

General Overview of England, Australia, Canada, and Romania's Healthcare Systems and Human Resources Management Strategies



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Abstract

It is quite a challenge to work with several relevant sources of data regarding healthcare systems and human resources management strategies, knowing that relationships' types define each element of these complex systems always under pressure to leverage human capital, while creating a positive employee experience and a continuously improved patient experience. As complex systems involve complex problems solving, it is rewarding to advance on a clear path to identify how healthcare systems obtain competitive advantage by implementing effective human resources management strategies, turning the strategic plans into actionable steps to achieve specific objectives and directing behavioral incidents toward particular outcomes. Without doubt, it is really important to reflect the significant changes that have been made based on new knowledge, experience and comprehensive understanding.

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JEL Classification: H51; I11; I18; M12

The World Health Organisation describes Health systems governance as encompassing the processes, structures, and institutions established to oversee and manage a nation's healthcare system. It regulates the interactions and relationships among various actors and stakeholders within the healthcare sector, including government agencies, healthcare providers, patients and their families, communities, civil society organizations, and private sector entities (*Health Systems Governance*, n.d.).

Each country in the world has a particular healthcare system that operates into specific parameters typical to that country. Usually, the healthcare system of each country is a direct representation of the country's ability and priority to care for the health of its citizens.

Typically, there are 5 major types of Healthcare systems: Beveridge Model (UK), Bismarck Model (Romania), National Health Insurance Model (Canada), Out-of-Pocket Model (developing and low-income countries) and Mixed Model (Australia) (Reid, 2010).

Australia

The healthcare system in Australia operates under a dual public-private model, primarily supported by Medicare, the national single-payer funding mechanism. Public health services are administered by state and territory governments, providing free care to eligible patients. While primary health services, such as general practitioner (GP) clinics, are predominantly privately owned, they receive Medicare rebates. Eligible recipients of Medicare include Australian citizens, permanent residents, and certain visitors and visa holders. Additionally, individuals are incentivized through tax surcharges to purchase private health insurance to cover services in the private sector, further financing healthcare (Dixit & Sambasivan, 2018).

Medicare, a universal health insurance scheme, underpins Australia's healthcare system. It offers rebates for medical services and procedures conducted by private practitioners, including general practitioners and other healthcare professionals. Medicare ensures Australians have access to free hospital services for public patients in public hospitals and subsidizes a range of prescription medications through the Pharmaceutical Benefits Scheme (PBS). However, certain medical and allied health services fall outside the purview of Medicare subsidies. Notably, ambulance services, most dental services, and optical aids such as glasses and contact lenses are typically not covered by Medicare (Podger, 2006). The issue of surgery wait times, especially for elective procedures, has been a persistent concern in Australia. Even prior to the COVID-19 pandemic in 2020, the capacity to meet the demand for elective surgeries in public hospitals was inadequate. The pandemic further exacerbated this problem by necessitating the suspension of many surgeries, leading to increased wait times (Healy et al., 2006).

England

The principle of free healthcare at the point of use is fundamental to the founding ethos of the National Health Service (NHS). This principle was established by the 1942 Beveridge cross-party report and subsequently implemented by the Labour government in 1948. Aneurin Bevan,

the Labour Minister for Health, is widely regarded as the founder of the NHS, although he was never officially designated as such (Grosios et al., 2010).

In practical terms, "free at the point of use" signifies that anyone who is legitimately and fully registered with the NHS—indicated by possession of an NHS number—is entitled to access a comprehensive range of critical and non-critical medical services without direct payment. This entitlement extends to all legal UK residents, regardless of nationality, but excludes non-resident British citizens. However, certain NHS services, such as eye tests, dental care, prescriptions, and aspects of long-term care, do incur charges. These charges are typically lower than those levied by private providers, and many services are provided free of charge to vulnerable or low-income patients (Montgomery et al., 2017).

The governance of the English National Health Service (NHS) is vested in the United Kingdom government, specifically through the Department of Health and Social Care (DHSC), which holds political accountability for the service. The Health and Social Care Act 2012 transferred the responsibility for resource allocation and oversight to NHS England, an autonomous public body. NHS England is tasked with commissioning primary care services, including general practitioners (GPs), and certain specialist services. It also distributes funding to 211 geographically defined Clinical Commissioning Groups (CCGs) throughout England. These CCGs are responsible for commissioning the majority of healthcare services within their respective regions, encompassing both hospital and community-based care .

Canada

Healthcare in Canada is administered via provincial and territorial systems of publicly funded healthcare, commonly referred to as Medicare. Canadian Medicare covers approximately 70 percent of the healthcare needs of its citizens, while the remaining 30 percent is financed through the private sector. This privately funded portion generally pertains to services either not covered or only partially covered by Medicare, including prescription medications, vision care, medical devices, gender-affirming care, psychotherapy, physical therapy, and dental care (Allin et al., 2015).

Both Canada and Australia implement universal healthcare systems designed to ensure all residents have access to essential medical services. In Canada, this system is known as Medicare, and it similarly bears the name Medicare in Australia. These healthcare systems aim to provide comprehensive coverage, with Canadian Medicare covering approximately 70 percent of healthcare needs and the remaining 30 percent financed through the private sector. This privately funded portion typically pertains to services not fully covered by Medicare, such as prescription medications, vision care, medical devices, gender-affirming care, psychotherapy, physical therapy, and dental care (Lee et al., 2021; Marchildon et al., 2020).

Both countries operate publicly funded healthcare systems where the government plays a crucial role in financing and regulating healthcare services. In Canada, healthcare is primarily funded

through general taxation. Conversely, Australia's healthcare system is financed through a combination of general taxation and a specific Medicare levy (Martin et al., 2018).

Romania

The Bismarck model, also known as the "Social Health Insurance Model," is a healthcare system wherein individuals contribute fees to a fund, which subsequently finances healthcare services. These services may be delivered by state-owned institutions, other government body-owned entities, or private institutions. Romania provides the advantages of a universal healthcare system, with the state funding primary, secondary, and tertiary healthcare services. Public health campaigns are independently financed by the Government of Romania. The Ministry of Health is mandated to manage and supervise the public healthcare sector. The public healthcare system in Romania encompasses national health insurance, which covers the majority of Romanian citizens, alongside an expanding parallel network of private healthcare services. According to the Government Program (2018-2020), the Ministry of Health prioritizes the needs of the citizen over the medical system itself. The ultimate objective is to design the healthcare system to be as accessible as possible to the citizen (patient), ensuring that individuals do not have to travel for high-quality medical care (Cosma et al., 2020).

In 1997, Romania adopted the Bismarck model through Law No. 145. This model, based on compulsory health insurance and the principle of solidarity, operates within a decentralized system. The implemented model in Romania includes the following features: Financial resources are derived from mandatory contributions paid by employees and employers. Additional resources are obtained from state, local, or national budget subsidies. Non-profit institutions also contribute to the financial pool. Insurance funds are managed and administered at the national level through social directorates (Petre et al., 2023).

As of 9 September 2015, every Romanian citizen is entitled to cost-free, unrestricted medical procedures, as determined by a physician, provided they present a health card verifying their insurance status. European Union citizens and Romanian citizens without insurance are entitled to free emergency medical assistance.

The current healthcare system in Romania operates under the framework of Law No. 95/2006, which was drafted and adopted by parliament and subsequently amended in 2012. Furthermore, the primary healthcare law (Act No. 95/2006 on Healthcare Reform) was modified in 2020 to facilitate the development and implementation of telemedicine. Starting from July 1st 2024, individuals who do not pay for health insurance will be entitled to the same rights as those who are insured, pursuant to the constitutional principle that asserts the equality of all citizens (Vlădescu et al., 2005, 2016).

Human resources management strategies

The healthcare sector is currently facing significant challenges due to rapid changes across various fields, the trend toward career internationalization, and ongoing transitions. These factors contribute to a complex and demanding environment for healthcare professionals. The Romanian healthcare system, characterized by its fragility and ongoing decline, is similarly affected. Human resources are the backbone of medical care, constituting up to 75% of current healthcare service costs in many countries, and thus play a critical role in the system's functionality.

To navigate this challenging landscape, it is imperative to identify and address deficiencies within the structure of human resources. This requires a thorough analysis of the Romanian healthcare system to understand its specific issues and underlying causes. Such an analysis is crucial for implementing strategies that enhance the efficiency and effectiveness of healthcare services. Strengthening human resource management is essential to adapt to the current and future changes within the healthcare network.

Furthermore, there is an urgent need to develop a strategic approach to human resource planning and management. This involves not only addressing immediate deficiencies but also anticipating future demands and challenges. By doing so, the healthcare system can ensure a stable and capable workforce that is prepared to meet the evolving needs of the population. Effective human resource management will also facilitate better allocation of resources, improve service delivery, and ultimately contribute to the overall stability and improvement of the Romanian healthcare system.

Human resources are crucial for delivering medical care, making up to 75% of the current costs of healthcare services in some countries. Eastern countries rely on ten or more healthcare professions, including medicine, nursing, pharmacy, dentistry, physiotherapy, occupational therapy, speech therapy, and social assistance. New professional groups are also emerging, either as subspecialties or as auxiliary roles to the original professions.

The workforce composition in healthcare does not strongly correlate with the gross national product or with mortality and morbidity indicators. Instead, it is influenced by social and political factors. Health services are provided by various professional groups, which can be divided into medical and non-medical personnel. Medical personnel include those with higher education (doctors, dentists, pharmacists, psychologists, biologists, chemists, social workers), those with secondary education (nurses, dental technicians, laboratory technicians), and auxiliary staff (nurses' aides). Non-medical personnel include the TESA group (accountants, secretaries), as well as librarians, cooks, and orderlies (Burney et al., 2010).

The World Health Organization (WHO) supports the development of health systems and human resources to balance the supply of personnel with the numerical and competence needs of different countries. Almost all European countries face a deficiency in their healthcare human resources (doctors, nurses, and other healthcare personnel). This imbalance has three dimensions:

- Quantitative: The over or under supply of specialists.

- Qualitative: The mismatch between medical training and job requirements.
- Distributive: Geographic, institutional, or specialty-based disparities.

Human resource policies should align closely with health services policies. When there is a misalignment, many problems can arise, especially during times of rapid change. Human resources are vital for providing medical care, but the composition of the workforce is influenced by social and political factors, including increasing industrialization.

Effective human resource management and strategic workforce planning are essential to address deficiencies and improve the efficiency of healthcare services. By understanding the specific issues and underlying causes within the Romanian healthcare system, strategies can be implemented to ensure a stable and capable workforce that meets the evolving needs of the population. This multi-faceted approach is vital for ensuring a responsive, efficient, and high-quality healthcare system.

In this context, planning for medical personnel is crucial to ensure the proper functioning of healthcare services, quality access to healthcare, the effectiveness and efficiency of health actions, and the cost and quality of medical care. Equity in access to care is determined by the overall availability and balanced distribution of medical personnel. Since personnel costs are the main component of healthcare expenditures, the need and distribution of doctors are closely linked to the allocative and technical efficiency of the entire healthcare sector's resources (El Aboudi & Benhlina, 2018). Moreover, strategic workforce planning is essential due to the long training period required for medical professionals (10-12 years).

The demand for healthcare personnel is significantly influenced by the demand for health services, which depends on several factors:

- Population demographics: Newborns, young children, pregnant women, and the elderly have higher care needs.
- Genetic, environmental, and lifestyle factors: With more survivors of genetic diseases today, there is a continued need for medical services.
- Changes in medical practice: Increased training of personnel due to new technologies, reduced length of hospitalization, and a greater role for home care.

Responsibilities for managing human resources in healthcare are shared between the Ministry of Health and Family (Department of Human Resources), the Ministry of Education and Research, and the Ministry of Labor. These responsibilities include workforce planning, training, and post-graduate continuing medical education for mid-level healthcare workers. This centralized approach provides a practical legislative framework for practice. However, the focus on centralization can lead to a lack of flexibility at the local level, making medical services inadequate for local needs.

To address this, increased flexibility is needed, which could involve implementing evaluation systems, improving methods for selecting and recruiting personnel, and using a variety of motivational incentives. This approach would help tailor medical services to better meet local needs and enhance the overall effectiveness and efficiency of healthcare delivery.

Government programs emphasize the need to shift from a centralized and command system to a decentralized and efficient one that benefits citizens. Increasing the autonomy of health services will stimulate competition and enhance the quality of medical services. The Ministry of Health and Family (MSF) retains responsibility for managing funds for national health programs, budget allocations, regulation of the public and private health sectors, health policy research, managerial development, and more (Walshe & Smith, 2011).

The Ministry of Finance plays a crucial role in decisions related to reform measures in the medical sector. The strategies proposed by the MSF can only be implemented with the approval of the Ministry of Finance. Any policy document involving public spending requires the Ministry of Finance's technical approval.

The College of Physicians, established by Law 74/1995, has become a key actor in the Romanian health system. It holds significant responsibilities in the training, education, and accreditation of doctors, as well as in health policy. The MSF requires the agreement and collaboration of the College of Physicians for critical decisions, such as determining resource allocation to different medical practices, principles of drug compensation, and the number and structure of the compensated drugs list. The College also sets criteria for the accreditation of medical personnel allowed to work in the insurance system.

The College of Pharmacists advocates for the specific interests of pharmacists. However, its influence on health policy is more limited compared to the College of Physicians. This is due to fewer extensive legal provisions and its focused interest in drug policy.

Representative and independent unions are relatively new to the Romanian social and political landscape. The Federation of Doctors' Chambers of Romania (CMR) is the main trade union association for the medical profession at the national level. However, it is not a particularly strong organization, lacks a significant number of active members, and has limited influence in decision-making processes related to sector reforms.

The private healthcare system

The private healthcare system in Romania started since the early 1990s, private medical services have progressively emerged. Initially, these comprised specialized private practices, the establishment of the first private clinics and laboratories dedicated to the collection and processing of medical tests, followed by the advent of family doctors, medical investigation centers, and private hospitals.

In the beginning, the private healthcare sector started slowly because Romania had no tradition and experience in having two healthcare systems, therefore the development of the latter was off to a laborious start. In 1996, MedLife inaugurated the first private clinic, providing family planning services and medical support to young couples (Guga, 2022).

The private healthcare system cannot substitute for the public healthcare system, nor does the public system compete with the private one. Instead, the private system acts as a complementary component, characterized by a limited range of activities that relieve the public system by addressing specific tasks and serving a limited population. Consequently, the discourse on public versus private healthcare is unproductive. This point is emphasized by the fact that no nation operates solely with a public or private healthcare system. Even in countries such as the USA, where the private system is perceived as predominant, public policies continue to fund private institutions.

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