

COMPARATIVE ANALYSIS BETWEEN FRENCH AND ROMANIAN HEALTH SYSTEMS – CASE STUDY USING TWO SIMILAR HOSPITALS

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INTRODUCTION

According to the World Health Organization (WHO) World Health Report 2000, a health system is represented by all the "resources, actors and institutions related to the financing, regulation and provision of health actions, where health actions are any set of activities whose primary intention is to improve or maintain health" [1,2]. The methodology for assessing the performance of health systems developed in 2022 by the European Observatory for Health Systems and Policies [2] presents the main functions of a health system (governance, resource generation, financing and service delivery) and introduces the sub-functions of each of the four functions as well as the connexions between them.

The governance function is the one drafting legislation and regulating all the other functions, giving them levers of action. The three sub-functions of the financing are: revenue raising, pooling and purchasing [2]. A question arises: what should we finance first?

This was the topic of a European Health Management Association (EHMA) Plenary Session in 2024. Romania's health care system is hospital-centred "with significant underinvestment in prevention and long-term care" and a "major challenge is the insufficient and uneven distribution of medical professionals, particularly in rural areas"[3]. Also, the research funds surged in the past years, but are very limited and the research has to focus on the actual needs of the population. At the time, the National Health Insurance House (NHIH) stated that "67% of health services are covered by NHIH, with 21% funded through out-of-pocket payments and the remainder by the state budget"[3]. This is a statement in favour of reducing the number of people exempt from paying social health insurance (SHI) and also in favour of introducing on the market the complementary health insurances (CHI). In Romania there were a lot of categories exempt from paying for social health insurance, but the categories were recently reduced through a Government Ordinance [4]. Romania is considered, according to a WHO analysis, one of the countries with a catastrophic out-of-pocket health spending [5]. Considering all of the above, more changes should be done in the Romanian health system and in order to make

This case study compares two hospitals, CHIRC in France and SMO in Romania, analyzing physician staffing levels, hospital activity, and efficiency indicators. CHIRC has 543 beds, organized into three major departments (obstetrics and geriatrics, and mental health and addictions), while SMO has 573 beds, organized into clinical, paraclinical, outpatient, and day care departments. Although bed capacity is similar, the two hospitals show significant differences in staffing structure and resource utilization.

CHIRC reported 55.05 full-time equivalent (FTE) physicians, compared to 128 FTE at SMO. This corresponds to 10.14 physicians per 100 beds at CHIRC and 22.33 at SMO. However, in relation to the activity carried out, CHIRC records 2.80 doctors per 1,000 admissions, compared to 7.18 at SMO. The staff structure is also reflected in the volume of pay slips, with a higher average at CHIRC (1,014 per month) compared to SMO (756), in line with the FTE distribution.

Hospital activity differs between the two units: CHIRC recorded 19,677 full hospitalizations, 3,612 day-hospitalizations and 85,947 outpatient consultations, while SMO reported 17,842 full hospitalizations, 24,114 day-hospitalizations and 108,579 consultations. The average length of hospital stay was higher at CHIRC (7.49 days) compared to SMO (5.47 days). The bed occupancy rate was 74.33% at CHIRC and 46.72% at SMO. Imaging activity was also higher at CHIRC (36,399 procedures) compared to SMO (21,810).

Overall, the results highlight important differences in resource organization and utilization patterns, with implications for the efficiency and planning of health systems.

Keywords: Health system, financing, revenue cycle management, DRG, T2A

some good and well-informed decisions we should compare our system to a similar one that works better.

Romania and France share similarities in terms of their basic political structure: both are semi-presidential republics with democratic institutions and bicameral parliaments [6,7]. However, there are also important differences in how their institutions function in practice, as well as in their political traditions and history. France has a longer-established democratic system and a more consolidated political culture [6]. Similarly, both countries show points of convergence and divergence in their healthcare systems as well — they are both public-centred but differ in terms of funding models, efficiency, accessibility, and quality of services.

The French health system is widely recognized for having a low out-of-pocket rate [8]. This is due to the fact that compulsory health insurance is composed of SHI and CHI and it currently "covers almost 100% of the resident population under various schemes" [6]. As the private CHI is mandatory in France this results in overall very low out-of-pocket payments. The main reforms in the past decade in France aim to "strengthen primary care by encouraging multidisciplinary group practices, while public health efforts over the last decade have focused on boosting prevention strategies and tackling lifestyle risk factors"[6]. Although the population's contribution works well and a lot of services are covered by the insurances, the cost-sharing is required for all essential services [6].

Comparing how the two countries spend their funds on health we should start from comparing their gross



domestic product (GDP) and the percentage each spends on health [9].

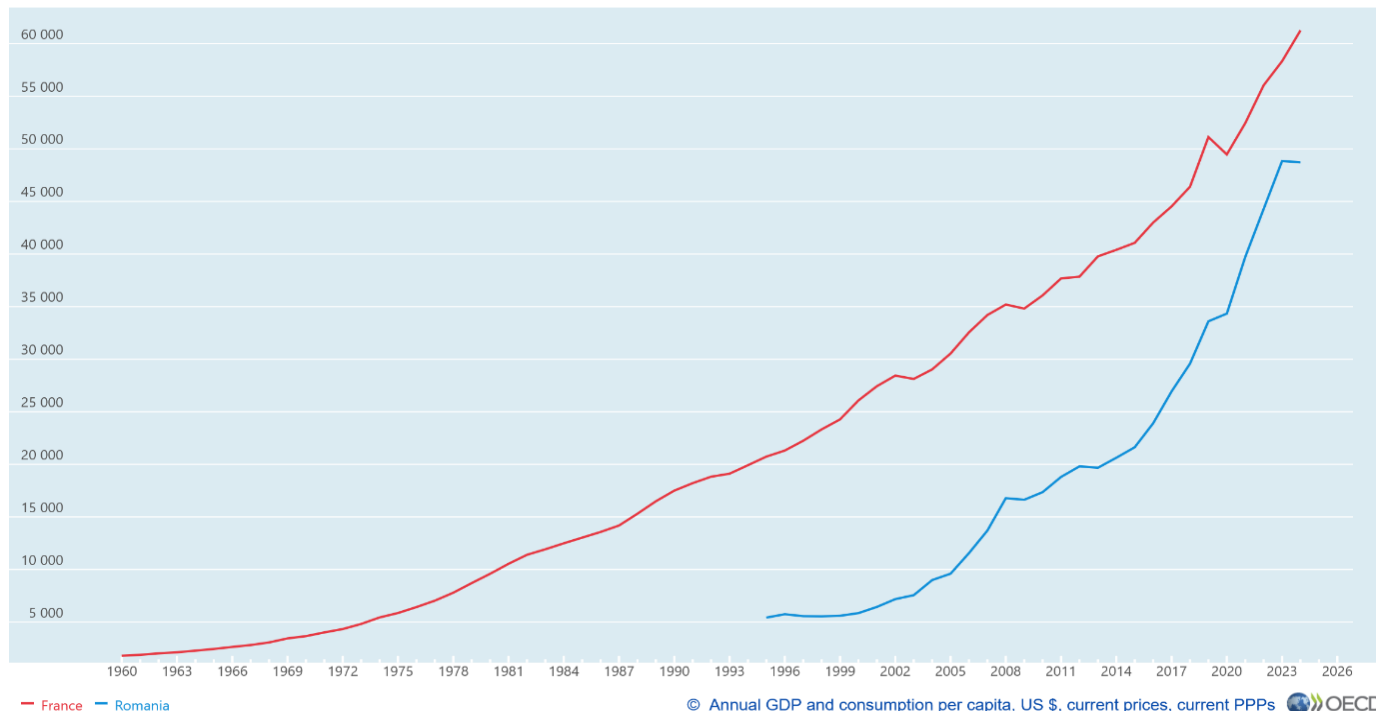
Not only that Romania has a lower GDP, but the percentage of the GDP spent on health is also lower. Last data available for both countries shows that while France had spent 11.5% of GDP on health, Romania had only spent 5.8% of GDP.

These percentages of the GDP had been spent on health via several budget lines. This is how the money were allocated in both countries in the last year available, 2023 [10]:

Both countries spent the biggest amount of the health budget on hospital services. Therefore, it is worth mentioning which are the main lines in the health budget from which hospitals draw their income.

Annual GDP and consumption per capita, US \$, current prices, current PPPs

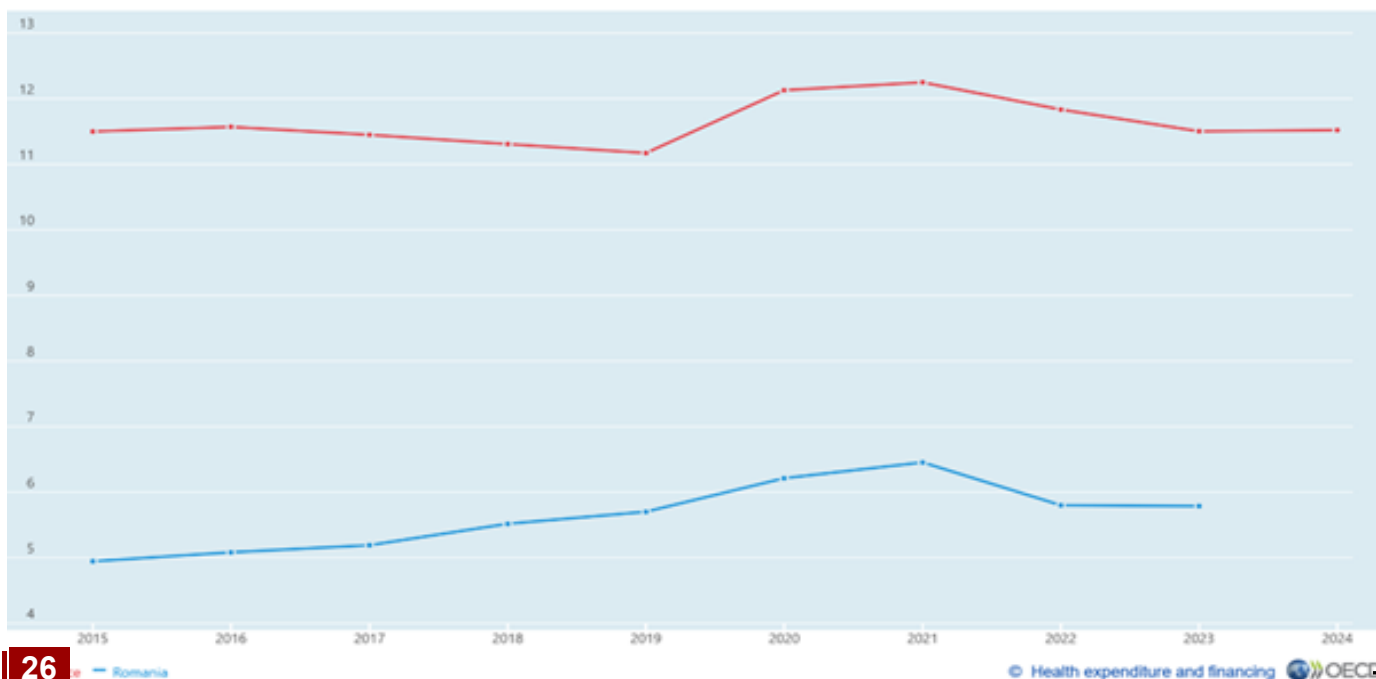
Institutional sector: Total economy • Counterpart institutional sector: Total economy • Transaction: Gross domestic product, per capita

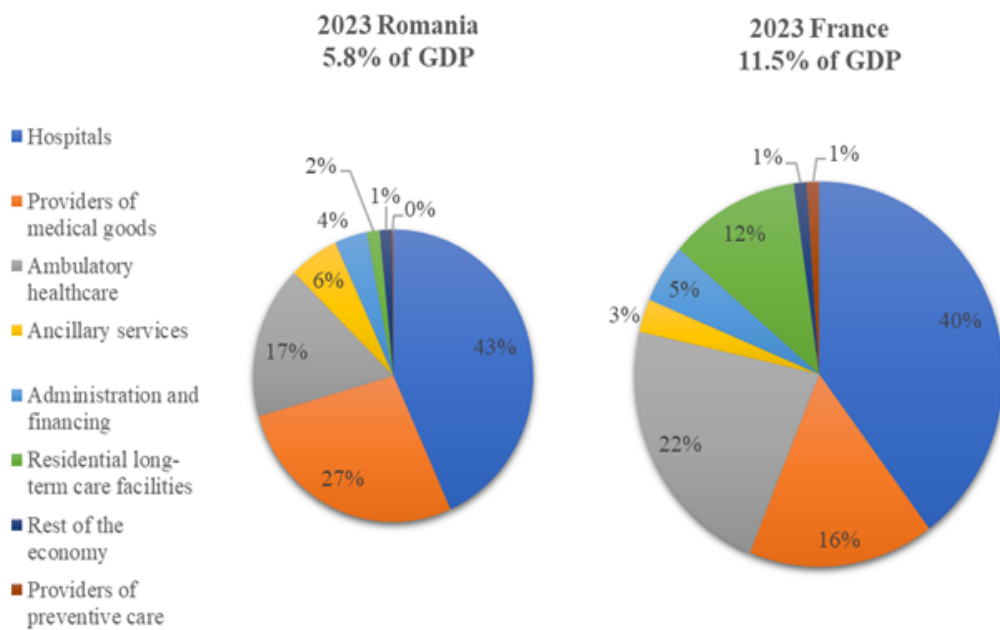


Health expenditure and financing

Frequency of observation: Annual • Measure: Expenditure

Combined unit of measure: Percentage of GDP





There are several ways for billing for hospital medical services. The process is usually known as revenue cycle management (RCM) [11].

The main sources of revenue for hospitals both in Romania and France are the following: acute cases that are reimbursed either as a rate per DRG case or as an average rate per resolved case in Romania and according to a fee-for-service model (T2A), chronic cases are reimbursed using a daily hospitalization rate and day care cases and ambulatory consultations are reimbursed using specific rates according to diagnoses and/or procedures.

In Romania, in acute inpatient departments, there is a rate per resolved case that can be granted in the DRG system or as an average rate per resolved case, for certain specialties [12]. The DRG system, which was introduced in Romania in 2005, is a patient classification scheme that groups similar patients based on both diagnosis and complications to determine a standardized, hospital payment. It encourages hospitals to control costs and be more efficient by paying a lump sum for the entire hospital stay of a patient, rather than for each individual service. Each DRG has a relative value reflecting the average resources required to treat a patient in that group, and are used to determine hospital payment rates by multiplying the DRG's relative value by the hospital's base payment rate [13]. In France for acute inpatient departments 70% of the hospital's revenues are made of the tariffication activity. It has been implemented in 2004. Before, all of the hospital's budgets were made with a global budget, since 1984 [14]. This model was encouraging productivity gains but it limited the room for maneuvering of certain institutions and created situations of rent-seeking for hospitals whose financial situation was positive [14]. In fact, it was decided to move from global hospital funding to a fee-for-service model (T2A), using patients' classification into Homogeneous Patient Groups ("groupes homogènes des maladies" - GHM) a French DRG system (same principles but specific groups derived from French medical practice). The rates for each

GHM are set annually by the Ministry of Health (MoH) [15]. Each GHM corresponds to a Homogeneous Stay Group (GHS). In 2022 the French classification system included nearly 3,700 rates [16]. It should be noted that this change took place at around the same time as the transition to the DRG system in Romania.

In Romania, chronic inpatient departments have a daily hospitalization rate based on specific indicators. This rate varies by clinical department and may differ between hospitals. Typically, the NHIH covers all days of hospitalization, according to gov-

ernment regulations [17]. In France, hospital stays are reimbursed through the **T2A system**, which assigns a national rate based on diagnosis, procedures, and care complexity [16].

In Romania, there is also the possibility for hospitals to settle services based on a rate per solved case/rate per medical service for hospital-type medical services provided on a day hospitalization stay, provided for in the regulatory acts in force [12]. In France day hospital activities receive funding based on activity-based pricing, which takes into account the nature and duration of the care provided, as well as grants linked to their role in coordinating and ensuring continuity of care. This model, supported by the Social Security Financing Act (LFSS) for 2024 and 2025, involves majority public funding from health insurance, with pricing regulated by the State and a moderate increase in hospital rates in 2025 (+0.5% on average).

In both countries hospitals can also access revenue through other side sources. One of these sources is comprised by National Programs

Hospitals can access funds related to National Programs (NPs) with curative purposes. In Romania, these funds are allocated to cover the costs of medicines, specific sanitary materials, medical devices and treatment and/or diagnostic services. To access these funds, hospitals must enter into separate contracts with county health insurance houses. All the requirements for these contracts are regulated at national level by technical norms approved by MoH [12]. Starting 2022, the Romanian MoH implemented and financed 13 NPs with major impact on public health (for which were allocated €173.2 million in 2024) [18]. The NHIH runs and finances 16 national curative health programs in Romania. For example, certain reimbursements are granted for renal replacement therapy including "specific medical supplies, non-medicalized transport of medicines and home delivery, monthly transport of medicines and medical supplies specific to peritoneal dialysis at home" [12]. The procedure is similar to the other

NPs: revenue based on separate contracts signed with county health insurance houses [12].

In France The Social Security Financing Act provides for grants for specific missions, some of which target specific conditions with tailored regional initiatives. Certain specific pathologies are eligible for dedicated funding within the framework of missions of general interest and contractual support (MIGAC – Mission d'intérêt général et d'aides à la contractualisation) [19]. In particular, teaching, research, reference and innovation missions are funded from MER-RI (Missions d'enseignement, de recherche, de référence et d'innovation) and are included in the MIGAC, and is notably assigned to university hospitals and clinical research centres [19]. These missions involve activities that are difficult to account for on a T2A basis, such as coordinating care for certain chronic diseases, managing specific emergencies, or reference centres for rare or complex diseases. In France, MIGAC endowment finances specific activities that cannot be financed through regular activities. It represents €9.4 billion in 2023 and comprises two categories: Missions of General Interest that can be financed in a different way and Epidemiological surveillance and monitoring missions. Missions of General Interest that can be financed in a different way are in particular: SAMU (mission de service d'aide médicale d'urgence) and SMUR (Structures mobiles d'urgences et de réanimation) that received €833 million in 2019, and Care for patients in precarious situations that received €192 million [17].

Also, hospitals in Romania are reimbursed for paraclinical investigations performed on an outpatient basis. There are special rules for accessing these funds [12]. In France, paraclinical care is included in the overall package, which is integrated into T2A pricing. However, certain intensive paraclinical treatments (such as radiotherapy, for example) may be covered separately [20].

For home care services/home palliative care that meet the conditions established by the framework contract (between the hospitals and the county insurance houses) and by certain norms. These services are financed from the fund allocated for home care services [12].

In France, funding for home care (nursing, support and multi-skilled care) was reformed in 2023: it combines a basic component and a variable component linked to the level of autonomy of patients. The AGGIR grid represents dependency level for elderly people. It was established by the decree of 21 August 2008. This scale is calculated using a specific method that corresponds to the capabilities of the elderly person. GIR 1 represents people who remain in a chair or bed all the time. GIR 5 corresponds to a fully independent elderly person.

For palliative care in France, pricing is specific with dedicated GHSs, which differentiate between types of care (specialised unit, day hospitalisation, conventional hospitalisation). At home, palliative care is coordinated by the attending physician, who relies on specialised networks, mobile teams or home hospitalisation services. The national strategy for palliative care aims to strengthen the territorial coverage of dedicated units, improve city-hospital coordination and develop personalised support plans for patients at the end of life [19].

In Romania, palliative care services provided in hospitals are offered in specialized departments or units dedicated to patients with life-limiting illnesses. These services focus on improving quality of life by managing pain and other distressing symptoms, while also addressing emotional, psychological, and spiritual needs. Hospital-based palliative care is delivered by multidisciplinary teams, which may include doctors, nurses, psychologists, and social workers, in accordance with national regulations and care standards [21].

METHODOLOGY

This is a descriptive transversal study.

Considering all the information about how hospitals in France and Romania are financed, it was decided to compare two similar hospitals in the two countries.

A hospital in France was chosen at random: Centre Hospitalier Intercommunal de Redon-Carentoir (CHIRC). The normative particularities of the hospital were analyzed in order to find a similar hospital in Romania: the number of beds, the available specialties, and the existence of outpatient services. A similar hospital was subsequently found in Romania: Municipal Hospital Onești (MHO).

After having the data from the two hospitals available, we compared the activity in the two hospitals either using raw data or by calculating the following: no. of beds, no. of admissions per year, average length of hospitalization at the level of the entire hospital, bed occupancy rate at the level of the entire hospital, no. of doctors reported to no. of patients and no. of nurses reported to no. of patients.

Because in Romania the staffing levels are done in relation to the number of beds, we also calculated the indicator: no. of doctors reported to no. of beds. Some data were also represented graphically for a better interpretation of the results, using the Excel application from the Microsoft Office package.

We subsequently analyzed the sources of income of the 2 hospitals, from the sources previously mentioned in the introductory part, and how the income was used to cover various expenses over the course of a year. We used the last public data available on the websites of the hospitals.

RESULTS

We extracted the last fully reported numbers.

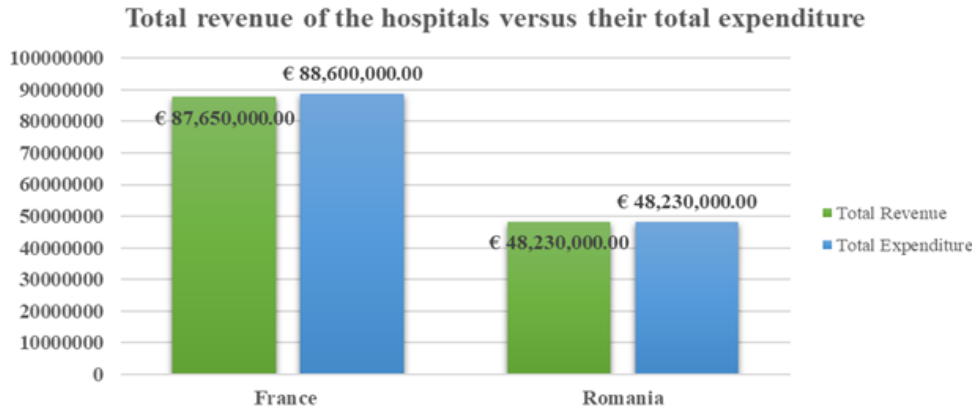
The report for CHIRC is from 2024 and the report for MHO is since 2023.

We compared the budget and financial overview. (Graph 1)

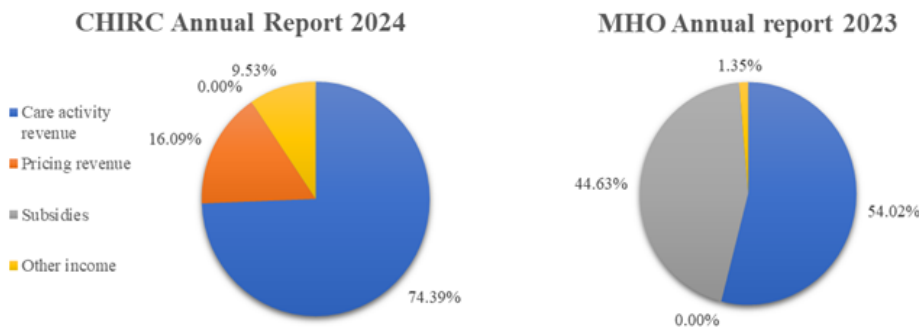
In France, CHIRC reported to have made €65.2 million from care activity revenue, €14.1 million from pricing revenue, and other income €8.35 million. In Romania, MHO reported to have made €26.05 million from care activity revenue, €21.52 million from subsidies, and other income €0.65 million. (Graph 2)

In France, CHIRC reported to have spent €63.5 million for payroll, €9.73 million for medical expenses -goods and services, €12.83 million for hospitality costs, and €2.53 million for exceptional costs. In Romania, MHO →

Graph 1. Total revenue of the hospitals versus their total expenditure



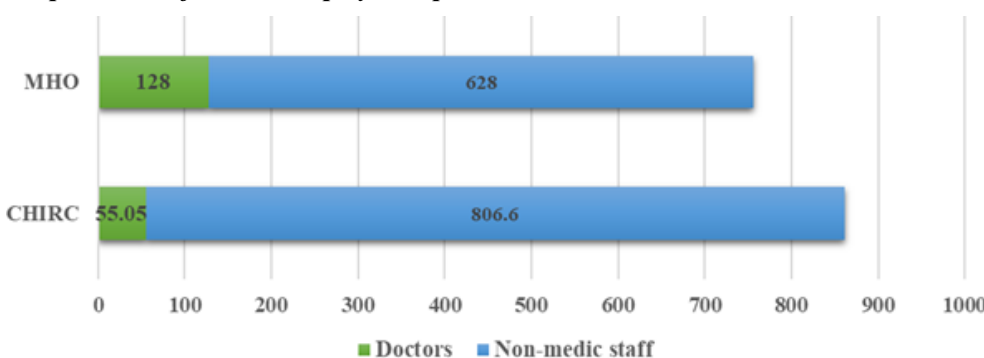
Graph 2. Overview of the total revenue of the hospitals



Graph 3. Overview of the total expenditure (in million euros)



Graph 4. Total full-time employees equivalents



reported to have spent €24.32 million for payroll, €12.38 million expenditure for goods and services, €11.52 million for investments, and €0.01 for other expenses. (Graph 3)

Both hospitals had funds allocated for professional training and other related activities. CHIRC allocated €1.02 million while MHO allocated €0.12/€0.16 million.

We have extracted data regarding human resources in the hospitals. It is worth noting that, in the French hospital, there is the possibility of hiring part-time staff, which results in a higher number of employees than the number of declared full-time equivalent (FTE) positions. (Graph 4)

This difference reflects the respective staffing structures, with CHIRC reporting an average of 1,014 monthly payslips compared to 756 in MHO, consistent with the number of full-time equivalent (FTE) positions.

Regarding the hospital structure, CHIRC had 543 beds. It has 3 big departments: medicine and obstetrics surgery department, geriatric department, and mental health and addiction department.

MHO in Romania has 573 beds and more departments that we grouped in: clinical departments, paraclinical departments, outpatient consultations, and day hospitalization department.

The hospital activity of the two was represented in the table below. (Table 1)

A total of 36,399 imaging procedures were performed at CHIRC in 2024, compared to 21,810 at MHO in 2023, both excluding ultrasounds.

To assess hospital bed utilization, we calculated the bed occupancy rate (BOR) for each facility, based on the total number of inpatient days, the number of available beds, and the duration of the reporting period. BOR for CHIRC was 74.33% during 2024 and for MHO was 46.72% in 2023.

Table 1. Hospital activity

Hospital		CHIRC	MHO
Hospital stays	full hospitalizations	19,677	17,842
	day hospitalizations	3,612	24,114
Outpatient	sessions	85,947	108,579
	procedures	17,624	16,927
Average length of stay		7.49	5.47

In terms of staffing, CHIRC employed 55.05 full-time equivalent (FTE) physicians for 543 beds and 19,667 admissions, resulting in 10.14 physicians per 100 beds and 2.80 per 1,000 patients. In contrast, MHO had 128 FTE physicians for 573 beds and 17,842 admissions, corresponding to 22.33 physicians per 100 beds and 7.18 per 1,000 patients.

Due to differences in the definitions of the other positions, it was difficult to assess the number of nurses relative to the number of beds or the number of patients.

DISCUSSIONS

To support the interpretation of our findings, we consulted relevant literature as well as several experts in this field.

Findings from the literature point to the widespread adoption of DRG or DRG-like payment systems globally, as they offer a relatively objective and consistent method for compensating certain forms of inpatient care [22].

According to the insights of the experts we discussed with, they all shared the view that the Romanian healthcare system is significantly underfunded. The main problem does not really stem from the system itself, but rather from the lack of funds for hospitals. The constraints are first and foremost financial. While the idea of increasing health contributions was broadly supported, concerns were raised about equity and the potential negative impact on vulnerable segments of the population.

Beyond this common ground, individual experts raised distinct points worth highlighting.

According to the assessments in healthcare financing, the predominant strategy for managing hospital funding involves reducing inpatient capacity—primarily by decreasing the number of hospital beds—and reinforcing the transition toward outpatient care, following trends observed in systems such as that of France (in France 22% of the health budget goes to ambulatory care and the trend is to allocate even more vs in Romania only 17%). This reorganization is intended to improve efficiency and contain costs. In this context, the national health insurance fund remains the principal source of hospital financing, with the state budget intervening to offset any deficits.

Among the key cost drivers identified by experts, salary increases represent a significant and ongoing financial burden for hospitals.

World Health Organization (WHO) in Romania collaborates closely with the Ministry of Health, particularly in the context of the National Recovery and Resilience Plan (PNRR). This collaboration is governed by biennial agreements that outline areas where WHO provides technical assistance, especially in domains where institutional capacity is still developing. The WHO's support is focused on four key pillars: improving quality of care, strengthening human resources in health [23], enhancing health service management, and advancing digital health. Under the PNRR framework, the WHO is also involved in initiatives related to health system financing and performance measurement. More recently, the organization has put forward a set of policy recommendations aimed at improving the distribution of medical personnel, with a particular focus on attracting young hospital practitioners to rural areas. These proposals include measures to strengthen medical education and continuous professional development, provide financial and non-financial incentives, support hospital management through improved access to European funding, and establish a comprehensive legal framework to enable the implementation of these strategies [24]. According to these guidelines, local authorities could involve in the financial incentives in order to motivate young professionals to practice in small urban or rural areas, so as to reduce the financial burden on hospitals due to wage increases [24]. France also faces these challenges.

CONCLUSIONS

In Romania, hospital staffing levels are regulated according to the number of beds, meaning that the number of staff positions is directly tied to bed capacity rather than actual patient load or service demand. Similar to the situation in France, Romania continues to face a shortage of medical specialists in small urban centres and rural areas, highlighting a persistent gap in the equitable distribution of healthcare professionals.

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