time when there will be many priorities.

In a more personal register, also with hope and caution. The hope that I will be able to capitalize on at least part of the experience and training I have. Caution, in the sense that I take responsibility for a complicated system, with a lot of history.

R: *Given your professional training, expertise and experience gained, both in the field of health. economics and health administration and policies, we would like to obtain from you an informed opinion on the current state of the health system in Romania.*

- First of all, please share with our readers some of your professional achievements.

AG: I had the professional chance to work in health systems in very different countries, in many regions (Europe, Central Asia, South Asia, sub-Saharan Africa, the Middle East, Oceania). Also, through my professional positions at the London School of Hygiene & Tropical Medicine and Imperial College London, I had the chance to work directly with global leaders in public health and health systems economics, such as Peter Piot, Kara Hanson, Kalipso Chalkidou or Katharina Hauck. Nationally, in 2016 I was an adviser to the Minister of Health and I dealt with the patient feedback mechanism and regional health service plans. I think that I have a professional experience of international level and from several perspectives - academic, consulting, public administration - quite rare for this point of most careers and which can be valuable in the right context.

-Why Great Britain? And why Romania again?

AG: When I first became interested in the concept of "health economics" in 2007-2008, I only vaguely understood what it meant, but I was curious. I managed to talk on the phone for ten minutes, through an acquaintance of my mother, with a Romanian who worked in the field of pharmacoeconomics in the United States and he told me that if I wanted to study further, in Europe, to go to Great Britain or the Netherlands. I arrived in the UK at the University of Birmingham and later, through a succession of professional opportunities, I continued to stay in that country. I returned to Romania, and in 2016 (and now, at the beginning of 2021), because it seemed to me that some windows of opportunity are opening in which some progress can be made which my knowledge, attitude and experience, as much as they are, could support. I want to apply in Romania the profession for which I have prepared.

R: *Mr. President, even if you have been coordinating NHIH for a short time, you have held important positions in the health administration (including adviser of the Minister of Health) and you are a good connoisseur of the Romanian health system.*

- Overall, how do you assess the level of development, organization and functioning of the health system in Romania?

AG: I think that this level corresponds to the level of socio-economic development of the country, reflected by macro indicators such as GDP per capita or Human Development Index. From a development point of view, I think it is a rather entrepreneurial system - in the absence of a clear system vision, assumed, accepted and stable over time, each of us (from the patient, through health care providers and local public authorities, and even the minister) has done what they could. A rather hierarchical and opaque organizational model, in which the principle of autonomy materializes, mainly at the declarative level, has maintained for years this entrepreneurial model that now makes central strategic planning very difficult, if not impossible - both technically and politically.

- Do you think we have an effective and efficient system?

AG: In the absence of a national health system performance framework, comparisons with other health systems are the main angle from which we can answer the question at this time. This limitation is a major one in my opinion, especially from the perspective of NHIH: I find it unacceptable that there are too few credible sources of data to objectively assess the extent to which the Fund contributes to the objectives of the system, especially in the results in the area of preventable mortality or quality of life. From an international perspective, I believe that we have, on the whole, a reasonably efficient and effective system; however, I expect very wide variations, both within and along the levels of services, geography, socio-economic gradient.

- What essentials do you think are missing?

AG: Above all, assumed priorities. Not everything can be a priority and no priority can fail to assume the achievement of a result, a goal from the perspective of the decision maker.

The National Health Programs carried out by NHIH have the average cost per patient as the only efficiency indicator. How do we know if these programs save cancer patients or keep diabetes under control? We have anecdotes, mainly. Leaving aside, for a second, the disease registers, necessary, but not sufficient, here I believe that more debate, analysis and communication is needed, with patients and doctors at the center of the process, to agree on the directions in which to spend public money in order to achieve the expected results. Giving everyone something, but without solving any real problem, cannot lead to performance, or at least not to performance measured by comparing absolute indicators with values in other European Union countries; it's a losing battle from the start.

Then, there is a need for a framework for stimulating, measuring and monitoring health performance, as mentioned above. There are international models to build on, we do not need to invent anything, but only to take it upon ourselves that we are really interested in the subject. There is also the issue of coordination between central institutions with a role in health, which can be greatly improved. Last but not least, I think more confidence in data is needed. The volume of data is not a problem, we have data, but most of the data in the health system, especially those of a medical nature, are self-reported and go through only minimal checks. The existing data culture, as much as it is, is also a problem: data is mainly used to detect mistakes and punish, often with legal consequences; rarely, almost never, is data used to guide, formulate policy or reward positive achievements. People in the system have too little motivation to report correctly and too much motivation to report defensively so as to avoid problems. Such data is very difficult to work with when it comes to making a decision, it simply takes a lot of cross-analytical perspectives to get a reasonable idea of any topic.

- What are the positive elements and foundations on which the Romanian health system can be developed and streamlined?
AG: The tradition of the Romanian medical school, a relatively evenly distributed public health care infrastructure, and a history of centralizing public policy decisions are elements that can be built on, not necessarily in the sense of perpetuating them (e.g., hyper-centralized decisions), but in the sense that these elements could facilitate a coordinated transformation effort. But these fundamental elements are also constantly changing, in turn: we produce many medical graduates per capita, but most go directly to other countries; medical infrastructure is developing very unevenly and speculatively; and decisions are made at the center, but most with little consultation and little inclination towards effective implementation, which permanently erodes their credibility.

R: *The new position you hold, that of President of NHIH, can be considered for you a new professional and managerial challenge.*

- What were the main problems you faced, as president of NHIH?

AG: Externally, not necessarily a problem but rather a continuous challenge during this period was to maintain very close communication with the Ministry of Health and the Ministry of Finance, both for the adoption of the budget law and the development of pandemic control measures. Internally, with insufficient dialogue, both within NHIH structures and between NHIH and the local Health Insurance Houses. Beyond regular video conferences, in two months I visited five Health Insurance Houses and met, in Bucharest, with a few other General Managers; I will continue to travel in the territory in the next period.

- What do you consider to be the priorities at the beginning of 2021 for the institution you lead?
The immediate priority is the new Framework Contract, together with the methodological norms. Also, the transition from the funding rules from the state of emergency / alert back to the provisions of the Framework Contract, especially for hospitals. At the organizational level, the motivation of human resources in this difficult context and the coverage of capacity gaps - some historical, others more recent.

-And what would be the priorities for action in the medium term? In this context, what premises should exist for these priorities for action to be implemented?
AG: In the medium term, I believe that the relationship between citizens and NHIH must improve decisively in order to increase mutual trust. On the part of NHIH, trust in the voice of the citizen as a partner, not only as a beneficiary; on the part of the citizen, the trust in the NHIH processes as a decision-maker, not only as a payer. On a more concrete and technical level, I believe that rethinking the financing of hospitals must be addressed as a priority, not only because a significant volume of resources is directed here, but also in the context of regional hospitals and the transformations they will bring.

- How much, and in what sense, does the current pandemo-epidemic context interfere with the action plans at the level of the institution you lead and coordinate?
The context determined by Covid-19 mainly affected the human resource, both in terms of physical availability for those who became ill, but also of mental availability due to the wear accumulated recently. We have, since March 2020, more than a year of important and frequent legislative changes (such as reimbursement of hospital expenses, processing of a large number of sick leave requests, funding of vaccination activities and monitoring of patients with Covid-19), which have expanded the capacity and they limited the space for reform, for large-scale actions.

R: *Performance, transparency and predictability are three of the problems of the Romanian health system that you have in mind for the current mandate.*

- How do you think these goals can be achieved?
AG: Regarding performance, I have indicated above the main elements that I have in mind. Regarding transparency and predictability, I believe that NHIH can play a firmer, and somewhat more visible, role in communicating

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proactively with other components of the health system, mainly with the general public, and in participating in setting the agenda, not only to wait to implement or be challenged. We took a first step in the line of communication with the general public: we increased the frequency of processing notifications by phone, email and directly, both at NHIH and at all National Insurance Houses in the country, up to weekly (before they were centralized monthly); I identified the current topics and updated the "Frequently Asked Questions" on the NHIH website to reflect the time of March 2021. This list of frequently asked questions had not been updated since 2014. I also made public my external meeting agenda. These are small steps, but I see them as the first elements of a wider and more important opening signal. In meetings with external partners, such as medical professional organizations and patient organizations, I announced my intention to meet regularly at intervals of about 45 days so as not to discuss only in emergencies and to have the basis for a constructive and long-term dialogue. I have already had a first "second" such meeting and I will continue.

- Do you think that at the end of the term, we will be able to appreciate positively the activity of your institution in terms of the three objectives?

AG: These objectives are meant to guide my actions; for example, the 2020 activity report will also contain some new elements in this regard. My team is aware of them, we discuss them often and this helps us keep them in the spotlight. I want something to remain in this regard, at least as a foundation for the mandate of the future leadership.

R: *Would you like to add something else, maybe an answer to an unaddressed question in this interview?*

AG: I was asked, quite often, "how long do you think you will last?". It seems to me like a pertinent enough question, given the history of the position and the fact that I came from another country to take it over, but I suspect I am thinking about it less or less often than one would think. I don't approach every day as if it were my last in the job, I focus on what I have to do.

Thank you for kindly answering our questions.