Generating Political Priority for Primary Health Care Reform in Romania

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ABSTRACT
This paper examines how political priority was generated for comprehensive reforms to address inequitable access to high-quality primary health care (PHC) in Romania. We apply John Kingdon’s model of political agenda setting to explore how the convergence of problems, solutions, and political developments culminated in the adoption of a government program that included critical PHC reforms and approval of a results-based funding instrument for implementation. We draw on a review of the gray and peer-reviewed literature and stakeholder consultations, and use content analysis to identify themes organized in line with the dimensions of Kingdon’s model. We conclude this paper with three lessons that may be relevant for generating political priority for PHC reforms in other contexts. First, national PHC reforms are likely to be prioritized when there is political alignment of health reforms with the broader political agenda. Second, the availability of technically sound and feasible policy proposals makes it possible to seize the political opportunity when the window opens. Third, partners’ coordinated technical and financial support for negotiated issues can serve to raise their priority on the political agenda.

Introduction

In 2015, 193 countries in the United Nations General Assembly adopted the Sustainable Development Goals (SDGs), including the target of achieving Universal Health Coverage (UHC) by 2030. This goal of UHC commits countries to guaranteeing access to high-quality basic health services and providing financial risk protection to the entire population. As we enter the last decade before 2030, there are significant challenges in progressing toward UHC. Half of the world does not have access to a basic package of health services. An estimated 808 million people incur out-of-pocket payments for health care exceeding 10% of household consumption, pushing 97 million people into extreme poverty every year. Health reforms guaranteeing access to primary health care (PHC) are a cost-effective approach to comprehensively responding to population health needs, integrating services for communicable diseases, maternal and child health, and non-communicable diseases (NCDs), and ensuring access close to the community.

Through the 2018 Astana Declaration, countries have renewed their political commitment to investing in PHC as the programmatic engine for accelerating progress toward UHC. However, in many countries, PHC is in crisis and subject to underdevelopment, underfunding, and lack of human resources. Narrow scope and perceived low quality of PHC lead patients to bypass PHC for specialized care despite higher costs of and greater distances to the latter. These challenges are exacerbated by the health financing patterns that prioritize expensive but politically visible hospital reforms.

Romania is an example of a country where hospital spending has increased for conditions that are preventable and treatable by timely and effective PHC. Wagstaff and Moreno-Serra found that the adoption of social health insurance in Romania increased total health spending and hospital activity rates but did not lead to improvements in mortality from causes that should not occur in the presence of timely and more effective health care. These findings may reflect the gaps in coverage among some groups, such as the Roma, that then forego PHC until health conditions worsen. Indeed, on the demand side, PHC is less accessible to rural, poor, and ethnic minority groups due to physical, social, and financial barriers. Up to 14% of the population, or 2 million people, are uninsured, ineligible for the basic services package that includes preventative care, routine investigations, and minor acute care consultations. On the supply side,
PHC facilities, owned and operated by individually practicing family physicians, are under-equipped, underfunded, and unable to respond comprehensively to population needs.\textsuperscript{11,12} Supply of PHC services varies by geography, with one family physician per 1,000 inhabitants in urban areas and 1 per 2,500–3,000 inhabitants in rural areas.\textsuperscript{13} Addressing the supply and demand-side barriers to equitable access to high-quality PHC is key to making progress toward UHC in Romania.

**History of Health Care Reform in Romania**

Between the 1950s and 1990s, under a Semashko-style health system, all health professionals were hired by state-owned institutions and provided free services at the point of care. PHC services were provided at community dispensaries administered through the local hospital, rather than employing a family medicine model.\textsuperscript{14} Specialists provided the bulk of outpatient care and outnumbered PHC physicians, who were neither well regarded nor well resourced.\textsuperscript{15}

Since the dissolution of the Soviet Union in 1990, PHC reforms have garnered increased attention. In transitioning to a social health insurance system, PHC physicians became private providers contracted by the Ministry of Health (MoH) and later with the National Health Insurance House (NHIH). Instead of a fixed wage, PHC providers were paid with capitation and fee-for-service.\textsuperscript{15} Patients were free to choose their PHC providers. By the late 1990s, family medicine had become a medical specialty.

The reforms of the 1990s aimed to link outputs, including coverage of care, at the PHC level with fund flows to encourage competition and reduce reliance on hospital care. However, by the early 2000s, there were disparities in access to key PHC services and PHC funding fluctuated. A minimum service package was introduced to cover the uninsured, excluding them from the more comprehensive basic services package and only covering emergencies, pregnancy care, and infectious disease care. By 2009, PHC only accounted for 7.2% of the funds designated by the National Health Insurance Fund (NHIIF).\textsuperscript{16}

In 2004, the National Public Health Strategy identified a vast array of opportunities to improve PHC in terms of organization, funding, and scope of services.\textsuperscript{17} However, no funding was allocated in the national budget to implement reforms, and no alternative sources of funding were explored. Furthermore, the strategy lacked a detailed action plan and monitoring and evaluation framework. In 2014, the Government adopted the National Health Strategy 2014–2020 that identified key PHC reforms, an action plan with timelines, key performance indicators, and funding from the national budget and external sources.\textsuperscript{18}

**Raising PHC on the Political Agenda**

In 2019, guided by the National Health Strategy 2014–2020, Romania embarked on a series of PHC reforms aiming to strengthen PHC access, quality, and efficiency through the “Results Based Program in the Health Sector in Romania” that was ratified into law by the parliament in early 2021.\textsuperscript{19} The Program is financed by a commitment of 5 billion USD, of which 90% is allocated from the government budget and NHIH revenues, and has an implementation period through 2024. Given the historical challenges in adopting PHC reforms on the political agenda in Romania, useful lessons may emerge from exploring the factors facilitating legal and financial commitments to addressing challenges to PHC access, quality, and efficiency. Research on PHC strengthening tends to focus on technical details for reform design, including operational challenges to scaling effective interventions and performance of core PHC functions.\textsuperscript{20} Yet, case studies of countries that have adopted and undertaken PHC reforms highlight the importance of political factors in shaping reform design and feasibility.\textsuperscript{21,22} This paper examines how political priority was generated for comprehensive reforms to address inequitable access to high-quality PHC in Romania and offers lessons that may be relevant for reform efforts in other contexts.

**Materials and Methods**

**Conceptual Framework**

To examine the adoption of PHC reforms on the government agenda in Romania, we considered conceptual frameworks for health policy analysis by Shiffman and Smith,\textsuperscript{23} Walt and Gilson,\textsuperscript{24} Baumgartner and Jones,\textsuperscript{25,26} and Kingdon.\textsuperscript{27} While these conceptual frameworks are not exhaustive, they have informed analysis of health policy agenda setting in other contexts.\textsuperscript{28–31} Kingdon’s model for agenda setting overlaps significantly with the main elements of other frameworks. For example, the problem, policy, and politics streams within Kingdon’s model examine similar concepts as the issue characteristics, policy ideas, and political context in the framework described by Shiffman and Smith. Importantly, Kingdon’s model has a temporal element that facilitates reflection on how streams changed over time to converge on a specific period when a window of opportunity opens. We apply Kingdon’s model as our conceptual framework, retaining the original problem, policy, and politics streams that we describe in detail below, and reflect on the implications of our choice of conceptual framework in the discussion.
In the problem stream, the model examines how (negative) conditions come to command the attention of policymakers and become problems. In the health sector, conditions may be highlighted through routine or survey statistics, citizen feedback, external actor pressure, or shocks such as pandemics. A condition may also be highlighted because of a country’s poor performance relative to peers, health disparities within the country, or influential external actors highlighting the condition as important. When policymakers recognize the importance of a highlighted condition, it becomes a problem to be solved.

The policy stream of the model examines the process through which solutions to an identified problem are debated and revised. This process is often led by less visible policy entrepreneurs, including civil servants, academics, journalists, legislative staff, and other technical experts. Policy entrepreneurs often work on the solutions to problems regardless of the presence or absence of a window of opportunity for policy changes. The proposed solutions are likely to be adopted by policymakers if there is agreement among them that solutions are politically and technically feasible.

Under the politics stream, the political context and actions by politicians shape the adoption of policies (potential solutions to problems) onto the government’s agenda, involving a commitment to implementing these policies. Factors such as the electoral calendar, changes in government, and interest groups bargaining may introduce new political actors or change the influence or incentives of existing actors that facilitate or hinder policy adoption. Engagement of self-interested politicians should also consider the potential gains and costs in terms of political support.

Data and Methods

To examine the adoption of PHC reforms onto the government agenda in Romania, we combined in retrospect a review of gray and peer-reviewed literature from 2008 to 2019 and findings from recent stakeholder consultations to examine the problem, policy, and politics streams.

Our review of gray literature included government policies and statements, reports, and policy dialogue that focused on health outcomes, research on health policy, and health reform efforts. Government policies included official statutes, the legal framework for service delivery, and political declarations and press statements by government officials. Reports were drawn from both governmental and non-governmental sources and were included in analysis if they pertained to topics on health outcomes, health service utilization, or health service delivery organization. We also conducted a scoping review of peer-reviewed literature of past health policy research and projects in Romania where findings could inform PHC reform. We supplemented our literature review with documentation of dialogue from recent stakeholder consultations with different counterparts of the Government of Romania in 2018 and 2019. Participating stakeholders included representatives from the MoH, Ministry of Finance (MoF), NHIH, physician associations, the Roma Sounding Board, and European Union (EU) representatives.

Using our conceptual framework, we conducted a content analysis of results from our review of gray and peer-reviewed literature and documentation from stakeholder consultations to identify major themes along the framework dimensions of problem, policy, and politics streams. Themes were identified as recurring ideas that represented a single concept and explained at least one of the three streams.

We triangulated our findings by comparing themes from our literature review and stakeholder consultations during analysis and identifying areas of convergence or divergence. In our analysis, we organized these themes along the three streams and the window of opportunity during which PHC reform was highlighted on the policy agenda.

Results

Problem Stream

High NCD Burden and Low PHC Priority

Romania faces an increasingly high burden of NCDs. In 2019, the top four causes of deaths were ischemic heart disease, stroke, hypertensive heart disease, and lung cancer. The death rate from ischemic heart disease is almost three times higher in Romania than in the EU. The number of years lived in disability attributable to diabetes increased by 10.4% between 2007 and 2017, more than for any other disease in Romania. With incidence of many NCDs increasing with age, the overall NCD burden is projected to rise given the expected doubling of the share of the population older than 65 from 11% in 2017 to 20% in 2017.

NCD care is best initiated at and coordinated from the PHC level, where family medicine providers can screen, diagnose, treat, and manage conditions with specialty referral. However, in Romania, PHC is underutilized, which may partially explain the growing NCD burden. In 2013, average outpatient contacts per person in Romania was 4.8 per year, below the EU average of 6.96. Cervical cancer screening is also
below the EU average: in 2018, only 26% of women aged 20 to 69 years were screened within the last three years compared to the EU average of 61%. PHC is frequently bypassed and does not play a central role in coordinating care. In 2016, avoidable hospitalizations for ambulatory-care sensitive conditions made up 7% of all hospitalizations.

Utilization and quality gaps reflect the lower priority for PHC relative to specialist care and the financial barriers faced by disadvantaged groups. Romania’s 18% of health spending allocated to ambulatory care is the second lowest in the EU, which averages 30%. In contrast, the share of inpatient care expenditure, at 42%, is greater than the EU average of 29%. The inequity of health insurance coverage for different populations in Romania is well documented. Health insurance coverage is low among the poor, at 52% compared with the non-poor at 94%, and among specific minority groups, including the Roma population, of whom 50% have health insurance.

Macroeconomic Pressures and PHC Goals

The MoF faced wide macroeconomic imbalances, with Romania recording the widest deficit-to-GDP ratio in the EU in 2019 at 4.3% of the GDP. In parallel, Romania was nearing the end of the European Commission Partnership Agreement for Romania (2014–2020), which identified priority issues targeted for funding through EU grant mechanisms. This Partnership Agreement included an explicit reference to the imbalance between PHC and hospital-centric care in Romania: “The health sector will also be strongly supported, focusing on deprived communities and promoting an alternative to hospitals, like primary and ambulatory care or e-health services.”

The Romanian National Health Strategy 2014–2020, developed in response to the Partnership Agreement, echoed the priority to address barriers to PHC access and quality: “The strategic document is developed in the context of European funds’ allocation process for the 2014–2020 period and represents a vision document justified by the necessity to meet the ex-ante conditioning foreseen in the Commission’s Services Position regarding the development of the Partnership Agreement.” Development of the Partnership Agreement, which was the first of its kind for Romania, brought the challenges in access to high-quality PHC to the attention of policymakers. Specifically, a Consultative Committee on Health Services was coordinated by the Ministry of European Affairs and the MoH and consisted of several working groups of representatives of health authorities, providers, patient associations, other stakeholders. The committee held consultations culminating in the development of a socio-economic analysis of the health sector challenges that formed the basis of proposed health reforms in the 2014 Partnership Agreement. The analysis was endorsed by the Government-level committee that oversaw the development of the Partnership Agreement.

Policy Stream

Policy proposals to address gaps in high-quality PHC access and improve the efficiency of the Romanian health system have been put forward in gray literature sources such as reports and strategy documents by policymakers, civil society, multilateral agencies, and international consulting firms.

Policy research on PHC access barriers for minority groups include the 2013 World Health Organization case study of Roma health mediators. This study evaluated a program piloted by the Roma Center for Social Intervention and Studies, and later adopted by the MoH, that facilitates communication between PHC and Roma communities. In this program where Roma health mediators are hired by local governments with at least 700 Roma inhabitants, health mediators work in a community care team that includes a family physician, community nurse, and a midwife, to coordinate access to health services for Roma families. The evaluation highlighted program elements facilitating success, including collaboration between government and civil society in planning and implementation; broad geographical coverage; the focus on preventive care; and recruitment of women, recommended by their communities, to serve as mediators. The report also made policy-level recommendations, such as improved training and remuneration of health mediators and increasing ownership by central health authorities. However, program governance was transferred from county health authorities to local public administrators in 2009, leading to a reduction in resources for mediators, including for training and remuneration, and reflecting the low national priority of PHC and community care at the time.

Other policy proposals were put forward to address barriers to PHC access and quality more broadly. In 2008, the Presidential Commission for Health published “A Health System Focused on Citizens’ Needs,” noting the need to strengthen PHC as an essential element of health sector reform. The Commission recommended the development of multidisciplinary PHC teams, increasing financial resource allocations at the primary level to improve health system efficiency, and an increase in human and other resources for PHC
development. By 2012, the MoH commissioned the development of a strategy and action plan for PHC in underserved areas by Oxford Policy Management. The strategy identified key reforms to improve PHC in underserved areas, including financial support for refurbishing family medicine practices and increasing the budget for an expanded scope of care in family medicine, establishing linkages between community health nurses and family medicine practices, optimizing payment mechanisms for performance, and stimulating the involvement of local authorities to increase access in rural and remote areas. However, the recommendations toward improving primary and community health care did not gain prominence on the national policy agenda until the 2014–2020 Partnership Agreement.

In addition to highlighting the salience of addressing the barriers to accessing high-quality PHC, the 2014–2020 Partnership Agreement specified policies that would be eligible for funding. It signaled strong support for health sector investments focusing on deprived communities and promoting alternatives to hospitals, including PHC. The 2014–2020 Regional Operational Program included priority axes that emphasized access to PHC and community health care, particularly among the underserved. For example, Priority Axis 8.1 aimed to increase “access to health services, with focus on community services and ambulatory specialty services, especially in poor, remote areas.” Hence, the Romanian National Health Strategy included objectives in line with these policies. Strategic Objective 4.1 aimed to develop community health care services that are integrated and comprehensive, especially for the population in rural areas and vulnerable groups, including the Roma population. Strategic Objective 4.2 aimed to increase the effectiveness and diversification of PHC services. Strategic Objective 7.2 aimed to improve ambulatory health care service infrastructure through community health care, family medicine, and specialized ambulatory care.

**Political Stream**

The implementation of the proposed policies to reform PHC was enabled by electoral transition and an alignment of key political actors in the executive arm of the Romanian Government.

Romania has experienced frequent changes in political leadership that present challenges for policy continuity. Based on stakeholder consultations, the narrative emerged that while health care has remained a high-level political priority across administrations, attention to PHC increased following an electoral transition in 2016. Between 2016 and 2020, the government was led by a center-left coalition led by the Social-Democratic Party (PSD), with three prime ministers during this period. The president of Romania was from the center-right National Liberal Party (PNL). Despite differing views between the President and the Government, the priority for health care reforms, including PHC reform, represented a common ground. In particular, the President’s 2016 program prioritized the “balancing of care settings in the health care system by increasing the volume and quality of services in primary care and outpatient specialty care.” Further, the government program for 2018–2020 aligned with the President’s program and was aimed at “securing minimal equipment in primary care offices and training for family physicians so that patients do not overcrowd hospital emergency rooms for minor illnesses which should be treated by family physicians.”

Between 2018 and 2019, there was relative political stability. At the same time, the incumbent Ministers of Health and Finance had developed a collegial relationship and both prioritized PHC strengthening. Through statements and press releases, from the perspective of the Minister of Finance, there was a need to improve the efficiency of public spending, both because there are gains to be made in health spending and because there was pressure to find temporary funds for the budget while other public financial management improvements were ongoing. For example, in a press release, he championed the establishment of a National Office for Centralized Procurement to promote value for money through pooled procurement and undertook public spending reviews in the MoF to identify opportunities for efficiency gains. The MoF was concurrently involved in the analyses for efficiency improvements by participating in a review of public finance in Romania, and found gains to be made in health sector spending through PHC strengthening and other measures. The significant funding allocated to the health sector, at 10% of the public budget, further buttressed the potential scale of efficiency gains that may accrue to improved spending decisions. Prior to 2018, the MoF had not intervened in discussions of sectoral ministry allocations or advocated for increased spending efficiency, and conversely, there was historical resistance from the MoH and the NHIIH to involvement of non-sector actors in sector policy setting.

Public declarations and joint appearances highlighted alignment on PHC between the respective agendas of the Ministers of Health and Finance. The Minister of Health noted “family medicine needs to be stimulated . . . [through] additional services.” She referenced the low relative spending on PHC compared to hospital care, and that “only 6% of National Health Insurance
Fund spending is allocated to PHC.” They declared their commitment to strengthening PHC and expressed openness to requesting partners’ support for these efforts, including from the EU and the World Bank. Public technical discussions with the World Bank drew on policy proposals in the 2014–2020 National Health Strategy: the Minister of Health expressed the need to increase the share of PHC funding in the National Health Insurance Fund from 6.5% to 10%, while the Minister of Finance announced a program where PHC physicians would receive capital expenditure support to set up PHC practices in underserved areas.\(^5\) The design of the PHC reforms was also informed by extensive documented discussions with the EU and non-governmental stakeholders, such as the National Society of Family Medicine, the Roma Sounding Board, and patient associations.

**Convergence of the Streams on the Reform Window of Opportunity**

In the problem stream, Romania has been facing a growing burden of NCDs, many of which are ambulatory-care sensitive conditions, that were being treated in costly hospital-care settings rather than the more efficient PHC level. Simultaneously, macroeconomic pressures grew for improving the efficiency of public spending. PHC reform was sorted to the top of priorities for policymakers as a way to address both health and spending concerns. In the policy stream, Romania’s participation in the EU and National Health Strategy provided clear recommendations for addressing the identified problems through improving PHC. In the politics stream, during a period with political stability, more political attention was given to PHC and the heads of the MoH and the MoF agreed on specific policy solutions to achieve mutually beneficial goals.

Between 2018 and 2019, there was a convergence of a salient problem, a consensus over technically and politically feasible solutions, and high-level political alliances in the Ministries of Health and Finance that put PHC on the government’s agenda, culminating in the 2019 signing of an agreement to receive development partner support to implement the government PHC reform program and the 2021 ratification of Law no. 1/2021 on the Loan Agreement regarding the Results Based Program in the Health Sector in Romania (Figure 1).\(^5\) Of note is the 16-month period between signing and ratification, which was due to both the COVID-19 pandemic and a transition of government. With ratification under the new government, Romania has demonstrated commitment to PHC reform through legal and financial instruments.

**Table 1**\(^5\) describes specific PHC reform commitments of the Results Based Program. The COVID pandemic expedited some reforms: certain hospital-based specialty services transferred to family physicians, who held phone-based patient consultations and filled prescriptions over e-mail. In the years preceding the pandemic, the MoF and MoH also implemented several PHC-targeted interventions. For example, the number of residency positions in family medicine increased to 450 in 2018, up from 157 in 2017.\(^5\) Overall PHC funding increased by 25% both in 2018 and 2019, reflecting efforts to improve the efficiency of health care spending and increase allocations toward PHC.\(^56\)–\(^57\) The Government (represented by the MoF, MoH, and NHIH) also partnered with the World Bank on a Program-for-Results lending instrument, which would disburse based on pre-defined reforms and promote accountability for PHC improvements.\(^58\)

**Discussion**

In this paper, we examine the process of convergence of the problem, policy, and political streams that facilitated
Table 1. PHC reform commitment by the Government of Romania10

- Guarantee access to an essential package of PHC services for all Romanians, including the uninsured and ethnic minorities;
- Increase the share of the health budget allocated to PHC services;
- Expand the comprehensiveness of PHC to include services for ambulatory-care sensitive conditions, such as uncomplicated diabetes mellitus;
- Strengthen the coordination of care between PHC and community care to better serve vulnerable groups;
- Revise provider payment mechanisms to improve the incentive for broader coverage of preventive care and better quality in PHC;
- Provide financial support for investments in PHC infrastructure and equipment in underserved areas.

the adoption of PHC reforms in Romania. This analysis contributes to the empirical literature by providing lessons that may be useful to countries aiming to generate political attention for PHC and other neglected issues in the health sector. Below, we identify three lessons that emerge from the Romanian experience.

First, national PHC reforms are likely to be prioritized when there is political alignment of health reforms with the broader political agenda, which has been observed in other analyses of health system reform efforts. There was strong alignment between the Minister of Health and Finance on the need for reforms to improve efficiency of the health sector through PHC investments. At the same time, the head of the Romanian government had presented an agenda that proposed increased attention to PHC reforms. This alignment resulted in convergent public declarations and increased financing for PHC. The Romanian experience highlights the importance of framing reform efforts considering broader political objectives to generate high-level political support. Hence, while access to quality health care is essential to making progress toward UHC, emphasizing the importance of these objectives for fiscal efficiency was key to the political alignment between the Ministries of Health and Finance.

Second, the availability of technically sound and feasible policy proposals makes it possible to seize the political opportunity when the window opens, which in Romania’s case was the latter period of the National Health Strategy and Partnership Agreement. There was a large and coherent body of knowledge related to PHC reform in Romania that identified key interventions to address the physical, social, and financial barriers to high-quality PHC, and indicated overlaps with the health system efficiency agenda. These proposals were key to increasing the political feasibility of reforms and expediting reform activities. The technical proposals put forward also contributed to substantive discussion between key stakeholders like the MoF, MoH, and NHIIH.

Third, coordinated technical and financial support from partner organizations for neglected issues help raise their priority on the political agenda, particularly where there is high-level buy-in among national actors. Coordination between countries and partner organizations has been shown to be key to health strengthening efforts, particularly for PHC.61 Both the EU and the World Bank linked their funding to targeted PHC reforms, including support for the disadvantaged communities and institutional strengthening. These reforms received support from the highest levels of government, through the Ministers of Finance and Health. When the World Bank Program-for-Results project was negotiated, discussions on the EU’s next programmatic funding period also took place. As PHC investments were a priority for senior policymakers and both development partners, the results achieved through the World Bank loan could enable conditions to better absorb EU grant funding, while addressing efficiency, access, and quality challenges in the health sector.

This study has limitations. First, our findings based on a case study of Romania should be generalized with caution. While we have taken care to describe the health system and political context in Romania, which should inform applications of these lessons to other countries, Romania’s unique history and circumstances leading to current reforms should be taken into consideration to determine feasibility and acceptability of similar approaches. Second, we draw on consultations with key government stakeholders involved in negotiations for a World Bank activity, which may not be fully representative of all perspectives on PHC reforms. Three authors participated in these discussions on behalf of the World Bank, influencing the collection and interpretation of the data that may overrepresent external perspectives. However, we believe that this potential bias may be partially addressed by our close collaboration with two authors, one of whom participated in discussions on behalf of the government, who are Romanian and have experience with health policy research and administration of health programs in the country. This analysis draws on the perspectives of individuals involved in analysis of the challenges in the health sector and design of reforms, including public sector actors and non-governmental stakeholders. In triangulating findings from stakeholder discussions and our literature review, we are reasonably confident that this analysis presents a balanced picture of the process of generating political priority for PHC reforms in Romania. Finally, our analysis focused on examining the convergence of problem, policy, and political streams culminating in the adoption of the PHC reform on the government’s agenda. Additional analyses may examine in depth the
relative positions, power, and incentives of the key stakeholders. Future research may also explore the extent to which these reforms were implemented and achieved results, and the technical and political contributing factors.

In conclusion, this study illustrates an application of Kingdon’s three streams model for raising PHC reforms on the political agenda in Romania. The critical importance of PHC reforms as a vehicle for achieving UHC in Romania is consistent with evidence from other contexts, as highlighted in a seminal article on the experience of Latin American countries by Wagstaff et al.\textsuperscript{5} High-performing PHC can also lead to equity improvements by reducing disparities in access to services for common conditions.\textsuperscript{62} Further, PHC-oriented reform may lead to more equitable outcomes than general health system investments.\textsuperscript{63} The Romanian experience also highlights the role of political factors in shaping reform design. These lessons also emerge from examinations of the role of democratic transitions and other political shocks in driving UHC reforms in other contexts.\textsuperscript{64–66} As Romania moves forward with PHC strengthening and sets the policy agenda for 2021 and onwards, future research can explore the impact of reforms on furthering progress toward UHC in Romania.

Acknowledgments

We appreciate the engagement of the Ministry of Health, National Health Insurance House, Ministry of Finance, selected family physicians, patient associations, and other key stakeholders in the discussions that informed this article.

Disclosure of Potential Conflicts of Interest

The motivations, findings, interpretations, and conclusions expressed in this work do not necessarily reflect the views of The World Bank, its Board of Executive Directors, or the governments they represent. The World Bank does not guarantee the accuracy of the data included in this work. Authors HW, AC, RC, and TD disclose their involvement during scoping discussions of the Romania Program for Results project, which has a World Bank commitment of 507 million USD.

Funding

The authors received no specific funding for this work.

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Ethics Statement

This study involved secondary data collection through a literature review and policy discussions.

Author Contributions

HW, AC, and TD conceptualized the study. All authors contributed to the analysis, drafting, and approval of the final manuscript.

Data Availability Statement

Data sharing is not applicable to this article as no datasets were generated or analyzed during the current study.

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