Capacity Building and Development in the Health Sector: Implications for Romania

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Abstract

Capacity development is a key component in the overall improvement process of any branch of the public sector within a country. The role of capacity building is defined by the ability of a system to maximize its productivity and human resource availability and regeneration over time, through the enacting of positive policies which are beneficial to itself and to the people that comprise it. Due to recent events, it became essential to re-evaluate the development of the workforce capacity processes with respect to the of the swiftly changing global healthcare system requirements. In the case of the public health sector, capacity building and development are fully influenced by the number of human resources and financial investments that are poured into the apparatus, since one cannot ensure productivity without the other; these two factors are highly dependent on each other. From a political point of view, the ramifications of a failed development programme have been proved to be dire for the health sector within Romania as it can be observed, over the last two decades, what a subpar financial backing can do to such an institution. It is imperative for a country to invest into the infrastructure of its public health system just as much as it should invest in the workers within it, otherwise it is destined to fail to meet the popular requirement of medical care, which are of a paramount importance. Considering the mentioned objectives and motifs, this study`s main target is to explore how capacity building is to be improved to meet the newly formed demands of the public health system, due to the recent critical changes it has suffered.

Keywords

Capacity building, development, public health, human resource, infrastructure.

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Introduction

Clearly, health is a socioecological construction that begins with a biological foundation and individual physical and emotional characteristics that are shaped by the social and environmental aspects of our lives (Mc. Murray, 2007) The need to view health as a Social Capital, from the perspective of the community, leads us to consider the potential in the concept of building health in the population, from a network that includes different aspects of human resources based on the sanitary conditions of a given population. Community health capacity increases when there are health-promoting organizational structures, such as schools, workplaces, and community planning mechanisms (Bowen and Harris, 2001) This empowerment should be interpreted as participation in collective actions for the community's benefit (Fawcett et al., 1995). Capacity building refers to the well-known ideas of community and worker growth. Capacity development is the process of enhancing the current abilities of people, groups, organizations, or processes to improve participation, decision-making, and control of problems.

The concept of capacity development in health promotion comes from the realization that tactics can be more successful and durable if they stretch beyond conventional health sector limits. The advantages are obvious. Working across sectors can enhance community action, develop individual skills, and enable organizations to encourage lasting health behaviors and support healthy surroundings. Capacity building in the health sector should be an ongoing, dynamic process that is never inert; consequently, it requires ongoing investment and renovation. Capacity development is a means of achieving objectives. For decades, the concept of capacity building in development cooperation remained unchanged: it was

equated with individual training and organization restructuring (Milen, 2001). The current definition of capacity building implies a complex process that aims to alter the mentality and behavior of individuals through the introduction of more efficient technologies and resources.

Across the globe, the medical education and health systems were subjected to an unparalleled interruption due to the pandemic. The life-threatening symptomatology resulting from COVID-19 infections created challenges for medical education since the integrity and steadiness of the medical education process became restricted, along with the safe delivery of lectures by the faculty members. Another objective of this study is to reveal the critical aspects of medical education that need to be strengthened post-COVID-19, concentrating on creating an effective healthcare workforce, clinical training through clinical rotations which has been postponed due to the fact that medical students could become infected, thus spreading the virus further to the community (Zern et al., 2022). Such challenges caused restricted patient care resulting from the focus placed on treating COVID-19 cases, limiting the accessibility of bedside education for medical students.

1. Paper Body

Education and professional training have a particularly important role for the development of the capacity of the public health sector, as the personnel employed in this field, in general, are subject to a long training process, which can last up to 10 years, in the case of specialist doctors who work in hospitals. So, we can say that the professionalism and productivity of these employees are directly influenced by the level of knowledge and development accumulated throughout the period of schooling during the university internship, as they acquire more knowledge and experience in the field in which they work, they become more and more productive, this being the objective of capacity development.

In other words, the development of the capacity of this sector does not only depend on the investment made in hospital equipment and infrastructure, but also on the investment in the educational system, more precisely, in those who are going to use the aforementioned to maximize work efficiency, as much as it is difficult for a skilled employee to carry out his activity in an environment underdeveloped for his professional needs, the latest generation equipment becomes useless for an employee who lacks the necessary knowledge to use it correctly and efficiently.

To holistically manage health on several variables, including sanitation, economic, and social factors, integrated health services will be created at the neighborhood level. Children, the aged, people with impairments, and, where applicable, the Roma community will all receive extra care because they are fragile and at-risk groups. Local governments will create these services with federal help in terms of funding, logistics, and information. In the medium and long term, these combined community medical facilities are expected to serve as a viable and template for a standardized practice in Romanian cities. Integrating health services into local communities in a sustainable manner while building the administrative ability of key local players to deliver them. of comprehensive healthcare services delivered at the local community level by interdisciplinary teams. Expanding and professionalizing the school medicine network, as well as improving its contribution to prevention, acceptance of healthy behavior and health instruction.

Health-related human resources are demotivated, elderly, and primarily located in big metropolitan areas, particularly in areas with medical universities. In the areas of public health, primary healthcare, other basic (essential) health services, related services, and niche / hyperspecialized / high-performance medical services, the distribution of health professionals by specialties and skills does not meet the needs of the health system or the needs of the population. In state hospitals, the administration of human resources and organizational structure are strict and out of step with the actual requirements for healthcare in the regions they serve, as well as with the funding sources. Furthermore, there is a lack of equality in the regulations governing staff compensation between different employee classifications, and in the case of physicians, there is no clear connection between pay and the quality of the job done (Akers, Blough and Iyer, 2020). Finally, the health system is concerned about the lack of a suitable and affordable method for medium- and long-term planning of human resources that is based on detailed statistical data. Through the insufficiency of human resources and technical skills to meet its service requirements, this absence has significant detrimental impacts on the population's health (Crisp, Swerissen and Duckett, 2000).

The condition of medical staff has become a recurrent topic in public discourse because of the COVID-19 epidemic. Beginning in early 2020, discussions of the need for medical care, the risk of hospital staff contracting disease, and their excessive workload suddenly became commonplace issues. These discussions persisted through 2021, when the story ceased to be news and the pandemic situation

appeared to be gradually getting better. Since then, regular news about the dire state of hospitals has been replaced by sporadic reports about the severe shortage of personnel that some public hospitals are experiencing (Guga, 2022).

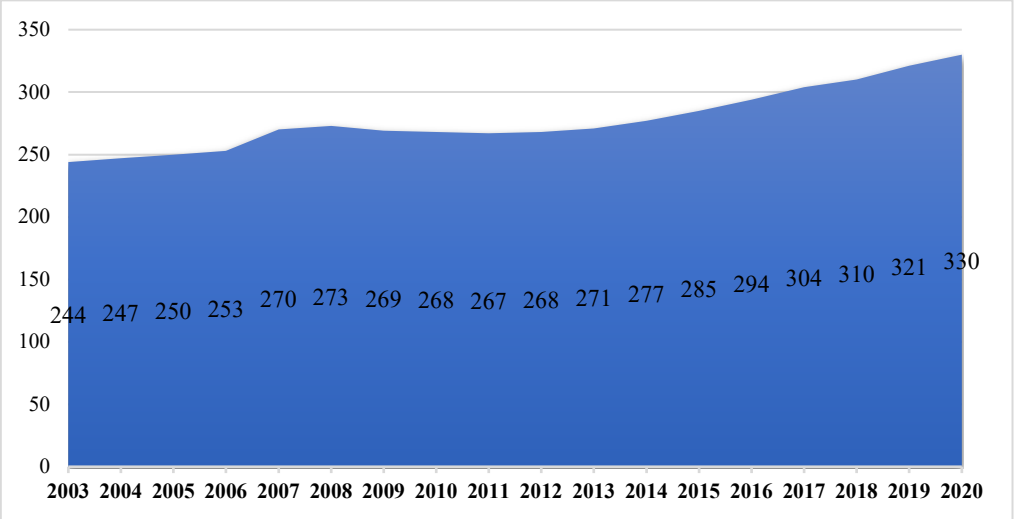

Figure no. 1. The Evolution of Personnel from the Public Health System
Source: INS ROMANIA

A straight-forward shift of action from one way to another is not at all how the private sector develops, nor is it how it interacts with the public sector. Between the state and the commercial health systems, there are significant variations in organizational personnel. First, auxiliary health personnel (7.5% compared to 31% in 2020) has a very low proportion in the private sector compared to the public sector (nurse, gurney carriers, firemen, etc.). This is mainly because there are no commercial emergency services, and the public system continues to handle most cases that are severe enough to require long-term confinement and special care. Together, they constitute about 37% of the health personnel in the private system, compared to less than 3% in the public system. In the second row, dentists, pharmacies, but also family physicians (after 2015) have a virtually insignificant representation in the system public. In the third paragraph, we note that there are fewer physicians in the commercial setting (10% compared to 20% in the public system), but that the share of typical healthcare personnel (primarily nurses) is roughly the same (46-47%). This disparity is primarily attributable to the fact that, in the private sector, physicians typically do not have a written job contract and instead operate under the "collaborators" norm.

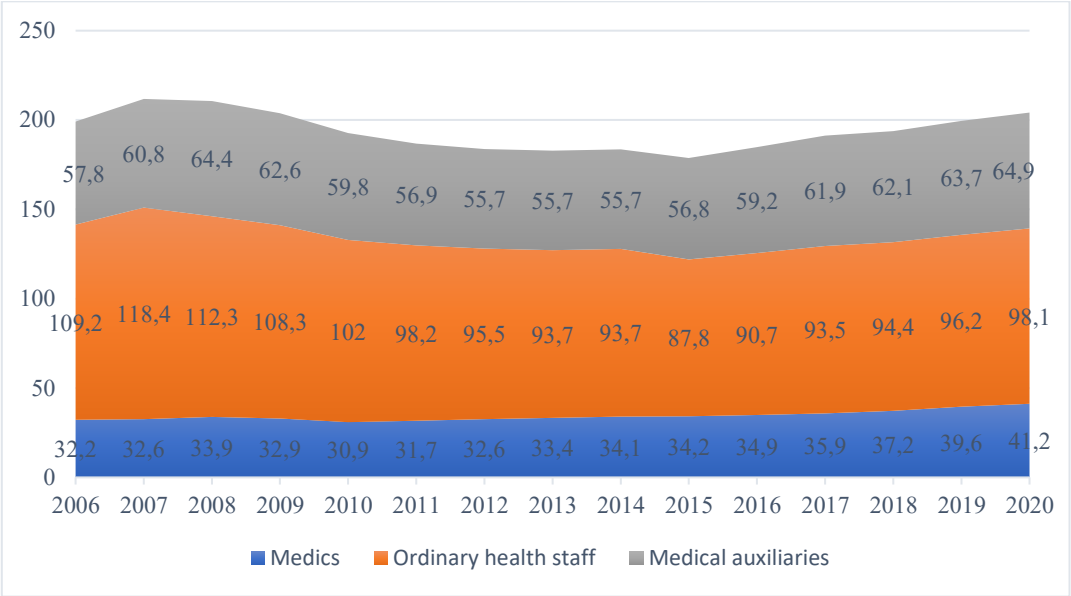

Figure no. 2. The Evolution of Personnel from Public Health Sector
Source: INS ROMANIA

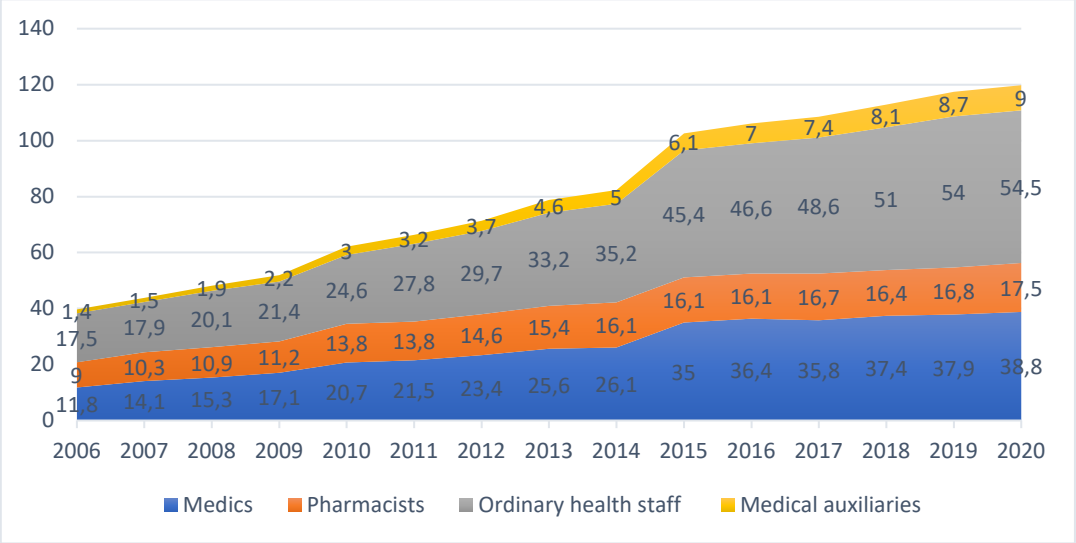

Figure no. 2. The Evolution of Personnel from Private Health Sector
Source: INS ROMANIA

Particularly after 2017, we observe a greater growth in the number of physicians in the public system, while the typical staff size has increased quantitatively much more strongly in the private sector. Regarding the public system, it should be mentioned that there are presently a high number of physicians (over 40 thousand, up from 34 thousand in 2008) and that the number of ordinary health staff is still quite low (under 100 thousand, compared to 120 thousand in 2007). The question that needs to be asked for the private system is whether the expansion of private health services aligns with the public objective of guaranteeing available health services for all citizens or not. Again, hypothetically speaking, this is not feasible because any private activity emphasizes development and revenue over service accessibility. We might anticipate, for instance, that private medical practice would be concentrated in towns and regions with comparatively high earnings rather than in impoverished ones. The most pertinent way to assess the situation would be to look at the spread of ordinary health personnel, as highly skilled personnel in the private system tend not to be directly hired and many public system physicians collaborate in the private system. The average net pay and the county spread of health workers are clearly correlated and as a result, private medical activity is more likely to focus on counties with better salaries, since, naturally, fewer people can afford private health care in impoverished counties. But as we'll see, regional disparities are also more evident in the public system, where the spread of medical staff is very comparable to that of the private system.

A vital component for the health and well-being of people is a national public health system that is viable, robust, and effective. The challenge of the COVID-19 epidemic and the prolonged shift characterized by its numerous incomplete changes emphasized the subpar ability of the public health system to meet the requirements and expectations of both residents and health workers.

The public health system has withstood numerous tests of change over the past 30 years, but its viability has been compromised by inadequate financing, population decline, and widespread professional movement. The public health system currently employs an insufficient number of experts who are also highly demotivated, burnout, and unsatisfied with their jobs. Additionally, the administrative bureaucracy, the inadequate information system for data collection, validation, and reporting, the erratic use of a variety of funding sources, and the priority focus on the financial component of national public health programs at the expense of monitoring health outcomes have all contributed to significant dysfunctions in the best implementation of crucial public health interventions. The health of the community, particularly during times of crisis, is not properly addressed, and the provision of preventive services is not understood as an essential component of well-being and is essentially non-existent due to the absence of an adequate regulatory framework, variable but rather low interest, and inappropriate use of available human resources (such as community nurses).

A public health system that has been rebuilt on solid principles can respond quickly, flexibly, and adequately to current and future public health challenges. It also has increased resilience of surveillance and monitoring systems for the major public health issues, continuously invests in multidisciplinary human resources, values teamwork, and makes adequate use of digital and health information systems to connect, respond quickly, and coordinate to threats (DeCorby-Watson et al., 2018). A population health management system that prioritizes the proactive participation of local communities with public health

institutions and professionals to improve the quality of life, the workplace and social interactions for its residents while also addressing the social determinants of health status, inequities in health status, both individually and collectively. A public health system that adequately and continuously monitors and addresses health risks through the proactive participation of citizens in decisions about their own health and that of the community in which they live through adequate health information and education throughout their life, and that comprehensively addresses the main preventive interventions for prior communicable diseases and chronic diseases with a major impact on disability and preventable morbidity.

To coordinate health in all area policies with the other organizations or agencies concerned, the Ministry of Health takes the position of a proactive interministerial collaborator.

- An integrated method for tracking health programs that produces frequent reports.
- Increasing the number of people working in public health by more than 50% and broadening their skills sets.
- A fifth of local public bodies have joint ventures with DSPs to improve the health of the member population and public health.

Geographically speaking, the health sector's labor deficit is dispersed more and more widely. One of the most effective public policy initiatives in recent memory focused on the condition of health workers: Law 153/207, which mandated historically high wage increases in the public health system, raises whose stated goal was to decrease departure and solve the staff scarcity issue. On a larger scale, Law 153/2017 was incredibly successful in reducing the departure of trained health workers to very low levels in a brief period and even causing an excess of workers in the cities of wealthy counties. Salary rises, however, did not address the issue of a dearth of people outside of established metropolitan areas, and to some degree even served to exacerbate spatial inequality. The issue of staff gaps in the public health system proved to be difficult to address despite the need for salary increases. Meanwhile, the officials' primary goal has changed to investing in healthcare facilities while also taking advantage of the cash chance provided by the PNRR. Like salary rises, infrastructure investment is unquestionably necessary, but may fall short due to the possibility that some of the new facilities will not have enough employees to function. Although they are crucial and represent significant departures from the public policy of previous decades, the already realized case of wage increases and the potential future investments in infrastructure also highlight the shortcomings of piecemeal solutions to a very complex problem, whose effects go far beyond the issue with the sanitary system. They should be supplemented by additional steps involving medical staff and the healthcare system, as well as a larger plan to lessen social disparities between and within regions. Commuting subsidies, military housing, and wage increases are just a few of the subsidies that have been debated frequently over the years and are tacitly recommended in the most recent public policy papers. Although such actions would be required, there is little probability that they will solve the issue. Reassessing the training program would be another crucial move. Residency programs are currently only offered in university settings, and the fact that new physicians begin their careers by spending several years in these settings undoubtedly lessens the appeal of other regions of the nation. However, without a more comprehensive plan to address rising social disparities, an efficient and long-lasting answer is not feasible. There is a point beyond which any additional funding for health professionals in the area will ultimately prove insufficient, as health professionals already lament the lack of opportunities for a professional and personal life that are comparable to those provided by developed urban areas, rather than a lack of funding. From this vantage point, the predicament of health professionals in underdeveloped areas is just one small aspect of a much broader picture in which most of the country's territory and people continue to trail behind a few wealthy cities. The clearest proof that such a plan did not exist over the past few decades is the constant escalation of these disparities despite shifts in administration and the overall economic direction.

Conclusions

Compared to 2022, the health system is experiencing a totally different kind of staffing deficit. During this time, the number of health professionals has greatly grown; even though the Romanian health system has undergone several fundamental changes, the public sector's employee numbers are still fewer than they were at the end of the 2000s, despite the private health system's rapid growth and the public sector's financial success. The increasing separation of duties between the public and private sectors is especially evident in the almost complete outsourcing of some health-related activities. Family medicine, which is now primarily a private practice, fell far behind other medical services in terms of numbers. Geographically, the lack of family physicians is not widespread but is more pronounced in some regions of the country. To provide personnel (particularly physicians) and handle complex situations, the private

system continues to be reliant on the functioning of the public system. The rapid increase in the percentage of physicians under 35 years of age demonstrates the revitalization of the staff. The reality that Romania has many graduates from specialist institutions supports this encouraging trend, expanding spatial disparities between wealthy and impoverished areas, as well as between major cities and the surrounding area. Rich areas have benefited most from the recent rise in health workforce, whereas impoverished areas are experiencing stasis or even decline.

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