# Romania

## Health Care & Long-Term Care Systems

An excerpt from

**the Joint Report on Health Care and Long-Term Care Systems & Fiscal Sustainability,**

published in October 2016
as Institutional Paper 37
Volume 2 - Country Documents

*Economic and Financial Affairs*
*Economic Policy Committee*

# Romania

Health care systems

# 1.23. ROMANIA

## General context: Expenditure, fiscal sustainability and demographic trends

### *General statistics: GDP, GDP per capita; population*

In 2013, GDP per capita (12,700 PPS) in Romania was one of the lowest in the EU. Romania's economy has grown significantly since accession to the European Union, but the country is still facing important development challenges. In light of a continuously difficult economic and fiscal situation, Romania was under three precautionary Balance-of-Payments assistance programmes provided by the European Union and the International Monetary Fund. Health care reforms were part of the conditionality agreed under the programmes. Current population is estimated at 20.0 million. Romania's population is characterised by a declining growth with an ageing population and a rising share of older age cohorts. The population is projected to decrease to 17.4 million until 2060.

### *Total and public expenditure on health as % of GDP*

Romania has historically committed a relatively low share of its GDP to health care. Total expenditure on health was at 5.3% of GDP in 2013, i.e. nearly half the EU expenditure level (EU: 10.1% in 2013). Public spending on health was at 4.3% of GDP (EU: 7.8%). Spending relative to GDP has been relatively constant since 2003. In 2013, only 8.4% of total government expenditure was channelled towards health spending ([241]) (EU: 14.9%). In per capita terms, total (767 PPS) and public spending (607 PPS) are well below the respective EU averages (2,988 PPS and 2,208 PPS). However, per capita expenditure has tripled in the past ten years.

### *Expenditure projections and fiscal sustainability*

Public expenditure on health care is projected to increase by 1.0 pp of GDP (AWG reference scenario), above the average increase of 0.9 pp for the EU. When taking into account the impact of non-demographic drivers on future spending growth (AWG risk scenario), health care expenditure is expected to increase by 1.7 pp of GDP from now until 2060 compared to the EU average of 1.6 pps Overall, projected health care expenditure poses a risk to the medium and long-term sustainability of public finances. ([242]) Sustainability risks appear for Romania over the long run. These risks derive primarily from the unfavourable initial budgetary position, compounded by age-related public spending, notably for healthcare and long-term care. ([243])

### *Health status*

Health outcomes in Romania are lagging behind EU standards. Life expectancy at birth is 71.6 years for men and 78.7 years for women, far below the EU averages (EU: 77.6 for men and 83.1 for women). Also healthy life years are below the EU averages for women (57.9 vs. 61.8 years), and for men (58.6 vs. 61.6 years). Amenable mortality rates, i.e. deaths that should not occur with timely and effective care, are well above EU average (353 deaths in Romania versus 128 deaths in the EU per 100 0000 inhabitants). Infant mortality is at a high level of 9.2‰ in 2013 (EU: 3.9‰ in 2013).

## System characteristics

### *Administrative organisation, system financing, revenue collection mechanism,*

Law 95/2006 on Health Care Reform is the basic health care law in Romania, defining the role of social health insurance, private health insurance, hospitals organisation, community care, primary health care, pharmaceuticals, emergency services, public health, and national health programmes. The system is organised on two main levels: national/central and district. The national level is responsible for defining general objectives and ensuring the fundamental principles of government health policy; the main central institutions in charge are the Ministry of Public Health (MPH) and the National Health Insurance House (NHIH). The ministry defines the health policies, while NHIF autonomously administrates the social health insurance system. The NHIF is the main

([241]) This is according to the Classification of the functions of government (Cofog) data. According to national data, the figure is 11.6% in 2013.

([242]) The 2015 Ageing Report: http://europa.eu/epc/pdf/ageing_report_2015_en.pdf

([243]) Fiscal Sustainability Report 2015: http://ec.europa.eu/economy_finance/publications/eeip/pdf/ip018_en.pdf

financial source of the system receiving contributions collected by National Agency for Fiscal Administration (NAFA). Through an annual framework contract, the health care services are contracted between the NHIH and providers as well as the MPH.

Financing is based on income related health insurance contributions. The rate is 10.7% of payroll, of which the employer pays 5.2% and the employee 5.5%. The self-employed categories pay 5.5% of their earnings. Theoretical coverage is 100% of the population. Many groups including children, dependants, disabled, unemployed, military personnel and war veterans, and those on sickness or maternity leave have free access to health insurance. Due to these exceptions there are around 5 million contributors and 20 million beneficiaries. Overall, the revenue base is very narrow.

A total of 42 District Health Insurance Funds (DHIFs) purchase and reimburse care for their respective population by establishing contracts with care providers, while the NHIH, which regulates and administers the mandatory health insurance, establishes contracts with the College of Physicians, defining remuneration systems. The State budget (through taxation revenues) covers public health services funding (health promotion and disease prevention activities) and capital investment. The basic benefits package is defined yearly in agreement between the NHIF and the Ministry of Health, and approved by the Government.

Since 2009, with the support of the European Commission (EC), the World Bank, and the International Monetary Fund (IMF), the Government of Romania has been working on a structural reform of its health care system. The reform program seeks to put emphasis on primary and secondary prevention, reduce unnecessary inpatient admission services, and develop sustainable access to higher-quality secondary ambulatory services. Recently, a new basic benefits package was approved for this purpose. A hospital rationalisation plan was developed and some small hospitals were closed. A simple Health Technology Assessment (HTA) tool has been implemented for evidence-based access to essential technologies, and some medicines without proof of health benefits were excluded from the list of compensated drugs, resulting in budgetary savings. The basic package should be fully functional in three to five years, and during this period it is necessary to perform continuous monitoring, timely evaluation, and economic/budget impact analysis in order to adjust the package to the population health needs, in accordance to health system performance targets.

The pace of health sector reform implementation has been slow due to the lack of resources to finance some critical steps necessary to support the new policies, as well as lack of administrative capacity. It is a challenge to consolidate the current hospital structure if an alternative modern ambulatory service is not fully functional before closing down and eliminating unnecessary beds. Merging fragmented services from multi-building hospitals cannot be easily completed without the rehabilitation of an appropriate building to host the new comprehensive and articulated hospital.

### *Coverage and role of private insurance and out of pocket co-payments*

Social health insurance is compulsory for all citizens and for foreigners residing in the country.

The share of private total health expenditure (20% in 2013) is below the EU average of 23%, as a result of a large reduction in out-of-pocket expenditure (19.4% of total health expenditure in 2011 vs. 34% in 2001) and the efforts by national authorities to improve access to care for certain groups of the population. However, there remains about 5% of the population that is not correctly insured and cannot access services because they do not pay contributions, lack the appropriate official papers and residency requirements or have not registered with a family doctor/GP. There are plans to give the uninsured access to certain preventive health programmes on top of emergency care.

Access to healthcare remains a major concern. Despite a mandatory health insurance system, only 86 % of the population was insured in 2014. Compared with a EU average of 3.7 %, 10.4 % of the Romanians report having had unmet healthcare needs due to cost, distance or waiting times. Widespread informal payments add to the costs and are among the main reasons for poor access to healthcare, especially for patients with low income. Access to healthcare is further hindered by

the unavailability of health professionals. The number of physicians and nurses per inhabitant is very low compared with the EU average, mainly due to the emigration of qualified physicians to other EU countries, poor working conditions and low salaries. Despite this situation, there is no formal strategy on healthcare human resources in place.

Current cost-sharing rules do not necessarily encourage a greater use of primary care services vis-à-vis specialist and inpatient care, or a greater use of more cost-effective services, although they encourage the use of generics. In April 2013, co-payments for certain medical services were introduced. Contributions are between RON 5 and 10 per patient. Emergency care, family doctors and medical laboratories do not charge the co-payment. Children up to 18 years, youth aged 18-26 without income, pregnant women, war veterans, persons with chronic diseases, and pensioners receiving a pension benefits inferior to RON 740 per month are exempted from these co-payments.

There are reports of significant informal (non-official) payments. While they may increase the income of physicians, informal payments do not bring additional revenues to the insurance funds, do not encourage a more effective use of services and constitute an additional barrier to access as there are no exemptions for low income or high risk groups. Some studies estimate that they increase out-of-pocket expenditure to more than 30%. Hence, it would be worth investigating if the current cost-sharing could be adjusted to encourage greater use of more effective and cost-effective services: e.g. more use of primary care than specialist care, more health promotion and disease prevention activities (e.g. vaccination), more cost-effective pharmaceuticals, while tackling informal payments.

Private insurance companies can offer supplementary and/or complementary health insurance. Packages cover the services not included in the basic benefit package, higher-comfort hospital accommodation and co-payments charged by providers for the services included in the basic benefit package. Eligibility for private co-insurance is conditioned on paying the mandatory contribution for the basic package of services.

### *Types of providers, referral systems and patient choice*

Public and private provision coexist. Primary care is provided by independent general practitioners and nurses operating in private practices. Ambulatory specialist care is provided in specialised centres and hospital outpatient departments. Inpatient hospital care is provided in hospitals, mostly publicly owned, and is increasingly under the responsibility of local authorities. All these providers establish contracts with the NHIF.

The total number of practising physicians per 100 000 inhabitants (264 in 2013) is well below the EU average (344 in 2013), but has been rising continuously throughout the last decade. This may explain the difficulties in availability and distribution of physicians across the country. Data on the physician skill-mix indicates that the number of GPs per 100 000 inhabitants (64 in 2013) is below the EU average (EU: 78). Moreover, GPs seem to have a limited medical role in health care delivery. The number of nurses (601 in 2013) per 100 000 inhabitants is below the EU average of 837. Romania has suffered heavily from staff migration to other EU countries, where qualified health staff is needed and wage levels are higher.

National authorities have made limited efforts to enhance primary care financing and provision and strengthen the referral system from primary care to specialist doctors as well as the gatekeeping role of GPs (to reduce the unnecessary use of specialist and hospital care). All inhabitants have to register with a GP, who acts like a family doctor and as a gatekeeper referring patients to specialist and hospital care. However, despite it being mandatory, many have not yet registered with a GP and the referral system is often bypassed by some groups of the population. In addition, urgent /after-hours access to primary care services is very limited resulting in an unnecessary use of hospital emergency wards. Patients can choose their GP and choose the specialist and hospital after referral. This referral and coordination role is to be further enhanced through the use of ICT systems and the implementation of electronic patient records, as started in 2015, and electronic monitoring of prescriptions, which can help control expenditure. In 2014, the budget for primary care physicians

was increased to roughly 8% of expenditure by the NHIH. However, compared to the EU, the budget for primary care lags significantly behind.

Romania has seen only a modest reduction in the number of acute care beds per 100 000 inhabitants in the last decade (456 in 2003 vs. 450 in 2013) and its number is still higher than the EU average (EU: 356). Many hospital beds in Romania are however not necessarily used for acute care but for other purposes such as long-term hospitalisation of patients with chronic diseases. Further reductions in hospital capacity is an area where further improvements can still be made, but the total number of beds and its use will, in the medium and long-run strongly depend on the changes in the provision of long-term care services implemented in Romania (which can reduce bed blocking in acute care settings) as well as changes in surgical practices.

Public expenditure on inpatient care as a share of GDP is below the EU average (1.9% vs. 2.6% in the EU). However, inpatient care accounts for roughly 46% of public expenditure on health in Romania, compared to 34% in the EU. The number of hospital inpatient discharges was at a very high level, with 22 discharges per 100 inhabitants, in 2013 (EU: 16.5 in 2013).

Total and public expenditure on outpatient care as a share of GDP were below the EU average (0.6% and 0.4% vs. 2.2% and 1.8% in the EU). Total and public expenditure on outpatient care as a share of current health expenditure were also below the EU average (11% and 8% vs. 23% and 23% in the EU). Low expenditure may be a sign of a health system which is oriented away from ambulatory and towards hospital care, providing potential to increase the relatively cost-effective of care, by shifting away from hospital centric health care provision.

### *Price of healthcare services, purchasing, contracting and remuneration mechanisms*

Payments systems have evolved over the years involving a mixture of remuneration schemes. GPs receive a mix of capitation and fees for defined activities (health promotion, disease prevention and disease management activities). This mixed system intends to render primary care more attractive and provide incentives for primary care provision, including some health promotion, disease prevention activities and disease management. Ambulatory specialists are remunerated on a fee-for-service basis while hospital staff is paid on a salary basis. Acute care hospitals remuneration is based on prospective activity-based payment using DRGs and fee-for-services or flat rate per case. Although significantly improved and based on complex criteria, the basis for establishing contracts between the NHIH and the various providers could be further improved to favour cost-effective interventions in the long-run.

The introduction of a new benefits package would require a revision in health provider payment mechanisms. The hospital payment system is based on production of services (a Diagnosis Related Group [DRG] system, which was piloted in 2003 and implemented in 2005), but the system needs to be transformed to better estimate the costs and eliminate perverse incentives. For example, some mild cases that could be treated in ambulatory services are being admitted because the DRG system overestimates the cost of treating those cases. On the other hand, some more complex cases are being referred because the DRG value is below the real cost. In parallel, in primary care, NHIF allocates (6%) of the total insurance found introducing a cap in the annual contract that eliminate the incentives to increase the PHC services.

### *The market for pharmaceutical products*

Total spending on outpatient pharmaceuticals has reached a respectable level 1.8% of GDP in 2013, rising by from 1.1% of GDP in 2003. Overall, spending in the pharmaceutical sector grew faster than spending in the health sector. As a consequence, the share of pharmaceutical within total health expenditure has reached a high 35% (from 20% in 2003). This is one of the highest shares in the EU. Much of the growth in expenditure has been borne by the private sector financing of outpatient pharmaceuticals.

In order to control the spending bill for the public payer, pharmaceutical spending is limited by a defined threshold, and overspending is recuperated from the manufacturers (payback, claw-back system). The system has been criticised, because of the high overspending that has to be financed by

manufacturers, but has proved to provide an effective budget ceiling. The pharmaceutical budget is still structurally overspent increasing future fiscal risks. While overspending is recovered via the claw-back tax and is thus budget neutral, it has led to withdrawals of cheap generic medicines from the market. The planned revisions of the claw-back tax and of the public reimbursement for distributors of pharmaceutical products to incentivise the provision of low cost medicines to patients are yet to be implemented.

Recommendations regarding the listing of medicines on the national formulary are the responsibility of the National Transparency Committee (NTC). However the NTC Processes appear to be opaque and ad hoc. Recently, an interim HTA process was elaborated for the approval of new drugs, and since 2015, the Ministry of Health applies a rapid systematic HTA process to delist and enlist molecules from the list of reimbursable medicines.

With respect to pricing, there is extensive reliance on the use of external reference pricing for medicines manufactured outside Romania (with cost-plus pricing for those manufactured domestically). External reference pricing is based on the lowest price from within a basket of 12 EU countries according to an algorithm published by the Ministry of Public Health. However, prices have not been updated in the past years.

Prescription medicines are subsidised in accordance with four reimbursement lists:

- List A: includes most commonly used medicines (largely generics), reimbursed at 90% (10% co-insurance)
- List B: includes mostly originator medicines; reimbursed at 50% (50% co-insurance)
- List C: comprises medicines for chronic diseases included in the National Health Programs and/or for specific population groups (pregnant women, children, teenagers, etc.). List C medicines are fully reimbursed for eligible beneficiaries.
- List D: medicines without proven effectiveness, reimbursed at 20%.

### *Use of Health Technology Assessments and cost-benefit analysis*

An interim Health Technology Assessment (HTA) tool to implement evidence-based access to essential technologies has being implemented, and reimbursement rates of some medicines without proof of health benefits were reduced to 20% from the list of compensated drugs, resulting in significant savings. Based on the tool, the list of subsidised medicines based on was undertaken in 2015.

### *Corruption*

Corruption is present in many economic sectors and involves appointed and elected officials at all levels of government as well as civil servants and employees of public institutions. This is borne out by the record of criminal investigations and convictions for corruption ([244]). Preventing corruption in public administration was one of the key priorities of the 2012-2015 national anti-corruption strategy. The evaluation of the strategy shows some progress in putting in place corruption prevention measures at the level of national administration. It concludes, however, that local administration structures are severely lagging behind in terms of building up the necessary capacity to prevent corruption effectively. The government plans an extension of the strategy that will include additional measures to remedy the weaknesses identified in the evaluation.

Corruption remains a challenge in the health sector, despite some recent action to combat the problem. Oversight of public procurement contracts in the health sector is insufficient (see section 3.1). The centralised procurement unit in the Ministry of Health is heavily understaffed and its mandate covers only 25 % of hospitals. The lack of transparency in medical reimbursements constitutes a severe challenge in putting in place measures to prevent fraud and corruption over reimbursement claims. This has a direct impact on the health budget. Although services provided in private health units are partially covered by public funds under the single national health insurance scheme, they are not included in the monitoring exercise for the use of public funds. While healthcare was one of the key sectors addressed by

([244]) COM (2016) 41 final; SWD (2016) 16 final.

the 2012-2015 national anti-corruption strategy, the sectorial strategy did not produce tangible results. The challenge facing the renewed sectorial strategy is to integrate the findings of existing policy assessments into a comprehensive approach that extends to all relevant players and processes.

### Recently legislated and/or planned policy reforms

Romania has embarked on a set of reforms in recent years. A National Health Strategy 2014-2020 was approved by the end of 2014. The strategy covers the following areas: public health and health care (with a focus on improving the health of women and children, reduce morbidity and mortality of non-communicable diseases ensuring equitable access – especially for vulnerable groups – to healthcare quality and efficient in terms of cost), health research, eHealth technologies and health infrastructure (the national, regional and local).

Several pilot projected were implemented, such as to improve access to health care for vulnerable persons, programs for prevention and curative health of women and children, to increase the access of persons belonging to remote and isolated communities to health care.

In addition, in 2014 a new package of basic health services was approved, introducing chronic disease management provided by family doctors. At the primary health care level, preventive consultations were introduced for people over the age of 18 to check for certain major diseases and conditions.

Also day hospitalisations were regulated and their financing improved to reduce excessive use and duration of hospitalisations. The basic package aimed to decrease admissions to hospitals, increase the number of cases resolved in day- care facilities and to establish the conditions for the development of primary health care and ambulatory services. Under the package, certain diagnoses (104 medical conditions), surgical procedures (96) and medical services (36) will be dealt with in day-care facilities. Admission to hospital is allowed, however, in cases of medical need.

In order to generate savings, a centralised procurement system was developed and the capacity of centralised procurement unit enhanced, focusing on the procurement of medicines, vaccines and of other medical supplies. In 2014, there were 15 centralised procurements for drugs, vaccines and other medical supplies, with savings of more than RON 47 million.

In order to modernise the IT infrastructure, following the introduction of electronic prescriptions in 2012 a system of eHealth cards was implemented in 2015. Cards serve as a mandatory tool for reimbursement for most medical services delivered by registered providers. NHIH distributed more than 15 million health insurance cards, and health insurance card usage commenced in February 2014 and became mandatory on 1 May 2015. In 2014, NHIH also implemented the electronic patient file system, replacing the prior hard-copy patient file system. The electronic file system is currently functional and accessible.

In order to reduce the excessive use of hospitalisation, the funds allocated for outpatient care and primary health care were increased to encourage treating patients in ambulatory specialist and the family physician. Additional funds have been allocated for primary care from RON 1424.9 mln in 2014 (6.7%) to RON 1513.7 mln in 2015 (6.97% from total health expenditure of NHIH). In the period 2016-2018 the aim is that of an annual increase of 5% (compared to the allocation for 2015) of funds for primary health care. In 2016 the budget for primary care is in the amount of 1515.5 million (including permanent centres), approximately at the level of 2015, and it represents 6.97% of total health care expenditure of NHIH, excluding amounts for cost-volume contracts and cost for salary increases related to personnel paid from public funds provided by GEO 35/2015.

To reduce informal payments, the project Good Governance in the health system aims to develop a coherent policy to prevent and combat corruption in health.

To increase the quality of care and reduce vulnerabilities, the order regarding ethics council in public hospitals, regulating the organisation of a system for monitoring and control of notifications and complaints regarding patients' rights and their abuse to healthcare professionals, was approved.

In line with strategic directions of the health strategy, an analysis on the resources needed to modernise the healthcare infrastructure was developed and set out in the World Bank project which was negotiated with representatives of the World Bank. A loan was also approved by the World Bank Board in March 2014 in this regard, and the project has become effective in 2015. The main objectives of the project on health sector reform - improving the quality and efficiency of the health system are:

- rationalising the hospital network by providing goods, services other than consulting, advisory services and training in emergency regional hospitals, district hospitals and regional hospitals selected;
- strengthening secondary care outpatient specialist by providing goods, works, services other than consulting, consultancy and training;
- improving the capacity of the Ministry of Health and other relevant government institutions for governance and management sector, to reduce the gap between policy and practice and to reinforce the capacity and improve quality of care by providing goods, works, services other than advisory, consultancy and training; and
- supporting the Ministry of Health and the Project Management Unit (PMU) in the management and implementation of the project, including fiduciary duties, monitoring, evaluation and reporting by providing goods, works, services other than consulting, consulting services, training, audit and operational costs.

### Challenges

The analysis above shows that a number of reforms have been implemented over the years aiming to improve the efficiency of care delivery and which Romania should continue to pursue. Reforms have met with a number of obstacles and there is still room for improvement in core areas of care. The main challenges for the Romanian health system are as follows:

- To continue increasing the efficiency of health care spending in order to adequately respond to the increasing health care expenditure over the coming decades, which is a risk to the long-term sustainability of public finances.
- To improve the basis for more sustainable and larger financing of health care in the future to improve access as well as quality of care and its distribution between population groups and regional areas.
- To increase equity in financing of care and tackle informal payments.
- To define a comprehensive human resources strategy to ensure a balanced skill-mix, avoid staff shortages and motivate and retain staff to the sector.
- To continue to enhance and better distribute primary health care services and basic specialist services to improve equity of access and the effectiveness and efficiency of health care delivery; to ensure an effective referral systems from primary to specialist and hospital care and improving care coordination between types of care, notably by ensuring that users register with their GP and through the development of electronic patient records in the future.
- To continue the efforts to decrease over and unnecessary use of hospital inpatients care by decreasing the number of hospital beds, through hospital restructuring and rationalisation: to increase day case surgery, to improve the provision of after-hours primary care services, and to reduce the number of uninsured who tend to use emergency services rather than primary care services (which are not covered to large extent).
- To make more use of cost-effectiveness information, as planned, in determining the basket of goods and the extent of cost-sharing and define the latter to induce cost-effective behaviour. To explore if current cost-sharing could be adjusted to encourage greater use of more effective and cost-effective services: e.g. more use of primary care than specialist care, more health promotion and disease prevention

activities (e.g. vaccination), more cost-effective pharmaceuticals.

- To reduce the causes of structural overspending of the pharmaceutical budget, increasing the cost-effectiveness of prescribed and used medicines, which could make more room for financing of new cost-effective innovations.

- To tackle corruption in the health system.

- To continue to improve accountability and governance of the system and identify possible cost-savings in the health sector administration, as it currently involves many national and district institutions. To ensure that resource allocation between regions is not detrimental to poorer regions.

- To continue to improve data collection and monitoring of inputs, processes, outputs and outcomes so that regular performance assessment can be conducted and use to continuously improve access, quality and sustainability of care.

- To clearly establish public health priorities and enhance health promotion and disease prevention activities, i.e. promoting healthy life styles and disease screening given the recent pattern of risk factors (smoking, alcohol) and the pattern of both infectious and non-infectious diseases.

Table 1.23.1: **Statistical Annex – Romania**

| General context | | | | | | | | | | | | EU- latest national data | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **GDP** | **2003** | **2004** | **2005** | **2006** | **2007** | **2008** | **2009** | **2010** | **2011** | **2012** | **2013** | **2009** | **2011** | **2013** |
| GDP, in billion Euro, current prices | 53 | 61 | 80 | 98 | 125 | 142 | 120 | 127 | 133 | 134 | 144 | 9289 | 9800 | 9934 |
| GDP per capita PPS (thousands) | 13.5 | 13.4 | 12.8 | 13.4 | 13.7 | 13.8 | 12.5 | 12.6 | 12.7 | 13.0 | 12.7 | 26.8 | 28.0 | 27.9 |
| Real GDP growth (% year-on-year) per capita | 5.7 | 9.1 | 4.8 | 8.5 | 7.9 | 9.2 | -5.8 | -0.6 | 2.8 | 1.0 | 3.9 | -4.8 | 1.4 | -0.1 |
| Real total health expenditure growth (% year-on-year) per capita | -1.2 | 11.8 | 5.6 | 0.4 | 11.1 | 13.4 | -2.0 | 4.5 | -3.2 | 0.3 | -0.2 | 3.2 | -0.2 | -0.4 |

| **Expenditure on health*** | | | | | | | | | | | | **2009** | **2011** | **2013** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Total as % of GDP | 5.3 | 5.5 | 5.5 | 5.1 | 5.2 | 5.4 | 5.7 | 6.0 | 5.6 | 5.6 | 5.3 | 10.4 | 10.1 | 10.1 |
| Total current as % of GDP | 5.2 | 5.4 | 5.5 | 5.0 | 5.1 | 5.3 | 5.6 | 5.8 | 5.5 | 5.5 | 5.2 | 9.8 | 9.6 | 9.7 |
| Total capital investment as % of GDP | 0.1 | 0.0 | 0.0 | 0.0 | 0.1 | 0.2 | 0.1 | 0.1 | 0.1 | 0.1 | 0.2 | 0.6 | 0.5 | 0.5 |
| Total per capita PPS | 236 | 303 | 358 | 398 | 497 | 663 | 678 | 751 | 751 | 790 | 815 | 2828 | 2911 | 2995 |
| Public as % of GDP | 4.5 | 4.1 | 4.4 | 4.1 | 4.3 | 4.5 | 4.5 | 4.8 | 4.4 | 4.5 | 4.3 | 8.1 | 7.8 | 7.8 |
| Public current as % of GDP | 4.4 | 4.0 | 4.4 | 4.0 | 4.2 | 4.3 | 4.4 | 4.7 | 4.3 | 4.4 | 4.1 | 7.9 | 7.7 | 7.7 |
| Public per capita PPS | 194 | 222 | 286 | 312 | 397 | 513 | 518 | 575 | 596 | 634 | 650 | 2079 | 2218 | 2208 |
| Public capital investment as % of GDP | 0.1 | 0.0 | 0.0 | 0.0 | 0.1 | 0.2 | 0.1 | 0.1 | 0.1 | 0.1 | 0.2 | 0.2 | 0.2 | 0.1 |
| Public as % total expenditure on health | 84.8 | 74.5 | 80.4 | 79.8 | 82.1 | 82.0 | 79.0 | 80.3 | 79.3 | 80.2 | 79.7 | 77.6 | 77.2 | 77.4 |
| Public expenditure on health in % of total government expenditure | 10.4 | 7.4 | 8.0 | 7.6 | 9.7 | 9.7 | 10.2 | 10.2 | 10.4 | 10.4 | 11.4 | 14.8 | 14.9 | : |
| Proportion of the population covered by public or primary private health insurance | : | : | : | : | : | : | : | : | 100.0 | 100.0 | : | 99.7 | 99.7 | 98.7 |
| Out-of-pocket expenditure on health as % of total expenditure on health | 15.1 | 24.3 | 18.5 | 20.0 | 17.6 | 18.2 | 20.8 | 19.6 | 20.7 | 19.5 | 19.7 | 14.1 | 14.4 | 14.1 |

Note: *Including also expenditure on medical long-term care component, as reported in standard internation databases, such as in the System of Health Accounts. Total expenditure includes current expenditure plus capital investment.

| **Population and health status** | | | | | | | | | | | | **2009** | **2011** | **2013** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Population, current (millions) | 21.5 | 21.5 | 21.4 | 21.3 | 21.1 | 20.6 | 20.4 | 20.3 | 20.2 | 20.1 | 20.0 | 502.1 | 504.5 | 506.6 |
| Life expectancy at birth for females | 75.1 | 75.1 | 75.4 | 76.1 | 76.8 | 77.5 | 77.7 | 77.7 | 78.2 | 78.1 | 78.7 | 82.6 | 83.1 | 83.3 |
| Life expectancy at birth for males | 67.9 | 67.8 | 68.4 | 69.0 | 69.5 | 69.7 | 69.8 | 70.0 | 70.8 | 70.9 | 71.6 | 76.6 | 77.3 | 77.8 |
| Healthy life years at birth females | : | : | : | : | 62.5 | 62.9 | 61.7 | 57.5 | 57.0 | 57.7 | 57.9 | : | 62.1 | 61.5 |
| Healthy life years at birth males | : | : | : | : | 60.5 | 60.0 | 59.8 | 57.3 | 57.4 | 57.6 | 58.6 | : | 61.7 | 61.4 |
| Amenable mortality rates per 100 000 inhabitants* | 233 | 223 | 225 | 216 | 198 | 185 | 182 | 179 | 357 | 353 | : | 64.4 | 128.4 | : |
| Infant mortality rate per 1 000 life births | 16.7 | 16.8 | 15.0 | 13.9 | 12.0 | 11.0 | 10.1 | 9.8 | 9.4 | 9.0 | 9.2 | 4.2 | 3.9 | 3.9 |

Notes: Amenable mortality rates break in series in 2011.

| **System characteristics** | | | | | | | | | | | | EU- latest national data | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Composition of total current expenditure as % of GDP** | **2003** | **2004** | **2005** | **2006** | **2007** | **2008** | **2009** | **2010** | **2011** | **2012** | **2013** | **2009** | **2011** | **2013** |
| Inpatient curative and rehabilitative care | 2.28 | 1.97 | 2.02 | 1.87 | 1.84 | 1.93 | 2.09 | 2.35 | 1.89 | 1.98 | 1.92 | 3.13 | 2.99 | 3.01 |
| Day cases curative and rehabilitative care | 0.00 | 0.09 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | : | 0.13 | 0.18 | 0.18 | 0.19 |
| Out-patient curative and rehabilitative care | 0.51 | 0.52 | 0.50 | 0.42 | 0.47 | 0.58 | 0.52 | 0.53 | 0.51 | 0.55 | 0.55 | 2.29 | 2.25 | 2.24 |
| Pharmaceuticals and other medical non-durables | 1.07 | 1.46 | 1.55 | 1.41 | 1.36 | 1.36 | 1.39 | 1.44 | 1.68 | 1.61 | 1.81 | 1.60 | 1.55 | 1.44 |
| Therapeutic appliances and other medical durables | 0.03 | 0.04 | 0.03 | 0.03 | 0.04 | 0.04 | 0.04 | 0.03 | 0.02 | 0.02 | 0.02 | 0.31 | 0.31 | 0.32 |
| Prevention and public health services | 0.33 | 0.36 | 0.37 | 0.27 | 0.34 | 0.31 | 0.46 | 0.36 | 0.38 | 0.37 | : | 0.25 | 0.25 | 0.24 |
| Health administration and health insurance | 0.31 | 0.26 | 0.22 | 0.32 | 0.29 | 0.09 | 0.08 | 0.11 | 0.11 | 0.09 | : | 0.42 | 0.41 | 0.47 |
| **Composition of public current expenditure as % of GDP** | | | | | | | | | | | | | | |
| Inpatient curative and rehabilitative care | 2.23 | 1.87 | 1.98 | 1.82 | 1.80 | 1.89 | 2.04 | 2.31 | 1.87 | 1.95 | 1.89 | 2.73 | 2.61 | 2.62 |
| Day cases curative and rehabilitative care | 0.00 | 0.09 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | : | 0.13 | 0.16 | 0.16 | 0.18 |
| Out-patient curative and rehabilitative care | 0.41 | 0.34 | 0.36 | 0.31 | 0.36 | 0.44 | 0.37 | 0.34 | 0.32 | 0.35 | : | 1.74 | 1.71 | 1.80 |
| Pharmaceuticals and other medical non-durables | 0.45 | 0.46 | 0.74 | 0.58 | 0.63 | 0.61 | 0.47 | 0.58 | 0.79 | 0.79 | 1.01 | 0.79 | 1.07 | 0.96 |
| Therapeutic appliances and other medical durables | 0.01 | 0.01 | 0.02 | 0.02 | 0.02 | 0.01 | 0.01 | 0.01 | 0.01 | 0.01 | 0.01 | 0.13 | 0.12 | 0.13 |
| Prevention and public health services | 0.33 | 0.31 | 0.34 | 0.26 | 0.33 | 0.31 | 0.45 | 0.36 | 0.38 | 0.37 | : | 0.25 | 0.20 | 0.19 |
| Health administration and health insurance | 0.28 | 0.24 | 0.19 | 0.32 | 0.33 | 0.14 | 0.10 | 0.11 | 0.11 | 0.09 | : | 0.11 | 0.27 | 0.27 |

***Sources:*** EUROSTAT, OECD and WHO

Table 1.23.2: **Statistical Annex - continued – Romania**

| | | | | | | | | | | | | EU- latest national data | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Composition of total as % of total current health expenditure** | **2003** | **2004** | **2005** | **2006** | **2007** | **2008** | **2009** | **2010** | **2011** | **2012** | **2013** | **2009** | **2011** | **2013** |
| Inpatient curative and rehabilitative care | 43.7% | 36.3% | 36.8% | 37.1% | 35.8% | 36.6% | 37.4% | 40.4% | 34.3% | 36.3% | 37.3% | 31.8% | 31.3% | 31.1% |
| Day cases curative and rehabilitative care | 0.0% | 1.7% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | : | 2.5% | 1.8% | 1.9% | 1.9% |
| Out-patient curative and rehabilitative care | 9.8% | 9.6% | 9.1% | 8.3% | 9.1% | 11.0% | 9.3% | 9.1% | 9.3% | 10.1% | 10.7% | 23.3% | 23.5% | 23.2% |
| Pharmaceuticals and other medical non-durables | 20.5% | 26.9% | 28.2% | 28.0% | 26.5% | 25.8% | 24.9% | 24.7% | 30.5% | 29.5% | 35.1% | 16.3% | 16.2% | 14.9% |
| Therapeutic appliances and other medical durables | 0.6% | 0.7% | 0.5% | 0.6% | 0.8% | 0.8% | 0.7% | 0.5% | 0.4% | 0.4% | 0.4% | 3.2% | 3.3% | 3.3% |
| Prevention and public health services | 6.3% | 6.6% | 6.7% | 5.4% | 6.6% | 5.9% | 8.2% | 6.2% | 6.9% | 6.8% | : | 2.6% | 2.6% | 2.5% |
| Health administration and health insurance | 5.9% | 4.8% | 4.0% | 6.3% | 5.6% | 1.7% | 1.4% | 1.9% | 2.0% | 1.6% | : | 4.2% | 4.3% | 4.9% |
| **Composition of public as % of public current health expenditure** | | | | | | | | | | | | | | |
| Inpatient curative and rehabilitative care | 50.6% | 46.4% | 44.9% | 45.4% | 42.9% | 44.1% | 46.4% | 49.7% | 43.1% | 44.7% | 46.3% | 34.6% | 34.1% | 34.0% |
| Day cases curative and rehabilitative care | 0.0% | 2.2% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | : | 3.2% | 2.0% | 2.1% | 2.3% |
| Out-patient curative and rehabilitative care | 9.3% | 8.4% | 8.2% | 7.7% | 8.6% | 10.3% | 8.4% | 7.3% | 7.4% | 8.0% | : | 22.0% | 22.3% | 23.4% |
| Pharmaceuticals and other medical non-durables | 10.2% | 11.4% | 16.8% | 14.5% | 15.0% | 14.2% | 10.7% | 12.5% | 18.2% | 18.1% | 24.8% | 10.0% | 13.9% | 12.5% |
| Therapeutic appliances and other medical durables | 0.2% | 0.2% | 0.5% | 0.5% | 0.5% | 0.2% | 0.2% | 0.2% | 0.2% | 0.2% | 0.2% | 1.6% | 1.6% | 1.6% |
| Prevention and public health services | 7.5% | 7.7% | 7.7% | 6.5% | 7.9% | 7.2% | 10.2% | 7.7% | 8.8% | 8.5% | : | 3.2% | 2.7% | 2.5% |
| Health administration and health insurance | 6.3% | 5.9% | 4.2% | 8.0% | 7.8% | 3.4% | 2.2% | 2.4% | 2.4% | 2.1% | : | 1.4% | 3.5% | 3.5% |

| | | | | | | | | | | | | EU- latest national data | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Expenditure drivers (technology, life style)** | **2003** | **2004** | **2005** | **2006** | **2007** | **2008** | **2009** | **2010** | **2011** | **2012** | **2013** | **2009** | **2011** | **2013** |
| MRI units per 100 000 inhabitants | : | : | : | : | 0.11 | 0.13 | 0.19 | 0.24 | 0.31 | : | 0.44 | 1.0 | 1.1 | 1.0 |
| Angiography units per 100 000 inhabitants | : | : | : | : | 0.1 | 0.2 | 0.2 | 0.2 | 0.2 | : | 0.3 | 0.9 | 0.9 | 0.8 |
| CTS per 100 000 inhabitants | : | : | : | : | 0.3 | 0.4 | 0.5 | 0.6 | 0.7 | : | 1.0 | 1.8 | 1.7 | 1.6 |
| PET scanners per 100 000 inhabitants | : | : | : | : | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | : | 0.0 | 0.1 | 0.1 | 0.1 |
| Proportion of the population that is obese | : | : | : | : | : | 7.9 | : | : | : | : | : | 14.9 | 15.4 | 15.5 |
| Proportion of the population that is a regular smoker | 21.4 | : | : | : | : | 20.5 | : | : | : | : | : | 23.2 | 22.4 | 22.0 |
| Alcohol consumption litres per capita | 8.8 | 9.8 | 7.7 | 8.5 | 10.6 | 11.9 | 10.4 | 9.0 | 9.1 | : | : | 10.3 | 10.0 | 9.8 |

| **Providers** | **2003** | **2004** | **2005** | **2006** | **2007** | **2008** | **2009** | **2010** | **2011** | **2012** | **2013** | **2009** | **2011** | **2013** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Practising physicians per 100 000 inhabitants | 199 | 208 | 217 | 216 | 212 | 221 | 226 | 237 | 239 | 261 | 264 | 329 | 335 | 344 |
| Practising nurses per 100 000 inhabitants | 528 | 535 | 548 | 563 | 566 | 555 | 569 | 526 | 534 | 580 | 601 | 840 | 812 | 837 |
| General practitioners per 100 000 inhabitants | : | 56 | 67 | 82 | 123 | 128 | 83 | 68 | 68 | 69 | 64 | : | 78 | 78.3 |
| Acute hospital beds per 100 000 inhabitants | 452 | 443 | 456 | 456 | 448 | 450 | 462 | 433 | 413 | 442 | 450 | 373 | 360 | 356 |

| **Outputs** | **2003** | **2004** | **2005** | **2006** | **2007** | **2008** | **2009** | **2010** | **2011** | **2012** | **2013** | **2009** | **2011** | **2013** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Doctors consultations per capita | 5.6 | 4.5 | 4.8 | 5.0 | 4.9 | 5.1 | 5.2 | 5.0 | 4.8 | 4.9 | 4.8 | 6.3 | 6.2 | 6.2 |
| Hospital inpatient discharges per 100 inhabitants | : | : | : | : | 21.3 | 22.5 | 24.5 | 23.3 | 21.4 | 21.8 | 22.0 | 16.6 | 16.4 | 16.5 |
| Day cases discharges per 100 000 inhabitants | : | : | : | : | : | : | 4,333 | 5,205 | 5,569 | 6,819 | 8,399 | 6368 | 6530 | 7031 |
| Acute care bed occupancy rates | : | : | : | : | : | : | 73.1 | : | : | : | : | 72.0 | 73.1 | 70.2 |
| Hospital curative average length of stay | : | : | : | : | : | : | 6.6 | 6.5 | 6.5 | 6.5 | 6.3 | 6.5 | 6.3 | 6.3 |
| Day cases as % of all hospital discharges | : | : | : | : | : | : | 15.0 | 18.3 | 20.6 | 23.8 | 27.6 | 27.8 | 28.7 | 30.4 |

**Population and Expenditure projections**

| **Projected public expenditure on healthcare as % of GDP*** | **2013** | **2020** | **2030** | **2040** | **2050** | **2060** | **Change 2013 - 2060** | **EU Change 2013 - 2060** |
|---|---|---|---|---|---|---|---|---|
| AWG reference scenario | 3.8 | 4.1 | 4.3 | 4.6 | 4.7 | 4.8 | 1.0 | 0.9 |
| AWG risk scenario | 3.8 | 4.3 | 4.8 | 5.2 | 5.4 | 5.5 | 1.7 | 1.6 |

Note: *Excluding expenditure on medical long-term care component.

| **Population projections** | **2013** | **2020** | **2030** | **2040** | **2050** | **2060** | **Change 2013 - 2060, in %** | **EU - Change 2013 - 2060, in %** |
|---|---|---|---|---|---|---|---|---|
| Population projections until 2060 (millions) | 20.0 | 19.7 | 19.0 | 18.4 | 17.9 | 17.4 | -12.9 | 3.1 |

***Sources:*** EUROSTAT, OECD and WHO

# Romania

Long-term care systems

# 2.23. ROMANIA

## General context: Expenditure, fiscal sustainability and demographic trends

GDP per capita in PPS is at 12,700 and far below the EU average of 27,900 in 2013. Romania has a population of 20 million inhabitants. During the coming decennia the population will steadily decrease, from 20.1 million inhabitants in 2013 to 17.4 million inhabitants in 2060. Thus, in Romania the population is expected to decrease by 13%, while it is expected to increase at the EU level by 3%.

### *Health status*

Life expectancy at birth for both women and men is respectively 78.7 years and 71.6 years in 2013 and is below the EU average for women and above the EU average for men (83.3 and 77.8 years respectively). Healthy life years at birth are, with 57.9 years (women) and 58.6 years (men), far below the EU-averages (61.5 and 61.4, respectively). The percentage of the Romanian population having a long-standing illness or health problem is considerably lower than in the Union (19.5% in Romania versus 32.5% in the EU). The percentage of the population indicating a self-perceived severe limitation in daily activities stands at 8.3%, which is lower than the EU-average (8.7%).

### *Dependency trends*

The number of people depending on others to carry out activities of daily living is projected to increase over the coming 50 years. From 1.5 million residents living with strong limitations due to health problems in 2013, an increase of 36% is envisaged until 2060, to slightly more than 2 million. That is a less steep increase than in the EU as a whole (40%). However, due to the population decline, when measured as a share of the population, the dependents are becoming a bigger group, from 7.7% to 12%, an increase of 56%. This is more than the EU-average increase of 36%.

### *Expenditure projections and fiscal sustainability*

With the demographic changes, the projected public expenditure on long-term care as a percentage of GDP is steadily increasing. In the "AWG reference scenario", public long-term expenditure is driven by the combination of changes in the population structure and by a moderately positive evolution of the health (non-disability) status. The joint impact of those factors is a projected increase in spending of about 0.9 pps of GDP by 2060 ([432]). The "AWG risk scenario", which in comparison to the "AWG reference scenario" captures the impact of additional cost drivers to demography and health status, i.e. the possible effect of a cost and coverage convergence, projects an increase in spending of 3.2 pps of GDP by 2060. This reflects the fact that coverage and unit costs of care are comparatively low in Romania, and may experience an upward trend in future, driven by demand side factors.

Sustainability risks appear for Romania over the long run. These risks derive primarily from the unfavourable initial budgetary position, compounded by age-related public spending, notably for healthcare and long-term care ([433]).

## System Characteristics

There is no explicit and separate long-term care insurance scheme in Romania. Long-term care is fragmented and governed by several laws relating to healthcare, social assistance, pensions and rehabilitation. In most cases, families take care of elderly and dependent people. Medical long-term care needs are covered mostly in the formal health care sector.

Most formal long-term care responsibilities are assumed by local authorities. Financing is provided via central and local resources. NGOs play an important role in the delivery of services. At the central level, financing is shared by the state budget and the National Health Insurance Fund (NHIF), with the latter providing resources for medical services. As from the second half of 2015, Romania has eliminated the restriction of social services to be provided by the profit-making companies. Consequently, the potential of the private social service suppliers, related to the long term care of dependent elderly, is likely to increase. Out-of-pocket-payments complement public resources; their level is set by the local authorities

([432]) The 2015 Ageing Report: http://europa.eu/epc/pdf/ageing_report_2015_en.pdf.
([433]) Fiscal Sustainability Report 2015: http://ec.europa.eu/economy_finance/publications/eeip/pdf/ip018_en.pdf.

Depending on the nature of the benefit provided, financing is ensured from the public pension budget (pensions- only disability pensions), the NHIF (medical services), local budgets (home attendance), and the funds allocated from the state budget to the Ministry of Labour, Family, Social Protection and Aged Persons (MLFSPAP) (indemnities and allowances).

Public spending on long-term care was at the level of 0.7% of GDP in 2013, much below EU average of 1.6% of GDP. Virtually 100% of this expenditure was spent on in-kind benefits (EU: 80%), while close to zero spending was provided via cash-benefits (EU: 20%). Thus, Romania does basically not use cash benefits.

In the EU, 53% of dependents are receiving formal in-kind LTC services or cash-benefits for long-term care. This share is, with 55%, higher in Romania. Overall, 4.3% of the population (aged 15+) receive formal long-term care in-kind and/or cash benefits (EU: 4.2%).

The expenditure for institutional (in-kind) services makes up only 12% of public in-kind expenditure (EU: 61%). Thus, relative to other Member States, Romania has a very low focus on institutional care, which is basically reflecting the low coverage with formal institutional care benefits. However, lots of long-term care spending may not be accounted for as such, as it will be provided in acute care settings, thus being effectively registered as health care expenditure. In this case, there is need to shift long-term care patients out of acute care to long-term care service providers.

### *Types of care*

According to Law 17/2000, which regulates the social care for elderly persons, long-term care for this category provides three types of community services: temporary or permanent home attendance; temporary or permanent attendance in a residential centre; attendance in daily centres. Home attendance implies the provision of: household services (prevention of social marginalisation and supporting social reintegration, legal and administrative counselling, payment of certain household obligations, catering, etc.); socio-medical services (personal hygiene, socio-cultural activities, etc.); medical services (medical consultations, medicine administration, etc.).

According to the Social Assistance Law no. 292/2011, any dependent person is entitled to personal care services, provided according to his/her individual need of aid to accomplish the daily activities, to his/her family according to the socio-economic situation and to his/her personal life environment. Long-term care represents the personal care lasting more than 60 days. The beneficiaries of personal care are the elderly, the disabled and those suffering from chronic disease. Personal care services can be also organised and provided in an integrated form, together with medical care, rehabilitation and environment adaptation or other recovery services.

The home care services are presently financed from the National Health Insurance Fund, while the expenditures incurred with the social services of personal care are ensured from the local or central budget (in the forms of indemnification/payment of salaries for professional formal care givers and/or finance/subsidies for the services rendered by authorised providers), as well as from the contributions made by the beneficiaries.

The long-term care of disabled persons is coordinated by the National Authority for the Protection of Persons with Disabilities, coordinated by the Ministry of Labour, Family, Social Protection and Aged Persons (MLFSPAP). Disabled persons are entitled to cash benefits (monthly disability indemnity, additional monthly personal budget, allowances and other indemnities and facilities) and in-kind services of social and medical nature. Two types of services are provided: primary, aimed at preventing the social exclusion, and specialised, to ameliorate the individual's physical and psychical capacities. Concretely, the services provided to disabled persons are the same as those delivered to aged people.

There are no cash benefits for the informal care of elderly people, but only for persons who are officially recognised as having a disability. However, older persons who are chronically or terminally ill or have multiple comorbidities may be assessed as presenting a degree of disability. In

this way, they can benefit from care allowances usually granted to a member of their family. The personal care involving aid for accomplishing the daily instrumental activities is provided by formal caregivers, only if no informal or volunteer caregivers are available.

### *Eligibility criteria and user choices: dependency, care needs, income*

Benefits and services for the persons with disability are granted on the basis of a certificate attesting the disability, as follows: cash benefits and social services granted in home or in residential/day care centres. The person with a severe disability, according to its nature and to the specific care needs can be assisted at home by a family member or another person employed as a personal assistant. The recipient of care can also choose to receive a monthly indemnity.

Local budgets can grant allowances to the spouse or a relative who takes care of a dependent older person, but this is subject to local initiative. If the carer is salaried and working part-time, he can apply for support equal to the remainder of the salary - equivalent of a gross monthly salary of a newly qualified social assistant with an intermediate level of training. In all cases, the allowance is granted on the basis of a means-tested assessment.

### *Prevention and rehabilitation measures*

The Strategy for Social Inclusion of Persons with Disabilities 2014-2020 is under development, continuing and developing the approach initiated by the National Strategy for protection, integration and social inclusion of people with disabilities in the period 2006 – 2013.

The Strategy is related to the principles and obligations arising from the ratification of the UN Convention on the Rights of Persons with Disabilities. The UN Convention provides a framework for developing public policy and for the modernisation of practices, tools and methods to support the community, leading to a barrier-free participation of persons with disabilities in society, to a dignified and fulfilled life in the community.

The Strategy for Social Inclusion of Persons with Disabilities 2014-2020 will be divided into nine main areas of reference: 1. accessibility; 2. participation; 3. equality; 4. quality community based services; 5. employment; 6. education and training; 7. social protection; 8. health; 9 international cooperation.

There is a medium-term (2016-2018) operational action plan underway to be legislated, in order to fulfil the objectives established by the National Strategy for Promoting the Active Ageing and the Protection of Elderly 2015-2020 and by the Strategic Action Plan 2015-2020. This project stipulates, among others, the establishment within the Ministry of Labour of a long-term care Directorate, responsible for the coordination, planning and settlement of all the LTC issues and for the joint development (together with the Ministry of Health) of a "Long-term Care Program", which is meant to integrate all the benefits and services afferent to LTC, under a unified system.

### *Formal/informal caregiving*

Most of dependent elderly people benefit from the care services provided inside the family.

## Recently legislated and/or planned policy reforms

The National Health Strategy 2014-2020 outlines a specific objective on increasing access to quality services for rehabilitation, palliative and long-term care adapted to the demographic ageing phenomenon and epidemiological profile of morbidity:

13. Development of a National Plan for medium and long term on rehabilitation services, palliative care and long-term including a

- review of the regulatory framework regarding the organisation, financing and delivery of long term;
- hospital network reorganisation of chronic diseases and medical and social assistance; Classification of providing long-term care according to levels and types of care, with continued reduction for acute beds at more than 4.5 per 1,000 population in 2020; diversification of funding sources, including

accessing funds repayable grants or by supporting private investment in the construction and equipping of facilities providing long-term care.

14. The implementation of the National Plan on rehabilitation services, palliative and long-term care:

- identification, reorganisation and rehabilitation of infrastructure at county / regional / national hospitals for chronic diseases, rehabilitation centres according to demographic and morbidity profile;
- increasing access to programs of continued medical education and training diversified and focused on development needs and the needs of patients served;
- development and implementation of standards of organisation and operation, practice guidelines and procedures "therapeutic pathway;
- developing mechanisms, standards or institutional work procedures that ensure an integrated and effective response on the rehabilitation of adults and children with disabilities.

### Challenges

Romania has a relatively fragmented system of long-term care, with low coverage and a large provision of informal care that is privately financed. The main challenges of the system appear to be:

- **Improving the governance framework**: to establish a coherent and integrated legal and governance framework for a clear delineation of responsibilities of state authorities concerning the provision of long-term care services; to set the public and private financing mix and organise formal workforce supply to face the growing number of dependents, and provide a strategy to deliver high-performing long-term care services to face the growing demand for LTC services, such opening the market for private providers of care services; to strategically integrate medical and social services via such a legal framework; to define a comprehensive approach covering both policies for informal (family and friends) carers, and policies on the formal provision of LTC services and its financing; to establish good information platforms for LTC users and providers; to set guidelines to steer decision-making at local level or by practising providers; to use care planning processes, based on individualised need assessments, involving health and care providers and linking need assessment to resource allocation; to share data within government administrations to facilitate the management of potential interactions between LTC financing, targeted personal-income tax measures and transfers (e.g. pensions), and existing social-assistance or housing subsidy programmes; to deal with cost-shifting incentives across health and care.
- **Improving financing arrangements:** to face the increased LTC costs in the future e.g. by tax-broadening, which means financing beyond revenues earned by the working-age population; To foster pre-funding elements, which implies setting aside some funds to pay for future obligations; To explore the potential of private LTC insurance as a supplementary financing tool.
- **Providing adequate levels of care to those in need of care:** To adapt and improve LTC coverage schemes, setting the need-level triggering entitlement to coverage; the depth of coverage, that is, setting the extent of user cost-sharing on LTC benefits; and the scope of coverage, that is, setting the types of services included into the coverage as stipulated in the actual legislation. To provide targeted benefits to those with highest LTC needs; to reduce the risk of impoverishment of recipients and informal carers
- **Ensuring availability of formal carers:** To determine current and future needs for qualified human resources and facilities for long-term care; to improve recruitment efforts, including through the migration of LTC workers and the extension of recruitment pools of workers.

- **Supporting family carers:** to establish policies for supporting informal carers, such as through flexible working conditions, respite care, carer's allowances replacing lost wages or covering expenses incurred due to caring, cash benefits paid to the care recipients, while ensuring that incentives for employment of carers are not diminished and women are not encouraged to withdraw from the labour market for caring reasons.

- **Ensuring coordination and continuity of care:** To establish better coordination of care pathways and along the care continuum, such as through a single point of access to information, the allocation of care co-ordination responsibilities to providers or to care managers, via dedicated governance structures for care co-ordination and the integration of health and care to facilitate care co-ordination.

- **To facilitate appropriate utilisation across health and long-term care:** To create better rules, improving (and securing) safe care pathways and information delivered to chronically-ill people or circulated through the system; To steer LTC users towards appropriate settings.

- **Improving value for money:** to invest in assistive devices, which for example, facilitate self-care, patient centeredness, and co-ordination between health and care services; to invest in ICT as an important source of information, care management and coordination.

- **Prevention:** to promote healthy ageing and preventing physical and mental deterioration of people with chronic care; to employ prevention and health-promotion policies and to identify risk groups and detect morbidity patterns earlier.

Table 2.23.1: **Statistical Annex – Romania**

**GENERAL CONTEXT**

| **GDP and Population** | **2003** | **2004** | **2005** | **2006** | **2007** | **2008** | **2009** | **2010** | **2011** | **2012** | **2013** | **EU 2009** | **EU 2010** | **EU 2011** | **EU 2012** | **EU 2013** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| GDP, in billion euro, current prices | 53 | 61 | 80 | 98 | 125 | 142 | 120 | 127 | 133 | 134 | 144 | 9,289 | 9,545 | 9,800 | 9,835 | 9,934 |
| GDP per capita, PPS | 13.5 | 13.4 | 12.8 | 13.4 | 13.7 | 13.8 | 12.5 | 12.6 | 12.7 | 13.0 | 12.7 | 26.8 | 27.6 | 28.0 | 28.1 | 27.9 |
| Population, in millions | 21.6 | 21.5 | 21.4 | 21.3 | 21.1 | 20.6 | 20.4 | 20.3 | 20.2 | 20.1 | 20.0 | 502 | 503 | 504 | 506 | 507 |
| **Public expenditure on long-term care** | | | | | | | | | | | | | | | | |
| As % of GDP | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.7 | 0.8 | 0.8 | 0.7 | 0.6 | : | 1.0 | 1.0 | 1.0 | 1.0 | : |
| Per capita PPS | 34.5 | 38.2 | 40.8 | 48.1 | 56.3 | 79.0 | 88.0 | 92.4 | 87.2 | 84.2 | : | 297.1 | 316.7 | 328.5 | 317.8 | : |
| As % of total government expenditure | : | 1.5 | 1.5 | 1.5 | 1.4 | 1.7 | 1.9 | 1.9 | 1.8 | 1.7 | : | 2.1 | 2.2 | 2.2 | 2.1 | : |
| Note: Based on OECD, Eurostat - System of Health Accounts | | | | | | | | | | | | | | | | |
| **Health status** | | | | | | | | | | | | | | | | |
| Life expectancy at birth for females | 74.8 | 75.1 | 75.4 | 76.1 | 76.8 | 77.5 | 77.7 | 77.7 | 78.2 | 78.1 | 78.7 | 82.6 | 82.8 | 83.1 | 83.1 | 83.3 |
| Life expectancy at birth for males | 67.4 | 67.8 | 68.4 | 69.0 | 69.5 | 69.7 | 69.8 | 70.0 | 70.8 | 70.9 | 71.6 | 76.6 | 76.9 | 77.3 | 77.4 | 77.8 |
| Healthy life years at birth for females | : | : | : | : | 62.5 | 62.9 | 61.7 | 57.5 | 57.0 | 57.7 | 57.9 | : | 62.6 | 62.1 | 62.1 | 61.5 |
| Healthy life years at birth for males | : | : | : | : | 60.5 | 60.0 | 59.8 | 57.3 | 57.4 | 57.6 | 58.6 | : | 61.8 | 61.7 | 61.5 | 61.4 |
| People having a long-standing illness or health problem, in % of pop. | : | : | : | : | 19.5 | 19.2 | 19.5 | 19.7 | 20.8 | 19.8 | 19.7 | : | 31.4 | 31.8 | 31.5 | 32.5 |
| People having self-perceived severe limitations in daily activities (% of pop.) | : | : | : | : | 7.1 | 6.7 | 6.7 | 7.1 | 8.2 | 8.0 | 8.3 | : | 8.1 | 8.3 | 8.6 | 8.7 |

**SYSTEM CHARACTERISTICS**

| **Coverage (Based on data from Ageing Reports)** | **2003** | **2004** | **2005** | **2006** | **2007** | **2008** | **2009** | **2010** | **2011** | **2012** | **2013** | **EU 2009** | **EU 2010** | **EU 2011** | **EU 2012** | **EU 2013** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Number of people receiving care in an institution, in thousands | : | : | : | : | 86 | 97 | 108 | 119 | 121 | 122 | 189 | 3,433 | 3,771 | 3,851 | 3,931 | 4,183 |
| Number of people receiving care at home, in thousands | : | : | : | : | 120 | 142 | 164 | 186 | 189 | 192 | 204 | 6,442 | 7,296 | 7,444 | 7,569 | 6,700 |
| % of pop. receiving formal LTC in-kind | : | : | : | : | 1.0 | 1.2 | 1.3 | 1.5 | 1.5 | 1.6 | 2.0 | 2.0 | 2.2 | 2.2 | 2.3 | 2.1 |
| Note: Break in series in 2010 and 2013 due to methodological changes in estimating number of care recipients | | | | | | | | | | | | | | | | |
| **Providers** | | | | | | | | | | | | | | | | |
| Number of informal carers, in thousands | : | : | : | : | : | : | : | : | : | : | : | : | : | : | : | : |
| Number of formal carers, in thousands | : | : | : | : | : | : | : | : | : | : | : | : | : | : | : | : |

***Source:*** EUROSTAT, OECD and WHO

Table 2.23.2: **Statistical Annex - continued – Romania**

**PROJECTIONS**

| Population | 2013 | 2020 | 2030 | 2040 | 2050 | 2060 | MS Change 2013-2060 | EU Change 2013-2060 |
|---|---|---|---|---|---|---|---|---|
| Population projection in millions | 20.0 | 19.7 | 19.0 | 18.4 | 17.9 | 17.4 | -13% | 3% |
| **Dependency** | | | | | | | | |
| Number of dependents in millions | 1.53 | 1.62 | 1.77 | 1.90 | 2.00 | 2.08 | 36% | 40% |
| Share of dependents, in % | 7.7 | 8.2 | 9.3 | 10.3 | 11.1 | 12.0 | 56% | 36% |
| **Projected public expenditure on LTC as % of GDP** | | | | | | | | |
| AWG reference scenario | 0.7 | 0.8 | 1.0 | 1.2 | 1.4 | 1.6 | 124% | 40% |
| AWG risk scenario | 0.7 | 0.9 | 1.1 | 1.7 | 2.4 | 3.9 | 465% | 149% |
| | | | | | | | | |
| **Coverage** | | | | | | | | |
| Number of people receiving care in an institution | 188,846 | 203,088 | 217,519 | 243,638 | 261,342 | 287,329 | 52% | 79% |
| Number of people receiving care at home | 204,489 | 222,667 | 244,389 | 280,163 | 306,177 | 342,537 | 68% | 78% |
| Number of people receiving cash benefits | 459,602 | 491,451 | 523,717 | 575,315 | 616,482 | 669,935 | 46% | 68% |
| % of pop. receiving formal LTC in-kind and/or cash benefits | 4.3 | 4.7 | 5.2 | 6.0 | 6.6 | 7.5 | 75% | 68% |
| % of dependents receiving formal LTC in-kind and/or cash benefits | 55.7 | 56.6 | 55.7 | 57.9 | 59.3 | 62.5 | 12% | 23% |
| **Composition of public expenditure and unit costs** | | | | | | | | |
| Public spending on formal LTC in-kind ( % of tot. publ. spending LTC) | 98.8 | 98.7 | 98.8 | 98.9 | 98.9 | 98.9 | 0% | 1% |
| Public spending on LTC related cash benefits ( % of tot. publ. spending LTC) | 1.2 | 1.3 | 1.2 | 1.1 | 1.1 | 1.1 | -16% | -5% |
| Public spending on institutional care ( % of tot. publ. spending LTC) | 11.8 | 11.5 | 11.1 | 10.5 | 10.2 | 9.8 | -17% | 1% |
| Public spending on home care ( % of tot. publ. spending LTC in-kind) | 88.2 | 88.5 | 88.9 | 89.5 | 89.8 | 90.2 | 2% | -1% |
| Unit costs of institutional care per recipient, as % of GDP per capita | 8.6 | 9.0 | 9.2 | 9.3 | 9.4 | 9.1 | 6% | -2% |
| Unit costs of home care per recipient, as % of GDP per capita | 59.2 | 63.3 | 65.4 | 68.8 | 70.8 | 70.7 | 19% | -3% |
| Unit costs of cash benefits per recipient, as % of GDP per capita | 0.4 | 0.4 | 0.4 | 0.4 | 0.4 | 0.4 | 13% | -2% |

***Source:*** Based on the European Commission (DG ECFIN)-EPC (AWG), "The 2015 Ageing Report – Economic and budgetary projections for the 28 EU Member States (2013-2060)".