



Volintiru, C. and Gherghina, S. (2022) We are in this together: stakeholder cooperation during COVID-19 in Romania. *European Political Science*, (doi: [10.1057/s41304-022-00383-9](https://doi.org/10.1057/s41304-022-00383-9))

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Deposited on 3 May 2022

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We Are in This Together: Stakeholder Cooperation during COVID-19 in Romania

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Abstract

Romania is characterized in general by poor institutional capacity and low popular trust in public institutions. In this context, it is an unlikely case for an effective stakeholder cooperation in times of crisis. However, this article shows that during the pandemics the structural vulnerabilities in the public system led to many solutions to be delivered through public and private stakeholder cooperation. The healthcare system engaged with community stakeholders to complement public efforts in managing the pandemics. A consistent institutional approach towards public engagement can compensate for systemic vulnerabilities and adds to societal resilience in times of crisis.

Keywords: resilience, public sector, private stakeholders, Romania

Introduction

The COVID-19 pandemics stretched the limits of healthcare systems throughout the world in 2020-2021. The countries with a poor governance and low institutional capacity track record proved to be particularly vulnerable (Zakaria 2020). Romania is a representative case for this category of countries. The key vulnerabilities of its healthcare system include low public healthcare expenditures, low preventive care expenditures, and the very high prevalence of both treatable mortality and respiratory disease in Romania (EC 2020). The country is known for long-lasting issues with poor governance, corruption, and inefficiencies such as delays in providing public services or poor management of public resources (Rothstein and Teorell 2012, Charron et al. 2014, Gherghina and Volintiru 2017). At the beginning of the pandemics in March 2020, the spread of the virus was relatively slow and there was a quick reaction from national authorities to enforce strict restrictions (UBB 2021). Once these restrictions were lifted in the summer of 2020, the spread of the disease significantly increased and created blockages in hospitals. By November 2020, over 10,000 new cases were registered daily (UBB 2021). The direct care of COVID-19 patients was difficult due to a low number of beds and

personnel in intensive care units, and significant delays occurred in the treatment of chronic patients because hospitals were used exclusively as COVID-19 care centres.

The overall reaction of the Romanian healthcare system to the COVID-19 pandemics is somewhat puzzling. Despite its many structural vulnerabilities and low levels of confidence from citizens, the state used key capabilities through collaboration with various societal stakeholders such as private companies or civil society organizations and provided a swift reaction through centralized decision-making process. This article aims to explain why despite structural vulnerabilities, the Romanian healthcare system showed resilience in the COVID-19 context. We use public records, public statements, survey data and several in-depth interviews with stakeholders to develop a systematic assessment of the institutional resilience of the healthcare system in Romania, across the three dimensions presented in the introductory article to this Symposium: preparedness, agility and robustness (Gherghina et al. 2022). Based on these indicators, we identify the impact of resilience in society.

To analyse the compensatory function of third parties in mitigating the impact in society of the public healthcare system, this article covers two major private companies (Vodafone Romania and Kaufland) that had the highest public involvement during the crisis (UBB 2021). The COVID-19 Romania Economic Impact Monitor dashboard developed by Babes-Bolyai University Cluj covered all the crisis-related activities of the top 50 companies in Romania since the first coronavirus case was diagnosed in the country. The dashboard included various measures: internal and organisational (e.g., layoffs, flexible work program, work from home, employees support hotline, cancelling business trips), customer-targeted (e.g., hygiene and safety measures) or society targeted (e.g., donations, information campaigns). This comprehensive catalogue of company measures allows comparing the companies' social engagement, the extent to which they were hurt financially by the crisis, and the measures undertaken.

The central argument of the article is that this reaction was possible through the cooperation between public and private stakeholders. The cooperation was primarily formed in the specific area of disaster relief where public sector institutional capacity existed within the Department of Emergency Situations. It also developed in the area of healthcare where public sector capacity is overall weak and where private sector actors and civil society have stepped up over the last decade to provide a compensatory function of quasi-public services. Examples of the latter include building hospitals or hospital wings out of private donations or

deploying in-field assistance to the elderly population and other vulnerable groups. The social impact of large multinational companies in Romania grew during COVID-19 via synergies with public sector and civil society stakeholders, resulting in targeted assistance to urgent needs.

The second section of this article assesses the institutional resilience in times of crisis with emphasis on three indicators: preparedness, agility and robustness. The following section discusses the societal impact of stakeholder cooperation and provides evidence of the process. The final section summarizes the key findings and covers the main implications of this analysis for the broader field of study.

Institutional Resilience in Times of Crisis

This section presents the three indicators of institutional resilience and assesses their status during the COVID-19 crisis in Romania. Table 1 includes these indicators and the subsections below explain the scores we provide to each of them.

Table 1: An Assessment of Resilience Indicators in Romania

Indicator	Score	Reasons for Score
Preparedness	2	Limited public expenditure and infrastructure Outdated facilities Migration of healthcare workers
Agility	3	Centralised decision-making Slow reacting hospital management
Robustness	3	Specialised infectious disease hospitals Integrated emergency services

Preparedness

There are many signs that the healthcare system in Romania was not prepared for the pandemics. We provide a score of 2 for three reasons. First, Romania has the lowest public expenditures on healthcare in the EU, way below the average. In terms of percentage of the GDP, Romania allocates 5% to health compared to 9.8% the EU average. In terms of per capita expenditure, Romania has 1,029 € compared to 2,884 € as the EU average (Eurostat 2020). This low healthcare expenditure is reflected in a lack of appropriate medical infrastructure and medical supplies. For example, hospitals had a low testing capacity and insufficient beds for intensive care units. In general, there was limited medical equipment for the pandemics. Based on the European Centre for Disease Prevention and Control data, the testing capacity

in Romania was lower than half the EU average, with only 1,090 weekly tests per 100,000 persons during the peak month of November 2020. This was the lowest testing capacity level in the EU - alongside Bulgaria – while the positivity levels in the country in the same interval were double that of the EU average levels (ECDC Website 2021). At the national level, only a little over 1,000 intensive care units (ICU) with ventilators existed in Romania at the beginning of the pandemics, despite having over 500 hospital beds per 100,000 persons compared to the EU average of approximately 300. Throughout the peak of the pandemics in 2020, ICU capacity was full, with many new admissions unable to receive specialised care.

Second, most health facilities in Romania were outdated, built during the communist period, with non-systematic facility improvement over the past decades, and heavily skewed towards some regional poles. The territorial network of medical facilities was not equipped to manage appropriately specialised treatment such as intensive care. Even early diagnostic and at-home care was problematic in many of the poorer counties in Romania, where the number of general practitioners has decreased significantly over the previous decade (Social Monitor 2021). The hospital units did not meet the safety and hygienic-sanitary norms, determining increased risk of infections and a high degree of unsatisfied medical needs. There were several fire incidents with multiple casualties in public hospitals during the first year of the pandemics occurred because of poor safety measures and implementation of technical standards.

Service delivery is affected by the poor medical infrastructure in Romania. Roughly 11% of the population remains uninsured and has access only to a restricted package of services. There is a decreasing trend in the coverage of healthcare insurance in Romania, with a significant gap between urban and rural areas. The level of unmet medical needs is about 28% higher in rural areas than in the whole country (Ministry of Investments and European Projects 2021). This is reflected in the poor accessibility to specialised care for less developed regions and rural areas. Almost 20% of healthcare expenses are out-of-pocket in Romania, which rises to almost 50% for chronic disease such as cancer where patients travel sometimes up to 12 hours to reach a specialised treatment centre or wait for up to 6 months for a diagnosis (Volintiru et al. 2021).

Third, the Romanian healthcare system is plagued by a massive exodus of medical staff, especially in key specialisations for pandemics such as nurses or intensive-care personnel (Interview Vlad Mixich 2021). Until recently, the public sector salaries in Romania were very

low compared to private sector employment. The austerity measures in 2009 meant a further 25% decrease of healthcare salaries that led to outward migration of medical personnel (Interview with Raed Arafat 2021). Although in the recent years there is a significant rise in the wages of medical personnel, there is a time lag in retaining future generations of medical professionals. In 2017, Romania had 2.9 doctors and 6.7 nurses per 1,000 inhabitants compared to the EU average of 3.6 doctors and 8.5 nurses (Eurostat 2020). Drawing back medical personnel is much harder to achieve. Romania's public healthcare system has a deficit of almost 40,000 healthcare workers today, equivalent to 17.46 per cent of staffing needs at public hospitals (Gillet 2020).

Agility

The assessment of agility for the Romanian healthcare system is done relative to the swiftness of reaction and to the type of decision-making process. We provide a score of 3 for two main reasons. First, there was a centralised decision-making system characterised by speed and coordination (Interview with Raed Arafat 2021). At central level, there was a prompt reaction about the threat of the pandemics. A state of emergency was declared in March 2020, allowing for an increased effectiveness of governmental measures especially in imposing and enforcing restrictions. Government measures aimed at diminishing the spread of COVID-19 before vaccination involved travel restrictions, curfew, and quarantine. These measures had a direct negative impact on the economic activity in a country with a GDP linked greatly to consumption. Consequently, gradual relaxation ensued and the initial advantage from the agile reaction in the beginning of the pandemics in terms of controlling the spread of the disease was lost by the fall of 2020 when the number of cases rose significantly.

Second, the capacity of the healthcare system components such as hospitals or local directions of public health in charge of the epidemiological management varied greatly, and so did the agility of their reactions. Better organized institutions had an agile reaction in adopting national regulations and developing their own internal procedures. However, in Romania hospital management is usually filled by medical professionals. Due to either heavy work burden of medical care or to poor managerial specialization, the hospital administrative procedures are often lagged. Overall, hospitals had a slow reaction both in terms of internal organization (e.g., access circuits in hospitals) and of logistics and acquisitions (e.g., public procurement for ventilators or personal protection equipment). For example, most of the first

line medical personnel lacked personal protective equipment for several months after the beginning of the pandemics. Time-consuming public procurement procedures at hospital level made the system highly ineffective in ensuring necessary supplies. Due to this low agility of public institutions regarding the public procurement, much of the medical staff got sick and there was high incidence of COVID-19 infections during hospitalisation.

Robustness

Two dimensions of the Romanian health system contribute to a score of 3 for the robustness of the healthcare system: the specialised infectious disease hospitals and the emergency services. First, the Romanian healthcare system managed to turn one of its liabilities into a key capability during pandemics. Romania has a relatively high number of stand-alone dedicated facilities because of high incidence of infectious disease. Furthermore, being old buildings from the in-between the war period, many Romanian hospitals still have a pavilion-based architecture that facilitated the safety circuits for the care of COVID-19 patients (Interview with Medical Professional 2021).

The second element of robustness in the Romanian healthcare system is the emergency service. The system has a complementary Department for Emergency Situations within the Ministry of Internal Affairs that coordinates all emergency services including fire and rescue, civil protection, prehospital medical emergency response, air rescue and emergency departments. The Department coordinates the Mobile Emergency Service for Resuscitation and Extrication in collaboration with county, regional and local public authorities. This structure integrates the reanimation teams specialized in providing emergency medical and technical assistance, as well as teams with paramedical personnel, specialized in granting qualified first aid are integrated. This integrated emergency system compensated to a large extent many of the institutional weaknesses of hospitals related to quick reaction. It offered standardized procedures and action plans, coordinated hospital needs and resources, and addressed to the best of its ability the many disparities of capacity across Romanian medical facilities.

Stocks of key medical equipment such as ventilators and personal protection equipment became a norm of preparedness for healthcare systems around the globe (Ranney et al 2020). As hospital management procedures were moving decisively towards efficiency and diminishing costs (Eurofound 2017), the general assumption was that it was not worth

having large stocks of such products. Hospital managers in Romania struggled with a trade-off between efficiency and the resilience of their institution in the face of a medical crisis like COVID-19 (Interview with Hospital Manager 2021). While the national authorities recognize the resilience requirement of stocks to achieve the robustness of the healthcare system, national auditing institutions have changed their legal position thus creating the potential for future blockages (Interview with Raed Arafat 2021).

Finally, the healthcare system in Romania is plagued by corruption that affects both the immediate and long-term resilience of the healthcare system. As medical professionals in Romania were scrambling to get personal protection equipment on their own, the national procurement agency was still engaging in kick-back negotiations with overpriced suppliers (Gascón Barberá 2020).

Societal Impact of Resilience in Romania

This section assesses the impact in society generated by the three resilience indicators described above. Our analysis shows that the effects are two-sided. On the one hand, the poor delivery of healthcare services and the large subnational disparities continued to exist. The long-lasting vulnerabilities of the healthcare sector (e.g., poor funding, inefficiency) led to a very poor capacity to manage the crisis at local level in many instances. Despite an agile reaction from central authorities, the large territorial imbalances in both material and human resource distribution led to a differentiated impact of the healthcare system. Richer regions in the West of the country had a better service provision and lower average mortality rate per capita than in the Eastern regions. The latter had both a poorer local epidemiological management and major problems with hospital facilities (e.g., fire). Low stocking and corrupt practices affected the robustness of the healthcare system overall. The poor transmission belt of procedures and capabilities in times of crisis left many localities vulnerable in the face of a crisis and lowers the overall societal impact of the healthcare system in Romania.

On the other hand, there was good cooperation between the public and private sector to address imminent needs during the pandemic. Their consolidated capabilities over recent years provided a strong compensatory function during the first year of the COVID-19 pandemics. The general uncertainty and slow institutional reactions were compensated by some of the local civil society organizations' strong track record in mobilizing broad stakeholder support for healthcare service provision. For example, in a context of scarce

personal protection equipment for medical personnel, 74% of general practitioners in the city of Cluj-Napoca reported assistance from the civil society in the form of donations of personal protection equipment (National Federation of Employers of Family Physicians in Romania 2020).

The public-private cooperation

The public-private cooperation was illustrated by the Association for Community Relations relationship with the Ministry of Health and the Department for Emergency Situations. This association mobilized its network of donors, organizations, and partner local authorities to identify and assist in solving urgent needs. The latter include providing medical supplies to hospitals and the creation of a testing facility at the border in a context of massive population return from abroad following restrictions across Europe. It provided over 14 million € in the first several months of the pandemics to assist vulnerable groups across the country (Interview with Alina Kasparovschi 2020).

The Department for Emergency Situations built long-standing relationships with specific civil society organizations in preparation for a disaster such as a major earthquake and based on capacity, resources, or knowhow these associations were designated official partners of the Department (Interview with George Manea 2020). For example, the Department for Emergency Situations built on a long-standing partnership with the Romanian Red Cross Foundation. This partnership is now framed in the institutional procedure: in case of a disaster the Red Cross can coordinate the national response and relief efforts (Interview with Alexandra Calin 2020). For example, at local level, in Suceava which was amongst the worst hit cities in Romania in the first quarter of the pandemics, over 1 million € were raised by local entrepreneurs in a fortnight and used through the local branch of the Red Cross for medical and protective equipment for medical units in Suceava (World Bank 2020: 70).

The COVID-19 crisis led to a new wave of civic involvement in Romania, which included formal and informal groups motivated by the crisis. This web of support networks included civil society organizations, private companies with existent corporate social responsibility (CSR) track-record (e.g., Vodafone Foundation)¹, private individuals willing to offer their time

¹ According to the Romanian legislation (Law 32/1994), company donations can be redirected from fiscal duties for social responsibility purposes in the amount of 5% of the annual turnover, or 20% of the annual profit tax. This provides a relatively attractive possibility for societal involvement.

as volunteers or financial resources in donations, and public bodies from local governments to national entities. A key element of this multi-stakeholder cooperation proved to be the ability of all parties to communicate with each other, as hospital staff or public authorities identified needs, and civil society organizations or private companies stepped up to help.

The civil society organizations have brought over time significant improvements to the public healthcare system. For example, *Daruieste Viata* (Offer Life) is a leading Romanian civil society organization established in 2012 with the mission “to reform the Romanian medical system, convince authorities to respect the right to life and treatment, implement large-scale projects so that cancer patients receive proper treatment and support in Romania”. It has set up the Elias 1 Modular Hospital to ensure treatment conditions for patients with COVID-19. It also rebuilt the Piatra Neamt Modular Hospital for COVID-19 patients after a fire. Similarly, following pre-existent projects related to hospital renovation and modernization, companies such as Vodafone or Kaufland supported the Piatra Neamt Modular Hospital.

Sometimes, due to the traditionally poor relationship between civil society and state authorities, several civil society organizations collaborated directly with medical personnel to identify the required support actions. They developed coordinated actions amongst themselves for fundraising from private donations. To use the same example, *Daruieste Viata* communicated directly with the medical staff via an online platform regarding necessary equipment and supplies, and donated 17 tons of equipment to 180 hospitals in Romania just in the first quarter of the pandemics (World Bank 2020: 71).

The limited resources of some hospitals were boosted ad-hoc by donations from private companies. We cover in this article two of the most visible actors with specific forms of engagement. Vodafone Romania is a phone company that has long established a distinctive Foundation, which over the past two decades has financed over 1,132 programs with 730 local civil society partners in the fields of health, education and social services. Some of its leading programs with a relevant impact during the COVID-19 crisis included delivering tablets and laptops to schools, kids and teachers, thus mediating the sudden shift to online learning in Romania. Vodafone responded very quickly to requests of digital support in medical facilities as well, all throughout the crisis, having established round-the-clock crisis management units within its organization (Interview with Ioana Tinca 2021). It collaborated with local associations to create testing facilities at the Romanian border and continued to provide 1 million € grants for the renovation of maternity wards across Romania.

Kaufland Romania is a supermarket franchise that partnered with an established civil society platform in Romania over the past years, as it implemented with the Foundation for the Development of the Civil Society a program called “Stare de bine!” (Wellness State) offering over 1 million € in grants to local civil society organizations for projects related to cultural activities, sports, or healthy lifestyle (Website Wellness State. 2021). Kaufland Romania was ranked as the leading company in Romania in terms of sustainability: a total of 7.7 1 million € invested in projects of corporate social responsibility with 2.41 million beneficiaries (Romania CSR Index 2020).

Conclusions

This article aimed to examine the extent to which the healthcare system in Romania was resilient in the face of the COVID-19 crisis. With the help of the three indicators proposed by this symposium the analysis showed that the preparedness was low, while the agility and robustness were average. Overall, the institutional resilience benefitted from the involvement of private companies and civil society. This involvement however provided an ad-hoc compensatory function and did not reflect a structured pre-existing partnership between private sector actors and the public healthcare sector in this country.

A poor institutional track record amplified the vulnerabilities of the healthcare system during the crisis. Nevertheless, the COVID-19 crisis offered the chance to develop new cooperation and trust relationships amongst different stakeholders. While the crisis context usually meant a trade-off between health and economic security, the stakeholder cooperation in Romania proved to be a strategy pursued by both public and private sector actors. For a long time, scholars have pointed to the fact that the relationship between the public and the private sector is broken (Mazzucato 2020), with private sector usually trying to avoid any form of regulatory oversight from the state. However, the COVID-19 pandemics outlined once again the deep societal interdependence, and the need to move forward in a new multi-stakeholder form of cooperation. The latter produced an impact in society, which complemented the direct effects of the resilience indicators.

There are two important lessons to be drawn from this article. First, the assessment of resilience indicators reflects the reaction of the healthcare system in Romania during the COVID-19 pandemics. This means that the analytical framework proposed by this symposium works well in this specific single-case study and could be tried in other settings. Second, the

public-private partnership between state institutions and several private companies and civil society organizations provided a compensatory function to the public healthcare system in Romania. The compensatory function means delivering quasi-public goods and services to fill an unmet need in society. The low state preparedness, limited hospital agility and the magnitude of the crisis pushed for such a partnership in times of crisis.

Further research could follow two distinct paths. On the one hand, it may focus on possible explanations for how the public private cooperation improves the scores on the three indicators of resilience covered here in the long and short run. On the other hand, future studies could discuss in detail the link between the resilience indicators and impact in society. We suggest an argument about the compensatory function of the public-private partnership, but there could be more hidden under the surface.

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